Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard West a prisoner at HMP Winchester on 10 December 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Richard West died on 10 December of a heart attack while a prisoner at HMP Winchester. Mr West was 74 years old. I offer my condolences to Mr West's family and friends.

Mr West had a number of serious conditions and required an intensive personal nursing regime which the prison's healthcare team delivered. Unfortunately, there were also significant gaps in his care and the report makes a number of recommendations for the prison to address.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. Mr Richard West was sentenced on 24 June 2016 to five and half years' imprisonment for sexual offences and sent straight to HMP Winchester. He had a number of serious conditions, including diabetes and high blood pressure. He was held in the prison's healthcare centre from the time he arrived.

2. When Mr West arrived at Winchester, a nurse and a doctor saw him and prescribed medication for his various conditions. But when his community GP records arrived, the system was not noted with 'codes' to flag up his various illnesses.

3. Mr West had four admissions to hospital before his final admission in December 2016. These were in July, August, September and October 2016. On the first occasion he was diagnosed with dehydration and diarrhoea, the second with a deep vein thrombosis (blood clot) and gastritis, the third with a urine infection and low blood glucose levels and the fourth with another urine infection and low blood pressure.

4. Before and between these admissions, Mr West's blood sugars varied significantly. Multiple attempts to conduct tests to help identify what had happened with his blood sugars were either not processed or the results not chased. Mr West also required intensive nursing. He was incontinent, had limited mobility and started to experience swelling in his limbs.

5. On 8 December, Mr West's arms had significantly swollen and a nurse found him unresponsive in his cell. Staff called paramedics and he was taken to hospital where he died on 10 December at 2.05pm.

Findings

6. The clinical reviewer found that much of the care Mr West received was reactive rather than planned, although he acknowledges the high degree of intensive, personal nursing Mr West required and which staff delivered.

7. The clinical reviewer noted that nobody considered the swelling Mr West experienced as being possibly related to heart failure and staff did not investigate the cause. Requests to run blood tests to monitor his blood sugar levels were either not sent or the results not chased up. Mr West's diabetic care did not conform to all of the NICE guidelines and his fluctuating blood pressure was not reviewed (neither was the fact that he suffered from hypertension flagged on his record). It is unclear what happened to a social care referral and there does not seem to be clear information sharing between the social care team and the prison's healthcare staff. We make the following recommendations:

Recommendations

- The Head of Healthcare should ensure that staff refer patients for review when they identify abnormal clinical observations.
- The Head of Healthcare should ensure that, where blood test results are not received, staff chase the laboratory and record that they have done so.
- The Head of Healthcare should ensure that a patient's diabetic care adheres to the NICE guidelines and the nine care processes and that results are actioned or reviewed.
- The Head of Healthcare should ensure that staff review patients exhibiting fluctuating blood pressure and their records clearly note that they have such a condition.
- The Head of Healthcare should ensure that social care referrals are made where it is appropriate to do so and a mechanism exists enabling the social care team to share information with healthcare staff.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr West's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr West's clinical care at the prison.

11. We informed HM Coroner for Hampshire Central of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The investigator contacted Mr West's son, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not raise any concerns.

13. Mr West's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Winchester

15. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 sentenced men nearing the end of their sentences, known as West Hill. Central and North West London NHS Foundation Trust provides health services at the prison. The prison's healthcare centre has 24-hour nursing cover and doctors from a local practice run surgeries from Monday to Friday

HM Inspectorate of Prisons

16. The most recent inspection of Winchester was in July 2016. Inspectors reported that at the time of inspection Winchester had been operating a restricted routine mainly due to problems with staffing levels and supervision. Health services had improved, but staff shortages had led to problems in managing chronic diseases and running nurse-led clinics.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB noted that there were good standards of clinical care. They stated the healthcare provider provided a seamless service across the prison. Prison budget constraints had affected some initiatives, including a walk-in clinic, an end-of-life suite and a day service area for older prisoners.

Previous deaths at HMP Winchester

18. Mr West is the seventh prisoner to die from natural causes at Winchester since December 2014. In a previous case, a prisoner's high blood pressure was also not followed up.

