Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Ferris, a prisoner at HMP Winchester, on 22 March 2019

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 John Ferris died in hospital of sepsis on 22 March 2019, while a prisoner at HMP Winchester. He was 75 years old. I offer my condolences to Mr Ferris's family and friends.

Mr Ferris had only arrived at Winchester three weeks before he died. The clinical reviewer found that the care Mr Ferris received at Winchester was not equivalent to that he could have expected to receive in the community.

Mr Ferris was seen by healthcare staff on five occasions in the two days before he collapsed and was taken to hospital. The clinical reviewer found that staff did not refer to previous entries in Mr Ferris's medical record and therefore the assessments were done in isolation rather than in the context of his recent symptoms. As a result, the significance of Mr Ferris's deterioration was missed. Had sepsis been suspected earlier, the outcome could have been different.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2022**

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Summary

Events

1. Mr John Ferris was sent to HMP Winchester on 1 March 2019, after being sentenced to 11 years in prison for historic sex offences.

2. During the early hours of 14 March, officers asked a nurse to see Mr Ferris as he was complaining of knee pain. The nurse gave him pain relief. A GP saw him later that morning. The GP diagnosed suprapatellar bursitis (inflammation of the knee) and osteoarthritis. She prescribed pain relief and advised rest. Mr Ferris was also seen in the nurse's clinic later that day. The nurse gave him ice packs and repeated the GP's advice.

3. On the morning of 15 March, officers asked a nurse to see Mr Ferris as he was complaining of chest pain. The nurse took his clinical observations, which were normal, and gave him indigestion tablets. That afternoon, a prison nurse went to see Mr Ferris in his cell. She thought he looked frail and asked an officer to move him to the healthcare unit, where he could be monitored.

4. At around 6.40pm, officers asked for healthcare staff to attend after Mr Ferris collapsed. (He had not been moved to the healthcare unit and was still on the wing.) A prison paramedic assessed him and suspected he had sepsis. He asked for an emergency ambulance and Mr Ferris was admitted to hospital.

5. On 17 March, Mr Ferris had an operation to clean out the infection in his knee. However, his condition continued to deteriorate, and he died in hospital on 22 March.

6. The post-mortem examination found that Mr Ferris died of multiple organ failure, caused by septicaemia (blood poisoning), which had been caused by a bacterial infection.

Findings

7. The clinical reviewer concluded that Mr Ferris's clinical care at Winchester was not equivalent to that he could have expected to receive in the community.

8. On 14 and 15 March, Mr Ferris was seen by five different members of healthcare staff. The clinical reviewer was concerned that each assessment was done in isolation, rather than in the context of his recent symptoms. No one suspected sepsis until Mr Ferris collapsed on the evening of 15 March. The clinical reviewer considered the outcome could have been different if sepsis had been suspected earlier.

9. When a nurse saw Mr Ferris on the afternoon of 15 March, she thought he looked frail and asked for him to be moved to the healthcare unit. However, she did not take his clinical observations or calculate a National Early Warning Score (NEWS2 – a tool to identify clinical deterioration).

Recommendations

- The Head of Healthcare should ensure that healthcare staff receive further training on the recognition of sepsis.
- The Head of Healthcare should develop a Standard Operating Procedure for identifying and managing deteriorating patients, including clinical assessments, to provide a baseline and/or support clinical management, such as the NEWS2 tool.
- The Head of Healthcare should ensure that staff:
    - make full and accurate records either contemporaneously or as soon as possible after the event; and
    - clearly note where records are made in retrospect and demonstrate that they have referred to previous records.

The Investigation Process

10. 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.

11. The investigator interviewed six members of staff at Winchester on 2 July 2019. NHS England commissioned a clinical reviewer to review Mr Ferris's clinical care at the prison. They jointly interviewed healthcare staff.

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

13. One of the Ombudsman's family liaison officers contacted Mr Ferris's next of kin, his partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Winchester

15. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 500 adult remanded and sentenced men. It includes a separate lower security unit, known as West Hill, which holds up to 129 sentenced men who are nearing the end of their sentence. Practice Plus Group Health and Rehabilitation Services Limited have provided healthcare services at the prison since July 2020. Prior to that, healthcare services were provided by Central and North-West London NHS Foundation Trust.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Winchester was in June and July 2019. Inspectors found that the range of health provision was appropriate, and prisoners had good access to most clinics. They noted that healthcare staff were under pressure, particularly in primary care. Innovations to meet demand included the establishment of paramedic-led urgent response teams. Inspectors found there was too great a reliance on bank workers and agency staff, which was putting a strain on core staff as they had to undertake an increasing amount of developmental work, such as audits and kit checks.

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 31 May 2021, the IMB noted that the healthcare contract was moved to Practice Plus Group during the year and the effects of the transition had a major impact. Great efforts were made to keep service disruption for prisoners to a minimum. Major efforts to recruit staff continued during the year with good results although, due to turnover, it remained a constant challenge to maintain consistent staff levels especially for primary care nursing and mental health.

