Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alun King, a prisoner at HMP Winchester, on 22 March 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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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.

If my office is best to assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Alun King died of a duloxetine (an antidepressant) overdose on 22 March 2022, at HMP Winchester. He was 45 years old. I offer my condolences to Mr King's family and friends.

Mr King was prescribed duloxetine, which he took twice daily under supervision. It is unclear how he managed to take an excessive amount. It is possible he was not swallowing his medication and saving it for later use, though there was no intelligence to suggest he was doing so.

In their 2021/22 report, the Independent Monitoring Board said that although supervision of medication rounds was effective, they were concerned that prisoners could still be diverting medication. The Head of Security and Head of Healthcare may wish to review the measures in place for preventing the diversion of medication.

Mr King was taken to hospital on 20 March when he became unwell. When he returned in the early hours of 21 March after discharging himself, no one told healthcare staff. This was a missed opportunity for healthcare staff to monitor Mr King and check for signs of clinical deterioration.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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Summary

Events

1. Mr Alun King was remanded to HMP Winchester on 12 March 2022, charged with manslaughter.

2. Mr King had a history of drug use, chronic pain and depression. He was prescribed methadone (an opiate drug, usually used as a heroin substitute but in this case for pain relief), other pain relief medication and antidepressants, which he collected from the wing medication hatch twice daily.

3. On 18 March, Mr King made cuts to his arms because he said he was angry about not receiving items he had ordered from the prison shop. Staff took him to hospital to have his wounds stitched and he returned to Winchester later that day. Staff started suicide and self-harm prevention procedures (known as ACCT).

4. On the morning of 20 March, Mr King told healthcare staff at the medication hatch that he felt dizzy. They noticed that his speech was slurred, and he had right-sided weakness around his mouth. Healthcare staff examined him and found that his clinical observations were normal.

5. Around two hours later, a nurse went to check on Mr King. Staff told him that Mr King was out on the exercise yard, so the nurse assumed he was feeling better.

6. Later that day, Mr King felt unwell again with the same symptoms. A nurse found that his blood oxygen level was low and sent him to hospital. That evening, a hospital doctor called the prison to ask why Mr King had been sent to hospital and whether he had taken any illicit substances. There is no record of what healthcare staff at the prison told the doctor.

7. In the early hours of 21 March, Mr King discharged himself from hospital and staff returned him to Winchester. Healthcare staff were not told straightaway that Mr King had returned from hospital, but a nurse saw him later that morning and he said he felt much better. There is no record that the nurse took clinical observations.

8. That night, during an ACCT check, a member of staff saw Mr King lying on the floor of his cell with vomit by his head. She went to fetch a nurse and when she could not find one, she called a medical emergency code.

9. Staff entered the cell and started CPR, which paramedics continued when they arrived. However, resuscitation attempts were unsuccessful and at 12.25am on 22 March, paramedics declared that Mr King had died.

10. The post-mortem report concluded that Mr King died of a duloxetine (an antidepressant) overdose. Mr King was prescribed duloxetine.

Findings

11. It is unclear how Mr King was able to take an excessive amount of duloxetine as he was not allowed to administer it himself and collected it twice daily. It is possible

that he was not swallowing his medication and storing it for later use, but there were no suspicions that he was doing so. Mr King did not leave a note, and there was no evidence to allow us to conclude he had intentionally overdosed on his medication.

12. In its last report for 2021/22, the Independent Monitoring Board said that the supervision of the medication rounds was generally effective, but they were still concerned that prisoners were able to divert their medication. The Head of Security and the Head of Healthcare may wish to consider how they could strengthen measures to prevent the storing and diversion of medication.

13. The clinical reviewer found that aspects of Mr King's care were not equivalent to that which he could have expected to receive in the community. When Mr King returned from hospital on 21 March, no one told healthcare staff. The Head of Healthcare told us that they would have monitored Mr King had they known that he had arrived back at the prison.

Recommendations

- The Governor should ensure that healthcare staff are told promptly when a prisoner returns from hospital, regardless of the time of day or night.

The Investigation Process

14. HMPPS notified us of Mr King's death on 22 March 2022.

15. 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.

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

17. NHS England commissioned an independent clinical reviewer to review Mr King's clinical care at the prison. The clinical reviewer and investigator jointly interviewed eight members of staff in June and July 2022. Another investigator interviewed the Head of Security on 27 June 2023.

18. We informed HM Coroner for Portsmouth and Southeast 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.

19. The Ombudsman's family liaison officer contacted Mr King's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

20. We shared our initial report with HMPPS. They found no factual inaccuracies.

Background Information

HMP Winchester

21. HMP Winchester is a local prison that holds up to 690 men. It has a local category B unit for young and adult men and a separate category C unit for adult men. Practice Plus Group Health and Rehabilitation Services Limited has provided health services at the prison since July 2020.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Winchester was in February 2022. Winchester had struggled to recruit and retain enough staff and this problem was affecting the day-to-day running of the prison, where at times, there were simply not enough officers to ensure even the most basic regime for prisoners.

