An investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Winchester, in January 2007

Report by the Prisons and Probation Ombudsman
for England and Wales

January 2008

This is an investigation into the circumstances surrounding the death of a man in January 2007. The man was serving a sentence at HMP Winchester when he collapsed during a management and prisoner representative meeting. Sadly, he died soon afterwards. The man was in his early 70s and had a history of heart disease.

I would like to extend my condolences to the man's family, and to all those touched by his death.

The investigation was undertaken by one of my Assistant Ombudsmen. We would like to thank the Governor of Winchester and his staff for their co-operation during the investigation.

I asked Mid-Hampshire Primary Care Trust to carry out a review into the clinical care that the man received whilst he was at Winchester. A panel of five clinical staff carried out this review. I am grateful to the PCT for their assistance.

I make five recommendations taken from the clinical review and two other recommendations of my own. At draft report stage the Prison Service accepted all of the recommendations.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

1. The man was born in the 1930s and was therefore already an elderly man when he was sentenced to 18 months in prison in September 2006. The man suffered from arthritis and heart disease and took several medications for his heart condition.

2. The man moved onto West Hill unit within HMP Winchester at the end of October after having spent a period in healthcare and on normal location. West Hill unit is a category C unit than is run independently from the main prison. It is a more relaxed environment than the main residential units. The man was described by both staff and prisoners in West Hill as 'a bit of a character' and as someone who would 'speak his mind' and 'call a spade a spade'. They also said that he would sometimes get wound up and angry about things. However, the man was a much liked man on the unit and he enjoyed doing art and drama in the education classes run on the wing.

3. The man was recategorised to category D on 8 November. This meant that he would have been able to transfer to an open prison (the minimum security category of prison; one without a high fence or walls and one where prisoners are often trusted to work in the community during the day). However, due to some medical appointments at local hospitals his transfer was put 'on hold'.

4. In early January, a Home Detention Curfew (HDC or 'tagging') board met to discuss whether the man was suitable to be released with a tag later that month. Because of negative reports from the home probation team, from the police and from the prison based probation officer, the Head of Residence did not grant the man early release. The information that was the main driver behind the decision not to grant HDC concerned two charges, one of which had been dropped altogether and the other of which had not yet come to trial. My report considers these facts in light of the other information available about the man and the Prison Service Order about HDC. Amongst other things, I asked the national policy unit with responsibility for Home Detention Curfew to look at the paperwork and they said that "the proper procedures were followed and the decision to refuse release was entirely appropriate". The man lodged an appeal against his HDC refusal, but that appeal had not been heard by the time of his death.

5. One morning in January 2007, the man represented his landing at a regularly held prisoner representative meeting. Several other prisoners from other landings were also there, as well as the governor of the unit and representatives from the kitchen, canteen and gym. The man complained about the food that was served and in particular about the poor quality of the potatoes. He became quite heated during his discussions with the Unit Governor and then collapsed onto the prisoner sitting next to him. Medical help was called immediately, but the man stopped breathing shortly after and the medical team of both

nurses and the doctor were unable to resuscitate him. A post mortem indicated that the man died of ischaemic heart disease due to coronary artery atherosclerosis (hardening of the arteries that supply the heart).

6. My investigation was hampered by not receiving any staff or prisoner statements from HMP Winchester. I make a recommendation about this matter.

7. The clinical review panel considered the response to the man's collapse to be appropriate and timely and that the outcome could not have been avoided. They make five recommendations, three of which relate to chronic disease management within the prison.

THE INVESTIGATION PROCESS

8. The investigation was opened in January 2007. On that date, my investigator wrote to the Governor of HMP Winchester and asked him to display notices to staff and prisoners about the Prisons and Probation Ombudsman's investigation into the death of the man. One prisoner came forward from these notices and asked to speak to my investigator. He subsequently moved prisons, but was interviewed there by another of my investigators.

9. A liaison officer was appointed by the Governor. I am grateful to him for his assistance during the investigation. The liaison officer arranged for the main prison records and the man's medical record to be sent to me. My investigator subsequently visited Winchester on 20 March 2007 and spoke to some of the staff and prisoners who had known the man. Unfortunately, the prison did not ask staff or prisoners to complete any witness statements at the time of the man's death. This only came to light during my investigator's visit. She asked the liaison officer to ensure the staff who were present at the prisoner representative meeting, or those from the medical team who tried to resuscitate the man, make a statement as soon as they could, recalling as much detail as they were able. These statements have not been forthcoming and are the subject of one of my recommendations.

10. The Clinical Governance Manager for Mid-Hampshire Primary Care Trust, was invited to arrange for a clinical review to be carried out into the medical care that the man had received during his time in custody. The clinical review was sent to my office at the end of June 2007.

11. The Coroner was informed of the Ombudsman's investigation. He kindly agreed to send me a copy of the post mortem report and the police witness statements that had been taken from two members of staff. I will send the Coroner a copy of this final report and hope that it will assist him with his enquiries.

12. The man's next of kin, his wife, was contacted by one of my family liaison officers. She asked that my office talk to a friend of her husband and said that he was acting on her behalf in matters concerning her husband's death. This gentleman did not wish to be visited, but did raise several questions and concerns about the man's death. I have addressed these questions in the family issues section of this report.

13. At draft stage the report was sent to both the man's family and the Prison Service for their comments. The Prison Service accepted all of the recommendations made in this report and I have included their comments in the recommendations section.

HMP WINCHESTER

14. Winchester prison is located just outside the main city centre. Most of the prison is of a Victorian radial design and has a maximum capacity of 697.

15. West Hill is a category C unit within the category B prison. Prisoners are more trusted and are given keys to their own rooms (these can be overridden by staff keys). It acts as a resettlement unit and offers various work programmes. West Hill is not integrated with the rest of the prison in that it has its own distinct staff group and its own visits area. West Hill sometimes transfers prisoners on to open establishments such as Ford and Standford Hill. The unit can accommodate 127 prisoners in total, 87 within the main unit and 40 in an adjacent building called 'The Hearn'. The Hearn takes those prisoners who are the most trusted, those likely to get release on licence and those who work outside the prison. The main unit comprises a mixture of single and double cells. The man was in a double cell on the landing called 'Alfred 1'.

16. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, last inspected Winchester in December 2004. Ms Owers published her report in February 2005 and commented that:

> "Resettlement continued to be a very strong area of work. A specialist resettlement team provided a range of services; and now had the benefit of a separate resettlement unit in the annex at West Hill. However, this was not supported by a strong personal officer scheme among residential staff, and we remained unconvinced that there were effective partners in this enterprise."

17. In relation to catering, Ms Owers said, "the standard of food was acceptable and we received no complaints about it". However, she made a recommendation about the completion of regular food surveys and suggested the results could inform the menu choices offered.

18. The Independent Monitoring Board at Winchester published their Annual Report for 2005 – 2006 in January 2007. They said of the West Hill unit:

> "This reporting period has been difficult for West Hill and the Hearn Unit. To many it was perceived to be a resettlement establishment, one where many, if not all prisoners from the Hearn would be working in the community after Release on Temporary Licence. Alas this has not been the case. Too few applications have been successful. West Hill is perceived by staff and prisoners alike as an extension of the main prison, a cat C overflow."

19. The IMB went on to comment that the personal officer scheme in West Hill “seems to be working well”. Although the prisoner representative meetings were not always held regularly, “they are well run with the prisoners participating fully”.

KEY FINDINGS

20. The man was sentenced to 18 months imprisonment at Winchester Crown Court on 8 September 2006 for cultivating cannabis plants and conspiracy to supply a class C drug. He was one of four defendants in the case. The Prisoner Escort Record (PER) form which is completed by the contracted company responsible for taking the man from court to Winchester shows him arriving at the prison at 5.46pm.

21. The nationally used form 'First Reception Health Screen' was completed by a Heath Care Officer (HCO) in reception. The man said that he had been in Winchester before during February and March 2006. He said he was taking several prescribed medications. It was noted that he was allergic to penicillin. The man indicated he had concerns about his physical health due to his replacement ankle joint, angina and a double heart by-pass. The HCO noted that the man was walking on crutches, was breathless and had arthritis. The screening form goes on to indicate that there were no mental health concerns about the man and that he had never seen a psychiatrist nor tried to harm himself. The HCO decided to admit the man to the healthcare centre and to refer him to the doctor because of his physical health problems. The Cell Sharing Risk Assessment, a form used to help identify those prisoners who may not be suitable for sharing a cell with another, indicates that the man was regarded as a 'low risk' to others and could therefore share a cell. A decision was made to accommodate him in the healthcare centre initially. The officer completing the form incorrectly recorded his current offence as "firearms".

22. After going through the reception process, the man was put into one of the cells in the healthcare centre. The first entry in his medical record was that the man had been given Nicorandil and Co-proxamol. He was told that he might not be able to continue with this latter medication as it was being discontinued. The man apparently replied that it was the only painkiller you could take with 'ulcers'. The nurse informed him that this was not the case and noted that he was mobile with his crutches. The following day, the man was told that he would not be prescribed Co-proxamol, but could take Paracetamol instead. Over the next few days, staff noted that the man seemed settled and that he was compliant with his prescribed medication.

23. A 'Secondary Health Assessment' form was completed on the man, giving his height and weight and noting that there was a history of heart disease in his family. His blood pressure was recorded as 149/90 and his pulse 75. Unfortunately, the form is poorly designed and does not have a place to record the name or signature of the person completing it, nor somewhere to record the date of its completion. It is not therefore clear when this form was filled in.

24. The man was seen by the doctor on Monday 11 September. The Co-proxamol was replaced with Paracetamol.

25. On 21 September, the man was deemed suitable to go onto normal location within the prison. The medical advice was for him to be located “on the flat” (that is, on the ground floor) and a Discharge Care Plan was written reflecting this. It was noted that the man had suffered no incidents of angina or breathlessness since being in the healthcare centre. The Discharge Care Plan indicated that “poor mobility, angina and breathlessness” were the problems and that the short term goal was for the man to know where to go to collect his medication. The longer term goal was to maintain his care within the main prison.

26. The man was due to have a hip block at a hospital in the area on 11 October 2006. The appointment was cancelled by the healthcare unit at the prison on 9 October. There appears to have been some confusion over its re-booking. The man’s wife sent a letter into the prison with an appointment for 1 November. A subsequent appointment given for 22 November may have been sent directly to the man at Winchester, and so this date also had to be rearranged. A provisional appointment date was set for 6 December and it was noted in his medical record that the man would need to have an x-ray first.

27. The man’s security category was assessed on 24 October and he was given a security category of C. This was due to the fact that his current offence involved drugs. He was consequently recommended for West Hill unit.

28. The man attended the local hospital on 27 October for an x-ray of his lower leg. The results of that x-ray indicated that he had internal fixation of his distal fibula and an ankle joint prosthesis. There were unfortunately no previous films for comparison purposes. On his return from the hospital, the man was moved onto West Hill unit and underwent their own induction programme.

29. The man raised a couple of issues during his induction on West Hill. The first was a rates bill that he asked for someone to look into for him. The second were his medical problems. He told the officer that he had heart trouble, arthritis and stomach ulcers. The officer noted that the man said he did not like anyone smoking near him and that he “can’t climb stairs very well”.

30. West Hill unit adopts a policy of issuing medication in possession. The man was prescribed several medications. He now held and took these himself:

    Lisinopril – is used to treat high blood pressure. Lisinopril is in a class of medications called angiotensin-converting enzyme (ACE) inhibitors. It works by decreasing certain chemicals that tighten the blood vessels, so blood flows more smoothly.

Omeprazole - Prescription omeprazole is used alone or with other medications to treat ulcers (sores in the lining of the stomach or small intestine), gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and injury of the oesophagus (tube that connects the mouth and stomach), and erosive oesophagitis (swelling and wearing away of the lining of the oesophagus). Omeprazole delayed-release capsules are also used to treat conditions in which the stomach produces too much acid. Omeprazole is in a class of medications called proton-pump inhibitors. It works by decreasing the amount of acid made in the stomach.