Key Events

19. Mr Richard West was sentenced on 24 June 2016, to five and half years' imprisonment for sexual offences. He was sent straight to HMP Winchester. It was his first time in prison. He had a history of various conditions including diabetes, high blood pressure, kidney disease, eye disease, pancreatitis, gallstones, thyroid issues, poor mobility, falls, hypoglycaemic collapse and depression.

20. On 24 June, a nurse did Mr West's initial health screen. He noted Mr West was an ex-smoker, teetotal and had no history of substance misuse. Mr West reported he used a self-propelled wheelchair and had a history of 3 falls. He said he had been admitted to hospital for a fall 4-6 weeks before his prison admission. Mr West used pads to deal with incontinence issues. The nurse recorded his blood pressure as high at 159/69 (120/80 is ideal) and noted he had diabetes and would need a doctor to review his care. The nurse did not document his height or weight. He felt Mr West was mentally well with no history of self-harm. Mr West's BMs (an immediate test for blood sugar – blood glucose monitoring) were recorded later that day and at 8:30am the following morning. Both results were high.

21. On 25 June, a prison GP reviewed Mr West. He noted he was not confused but could not give clear details about his medication. He took Mr West's blood pressure which was high. His BM was recorded as satisfactory. Staff checked with his family regarding his medication while the prison team waited for the community GP records. He noted that blood tests to monitor Mr West's diabetes were requested (HbA1C tests measure blood sugar control over the previous 3 months) and prescribed a number of medications for blood pressure, diabetes, depression and stomach acid. There is no subsequent record to suggest that the blood tests were done

22. A nurse reviewed Mr West on 26 June. She noted that he had a social care package while at home in the community, and was assisted everyday to shower and dress. She also noted he was doubly incontinent on a daily basis. She noted his skin was intact but he had poor personal hygiene and planned to advise social care that Mr West needed an assessment. (Although the healthcare team subsequently had discussions about Mr West's social care and the appropriate team agreed to see him there is no evidence that the formal referral was made.)

23. On 29 June, the prison received Mr West's community GP records but there is no evidence anyone reviewed these.

24. On 14 July a prison GP reviewed Mr West's care on account of his recent high blood sugars. He thought it was possibly due to a recent urine infection and planned for staff to monitor Mr West's blood sugars twice weekly for two weeks. If the high blood sugar reading persisted the plan was to contact him, otherwise he would review the readings in two weeks' time. Again, a blood test to check for cholesterol and the blood sugar level over the past 3 months (HbA1C) was requested.

25. On 15 July, the laboratory indicated in a note they had received an insufficient sample so they just reported on urea and electrolytes, liver function tests and cholesterol. They showed a low albumin level (a protein made by the liver). A low score could indicate a chronic liver, kidney or heart condition or poor nutrition. The results also showed a low GFR (Glomerular Filtration Rate) - indicating poor kidney function. A repeat sample was collected for HbA1C testing, but no results were received.

26. On 16 July, Mr West saw a prison GP as he had had a fall. The GP found Mr West to be confused - he was not certain Mr West had been taking on enough fluids and he noted the previous day's blood results and drop in kidney function. He decided Mr West should be admitted to hospital.

27. Mr West stayed in hospital until 23 July. Doctors diagnosed dehydration and overflow diarrhoea (caused by constipation) and possibly a urine infection. They also considered he was at high risk of a blood clot. His medication was changed: linagliptin (a diabetes medication) was stopped and movicol (for constipation) started.

28. Mr West seemed fairly stable after his discharge although on 29 July, a prison GP noted Mr West's blood sugars seemed 'all over the place' but did not make a plan to review them or make any changes. He noted that he was only in Winchester for that day.

29. Over the next few days, Mr West had a fall, grew progressively weaker and developed a very swollen left knee. On 5 August, he was admitted again to hospital and discharged on 12 August, treated for a deep vein thrombosis (DVT) and mild gastritis.

30. On 5 September, a nurse made another request to check for cholesterol and the blood sugar level over the past 3 months (HbA1C). Again, this request did not result in a reading being obtained.

31. On 17 September, a prison GP reviewed Mr West as he had a swollen left leg. He thought the swelling related to the recent DVT in the same leg.

32. On 28 September, Mr West's blood sugars throughout the day were normal, but at 8.40pm a nurse found Mr West lying in his own vomit. He went to hospital who discharged him the same day. Doctors diagnosed a urine infection and treated Mr West for low blood glucose levels.

