

**An investigation into the circumstances surrounding the
death of a man in hospital
whilst in the custody of HMP Winchester**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2008

This is a report into the circumstances surrounding the death from natural causes of a man in hospital in April 2007. The man was 63 years old and a prisoner at HMP Winchester. He had been at Winchester for seven months having been transferred from HMP Kingston on 1 September 2006.

The man had been in prison for over 30 years. He was a life sentence prisoner who grew old in jail and had a history of physical and mental health problems. He was not a well man when he transferred to Winchester and over the coming months his health deteriorated further. He was transferred to hospital, and was diagnosed with chronic liver failure. Following a post mortem, evidence of advanced cancer was also found.

The death of a loved one is always distressing. 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 investigators. I would like to thank the Governor of Winchester, and his staff for their co-operation during the investigation. I would like to extend particular thanks to the Head of Healthcare.

I asked a representative from Mid-Hampshire Primary Care Trust to carry out a review into the man's clinical care whilst he was at Winchester. A panel of clinical staff from the PCT looked into the healthcare he received. I am grateful to the PCT for their assistance and attach the review as an annex to this report.

The circumstances reported here have been difficult to piece together. It became clear to my investigator that the man's time at Winchester was not always recorded appropriately. He was an older prisoner in poor health and known to Kingston's healthcare unit when he was transferred out for disciplinary reasons. The healthcare team at Winchester were not made aware of his transfer in advance, and he suffered delays in being followed up and treated. Initially, he fell through the net. Although earlier detection of his chronic disease history would not have changed the outcome for him, it might have provided better continuity of care in the months leading up to his death.

The issues relating to the management of the man at Winchester were largely clinical, and I have relied heavily on the clinical review. The review makes five recommendations. Of these, one is a repeat recommendation from a previous clinical review at Winchester. I have also repeated a recommendation made in one of my previous reports at the prison and make an additional five of my own.

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SUMMARY

The man was young when he was sentenced to life imprisonment in 1975, and he spent the majority of his adult life in prison. His medical history shows that he had ongoing chronic physical and mental health problems. In 1996, he was diagnosed with cirrhosis of the liver and a history of viral hepatitis. He suffered from depression and took medication to alleviate his low mood. The man also had a history of long term drug dependency and underwent a detoxification programme that same year.

As a life sentence prisoner, he served his sentence at a number of different prisons. He moved to HMP Kingston in 2001, and whilst there was admitted to hospital with chest pain and suspected angina. He was prescribed an inhaler to treat the condition. Between June and August 2006, he saw the healthcare team regularly and weight loss was recorded. He was taken to hospital again for chest pain and complained of experiencing some pain when passing urine. The man continued to use an inhaler for his angina. Three days before his transfer to Winchester, he reported to healthcare for a blood test. He had lost weight again and an appointment was made for him to see a doctor.

The man was unable to keep the appointment and was transferred to Winchester the same day. The move was for disciplinary reasons thought, at the time, to be of a serious nature. The transfer arrangements were agreed locally between the two prisons, and his move was swift.

When he arrived in Winchester's reception on 1 September, he was not picked up appropriately through the healthcare screening process. As a high risk prisoner, he was moved to A wing's first night in custody centre and was placed in a single cell. The following day, he went to the medications hatch on the wing to ask for his inhaler prescription. He saw a nurse and his request was logged in his medical record, but an opportunity to pick up his ongoing care from Kingston was missed for a second time.

The man did not see a doctor until approximately two weeks after his arrival at Winchester. Once he was seen, he continued to take his anti-depressants and use his inhaler. From December 2006, he was seen by a nurse and a doctor regarding an ear complaint. He was told he would need a syringe procedure but never underwent the treatment.

From January 2007 onwards, the man complained of chest pain which worsened when he coughed. He was diagnosed with chronic obstructive pulmonary disease (COPD) and was medicated for the condition. His weight loss was also recorded and, after a review by a doctor, he was referred for an x-ray and lung function test.

On 1 March 2007, the man's medication for severe indigestion was changed. His further weight loss was noted by a doctor who ordered urgent blood tests and further examination of his symptoms. Approximately two weeks later, a nurse queried the result of his x-ray and was told the report was not ready. He was assessed by a doctor again on 21 March. The man appeared slightly jaundiced and to be losing weight but said he was not in any pain. The doctor also noticed that his blood had not been tested and ordered the sample to be taken that day. The man experienced

another delay. His blood was taken on 27 March and his liver function test was carried out the following day.