Nicorandil – used to treat angina. The pain of angina is caused by too little oxygen reaching the heart when its workload increases, such as during exercise. This is usually a result of hardening of the arteries (atherosclerosis) that supply blood to the heart. The condition is also known as coronary heart disease. Nicorandil decreases the workload of the heart and also improves its blood and therefore oxygen supply.

Simvastatin – Simvastatin is used together with lifestyle changes (diet, weight-loss, exercise) to reduce the amount of cholesterol (a fat-like substance) and certain other fatty substances in the blood. Simvastatin is in a class of medications called HMG-CoA reductase inhibitors (statins). It works by slowing the production of cholesterol in the body.

Clopidogrel – Clopidogrel is used to prevent strokes and heart attacks in patients at risk. Clopidogrel is in a class of medications called antiplatelet drugs. It works by helping to prevent harmful blood clots.

31. The man put in an application to do some work and to attend art and drama classes. It was felt that he was unfit for most types of work so he was allocated to the ‘stamps workshop’ and to start the education classes he requested. A unit Senior Officer (SO) described the man as the sort of man who acted as a spokesperson for the younger prisoners. He said that the man was pretty mobile and that, even though his cell was on the ground floor, he seemed to have no problem going up to the education area on the upper floor. The SO said that he had had to have a few conversations with the man about his attitude and that at times he was too quick to speak his mind and got ‘heated’. He recalled that the man received regular visits from his wife and daughter.

32. Because he was an old age pensioner, the man asked to be given the flu injection on 31 October 2006. This request was reviewed on 3 November and a note was made that they were awaiting dates for injections. His medical record indicates that the man received the flu injection on 23 November.

33. An early review of the man’s categorisation took place on 6 November. He was recommended for category D status based on the fact that he

had not come to the attention of staff and that he "complies with instructions". The recommendation was approved by the Head of Security on 8 November, who said that the man's "custodial behaviour had reduced his risk". An entry by a prison officer in the man's wing history sheet on 16 November indicated that he had no "burning problems or issues to raise" and that the man was welcoming his transfer to Ford open prison in the near future. A medical record entry on the same day indicated that the man was "happy to stay on medical hold to get seen at hospital". This meant that the man would not be transferred out of Winchester until his medical appointments and follow ups had been completed.

34. On 6 December, the man attended a foot and ankle clinic at the local hospital.

35. The man had a GP appointment on 14 December. There is a reference on his medical record that he had been on Clopidogrel since his admission in September and questions whether he should still be on it. The entry goes on to note that the man, "had a MI [myocardial infarction – heart attack] 15 years ago. Has a history of peptic ulcers therefore not on aspirin but is on clopidogrel." The GP indicated that there was a risk of bleeding from either aspirin or Clopidogrel. He said that the man understood this. The entry went on to say that the man would prefer to stay on Clopidogrel. His prescription for this drug therefore continued. This was the last time that the man was seen by a doctor prior to his death.

36. There are various entries in the man's wing history sheet during November and December which indicate that he was, at times, abusive towards staff and did not always follow the rules of the unit. He was given an Incentives and Earned Privileges (IEP) warning at the end of December. (IEP is a system that operates in all prisons and links rewards such as in cell television, the amount of private cash that can be spent in the canteen and visits entitlements to behaviour and attitude in the prison.)

37. Over the Christmas period, the man took part in the drama production on West Hill entitled *Always Look on the Bright S*ide. All of the prisoners my investigator spoke to said that the man thoroughly enjoyed the drama classes he attended.

38. On 7 January 2007, the man was given a second IEP warning for continuing non-compliance with the rules of West Hill and abusive outbursts. The SO, who gave the warning, indicated that the man would not be given a single cell until his behaviour improved and that his next "offence" would result in a move to the basic (lowest) level of entitlements.

39. The man's Home Detention Curfew (HDC) date was 25 January 2007. He was told he had been refused the 'tag' on 10 January. The reason given was that he was a 'potential threat to public safety'.

40. Before a decision is reached by a governor grade (operational manager) about whether a prisoner is to be released on HDC, the views of prison staff, prison probation, home area probation and the police are sought. Their views are taken into account and considered alongside information such as the number of previous convictions, outstanding charges and the risk predictor information for future offending risk.

41. The section of the paperwork detailing the views of prison staff included comments from both an officer and a wing SO from West Hill. They commented that the man did not have any adjudications against him. However, the man had not completed any offending behaviour courses as he did not feel that he had any drug or alcohol problems to address. The officer went on to say that the man's behaviour was generally good, but that he had a short fuse if he did not get his own way. The SO was stronger in his comments and said that the man had several incidents of not complying with unit rules, two Incentives and Earned Privileges (IEP) warnings and was argumentative. He expressed doubts about the man's ability to comply with any HDC conditions.

42. Hampshire Constabulary did not recommend the man's release on HDC. Their report indicated that there were several other matters where he was either found not guilty or charges were not brought against him. The report indicated that there was information that the man was fraudulently claiming benefits for a vulnerable adult that had been living at their address, but who had moved on over a year previously. The officer compiling the report felt that the man's sentence did not reflect the extent of the crime for which he was responsible.

43. The home probation report from the Hampshire Probation Area indicates they did not recommend release on HDC either. The basis for this was Crown Prosecution Service (CPS) papers that stated that the man had solicited an individual to murder a witness (in the case for which he was serving his current sentence) and that a police search of his property had found a sawn-off shotgun. The Probation Area acknowledged that the man had not been found guilty of these offences but felt that they gave sufficient grounds for recommending against early release on the grounds of public protection.

44. In light of the comments from the probation office and those from wing staff, a Probation Officer from the prison probation team also felt that the man would not be a suitable candidate for HDC on the grounds that he would be a potential threat to public safety.

