Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Enoch Winchurch, a prisoner at HMP Wakefield, on 10 April 2020

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*

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Summary

1. 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.

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

3. Mr Enoch Winchurch, who was 94 years old, died of pneumonia on 10 April 2020, at HMP Wakefield. I offer my condolences to Mr Winchurch's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Winchurch received at Wakefield was equivalent to that which he could have expected to receive in the community. However, she made one recommendation.

5. We are concerned that an application for compassionate release was never completed for Mr Winchurch, and no one seemed to have overall responsibility for ensuring it was progressed.

Recommendations

- The Head of Healthcare should ensure that advance care plans are discussed with the prisoner at the earliest opportunity.

- The Governor and Head of Healthcare at HMP Wakefield should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Winchurch's clinical care at Wakefield. The clinical reviewer's report is attached as Annex 1.

7. The PPO investigator has investigated non-clinical issues, including Mr Winchurch's location, the security arrangements for his hospital escorts, and whether compassionate release was considered.

8. One of the PPO's family liaison officers wrote to Mr Winchurch's next of kin, a friend, to explain the investigation. She did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Previous deaths at HMP Wakefield

10. Mr Winchurch was the 19th prisoner to die at Wakefield since April 2018. Of the previous deaths, 16 were from natural causes and two were self-inflicted. We have previously made a recommendation to Wakefield about completing and submitting compassionate release applications promptly.

Key Events

11. On 1 June 2018, Mr Enoch Winchurch was remanded in custody, charged with sexual offences, and sent to HMP Leeds. He was later sentenced to 14 years in prison.

12. Mr Winchurch arrived at Leeds with several long-term health conditions, including chronic obstructive pulmonary disease (COPD – a group of serious lung conditions that cause breathing difficulties), angina (chest pain) and heart failure.

13. On 26 September, Mr Winchurch became unwell and was taken to hospital. He was told that his heart failure had got worse. Hospital staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with Mr Winchurch, who agreed that if he stopped breathing he did not want to be resuscitated.

14. Following Mr Winchurch's treatment, the hospital doctor said that he would need 24-hour care. Leeds could not provide this, so on 26 October, Mr Winchurch was sent from hospital to HMP Wakefield.

15. Mr Winchurch was located in the healthcare unit at Wakefield. Care plans for his COPD and heart disease were put in place in line with NICE guidance.

16. Over the next 18 months, Mr Winchurch was seen regularly by the prison GP, and his day to day care needs were met by nursing staff.

17. On 17 March 2020, a prison GP saw Mr Winchurch because he said that he was feeling unwell. The GP sent Mr Winchurch to hospital for further assessment. He was released on temporary licence (ROTL) and was accompanied at the hospital by a prison officer. Mr Winchurch was admitted to hospital, where he was treated for a urine and chest infection. On 21 March, he was discharged from hospital and was returned to Wakefield.

18. Mr Winchurch's health deteriorated further and on 4 April, it was noted that he would be treated for end of life care and for comfort only.

19. At 5.52am on 10 April, a prison nurse checked on Mr Winchurch. She noticed that he was not breathing and had no signs of life. At 9.17am, a prison GP confirmed that Mr Winchurch had died.

Cause of death

20. The Coroner accepted the cause of death provided by a prison GP and no post-mortem examination was carried out. The doctor gave Mr Winchurch's cause of death as pneumonia caused by COPD. Heart disease was listed as a contributory factor.

Non-Clinical Findings

Compassionate release

21. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can permanently be released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. The criteria include that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section of Her Majesty's Prison and Probation Service.

22. On 17 February 2020, a prison manager told Mr Winchurch's offender manager to start a compassionate release application for Mr Winchurch. It is unclear why, but the application was never completed. It appears that no one took overall responsibility for ensuring that the application was progressed. Therefore, we make the following recommendation:

    The Governor and Head of Healthcare at HMP Wakefield should ensure that applications for compassionate release are progressed in a timely manner and submitted as promptly as possible.

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Assistant Ombudsman

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