33. On 2 October, a nurse noted some swelling around Mr West's wrists and arm and, in general, that he did not look well but was due a GP review.

34. At approximately 11.30am on 4 October, a prison GP reviewed Mr West. Mr West's blood sugars were falling throughout the day but he found Mr West to be alert, well hydrated, eating and no other issues. Later that day, he was struggling to eat and he deteriorated over the next couple of days.

35. On 6 October, Mr West was admitted to hospital until 14 October. Doctors diagnosed him with a urine infection and low blood pressure. The Head of Healthcare noted his discharge and that his blood sugar needed monitoring twice daily and if Mr West's blood sugar rose to over 15mmol the community diabetic

team should be contacted. The records do not reflect that this was done every day or that when levels rose above 15mmol that the community team were contacted (on 30 October they were 19.9mmol).

36. On 23 November, a nurse recorded that that she had a conversation with a diabetic nurse specialist, who advised her that Mr West should have a HbA1C blood test and to ensure his blood sugars were tested twice a day because he was no longer taking insulin. She made an entry in the wing diary for the blood test to be done the next day. On this occasion it was and the result was recorded on 29 November.

37. On 5 December, a nurse recorded that Mr West's blood sugar was very low, but it stabilised through the day after he was given quick release sugar tablets and had some food. Over the next couple of days, nurses noticed Mr West had swelling in all his limbs and his face but did not seem to be complaining about it.

38. On 8 December, nurses noted severe swelling and fluid leaking from Mr West's arms. The nurse manager spoke to a prison GP and advised him about the oedema. The GP said that he did not think Mr West needed a hospital referral at that time but could be reviewed by a prison doctor the next day. He asked her to arrange blood and urine tests.

39. At 10.50am, a nurse spoke to the Community Diabetes Team and explained Mr West's recent 'BMs and insulin' and that he might have to be admitted to hospital. She planned to speak to the team again the next day.

40. Some time before 6.17pm, a nurse found Mr West unresponsive in his cell. He examined him and as Mr West was having some difficulty breathing the nurse called an ambulance. Paramedics attended and took him to hospital. Staff did not apply restraints.

41. Hospital staff cared for him over the next two days. He was on a glucose drip and intravenous antibiotics. His condition deteriorated and he died at 2.05pm on 10 December 2016.

Contact with Mr West's family

42. On 9 December 2016, a prison manager contacted Mr West's son and told him Mr West was in hospital and likely to die. He agreed that Mr West's family could visit and they were with him when he died on 10 December.

43. Mr West's funeral was on 4 January 2017. The prison made a contribution to the funeral costs in line with national policy.

Support for prisoners and staff

44. After Mr West's death, a prison manager debriefed the staff involved in the bedwatch to ensure they had the opportunity to discuss any issues arising and to direct them to support, if required.

45. The prison posted notices informing other prisoners of Mr West's death, and offering support. The investigator spoke to a Supervising Officer in the Safer Custody department. She was unable to confirm if staff had reviewed all

prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr West's death. She said that this was something staff would always normally do, but in this instance she was unable to confirm because all the prisoners considered at risk at the time had since left the prison and their paperwork was not now easily accessible. We are content that it is likely the appropriate checks were made.

Post-mortem report

46. The coroner provided a copy of the post-mortem report which said the cause of death was ischaemic heart disease and diabetes mellitus.

Findings

Mr West's clinical care

47. The clinical reviewer felt that not all the care Mr West received at HMP Winchester was equivalent to that he could have expected to receive in the community. Although Mr West was a very sick man whose conditions demanded intensive personal nursing which staff delivered, much of his care was reactive rather than planned.

Heart Failure

48. Mr West primarily died from heart failure and the clinical reviewer feels that he had this terminal condition when he came to HMP Winchester. However, the prison did not diagnose it. The clinical reviewer concludes that the swelling Mr West experienced should have alerted the healthcare team to the possibility he had heart failure. There were multiple examples of this.