Previous deaths at HMP Winchester

18. Mr Ferris was the ninth prisoner to die at Winchester since March 2017. Of the previous deaths, two were from natural causes and six were self-inflicted. There are no similarities between this case and the previous deaths.

Key Events

19. On 1 March 2019, Mr John Ferris was sentenced to 11 years imprisonment for historic sex offences and sent to HMP Winchester.

20. At around 12.30am on 14 March, wing officers asked a nurse to see Mr Ferris in his cell as he was complaining of pain in his left knee. The nurse noted that movement was normal, and the knee was not hot to the touch. She gave Mr Ferris pain relief and told him to keep his leg elevated. She booked him to be seen at the clinic later that day.

21. Later that morning, a GP assessed Mr Ferris in his cell. She diagnosed suprapatellar bursitis (inflammation of the knee) and osteoarthritis. She prescribed pain relief and advised rest. She booked a follow up review for two days' time.

22. A nurse saw Mr Ferris at the clinic that day. She noted that he walked to the treatment room and had already been seen by the GP. She gave him ice packs and repeated the GP's advice.

23. In the early morning of 15 March, wing officers asked for a member of healthcare staff to see Mr Ferris as he was complaining of chest pain. A nurse responded and noted that Mr Ferris was lying in bed watching television. He was complaining of a burning pain in his chest and an acidic taste in his mouth. The nurse took his clinical observations, which were normal, and treated Mr Ferris for indigestion.

24. That afternoon, a nurse saw Mr Ferris in his cell after she was alerted that he had not collected his medication. She noted that Mr Ferris was weak and lethargic and had limited mobility. She did not physically examine him but after discussing his condition with a senior nurse, it was agreed that Mr Ferris should be moved to the prison's healthcare unit for observation. The nurse asked a wing officer to move Mr Ferris that afternoon but this did not happen.

25. At 6.40pm, wing officers asked for a member of healthcare staff to see Mr Ferris after he collapsed in his cell. A prison paramedic responded. He noted that Mr Ferris was grey in colour, with mottling over his body. He took his clinical observations and assessed that he might have sepsis. He arranged for an emergency ambulance to take him to hospital. Mr Ferris was admitted to hospital, given antibiotics and placed on a ventilator and sedated.

26. On 17 March, Mr Ferris had an operation to clean out the infection in his left knee, but his condition continued to deteriorate. On 22 March, hospital doctors withdrew active treatment and Mr Ferris died later that day.

Contact with Mr Ferris's family

27. On 15 March, hospital staff contacted Mr Ferris's partner to inform her of his condition. The prison appointed an officer as the family liaison officer (FLO) to support the family.

28. On 22 March, the hospital consultant asked Mr Ferris's partner to attend the hospital to discuss his deteriorating condition. The FLO arranged to meet her outside the hospital and supported her when active treatment was withdrawn. In

the days that followed, the FLO maintained contact with Mr Ferris's partner. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

29. The duty governor held a debrief for staff involved when Mr Ferris's life support machine was switched off, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. He conducted welfare checks on the staff who were unable to attend to ensure that they were debriefed. All the staff interviewed said that they had felt supported.

30. The prison posted notices informing staff and prisoners of Mr Ferris's death, and offering support.

Post-mortem report

31. The post-mortem report concluded that Mr Ferris died of multiple organ failure, caused by septicaemia (blood poisoning), the result of a streptococcal (bacterial) infection in the knee.

Findings

Clinical care

32. Mr Ferris was seen on five occasions by healthcare staff on 14 and 15 March. The clinical reviewer noted that the staff did not refer to Mr Ferris's medical records when making their assessments, so they did not consider his symptoms in the context of what he had reported before. The clinical reviewer considered that, as a result, the significance of his deterioration was missed until the point he actually collapsed and sepsis was suspected. The clinical reviewer said that the outcome could have been different if sepsis had been suspected earlier.

33. The nurse who saw Mr Ferris on the afternoon of 15 March and noted that he appeared weak and frail, did not take his clinical observations. It is possible that his clinical deterioration could have been identified earlier had she done so.

34. The clinical reviewer noted that many of the entries in Mr Ferris's medical record were made retrospectively without this being clearly stated and many lacked detail.

35. The clinical reviewer concluded that the care Mr Ferris received was not equivalent to that he could have expected to receive in the community.

36. We make the following recommendations:

    The Head of Healthcare should ensure that staff receive further training on the recognition of sepsis.

    The Head of Healthcare should develop a Standard Operating Procedure for identifying and managing deteriorating patients, including clinical assessments, to provide a baseline and/or support clinical management, such as the NEWS2 tool.

    The Head of Healthcare should ensure that staff:

    - **make full and accurate records either contemporaneously or as soon as possible after the event; and**
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