45. The governor making the decision about HDC took all of the above information into account. He also considered the man's history of no previous convictions and his risk predictor profile for both a reconviction and re-imprisonment (he scored 'low' on both). He decided not to authorise release on HDC on the grounds that the man was a 'potential threat to public safety'. The Head of Residence notified the man of his decision to refuse HDC on 10 January. This meant that his release date would now be 8 June 2007.

46. The man lodged an appeal against the HDC decision that same day. He said that he had only been convicted for 'growing cannabis and to supply' and that he would have gone to Ford open prison as a category D prisoner except that he was on a medical hold at Winchester. The man went on to describe the situation at home and the medical needs of both his wife and himself. The Head of Residence sent an interim reply on 18 January stating that he had received some new information from the man's solicitor and that he would reconvene a board to consider the facts as soon as the information had been clarified.

47. The man's security category was recommended for change from category D to category C on 18 January 2007. The reason given was "information from probation and police that suggests the man is a threat to other drug associates". The upward recategorisation was approved by the Head of Security on 22 January. This meant that the man was no longer eligible to transfer to an open prison.

The day of the man's death

48. The man was to attend the prisoner representative meeting on a morning in late January 2007. As he was to raise questions about the quality of the food, it is relevant to quote from the report of the prison's IMB for the year ending 2006. In their report, the IMB comment that:

> "… the standard of food from the kitchen in the main prison has been high and the Board receives very few complaints. This is a remarkable achievement considering the age and condition of the kitchen, its equipment and its location.
>
> "West Hill and the Hearn Unit also receive cooked food from the main prison, although funding has now been approved to create a 'finishing' kitchen in West Hill … The prison buys food from a variety of sources. Some 26% is bought from Leyhill prison and there have been problems with the quality of its produce; the potatoes in particular, are poor."

49. The prisoner representative meeting usually starts shortly after 10.00am and is attended by a representative from each landing, the Unit Governor, a kitchen staff representative, one of the gym staff, someone from the canteen and an administrative member of staff. The meeting is held every month and provides an opportunity for prisoners

to raise issues that affect their day to day life on the unit. This meeting was the first occasion that the man had attended; he was just 'filling in' for the usual representative who was on a course that day. There were eight prisoners at the meeting.

50. The minutes from the last meeting were reviewed and the discussion then moved on to the quality of the food. It began with talk of the new kitchen. The man asked to raise a few comments. He talked specifically about the potatoes and cauliflower. He described the potatoes as being black and that everyone on the landings complained about them tasting horrible. He said the cauliflower was hard. The man said he wanted to visit the kitchens for himself to see how food was being prepared. The kitchen representative answered the man's questions and said that queries needed to be put to kitchen staff on the day they occurred and that the food complaints book should be completed. However, he said he did not object to the man visiting the kitchen if the Unit Governor agreed. A prisoner who was present told my investigator subsequently that the Unit Governor "fobbed the man off" though and would not allow him to go. The prisoner said the conversation between the man and the Unit Governor got more heated at this stage. He recalled that the man may have sworn, but said the Unit Governor remained calm and professional in his approach. In her police statement, the administrative member of staff present said that the man was getting quite wound up and was ranting and, although he did not raise his voice, he was talking over the Unit Governor. In her police statement the prison officer attending the meeting said that the man spoke with a raised voice but was not shouting. She went on to say that she could "not see why the man was agitated, there was no argument, he appeared to just wind himself up."

51. Whatever the exact sequence of the discussion, the man stopped talking quite suddenly and appeared to slump in his chair and then fall to his right onto the shoulder of the prisoner next to him. The administrative member of staff said she could hear that he was having difficulties breathing. People immediately got up and laid the man on a row of chairs. One prisoner said that he thought someone said "Call a doctor" and then the other prisoners present were ushered out of the room.

52. The prison officer present said she went over to the man but that, when she could get no response, she ran out of the room to the unit office in order to contact the healthcare centre. The unit SO was sitting in the SO's office in the wing when the officer entered. She said that she needed healthcare as the man was having "an episode or fit". The SO said that the officer said something like "it's a code 2 incident". The SO then left the room and the officer rang healthcare and gave them basic details of what had happened. The SO went into the meeting room and saw that the man was in the recovery position, lying on a row of armchairs. He said he knew the man was not having a fit. Another officer and the SO together checked the man. The officer made a

"code 1" radio message (code 1 is the code used to alert medical staff of a life threatening emergency), and also asked for an ambulance. The SO said the man's breathing became very laboured and that he was making snorting and snuffling sounds. The man then stopped breathing. The staff shook him and the man took a few more breaths, then stopped again. A nurse had just arrived at this point.

53. The healthcare centre received the code 1 radio message around 10.15am. A nurse went to the scene immediately. She also relayed a message that an ambulance was required. The man was lying on his right side on the chairs and, although not responding to the nurse, was initially taking shallow breaths. The nurse decided to move the man onto the floor and then inserted an airway. Using an ambubag, she and the officer who had made the 'code 1' call (a trained first aider) commenced cardio pulmonary resuscitation (CPR). She checked for a pulse but could not find one at this time and so continued CPR. The were two other nurses present. A defibrillator machine was attached to the man. Following its guidance, the man was given two shocks, but there was no output. A prison GP arrived about 10.25am and oversaw the CPR and defibrillator process. The medical team agreed to stop their efforts at 10.35am, about 15 to 20 minutes after CPR had first commenced.

54. Two paramedics arrived after the doctor had certified the man's death. They told the ambulance to stand down.

55. The staff who had been involved were taken to one side and asked if they were okay. Members of the Care Team within the prison came and spoke to staff and the Governing Governor also came over later in the day to talk to staff. A debrief was held at around 4.15pm. During the debrief, the officer who had helped with CPR said that he felt there should be defibrillator machines in all residential areas so that time was not lost trying to access one. One of the nurses said that this had already been discussed with the head of healthcare and that two more machines were on order. The unit SO said he had spoken to some of the prisoners who were at the meeting when the man died to see if they were feeling okay. There was a service that afternoon in the association room for the prisoners.

