Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Windle a prisoner at HMP High Down on 14 May 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

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

Mr Thomas Windle died on 14 May 2017 of heart failure, caused by heart disease, while a prisoner at HMP High Down. Mr Windle was 96 years old. I offer my condolences to Mr Windle's family and friends.

Mr Windle was an elderly man, but was in reasonable health until he died. He had chronic conditions that prison healthcare managed appropriately. I am satisfied that the care Mr Windle received was equivalent to that which he could have expected in the community.

The lack of communication between the bedwatch staff and the prison management team following Mr Windle's death is concerning and should be addressed.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **November 2017**

Contents

Summary

Events

1. Mr Windle was serving a 12 year sentence for historic sexual offences. Although an elderly man, he was in reasonably good health. He was transferred to HMP High Down on 3 September 2013. Mr Windle saw healthcare staff frequently for blood pressure monitoring, blood tests and daily for medication. There is no indication that he presented to healthcare staff with any health concerns in the days leading up to his death.

2. At about 11.15am on 13 May, a prisoner notified a nurse that Mr Windle was short of breath and was feeling 'light headed'. The nurse examined Mr Windle, called for assistance and requested an ambulance. Mr Windle went to hospital at 12.17pm and was admitted.

1. At 10.40pm the following day, Mr Windle fell and broke his hip. He was moved to another hospital at 5.35am on 14 May, but his condition suddenly deteriorated and he died at 1.08pm. The prison management team were not promptly informed that Mr Windle had died.

Findings

2. Although Mr Windle was in reasonably good health, he was very elderly, and naturally his health was gradually deteriorating. On 13 May, his condition rapidly deteriorated and Mr Windle died 14 hours after falling and fracturing his hip.

3. The clinical reviewer concluded that Mr Windle's care while at High Down was variable. Although monitoring of his chronic diseases was satisfactory, some aspects of his medical care were reactive rather than proactive. Overall, the standard of healthcare Mr Windle received was equivalent to that which he could have expected to receive in the community.

4. When Mr Windle died neither the control room nor the bedwatch officer told the duty manager promptly. The prison management team only found out Mr Windle had died when they contacted the bedwatch officer for an update, an hour after Mr Windle had died.

Recommendations

- The Governor should ensure that all escorting staff are aware of, and understand their responsibilities, while escorting prisoners on a bedwatch and ensure there are no delays in notifying the prison when a prisoner dies.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. A prisoner wrote to her with information relevant to Mr Windle's health.

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

7. NHS England commissioned a clinical reviewer to review Mr Windle's clinical care at the prison. We informed HM Coroner for Surrey of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. The investigator wrote to Mr Windle's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies. The clinical reviewer highlighted two factual inaccuracies, which have been amended.

Background Information

HMP High Down

11. HMP High Down is a local prison near Sutton, in Surrey, which at the time of Mr Windle's death held up to 1,150 men. Central and North West London NHS Foundation Trust provides primary health services and in-reach mental health care at the prison. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

12. The most recent inspection of High Down was in January 2015. Inspectors reported that health services were good overall. The health team had a rich skills mix. Nurses were always on site and the core team normally covered staffing shortages. A local GP practice provided regular GP clinics. Inspectors observed good practice, but ongoing training, supervision and quality assurance processes were weak. Prisoners over 55 had good access to annual health checks and relevant community screening programmes. Access to mobility and health aids was satisfactory. Prisoners with lifelong conditions were identified effectively and relevant clinics, including a weekly GP-led clinic, were provided. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments, which the inspectorate considered good practice.

Independent Monitoring Board

13. 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 December 2016, the IMB noted that the healthcare partners and prison management met regularly to discuss issues and take forward a Health Improvement Plan. The IMB also noted that under the Social Care Act 2015, Surrey County Council has a duty to provide relevant prisoners with social care interventions. Since August 2016, nine prisoners were receiving support from both the Care Team and Peer workers.

Previous deaths at HMP High Down

14. Mr Windle was the fourth prisoner to die of natural causes at High Down since January 2016. There were no similarities with previous investigations.

Key Events

15. On 3 September 2013, Mr Windle received a 12-year sentence for historic sexual offences. He was sent to HMP High Down on 3 September 2013, where he lived on the Vulnerable Prisoners Unit. Mr Windle was 96 years old when he died.

16. Mr Windle was an elderly man, but was in reasonably good health. He had ischemic heart disease, an irregular heartbeat and used a stick and a wheelchair to get around. Mr Windle took blood pressure medication, a blood thinner and a diuretic (to treat fluid retention).

17. From March 2014, Mr Windle started to complain of being short of breath and a prison GP prescribed him an inhaler, which helped to relieve his symptoms. In April and July, Mr Windle went to hospital with pleural effusion (fluid in the lining of the chest between the chest wall and the lung) and had a procedure to drain the fluid.

18. Mr Windle saw healthcare staff daily for medication, blood test monitoring and regular blood pressure monitoring. There were no significant recorded medical entries for Mr Windle between the periods from July 2014 to May 2017.

Events of 13 to 14 May 2017

19. At around 11.15am on 13 May 2017, a prisoner went to the wing treatment room and told a nurse that Mr Windle was short of breath and was feeling 'light headed'. The nurse went straight to Mr Windle's cell and noticed that he was wheezing. She examined Mr Windle and noted that his oxygen saturations were low, his pulse was 89 beats per minute and his blood pressure was in the 'pre-high' range.

20. At about 11.20am, the nurse telephoned for the emergency nurse and explained there was a code blue for Mr Windle (a code blue emergency signifies the patient is unconscious or having difficulty breathing and requires and immediate response). The prison control room requested an ambulance and the emergency nurse went to Mr Windle's cell immediately, along with a prison GP and a prison manager.