On 1 April, he fell on the stairs on B wing. A nurse went to see him and assessed that he had not sustained any injuries from the fall. His blood test results were followed up the same day.

Two days later, the man was admitted to hospital as an emergency. He remained a high risk prisoner, and was escorted under restraints. He went straight to the Emergency Medical Assessment Unit and from there to an appropriate ward. He was then examined and monitored by hospital staff who told the escort officers that he would be in hospital for at least another week.

The man stayed in hospital for just over two weeks. His security risk was reduced once it was apparent his physical condition had deteriorated. His restraints were removed three days after he arrived. The following week, after another review, his risk level was further reduced to one bedwatch officer.

The man did not return to Winchester. His health deteriorated rapidly and he was made as comfortable as possible in hospital. He became distressed, and on several occasions his behaviour became challenging as his condition worsened. One of the governors at Winchester telephoned his next of kin shortly after he was admitted to hospital and told her that he was very poorly and not likely to survive. Arrangements were also made for his nephew to pass a message to him during the last few days of his life.

The man's health deteriorated again. He died at 6.10pm with an officer close by.

My investigation was hampered by the lack of recorded information presented to my office. The man's wing history, his medical record and B wing's observation book did not provide the level of detail expected in an individual prisoner's files. The clinical review panel drew a similar conclusion and said that, on reflection, there were unable to come to any firm conclusions over the quality of healthcare he received at Winchester.

The panel considered the timeliness of the medical interventions the man received from the information gathered, and have made five recommendations to improve healthcare screening in reception, staffing levels, training to use the new IT record management system, chronic disease management, and to prevent delays in taking and obtaining the results of bodily samples.

In addition to the man's care, I have also focused on how Winchester responded to his death and urge the prison to review its local contingency plans and family liaison arrangements.

THE INVESTIGATION PROCESS

1. The investigation was opened on 24 April 2007. On that date, my investigator, wrote to the Governor of HMP Winchester and asked him to display notices of the investigation into the man's death to staff and prisoners.
2. A liaison officer was appointed by the Governor. The liaison officer arranged for the the man's main prison records and his medical record to be sent to me. My investigator subsequently visited Winchester on in August 2007 and spoke to three members of staff. Unfortunately, not all the key members of staff were available that day and the liaison officer was asked to arrange another visit. The Head of Healthcare assisted him and made healthcare staff aware of the investigation and forwarded additional documentation to my office.
3. The Clinical Governance Manager for Mid-Hampshire Primary Care Trust, was invited to undertake a clinical review into the medical care the man received during his time in custody. Two clinicians from the PCT accompanied my investigator to HMP Winchester for a second set of joint interviews on in September 2007. Unfortunately, they were not able to speak to all the members of staff identified, but did interview one member of the healthcare team. My investigator also interviewed a Governor separately. Subsequent interviews with prison staff took place over the telephone.
4. The Coroner was informed of the Ombudsman's investigation. He kindly agreed to send me a copy of the post mortem report. The report concluded that the man's cause of death was due to:
 - 1a. Hepatocellular carcinoma
 - 1b. Cirrhosis
 - 1c. Hepatitis C infection
 2. Chronic obstructive pulmonary disease

A draft copy of this report was sent to the Coroner, to assist him with his enquiries.
5. One of my family liaison officers (FLO), contacted the man's next of kin shortly after the investigation was opened. The FLO explained my office's role, provided information about the investigation process, and offered the man's family the opportunity to discuss any issues or concerns. His family did not want a visit and raised no concerns.
6. A draft copy of this report was sent to the man's family and the prison service. His family made no comments on the draft. I will send them a copy of this report. Of the eleven recommendations made, the prison service accepted ten and partially accepted one. The prison service response can be found on page 30 of this report.

HMP WINCHESTER

9. HMP Winchester is a category B local male prison, located just outside the main city centre. Built in 1846, most of the prison is of a Victorian radial design and has a maximum capacity of 697. .
10. The prison contains four residential units and one separate unit, West Hill, which is training unit for category C adult males. B wing holds approximately 173 convicted and remand prisoners.
11. Her Majesty's Chief Inspector of Prisons (HMCIP), last inspected Winchester in April 2007. HMCIP published her report in June 2007 and commented that:

“Like all local prisons, it faces considerable pressures and increased demands. There was some evidence, at this inspection, that this combination was testing the prison’s ability to sustain and continue improvements”.