Informing the man's wife of her husband's death

56. By coincidence, a nurse who had been involved in the efforts to resuscitate the man attended the same church as him and his wife. She suggested that the prison contact a lay preacher from their church and ask whether he would be able to go along with a governor to break the news of the man's death. The lay preacher agreed to this and they went to see the man's wife at about 2.00pm that afternoon to break the news of her husband's death.

57. A previous cell mate of the man spoke to his wife during her visit to the prison on a few days after his death. He also spoke at the memorial service held for the man and said that lots of prisoners from West Hill attended the service.

58. The Governor wrote a letter of condolence to the man's wife in late January. He also wrote to other family members and reiterated that a family liaison officer was able to assist with any information or advice that they needed. The prison offered assistance with the funeral expenses, an offer that was taken up by the family.

WHAT OTHER PRISONERS SAID

59. My investigator spoke to four of the man's fellow prisoners. The first of these moved onto West Hill unit at the end of November when the man was already there. The two men shared a cell. The prisoner described the man as very lively and enthusiastic and someone who liked to do things his own way. He said the man was the sort who would speak his mind. He said the man missed his wife terribly and would speak to her on the phone every morning and night. The prisoner told my investigator that the man was meticulous about taking his medication and that he never missed a dose. He said that, on the day the man died, he had got up and followed his normal routine and that at no stage did he complain of feeling unwell – he said the man had seemed fine. The prisoner was not at the prisoner representative meeting that morning. After the man had died, the prisoner said that he thought the prison was very good and remembered the chaplaincy service speaking to the prisoners. He also thought some Senior Officers (SOs) had been supportive.

60. The second prisoner moved onto West Hill in August 2006 and then The Hearn in February 2007. He was a member of the prisoner representative meeting and said that he knew the man "a little bit" from just being around the landings. He described the man as someone who was fun to be around and who made friends easily. He also said the man was quite forthright and would "call a spade a spade". The prisoner said that the issue about the quality of the potatoes, discussed at the prisoner representative meeting, had come up before. He said that many prisoners thought the quality of the potatoes was very poor. The prisoner described how the conversation between the man and the Unit Governor became more heated when the latter would not agree to the man going to visit the kitchens. However, he said that the Unit Governor stayed calm and professional. Nevertheless, the prisoner felt that the Unit Governor should have just ended the discussion and that the situation might have contributed to the man's collapse. After the man had died, the prisoner said that he talked to an SO about what had happened. He felt it would have been useful for him to have written a statement about it all. The prisoner suggested that the man should not have been allowed to go to the meeting because he "got too irate too quickly".

61. The third prisoner is the prisoner who asked to speak to my investigator about the man's death and who had subsequently been transferred to another prison. He had worked in the library at West Hill and said that the man was a regular visitor to the library in the months leading up to his death. He described the man as a strong character who "spoke his mind". The prisoner said that he thought the man was always slow when climbing the stairs to get to education or the library and that he would get out of breath. The prisoner attended the meeting at which the man died. He recalled that the man brought up the subject of the kitchens and the poor standard of food but he did not

specifically remember that an issue over potatoes came up. He said the kitchen staff did “not know how to handle the criticisms” and that the Unit Governor responded by “belittling” the man. The prisoner thought that the man then repeated his point about poor catering and that the Unit Governor “fuelled the fire”. He said after a couple more exchanges the man collapsed onto the wing representative sitting next to him. The prisoner thought it might have been the prison officer who attended the meeting who called for an ambulance and remembered another officer coming into the room and asking all the prisoners to leave. He said that, as he was walking down the corridor outside of the room, the medical team were running in. He also thought he passed the chaplain. The prisoner said he heard on the “grapevine” that the man had died. He did remember the Governor putting up notices to tell prisoners what had happened. The prisoner said that prison staff were offered care and support but that the prisoners were not offered the same service. He recalled attending a meeting about a week after the man had died where they were told that the man would have died anyway because of his medical history with heart trouble. The prisoner did not believe this was strictly true. In his opinion, the exchanges between the Unit Governor and the man played a “significant part” and might have brought on his collapse.

62. The fourth prisoner had moved onto West Hill around the same time as the man. He described the man as “a bit of a character” and said he was rather set in his ways and would speak his mind. The prisoner also said that the man would try to help people if he could and that, because of his age, other prisoners listened to him. The man attended the prisoner representative meetings on a regular basis. At the meeting in question, the prisoner said that he could not remember exactly what the man was talking about except that it he thought it was something to do with the cooking. He recalled that the man asked to go and visit the kitchens to look at how they were managing things. He said the kitchen staff were happy with this as long as the Unit Governor agreed. The prisoner said that the man was beginning to get wound up. He could not remember the Unit Governor saying that the man could not go to the kitchens, but he did remember the man being told that he should use the food complaints book and that issues should be brought up as they arose so that matters could be dealt with at the time. The prisoner offered the view that the man was getting himself too wound up by it all. He thought that the man had got his point across and that he should have let things move on. But he said that the man did not want to let the matter drop. According to the prisoner, the Unit Governor let the man “rant on” for a bit, and then suddenly the man fell onto him as he had been sitting next to him during the meeting. The prisoner said that he thought initially that the man was “playing around” but then he saw that he was shaking. He got up and laid the man across the chairs. He thought the prison officer who attended then left the room to call for medical staff. The prisoner said the man’s breathing was initially like snoring, and that the Senior Officer and Unit Governor tried to revive the man whilst medical staff

were on their way. The prisoner said he was told later that day by an officer that the man had died. He attended the memorial service that afternoon and remembered a few members of staff asking him if he was okay.

63. The prisoner recollections of the man are that he was a likeable man who was direct and not reluctant to speak up with his opinions. During the meeting on the day he died, the man became worked up during his discussions with the Unit Governor about the quality of the potatoes and whether he would be able to visit the kitchens. Most of the prisoners were of the view that the man “wound himself up”. The recollection of all but one prisoner is that the Unit Governor stayed calm throughout their discussions about the food. The man suddenly and unexpectedly collapsed onto the prisoner sitting next to him. There were no indications that he had been feeling unwell at any time leading up to his collapse.