21. The nurse noted that Mr Windle looked pale and grey, and was gasping for breath. On examination, his pulse was strong but irregular and his oxygen saturations were still low. She gave Mr Windle oxygen, which increased his saturations and his colour improved. The prison GP listened to Mr Windle's chest and heard crackles on both sides, suggesting a chest infection.

22. The ambulance arrived at High Down at 11.34am and paramedics assessed Mr Windle. They took him to hospital at 12.17pm.

23. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. Mr Windle's risk assessment noted that he used a wheelchair and was very frail. The security department considered him a low risk to public and staff, of hostage taking and of escape. Appropriately, the prison manager authorised no restraints due to Mr Windle's condition.

24. After Mr Windle was assessed in the Accident and Emergency Department, a hospital doctor told Mr Windle that he would need fluid drained from his chest and admitted him to a ward. It was expected that Mr Windle would be in hospital for about 24 hours. Mr Windle was able to move around independently and there were no other concerns about his health.

25. At 10.40pm, Mr Windle went to use the toilet. He fell and nursing staff helped him back to bed. An X-ray later that night showed Mr Windle had broken his hip, which required surgery at another hospital. Mr Windle was transferred to the other hospital at 5.35am on 14 May. The surgical team saw Mr Windle at 9.00am and explained that the fluid on his chest would need treating before he could have the surgery.

26. At about 12.45pm, Mr Windle told a bedwatch officer that his chest felt tight and he started to shake. The officer ran to get a nurse, who arrived about two minutes later and pressed the emergency button for assistance. Hospital staff attended to Mr Windle. They said he was entering the 'final stages of life' and made him comfortable. A hospital doctor pronounced Mr Windle dead at 1.08pm.

27. The officer said he contacted the prison control room at 1.30pm to tell staff that Mr Windle had died and said he would contact the duty manager. There is no entry in the control room log of his telephone call and he did not contact the duty manager straight away. As a result, the prison managers did not find out that Mr Windle had died until about 2.40pm when they contacted him for an update.

Contact with Mr Windle's family

28. When Mr Windle's condition deteriorated on 13 May, the prison manager attempted to contact Mr Windle's next of kin, his son, via telephone, but was unable to get through. The prison appointed a prison manager as the family liaison officer, who also tried to make contact Mr Windle's son.

29. The family liaison officer spoke with Mr Windle's son at 3.10pm on 14 May. He explained the hospital had already contacted him and she arranged to visit him that evening. She met Mr Windle's family at 7.30pm to offer support. She invited them to the prison to see Mr Windle's cell and to attend the memorial service.

30. Mr Windle's funeral was held on 30 June. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

31. After Mr Windle's death, the prison manager debriefed the staff who had been on bedwatch with Mr Windle to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

32. The prison posted notices informing other prisoners of Mr Windle's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Windle's death.

33. On 22 May, a prison chaplain led a memorial service at the prison for staff and prisoners. Mr Windle's family also attended.

Post-mortem report

34. The post-mortem report indicated that Mr Windle died of biventricular failure (when both sides of the heart fail to pump adequately), caused by hypertensive heart disease. The findings of the post-mortem suggest that Mr Windle was in congestive cardiac failure.

Findings

Clinical care

35. Mr Windle was an elderly man who was frail and had limited mobility. Despite his age, he was able to meet his own care needs and was in reasonable health. Mr Windle had regular interactions with prison healthcare staff who monitored his blood pressure, took regular blood samples and gave him his medications daily. There is no evidence in Mr Windle's medical records to suggest he gave healthcare staff any cause for concern in the days leading up to his death. When Mr Windle became unwell in his cell, healthcare staff acted promptly and examined him appropriately before sending him to hospital for an investigation of his symptoms. Mr Windle's condition declined rapidly; prison and healthcare staff could not have foreseen his death.

36. The clinical reviewer found that Mr Windle's health was gradually deteriorating; however, his symptoms on 13 May were a sudden deterioration that might have happened in a few hours. He concluded that Mr Windle's care while at High Down was variable. Monitoring of his chronic diseases was satisfactory; however, his day-to-day medical care was reactive rather than proactive. The prison healthcare team responded to Mr Windle's needs as they changed rather than planning ahead. For example, the healthcare team did not question why the hospital stopped his anticoagulant medication and there was no significant investigation into the cause of his pulmonary hypertension. Better forward planning would not have changed the outcome for Mr Windle, but would have made the standard of his care better.

37. Overall, the standard of healthcare Mr Windle received was equivalent to that we he could have expected in the community. The clinical reviewer has made a number of recommendations which are not material to the circumstances of Mr Windle's death and, therefore, not repeated in this report, but which the Head of Healthcare will wish to address.

Communication between bedwatch staff and the prison

38. Prison Service Instruction 33-2015 for escorts states that bedwatch staff should '*Ensure that prison management are kept informed of any significant changes in the prisoner's clinical condition… Bedwatch staff must maintain a record of important events...* Staff must ensure that entries are legible and that the observations are informative, timed and signed'.

39. There was a general lack of awareness of the protocol for dealing with bedwatch procedures in a death in custody. This meant that prison management was not immediately informed that Mr Windle had died. An officer said it was his first death in custody, which was a traumatic experience, and he wanted absolute confirmation and a time of death from hospital staff before notifying the prison management team. He should have contacted the prison straight away, so that prison managers could implement the contingency plans and contact Mr Windle's next of kin.

40. The bedwatch log did not contain sufficient detail of the telephone call between the bed watch officer and the prison regarding Mr Windle's condition. It was hard

to establish the timings of the call and what information was communicated to the prison managers.

The Governor should ensure that all escorting staff are aware of, and understand their responsibilities, while escorting prisoners on a bedwatch and ensure there are no delays in notifying the prison when a prisoner dies.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141