Healthcare

12. Winchester provides nurse-led primary care, inpatient care and a pharmacy service. It is separate from the main prison, although some healthcare and treatment takes place in wing-based treatment facilities on A and B wings. Healthcare services are commissioned by Hampshire Primary Care Trust (PCT) and the doctors are provided by a local general practice.
13. The Head of Healthcare is supported by a deputy who is also a clinical nurse manager and responsible for the care of older people. Winchester also draws upon doctors’ services from the local GP Practice. In addition, the healthcare centre is staffed by both general and mental health trained nurses and healthcare officers.
14. The healthcare unit has recently inherited an electronic record keeping system of all prisoners in its care. The “Vision” system went live in June 2007 and has widened access to records in all clinical areas. It is enabling healthcare staff to change the way they store and use medical data. Vision is designed to provide a full audit trail of medical histories and the interventions that each prisoner receives or is due to receive. It is a permanent electronic record that will be used to monitor the healthcare needs of transfers in and discharges to other prisons or the community.

Reception

15. On arrival in reception, a prisoner is seen by a nurse or, more commonly, a healthcare officer (HCO), and is screened in order to identify immediate healthcare needs. Prisoners then have the opportunity to see a doctor within 24 hours if required. Prisoners are also asked to sign a medication compact and to give consent for the prison to access their previous medical history.

Personal Officer Scheme

16. Winchester introduced a new personal officer scheme in early 2007. As part of the scheme, officers are required to introduce themselves within one week of a prisoner's arrival, and to make regular and relevant entries in a prisoner's wing history sheet. HMCIP found that the policy behind the personal officer scheme was good, but it did not reflect the work taking place in the main prison. Detailed personal officer entries were exceptional as many wing files contained few entries and considerable gaps between entries. Some entries were also unhelpful and unprofessional. The report found that few files showed any evidence of personal knowledge of a prisoner or reference to their personal needs. HMCIP recommended more training for officers on the role of a personal officer, and the inclusion of care plans in wing files for elderly or disabled prisoners.

Elderly Prisoners

17. Prisons are not principally designed for the elderly, and it is difficult for an individual establishment to accommodate an aged population. A thematic review by HMCIP in 2003 found that, although older prisoners (60 years and over) make up a small percentage of the overall prison population, the number of elderly prisoners had trebled between 1992 and 2002 and was continuing to grow. The study also said that there was no overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.
18. The thematic review found that some elderly prisoners will inevitably spend the rest of their lives in prison. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria and the thematic review stressed that the prison environment must be geared towards meeting the specific needs of its ageing population.
19. A report, *Growing Old in Prison*, published by the Prison Reform Trust in 2003 quoted a Department of Health study that focused on older prisoners. The study said that out of 203 prisoners aged 60 and over, 85 per cent had one or more major illnesses reported in their medical records. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory.
20. With the exception of a small number of establishments, prisons do not provide a separate regime for elderly prisoners. The man's experience is no exception to this. He was located on an ordinary residential wing. The healthcare centre at Winchester is currently devising an older prisoner policy and hopes to finalise a working document by mid-December 2007. Whilst this is being developed, older prisoners are being assessed in the Wellman clinic.