ISSUES CONSIDERED

Medical care

64. The clinical review was carried out by a panel of five clinical staff from Hampshire Primary Care Trust. I am most grateful to them for their work. Their review identified a number of points that I summarise in the paragraphs below.

65. The man suffered from chronic long term conditions (coronary heart disease and arthritis). He had previously undergone a coronary artery bypass graft and was on medication for his angina. The medication he was receiving was standard medication for somebody who had suffered a myocardial infarction 15 years ago. The panel would expect there to be a beta-blocker included in the medication, however there is no information in the medical records whether or not a beta-blocker was contraindicated. The PCT's Medicines Management team also commented on the lack of other anti-anginal medication such as a nitrate. Nicorandil is generally not a first-line agent for the treatment of chest pain so the panel would expect other medications to be prescribed for angina. However, there were no recorded instances of chest pain or complaints of coronary pain during the man's time in Winchester.

66. The medical records for the man indicate little in the way of chronic disease management that the panel would expect to be provided to a patient receiving primary care services. The records show one Blood Pressure recording which is not dated. There is no other recording of routine measurements or health promotion for a person with angina.

67. A hospital appointment for a hip block for the man was cancelled by the prison with no reason recorded in his records. A further hospital appointment for an x-ray at a county hospital was cancelled and changed to a hospital more local to the prison.

68. The man's medical records were factual, consistent and accurate but not comprehensive. They were written in a timely manner but do not necessarily provide current information about the care and condition of the patient. The records are not perfectly legible, nor accurately dated and timed. The records were respectful, consecutive, with a lack of jargon or abbreviations. They identified problems but not the action taken to rectify. There was clear evidence of the care planned but not communicated and the basis for decisions was not clear. Actions to the nursing care plans were also poorly documented in the records.

69. The panel considered the response to the man's collapse to have been appropriate and timely and the outcome could not have been avoided. They panel made the following recommendations:

The process for assessment on admission (reception-screening) needs to be audited to ensure compliance in relation to the completeness of the assessment tool and the accurate identification of patients requiring a medical assessment.

Patients with chronic disease and/or complex care management needs should be identified on admission and seen by a doctor at the earliest possible time. Management plans should include regular review, and not merely consist of reactive responses to isolated clinical events.

The Prison Healthcare Service should review its capacity to manage patients with long term medical conditions, particularly in light of the projected increase in the average age of prisoners. This review should include an audit of the prevalence of chronic disease in the prison and encompass the resources, expertise and training that is required to manage patients with complications, or complex nursing needs.

The primary care services provider should consider whether their GPs and nurses with training and experience in chronic disease management should work with the Prison Healthcare staff to promote a more proactive approach.

A computerised clinical system should be put in place to assist with record keeping, audit and chronic disease management.

70. In addition to the views of the clinical review panel, I also wish to comment on the locally developed form entitled, 'Secondary Health Assessment'. This form was completed at some point regarding the man. Unfortunately, the design of the form means that key information such as the date of completion and the name and details of the person completing the form are not captured. This form needs redesigning if it is to be of value in capturing the medical details of a particular patient at a given time.

The 'Secondary Health Assessment' form should be redesigned by the PCT and Winchester so that it captures key information such as the location of the prisoner, date of completion, name, signature and job title of person completing the form.

Staff and prisoner statements

71. My investigator first spoke to the liaison officer at Winchester prison on 29 January 2007. During their discussion, my investigator asked the liaison officer to send all of the relevant paperwork to my office so that the investigation could begin. She specifically requested documents such as the man's core record, his medical record, prison contingency plans for a death in custody and the staff statements. My investigator

subsequently received some papers in mid-February. There were no staff statements in the paperwork that had been sent. My investigator chased this up with the liaison officer during her visit to Winchester on 20 March. The liaison officer said that no staff statements had been made other than the completion of the "Orderly Officer's Incident Report".

72. My investigator then said that she had some information about the man's death in the medical record – entries made by the nurse and GP who attended, but that all staff present should have made a written statement as soon as possible after the man's death whilst the details were still clear in their minds. My investigator said that it might have been appropriate to ask some of the prisoners who were at the meeting to write down their recollection of events too. She said that she would be speaking to some of those prisoners during her visit that day, so there was no need to ask for statements from those people. However, all of the staff who had not written an account of what happened should be asked to do so now. The liaison officer agreed to arrange this and to forward the statements onto my investigator. Unfortunately, none was forthcoming.

73. Prison Service Order 1400 concerns Contingency Planning. In relation to a death in custody, it states that the first on the scene should write a statement to the governor about the incident and their actions. It goes on to say that the duty governor must, "Take note of the names of all staff and inmates who responded immediately to and/or witnessed the incident. Inform those involved to remain in the vicinity pending the taking of statements."

74. It is useful for staff to write down their recollection of what has happened, not just to assist in my investigation into the death, but also because some or all of the staff present may be called to attend the Coroner's inquest. That may be several months or even years after the death. Without a written statement to refresh their memory, staff may find it difficult to give a full and accurate account and to explain what actions they took to the Coroner.

    The Governor should ensure systems are put in place so that all relevant staff who are witnesses to, or involved in the resuscitation or aftermath of a death of a prisoner, write a full and comprehensive statement of their own recollection of events as soon as possible after the death. The Governor should also consider whether it is appropriate to ask some prisoners to write a statement.

Home Detention Curfew

75. The man was refused release on Home Detention Curfew (HDC) on 10 January 2007. Had he been successful his release would have been due on the day after he died.

76. Prison Service Order (PSO) 6700 on Home Detention Curfew states that all prisoners who are serving sentences of over three months but less than four years are eligible to be considered for HDC (unless they fall into an excluded category, for example, sexual offences). The PSO states that, "prisoners must normally be released on Home Detention Curfew unless there are substantive reasons for retaining a prisoner in custody until his or her conditional or automatic release date". The risk assessment to determine whether a prisoner is released or not "…must take into account the prisoner's previous convictions, the risk predictor assessment based on those convictions and the report of the home probation service…" Other documents, such as the pre-sentence report should also be taken into account where they are available.