23. The identification and management of patients with long term health conditions had improved. Care plans had been updated. A long term conditions nurse carried out prompt medicine reviews and annual health checks. Staff worked together to discuss patient care and address immediate health care needs.

Independent Monitoring Board

24. 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 2022, the IMB reported that the high l turnover of prisoners made the provision of healthcare services challenging, particularly when the prisoners' healthcare needs were complex. Prisoners with long-term conditions were provided with care plans. Supervision of medicines rounds was generally effective, but the IMB had concerns that prisoners were able to divert medication.

Previous deaths at HMP Winchester

25. Mr King was the fifteenth prisoner to die at Winchester since March 2019. Of the previous deaths, ten were from natural causes and four were self-inflicted. There are no similarities between the findings from our investigation into Mr King's death and our findings from the previous investigations.

Key Events

26. On 12 March 2022, Mr Alun King was remanded in prison, charged with manslaughter, and sent to HMP Winchester. It was not his first time at Winchester.

27. Mr King had a history of substance misuse, mental health issues and chronic pain. The reception nurse recorded that he had a history of self-harm but no current thoughts of suicide or self-harm. He said he had last attempted suicide in 2007.

28. Mr King was using buprenorphine (also known as Subutex, an opioid drug) patches for pain relief. However, the substance misuse nurse told him that he could not have these patches in his possession while in prison. Instead, the nurse prescribed methadone (another opioid drug, usually used as a heroin substitute but in this case prescribed as pain relief). He had been on methadone previously as part of a drug detoxification programme but not for a few years. He was prescribed a range of other medications for pain, depression and physical conditions (including asthma). His medications included pregabalin (to treat neuropathic pain but also widely abused for its euphoric effects when taken alongside opioid drugs), duloxetine and mirtazapine (both antidepressants). Mr King was not allowed to keep his medication in his possession and collected it from the medication hatch on the wing twice a day. Prison officers monitor the medication queue and are expected to check prisoners' mouths to ensure that they have swallowed their medication.

29. On 18 March, Mr King made cuts to his arms. He told staff he did it because he was angry that he had not received his canteen (items ordered from the prison shop). Staff took Mr King to hospital where his wounds were stitched. He was discharged later that day. Staff started suicide and self-harm prevention procedures (known as ACCT) and set observations at two an hour.

30. At his ACCT assessment interview the next day, Mr King said he was expecting a long sentence and was worried about his mental health. He said he heard voices which made him angry. He said the issue with his canteen had been resolved and that he had the support of his wife, daughter and parents. Staff held a case review the same day. They reduced observations to one an hour and scheduled the next case review for 24 March.

20 March

31. At 11.30am, on 20 March, Mr King told healthcare staff at the medication hatch that he felt dizzy. His speech was slurred, and he had right-sided weakness around his mouth. A nurse took Mr King's clinical observations, which were all normal, but he called for the duty nurse to examine Mr King more closely.

32. The duty nurse examined Mr King and noted his slurred speech, dry lips, and weakness. He took Mr King's clinical observations again, which were normal. Mr King said he had not taken any illicit drugs but had not been drinking enough fluids. Staff gave him a glass of water and the nurse noted that he would check on him again later.

33. At around 2.30pm, the duty nurse returned to the wing to review Mr King but was told he was on the exercise yard. At interview, he said he had assumed this meant

Mr King was feeling better and that he did not try to see Mr King as prisoners generally did not like having their exercise time interrupted.

34. At around 5.45pm, an officer called for a nurse to see Mr King as he had appeared dizzy and weak during an ACCT check. The duty nurse attended. He took Mr King's clinical observations and found that his blood oxygen level was low. He asked staff to call for an ambulance, and Mr King was taken to hospital.

35. Later that evening, a hospital doctor called the prison to ask why Mr King was sent to hospital, what his clinical observations were and whether he had taken any illicit substances. The call is noted in Mr King's medical record, but the entry does not say what the doctor was told. When interviewed, the duty nurse said that when a prisoner was sent to hospital, he would normally print off a summary from the medical record and pass it to the escorting officers and he would have done this for Mr King. However, there is no documentary evidence of this.

21-22 March

36. At around 2.10am on 21 March, Mr King discharged himself from hospital and staff returned him to Winchester. Staff took him straight to his cell and did not tell healthcare staff that he had returned from hospital.

37. Staff gave Mr King his methadone at around 8.40am. Around three hours later, a nurse noted that she saw Mr King and he said that he felt much better. There is no record that she took any clinical observations.