KEY FINDINGS

The man's transfer from HMP Kingston

21. The man was transferred from Kingston to Winchester on in September 2006. His transfer, following a serious allegation against him by another prisoner at Kingston, was locally arranged between the two prisons. Prior to his move, he had been seen in Kingston's healthcare centre for blood tests and was due to see a doctor on the day he was moved.
22. When the man arrived in Winchester's reception, he was booked in at the front desk and his property was checked and logged accordingly. His Prisoner Escort Risk Form said that he was a high risk prisoner as a result of the allegations against him. The man was next seen by a Senior Officer (SO) who carried out the Cell Sharing Risk Assessment Form (CSRA). The SO completed the relevant parts of the form and assessed his risk to others as high. The form also put him down for single cell occupancy in accordance with CSRA guidelines. Section four, to be completed by the locating or duty officer, was left blank.
23. At some point during the reception process, a reception Healthcare Officer (HCO), saw the man to complete section three of his CSRA. This section assesses a prisoner's risk to others based on information obtained during the reception healthcare screening. On the man's form, the HCO assessed him as low risk and suitable for multi-cell location. This indicated that the HCO saw no evidence from the information available that he was a risk to others.
24. Prior to completing section three, the HCO should have conducted a First Reception Healthcare Screening with the man. The purpose of this is to determine whether there are any immediate concerns about a prisoner's physical or mental health on arrival. The man's medical record did not contain a copy of the health screen and made no mention of the HCO seeing him in reception.
25. The man was located to a single cell on A wing. This wing doubles up as the first night in custody centre. As he was so far into his life sentence, he was familiar with custodial environments and therefore did not undertake a full induction into Winchester. An SO, who worked on A wing, told my investigator that he carried out two separate cell sharing risk assessment reviews whilst the man was on the wing and, although he denied the allegations against him, he remained in a single cell as a high risk prisoner. The SO said that, as a consequence of his risk status, the man stayed on A wing for longer than is usual whilst a suitable single cell was located for him elsewhere.
26. The man requested the medication he had been prescribed at Kingston the day after his transfer. He saw a nurse at the medications hatch on A wing and a prescription chart was ordered. He then reported to the triage clinic on 13 September and to a doctor two days later. This was two weeks after his arrival at Winchester. The doctor wrote in the man's medical record that he needed his blood taken. The doctor also noted that he had lost weight.

27. During his first week on A wing, the man should have had a follow-up secondary healthcare screening. This is normally carried out a few days after a prisoner's reception and consists of a more in depth assessment of a prisoner's healthcare needs. He had a history of chronic disease and, as an elderly prisoner, he might have benefited from a healthcare screening specifically tailored for the older prisoner population. The Head of Healthcare confirmed that Winchester did not conduct an older prisoner healthcare assessment.
28. On 1 November, the man was relocated to B wing and to a single cell on 'the threes'. This is, in fact, the first floor landing of the wing. He was allocated a personal officer, and settled into his new environment. The man kept himself to himself for the first few weeks. He chose not to participate in the daily regime on the wing and did not work. His wing history sheet said that he was happy with the move and had not caused staff any problems.
29. The man was next seen by a doctor on 29 November, and by another doctor on 30 November, for a review of his medication (dosulepin). His prescription was continued. He moved to another cell on the same landing after complaining that he was too cold. His wing history sheet said that he continued to comply with the regime and remained polite and quiet around staff. A review of his CSRA was due on 23 December.
30. The next time the man saw healthcare was on 30 December. According to his medical record, he was due to have his ears syringed. A nurse told him that this was not possible because there was not a suitably qualified member of staff available to carry out the procedure. He was told to continue with the ear drops he had been prescribed when previously reviewed by a doctor.
31. An appointment was made for the man to see a doctor on 5 January 2007. After an ear examination, the doctor agreed that he needed the syringe procedure and made a note for it to be arranged. The man's prescription was also repeated. During a routine management check of the quality of entries in his wing history, a Governor noticed that his CSRA review was overdue. He made a note of this and asked for the review to be completed as soon as possible. The man was reviewed by an SO the following day and remained high risk.
32. On 11 January, the man complained at the medications hatch, this time to a nurse, that he still needed his ears syringing. Again, he was told that there was nobody trained to carry out the procedure. The nurse made a note which said that this was becoming an issue and that she would bring it to the manager's attention.
33. On 25 January, the man saw a doctor after complaining of chest pain. He told the GP that the pain increased when he coughed. He was prescribed amoxicillin, an antibiotic, and ibuprofen (a pain-killer and anti-inflammatory). When the doctor saw him one week later, he felt there had been some improvement but requested a spirometry (a lung function test). This was recorded in the man's medical record. The doctor also said that he should

continue with his medication and should be reviewed if the pain he was experiencing continued.