49. On 17 September, a prison GP saw Mr West as he had been complaining of a swollen leg. He concluded that the swelling related to the DVT Mr West had previously been diagnosed with. On 2 October, a nurse noticed swelling around his wrists and arm and he was reviewed by a GP two days later. The GP noted that all other observations were normal but did not comment on the swelling (although we cannot be certain it was still present at that time). From mid-November onwards staff recorded upper limb swelling with more frequency. On 19 November, a nurse recorded oedema in both arms, but did not ask for a review. And on 6 December, two other members of healthcare staff noted the same and did not ask for a review.

    The Head of Healthcare should ensure that staff refer patients for review when they identify abnormal clinical observations.

Diabetes

50. Mr West also had diabetes which contributed to his heart failure. The clinical reviewer is critical of how staff managed this condition. The standard care for diabetes in the community is set by NICE (National Institute for Clinical Effectiveness) and assessed against nine care processes which should be assessed and managed each year. The nine care processes include HbA1C blood tests, blood pressure, cholesterol, weight, kidney function, smoking reviews, foot examinations and eye screens. Although most of these processes did occur, the clinical reviewer feels that they were done in an uncoordinated way and results were not always actioned or reviewed.

51. Staff made numerous plans to carry out HbA1C blood tests which measure blood sugar control over the preceding 3 months. Tests were requested on 25 June, 14 July, 5 September and 23 November – but it was only the 23 November request which resulted in a test actually being carried out.

52. We asked the current acting Head of Healthcare why this was. He said that the GP had made a request on 25 June for the tests but that the nursing team did not

pick these up. A further test sent on 14 July was not carried out because the laboratory said there was an insufficient sample and the repeat test that was done the next day did not provide a result. He confirmed that healthcare staff did not chase this up. He said that Mr West had attended accident and emergency at around that time and these events may have taken precedence. (We remain unclear why this would have had such an impact.) He told us that, on 5 September, a blood sample was taken, but the hospital reported that it was 'lost/unusable' (it is not clear which) and again healthcare staff did not pick this up.

53. The clinical reviewer also notes that BMs offer a snapshot test of blood sugar control at that moment. Spikes and drops in the reading can indicate hyper or hypoglycaemia and other infections or acute health problems. Mr West's BMs varied widely. Staff did not put a plan in place to manage Mr West's BMs until after his third hospital discharge on 14 October, and the records do not show that they adhered to the twice daily testing regime the hospital recommended. Some days staff only noted one test result and on others none were noted at all.

The Head of Healthcare should ensure that, where blood test results are not received, staff chase the laboratory and record that they have done so.

The Head of healthcare should ensure that a patient's diabetic care adheres to the NICE guidelines and the nine care processes and that results are actioned or reviewed.

Fluctuating Blood Pressure

54. Mr West had a history of high blood pressure but it is not clear if the prison healthcare team knew this even though they had his community health records. They have not noted it on his prison medical record if they did know it and it is not clear that the community health records were actually reviewed at all.

55. We asked the Head of Healthcare about this and he said that community records are reviewed in the first instance by the admin team and then all 'read codes' are transferred to the system by the GP team. Read codes include whether a patient has a condition such as hypertension but they were not completed in this instance.

56. Staff took Mr West's blood pressure frequently. Given his health complications NICE guidelines suggest that a blood pressure reading of 130/80 would be an appropriate target. Mr West had a history of high blood pressure, but while in hospital in October 2016 was diagnosed with low blood pressure. The readings were sometimes significantly below 130/80. There is no evidence that it was clinically reviewed.

The Head of Healthcare should ensure that staff review patients exhibiting fluctuating blood pressure and that their records clearly note that they have such a condition.

Social Care

57. Mr West had significant care needs which required a lot of the healthcare team's time and attention. While a nurse discussed Mr West's needs with the social

care team, The Care Act stipulates that, where a prisoner meets the eligibility criteria for social care, local authorities are responsible for meeting those needs – where they do not the local authority should help to develop a support plan. Although it is documented that the social care team agreed to see Mr West once a consent to share information form was signed, there is nothing to suggest this form was completed or that he was reviewed.

58. We asked the Head of Healthcare about this. He was unable to comment as he said that the social care team use a different reporting system to the prison's healthcare system and he could not see if any interventions had occurred or not. We would expect that if there had been any contact between Mr West and the social care team that the prison's healthcare team would record it and be aware of it.

The Head of Healthcare should ensure that social care referrals are made where it is appropriate to do so and a mechanism exists enabling the social care team to share information with healthcare staff.

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