38. Later that day, healthcare staff called the hospital to request Mr King's discharge summary. According to the Head of Healthcare at Winchester, during the call the hospital told a member of staff that Mr King had been given naloxone (a medicine that reverses the effects of opioid overdose) at the hospital. This was not mentioned on the discharge summary, which just said that Mr King had self-discharged prior to assessment.

39. That afternoon, staff recorded in the ACCT ongoing record that Mr King had asked about getting a wing job, that he had engaged with the regime and had no issues. Later, at around 5.00pm, they recorded that he seemed to be in a low mood.

40. At 11.07pm, an operational support grade (OSG) carried out Mr King's ACCT check. She said that Mr King was watching television and confirmed that he was well.

41. At 11.33pm, the OSG checked Mr King again. She saw Mr King on the floor with vomit around his head. She went to get help from the healthcare office nearby, but the nurse was not there, so she radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Two officers arrived at the cell at 11.34pm, followed by healthcare staff. They went into the cell and healthcare staff started CPR.

42. At 11.45pm, paramedics arrived and took over CPR. However, resuscitation attempts were unsuccessful. At 12.25am on 22 March, paramedics declared that Mr King had died.

Contact with Mr King’s family

43. On 22 March, the prison appointed a prison manager as the family liaison officer. He and a colleague informed Mr King’s wife of his death in person, later that day.

44. Winchester offered to contribute to Mr King’s funeral costs in line with national policy.

Support for prisoners and staff

45. After Mr King’s death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr King’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 King’s death.

Post-mortem report

47. Toxicology results showed that Mr King had a raised level of duloxetine in his blood, which could indicate overdose. He also had raised levels of pregabalin and mirtazapine, but both were far below the levels associated with fatalities. The other drugs detected were at levels consistent with therapeutic use.

48. The post-mortem report concluded that Mr King died from a duloxetine overdose. There was also evidence of food aspiration (breathing food into the lungs) and pneumonia that had contributed to death.

Findings

Duloxetine overdose

49. Mr King's post-mortem report concluded that he died from a duloxetine overdose. He did not leave a note so there is no evidence that it was a deliberate overdose. The fact that he reported to staff at the medication hatch that he was feeling unwell would also suggest that his overdose was not intentional.

50. Mr King was prescribed duloxetine (60mg twice daily), which he collected from the medication hatch on the wing. As Mr King did not keep his medication in his possession, it is unclear how he was able to take an excessive amount. Prison officers supervise the medication queue and are supposed to confirm that prisoners have swallowed their medication by checking their mouth. However, prisoners can still find ways to secrete medication. It is possible that Mr King did not swallow his medication and stored it for use later, but there were no suspicions that Mr King was storing or diverting his medication while at Winchester.

51. The IMB noted in their latest report for 2021/22 that although supervision of medicines rounds was generally effective, they had concerns that prisoners were able to divert medication. We do not make a recommendation, but the Head of Security and Head of Healthcare may wish to consider how they could reduce opportunities for prisoners to store and divert medication.

Clinical care

52. The clinical reviewer concluded that some aspects of Mr King's clinical care were not equivalent to that which he could have expected to receive in the community. She noted that there was no documented handover to the hospital, including clinical observations, when Mr King was sent to hospital on 20 March. She made some recommendations in her clinical review which the Head of Healthcare will need to address.

Communication between prison staff and healthcare staff on 21 March

53. When a prisoner returns from hospital out of hours, when the prison reception is closed, it is good practice for prison staff to tell healthcare staff so that they can ensure continuity of care.

54. At interview, the Head of Healthcare said that if her staff had been made aware that Mr King had returned from hospital, they would have taken Mr King's clinical observations and closely monitored him, either on the wing or transferred him to the prison's inpatient unit if necessary. The nurse involved in the emergency response also said in interview that he would have checked Mr King if he had known that he had returned from hospital. This was potentially a missed opportunity to monitor Mr King for any clinical deterioration (though it is noted that Mr King appeared to be well during the day of 21 March and only seemed to deteriorate much later on that evening).

55. We recommend:

The Governor should ensure that healthcare staff are told promptly when a prisoner returns from hospital, regardless of the time of day or night.

Inquest

56. The inquest concluded on 7 May 2024. The medical cause of death was found to be:

1a Respiratory Depression

1b Central Nervous System Depression

1c Combined Use of Complex, Prescribed Medication, Exacerbating Pre-Existing Chronic Lung Disease, due to Recurrent Aspiration Pneumonia and Chronic Obstructive Pulmonary Disease

57. The inquest reached a narrative conclusion:

"Alun died as a result of natural causes, though his ability to manage his respiratory challenges and his other co-morbidities was compromised by prescribed medication treatment that was potentially administered outside of the optimal prescribed times and a polymorphy review was due."

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