34. The man was reviewed by a doctor on 13 February and was referred for a chest x-ray. His medical record said that the spirometry results were not available and he would need to be reviewed again following the results.
35. The man continued to lose his appetite. Two officers told my investigator that other prisoners made sure he got his meals if he did not turn up himself. A B wing officer, also noticed that the man had not been eating properly due to his chest infection. The officer made a note in his wing history which said that he was making sure the man had his dinner and tea.
36. The next day, the man had an x-ray of his chest. On 20 February, an entry in his medical record said that the results were not available. The entry did not say where the procedure was carried out and by whom.
37. On 1 March, the man saw a doctor and his weight loss was noted. The doctor also requested a blood test and a stool sample. He was prescribed lansoprasole instead of omeprazole to alleviate his indigestion. Two weeks later, on 15 March, the doctor noted that he indigestion had improved but that the tests ordered had not been carried out. The following day, a nurse chased up his chest x-ray result and was told that the report had not been done.
38. During a review of the man's prescription for dosulepin on 21 March, a doctor noticed that he appeared to be jaundiced, was still losing weight, but was not in any pain. The doctor also noticed that the blood test, requested on 1 March, was still outstanding and wrote 'do urgently today'. He was then scheduled for an urgent review with the doctor once the test results were available.
39. The man's blood was taken by a nurse on 27 March. This was six days after the doctor had made an urgent request for the tests to be done immediately. When interviewed, the nurse explained that prisoners experienced frequent delays when it came to blood tests. The nurse said that there was no scheduled blood clinic at Winchester. Staff shortages and a handwritten booking system had caused delays for prisoners. The blood tests were divided into urgent and non-urgent books, but there were only two nurses qualified to carry out all the blood tests for the whole prison.
40. At some point during the day on 1 April, the man fell on the stairs. A nurse attended and examined him, but could find no sign of any injury. The nurse recorded his fall in his medical record but it is not clear whether an injury form (F213) was also completed. A B wing officer, recalled the incident and told my investigator that he had been frail and weak prior to his fall. His wing history sheet made no reference to his physical condition and no mention of his fall on the wing. There was also nothing in the wing observation book. Later the same day, a nurse from healthcare telephoned the hospital's Haematology Department to chase the man's blood test results. The hospital confirmed that the results had been sent back to Winchester.

41. It is difficult to say with any accuracy what happened over the next two days. The man's medical record, wing history sheet and wing observations book did not contain any information about the deterioration in his health, when he was next seen by a member of the healthcare team, or why he was transferred to hospital and how. His wing history did confirm that on 2 April the police dropped the charges against him.

The man's stay in hospital - 3 April to 20 April

42. The man arrived at the hospital on 3 April accompanied by two escort officers. He was attached to one officer using restraints (these security arrangements were authorised by a Governor at Winchester). A nurse filled in the healthcare section to say he was fit to be restrained. The Head of Healthcare at Winchester, told my investigator that she had no recollection of being consulted about his risk or that he had been admitted to hospital. He did not have a Prisoner Escort Record form (PER) for the transfer. Another Governor, told my investigator that the risk assessment acted as a valid transfer form in this instance.
43. The man went straight to the hospital's Emergency Medical Assessment Unit (EMAU). A referral letter from one of the prison's doctors, provided a medical history (chronic disease), the man's current symptoms of anorexia, jaundice, weight loss, and his recent test results. The letter was not copied into his medical record or repeated as a continuous medical entry and was not made available to my investigator.
44. From the EMAU, the man was placed on one of the wards, and he saw a hospital doctor. At 2.45pm, the doctor took a blood sample, examined him, and then moved him to another ward later that evening. He had a settled night and an SO and Officer, on night escort duty, began a bedwatch log of his condition.
45. At 7.30 am the following morning, two officers came on duty and recorded the medical interventions the man received throughout the day. The bedwatch log said that at 9.40am he was taken for an x-ray on his chest and abdomen. My investigator could not determine whether he was attached to an officer for the procedure. However, in light of the fact that x-rays are carried out in radioactive areas, I assume that his restraints were removed temporarily.
46. The doctor sent the man for an ultrasound scan at 3.10pm. One of the bedwatch officers made an entry in the log which said that he had experienced a disturbed afternoon and evening. The prison was kept informed of his condition throughout the day.
47. The man's discomfort continued throughout the next day. A log entry made by an officer at 11.00am on 5 April said that the doctor had decided to change his medication and move him to another ward. The doctor also told the officer that the man would be staying in hospital until 10 April. He did chat to officers and tried to get some sleep, but was in a lot of discomfort. A management check was carried out by the duty governor at 5.10pm and the prison was told that he would remain in hospital.