77. An enhanced assessment is completed for certain prisoners. The assessment must be completed by a board comprising at least a governor grade and a member of the seconded probation team. The board must consider the various forms that have been completed and other relevant factors such as "home circumstances and the stability of close relationships", "relevant behaviour in prison, for example disciplinary offences" and "previous criminal history".

78. The PSO states that, "It is not possible to guarantee an offender's law abiding behaviour upon release. The assessment of risk for HDC must therefore balance any risk to the public presented by the bringing forward of the release date against the potential benefits of incorporating a period of Home Detention Curfew within the prisoner's sentence". The PSO goes on to say that, "Assessment of risk must be on the basis of objective evidence of the prisoner's past record and current behaviour, and must be conducted in a way that is consistent with Prison Service values, rigorously and fairly and free from discrimination."

79. Section 5.13 of the instruction states, "… prisoners must normally be released on HDC unless there are substantive reasons for retaining the prisoner in custody until his or her conditional release date. The reasons must fall under one of the five headings below:

    - an unacceptable risk to the victim or to members of the public
    - a pattern of offending that indicates a likelihood of re-offending during the HDC period
    - a likelihood of failure to comply with the conditions of the curfew
    - lack of suitable accommodation for HDC
    - shortness of the potential curfew."

80. The man was refused release on HDC and given the reason that he was "a potential threat to public safety" (this falls under the first bullet point from the above list).

81. The PSO goes on to further describe what “risk to the public” means and states, “prisoners who present a clear and immediate threat to the public must not be released on HDC. Prisoners must be refused HDC on these grounds where they have displayed in their current, or previous behaviour, a clear tendency to violent or sexual offending and there is evidence to suggest that they continue to present an immediate substantive risk to members of the public.”

82. I have already outlined in detail the contents of the reports from West Hill unit staff, the prison based probation team, Hampshire police and the probation team regarding the man’s release on HDC. None of the reports was in favour of releasing the man on HDC. The most influential report was from the man’s local Probation Office. They did not recommend release for two reasons based on the Crown Prosecution Service (CPS) summary papers.

83. First, the man had been accused of soliciting an individual to murder in that he was alleged to have said to a named individual, “I need someone shut up permanently … if you dispose of this one person, the whole prosecution case will collapse.” The man allegedly then offered to pay the named individual between £30,000 and £35,000. The man had been charged with threats to kill under the Offences Against the Person Act 1861. The hearing for that case had not yet been scheduled.

84. Second, the police had searched a van belonging to someone other than the man. In the back of this van they found a sawn off shotgun and some other weapons. The owner of the van linked the shotgun to the man and said that he had seen him with it. This had led to a charge against the man of possession of a firearm but this was subsequently dropped by the police and CPS.

85. The ‘Risk Predictor for Sentence Planning’ is used to give guidance about the probability that an offender with the given history of offending will be reconvicted within two years. It is meant to aid the judgement of the person using the information. The man had no previous convictions and only the impending prosecution outlined above. He came out as ‘no history for a risk of reconviction for a violent offence’ a ‘low risk of reconviction for other offending’ and a ‘low risk of re-imprisonment’.

86. It is entirely understandable that the Head of Residence, faced with only recommendations against granting HDC to the man, decided to turn him down. Had the man complained against the decision to the Ombudsman’s office, I have no doubt that we would have found against him. No one could argue that the Head of Residence’s decision was unreasonable in the circumstances. That said, there were other factors that might have acted in the man’s favour. These factors included his age, the fact that he had no previous convictions for either violent or non violent offences, that he was not particularly

mobile, that this was his first time in custody, that he had no adjudications against him during his time in prison, that his risk predictor for any type of reconviction or re-imprisonment was low, and that he had a very close and stable relationship with his wife.

87. Moreover, the man was still a category D prisoner (on a medical hold) at the time of the HDC assessment board. This fact was not recorded on the HDC paperwork and does not appear to have been considered. It is very rare, although not wholly unknown, for a prisoner considered suitable for open conditions to be refused HDC. However, given that the man was quickly recategorised to C after pointing out his D status on his HDC appeal papers, it seems likely that the prison may have overlooked his categorisation during his HDC assessment.

88. My investigator approached the Home Detention Curfew policy unit within the National Offender Management Service (NOMS) for advice about the appropriateness of the decision made by the Head of Residence. The policy unit looked at all of the paperwork and said they were, "satisfied that the governor made a sound decision based on the information available to him … the proper procedures were followed and the decision to refuse release was entirely appropriate".

89. I make no formal recommendation but would invite the operational managers who make HDC decisions at Winchester to refresh themselves with the detail of PSO 6700.

The family's concerns

90. The family friend made the following comments during a telephone conversation with my senior family liaison officer on 22 February 2007:

- He felt that Winchester had been generally good at dealing with the family since the man's death. He said the family was offered help with the funeral expenses and that the prison had held a memorial service for the man which he had attended.

- He said that different arrangements could have been made for breaking the news to the man's wife. It would have been more appropriate if the person who had gone to visit her with the prison staff had been a family member - ideally a woman so that she could have stayed to comfort the man's wife, who was in a state of shock.

- He would like to have the sequence of events leading up to the man's death explained to him, particularly facts such as whether the man was standing or sitting when he collapsed.

- He said he was aware that the man had been due for early release the following week, but that this had been stopped because of the reference to firearms on his file. He said that the firearms charge had

been dropped and he felt that the paperwork should not have had firearms mentioned on it.

The way in which the news was broken to the man's wife

91. It is normal practice for a prison to break the news of a death by sending out two members of staff, often a senior manager and the chaplain or a trained family liaison officer. Because a nurse happened to know the family attended her own church, she suggested that the prison approach the lay preacher of that church so that he could offer some support when the man's wife was to be told of the death of her husband. This approach was adopted by the prison and I commend them for trying to be as sensitive as they could be, given the situation.

92. Whilst I acknowledge that the man's wife would have preferred the prison to have contacted a female relative who could have stayed with her after she was told that her husband had died, I find it hard to criticise the prison for their handling of the situation. The prison acted with the best of intentions and was not to know that she would have preferred the news be broken in a different way.