48. The next morning (6 April), the Duty Governor visited the hospital and authorised the removal of his restraints. The Governor amended his risk assessment form to reflect the change in security arrangements and said that they would be kept under review on a daily basis. His bedwatch log also recorded the change. One of the officer's on escort duty that day, made a further entry which said that the man had not eaten much and had been seen by the Registrar early that afternoon. When evening duty escort officers relieved the officer, they were given a full handover and told that the man was not to be restrained.
49. A typed note recording the contact made between Winchester and the man's next of kin was made available to my investigator. The note, typed by an administrator at Winchester, said that on 7 April a Governor telephoned the man's sister to tell her that he was in a serious condition and "due to die in the near future". The note also said that his sister expressed a wish to be contacted when he died.
50. The man's next 24 hours were uncomfortable. During the morning of 8 April, he was sick and was moved to the bay area of the ward. The ward nurse told escort officers that there had been an outbreak of sickness and diarrhoea. This was recorded in the bedwatch log. The Duty Governor visited the ward at 11.00am to review the security arrangements and made no changes.
51. At Winchester, the man's personal officer learnt that the man was now in hospital and updated his wing history sheet to reflect this. The assistant chaplain went to see him in the afternoon. At approximately 8.15pm, escort officers from another prison came on duty to relieve Winchester's officers. They received a handover and continued to complete the bedwatch log for that evening. The doctor on duty examined the man at 11.15pm and asked a nurse to take some blood. He had a quiet night but appeared weak. The chaplain visited him again the following morning.
52. Escort officers from the other prison continued to assist with bedwatch duty on 10 April. Throughout the day, a Governor, a Principal Officer and a representative from the Independent Monitoring Board (IMB), visited the ward. The man saw the doctor again at approximately 1.30pm and, following an examination, he went for another ultrasound scan later that afternoon. The Governor authorised a further reduction in his security arrangements that evening. The governor amended the man's risk assessment to reflect the change and that he was "currently very ill". If his situation improved, escort officers should inform the orderly officer or duty governor immediately. At 8.10pm, his bedwatch was reduced to a single officer.
53. An SO was the first officer to carry out bedwatch duty alone. The officer updated the man's bedwatch log as required and noted that he seemed a bit happier in mood. The SO wrote, "this is due to him taking on more fluids, staff should encourage more." The SO was relieved by an officer at 7.00am on 11 April. Another SO, this time from another prison, also reported for duty that morning, not having been told that security arrangements had been reduced to

one officer only. The SO was re-deployed to other duties at lunchtime once the prison was told of the changes.

54. At 12.50am on 12 April, the man became restless and attempted a trip to the toilet on his own. The escort officer on duty, saw him try to pull his medical equipment out as he fell to the floor. The nurses on duty assisted him before putting him back into bed. Another officer came on duty at 7.30am and recorded that the man remained uncomfortable throughout the day. An SO took over the night duty at 8.00pm, but was replaced by an officer at 4.00am due to sickness.
55. The man began to experience difficulty in taking his medication orally. He remained uncomfortable and was visited by the prison's chaplaincy team the next day. Soon after, nurses on the ward began to move patients having suspected that another patient had a sickness virus. An officer wrote in the bedwatch log that the patient was "constantly being sick". The officer also said that the virus was airborne and that staff should be aware. The communications staff at Winchester were told that the man had been moved to a two-bed room to reduce the risk of infection. The doctor saw him at 4.25pm and decided to administer his pain relief medication and fluids intravenously.
56. On 14 April, the man became more aggressive as his health worsened and he was warned by nursing staff. Later that evening, he used the buzzer above his bed to call for a nurse. When she arrived he said, "Turn all these machines off, I just want to die."
57. The man refused to take his fluids or eat his breakfast throughout the morning of 15 April. After speaking to the doctor, he agreed to comply. For the rest of the day, he became restless, buzzed for the nurse at regular intervals, but then refused help. He asked for more pain relief and an officer's entry in the bedwatch log said that the man had asked the nurse to "make it all stop". He was given a painkiller intravenously, slept for short periods and then buzzed the nurse for assistance to use the commode.
58. The man's restless behaviour worsened and the officers on duty during the day and evening of 16 April made a number of entries to that effect. He began to refuse help and treatment from both nurses and the consultant on duty. At approximately 10.40am, the consultant told one of the officer's that the man would remain in hospital "for at least another week". Winchester's communications staff were updated immediately. That afternoon, he swore at a nurse and told her to leave him alone. A few hours later, he swore at another nurse attempting to give him his medication and he was warned about his behaviour and attitude.
59. A PO carried out a security assessment at approximately 4.20pm. He spoke to the nurse in charge and was told that the man remained weak, unable to walk without assistance and was still refusing his food and fluid. The PO decided to leave the level of supervision as it was, but said that the single officer arrangements would need to be reviewed regularly. He informed the duty governor of his decision and recorded it on the bedwatch log.