The sequence of events during the prisoner representative meeting

93. I have given a detailed description of the meeting and the man's collapse on pages 14 to 16 of my report.

The man's early release and the firearms charges

94. The man's release on Home Detention Curfew and all of the issues surrounding that decision have been explored in the section immediately above this one.

Family response to the draft report

95. I received comments on my draft report from a family representative. She raised a number of issues, which I address below:

Speed of the response to the man's collapse

96. The family representative said that she was concerned that there was a delay to the resuscitation effort when the man collapsed.

97. As I have described on pages 14-16 of this report, the man collapsed just before 10.15am on 24 January 2007. After failing to get a response from the man, a prison officer ran to a nearby office to telephone the healthcare centre to request assistance. Another officer made a "code 1" radio call for assistance shortly afterwards, at around 10.15am. A nurse went to the scene immediately on receiving these messages.

98. The clinical review panel considered the response to the man's collapse to be "appropriate and timely". I agree.

Medical record

99. The family representative said that she was concerned at the lack of comprehensive medical records and assessment. She described the man's medical record as being "a bit hit and miss".

100. As I have noted in paragraph 68, the clinical review team did not consider the man's medical records to be comprehensive. As such, they made a recommendation regarding the introduction of a computerised clinical recording system (see recommendation 5, below). This recommendation was accepted by HMP Winchester.

The man's reluctance to seek treatment

101. The family representative said that the man "would never have wanted to seem ill". She said that he would not have pushed himself to get regular treatment as he would not want staff to think that he was whinging.

102. It is common for prisoners to be reluctant to seek medical attention when they are unwell. This is a choice that each individual must make. However, the man suffered from chronic long term conditions, including coronary heart disease. As noted by the clinical review panel in paragraph 66, the man's medical records "indicate little in the way of chronic disease management that the panel would expect to be provided". In the case of a prisoner such as this man, who has reported such conditions at his reception health screen, I would expect healthcare staff to be proactive in providing management plans and reviews.

103. The clinical review panel made four recommendations on this subject, each of which has been accepted by Winchester (see recommendations 1-4, below).

Pain relief for the man's ulcer

104. The family representative expressed concern that the man was given paracetamol for his ulcer, and felt that he should have had Co-proxamol or Co-codomol instead.

105. On the day of his arrival at Winchester, the man was told that he might not be able to take Co-proxamol as a painkiller for his ulcer as the medication was being discontinued. The man apparently replied that Co-proxamol was the only painkiller that you could take for an ulcer. He was told that this was not the case and, on 11 September, was seen by a doctor and prescribed paracetamol as a replacement.

106. The Clinical Governance Manager at the Hampshire Primary Care Trust and a member of the clinical review panel, said that it would have been appropriate to use paracetamol rather than Co-proxamol. I agree.

The man may have been under stress at the time of his death

107. The family representative said that the man may have been stressed because his application for release on the Home Detention Curfew scheme (HDC) had been turned down. As I have discussed in paragraphs 75-89 I consider the decision to refuse release on HDC to be reasonable.

108. The family representative also thought that the man may have been stressed because the person who he was alleged to have solicited to commit murder was apparently on the same wing. There are no entries in the man's prison records to indicate that there were any other prisoners on the wing with whom he did not get on or had a difficult relationship. There are also no entries to indicate that he wished to transfer to a different wing or put in an application for such a transfer. Indeed, on 16 November, the man said that he was happy to stay at Winchester until his medical appointments and follow ups had been completed, rather than transfer to an open prison.

RECOMMENDATIONS

Recommendations 1 to 5 are from the clinical review carried out by Hampshire Primary Care Trust.

1. The process for assessment on admission (reception-screening) needs to be audited to ensure compliance in relation to the completeness of the assessment tool and the accurate identification of patients requiring a medical assessment.

The Prison Service accepted this recommendation and said, "Computerised notes are in place which can be audited. Healthcare managers have already been instructed to carry out daily checks on reception screens".

2. **Patients with chronic disease and/or complex care management needs should be identified on admission and seen by a doctor at the earliest possible time. Management plans should include regular review, and not merely consist of reactive responses to isolated clinical events.**

The Prison Service accepted this recommendation and said, "Practice nurse to oversee all chronic disease referrals & follow ups".

3. The Prison Healthcare Service should review its capacity to manage patients with long term medical conditions, particularly in light of the projected increase in the average age of prisoners. This review should include an audit of the prevalence of chronic disease in the prison and encompass the resources, expertise and training that is required to manage patients with complications, or complex nursing needs.

The Prison Service accepted this recommendation and said, "Audit to be carried out by newly appointed practice nurse in conjunction with healthcare manager (previously a practice nurse). New IT system will enable closer monitoring and audit".

4. The primary care services provider should consider whether their GPs and nurses with training and experience in chronic disease management should work with the Prison Healthcare staff to promote a more proactive approach.

The Prison Service accepted this recommendation and said, "Recruitment drive underway; now one practice nurse and two with practice nurse experience have been appointed".

5. A computerised clinical system should be put in place to assist with record keeping, audit and chronic disease management.

The Prison Service accepted this recommendation and said, "IT system Vision went 'live' in June".

6. The 'Secondary Health Assessment' form should be redesigned by the PCT and Winchester so that it captures key information such as the location of the prisoner, date of completion, name, signature and job title of person completing the form.

The Prison Service accepted this recommendation and said, "New format on Vision in place; system automatically records details (e.g. .date /time / nurse name)".

7. The Governor should ensure systems are put in place so that all relevant staff who were witnesses to, or involved in the resuscitation or aftermath of a death of a prisoner, write a full and comprehensive statement of their own recollection of events as soon as possible after the death. The Governor should also consider whether it is appropriate to ask some prisoners to write a statement.

The Prison Service accepted this recommendation and said, "This is included in all contingency action sheets. The slippage in this case was down to human error. Guidance has been given and a notice to staff will be issued to reinforce this practice".