60. Throughout the morning of 17 April, the man became increasingly disturbed. An officer made lengthy and regular entries in his bedwatch log, describing his behaviour as poor and abusive to nursing staff. The man continued to use his buzzer to ask for pain relief and to use the commode. He was given paracetamol via a drip at approximately 2.00am, but used his buzzer again to ask for more. He was refused further medication until approximately 3.30am when he was given oral morphine.
61. Between 5.15am and 7.00am, officers noticed that the man pulled at his drip machine and tapped his bed to get the attention of staff. An officer made an entry in his bedwatch log which said he had been shouting for an hour and was a nuisance to staff. The officer telephoned Winchester and updated staff. Another officer then took over and, following attempts by nursing staff to wash the man, the officer gave him another warning for his behaviour and language. One of the nurses told the officer that, because the man was getting weaker, he was more confused and argumentative.
62. The man remained agitated and refused medical attention. He had a quiet night and during the morning of 18 April did take his medication. He became agitated again when another nurse tried to give him a bed bath. He attempted to hit the nurse and this was recorded in his bedwatch log by one of the officer's. At Winchester, the man's personal officer learnt that he remained in hospital and was not improving. The officer made a note in his wing history sheet.
63. The next morning (19 April), he became delirious. He was washed by nursing staff, and one of the doctors inserted a drip into his arm to enable him to take fluids. At midday, one of the escort officers received a telephone call from a member of staff at another prison. The officer was told that a member of the man's family wanted to speak to him but passed on his family's regards instead.
64. The man was moved to a single room. At approximately 7.00pm, an SO from the prison telephoned the hospital again and spoke to one of the officers. The SO explained that a member of the man's family had been told that he was not expected to live. The officer then spoke to the man's family member and said he would pass on a message. Shortly after this telephone call, the ward sister told the officer that she would be surprised if the man made it through the weekend.
65. On the morning of 20 April, the man deteriorated further. At 7.00am, an SO came on duty and noticed that he was sleepy. Nursing staff encouraged him to eat, but the man only managed a small amount of food. At lunchtime, he was given a wash and his bedding was changed. The doctor came to see him at 3.45pm, but found it difficult to wake him and told nursing staff to keep him as comfortable as possible. The man was offered liquid and painkillers by a nurse but refused to take anything.

66. At some point that afternoon, the Head of Healthcare at Winchester telephoned the staff nurse and discussed palliative care for the man. The Head of Healthcare told the staff nurse that it was not appropriate for the man to return to prison, and that a hospice would be a dignified environment given his circumstances. An entry in his medical record said that the hospital would be in touch about a transfer.
67. The man died at 6.10pm. An SO, who was at the hospital, telephoned the communications staff at Winchester. A few minutes later, the Duty Governor, arrived at the hospital. Both the SO and Duty Governor gathered his personal belongings and took them back to the prison.

Events following the man's death

68. When the Duty Governor returned to the prison at approximately 6.20pm, he went to the control room and took over from communications staff. The incident log sheet, normally filled in by communications staff, was also completed by him.. The Duty Governor recorded that both he and the Orderly Officer (Oscar One) were told of the man's death at 6.10pm along with staff at the gate. The Governor was contacted at 6.15pm, followed by other relevant internal and external parties.
69. According to the incident log, the Prison Service press office was contacted at 6.30pm and the man's next of kin approximately 20 minutes later. The Duty Governor spoke to his sister on the telephone and told her that he had died. According to the record of contact, the man's sister expressed a wish not to act as next of kin for the purposes of arranging the funeral. His sister suggested that his daughter might wish to. The Duty Governor was given his daughter's name and asked Winchester's Police Liaison Officer (PLO) to assist him in finding contact details for her. There was nothing in the record of contact to confirm that the other family member, who had been in contact, was also told about his death.
70. The following day, a Governor contacted Winchester's healthcare and told nursing staff that the man had died. A nurse made an entry in his medical record which said that the Head of Healthcare had been informed. His wing history sheet was not updated to reflect his death. His personal officer was on leave at the time and was told verbally by one of the Governors on her return to work. The wing observation book had one entry relating to his death. It was dated 21 August and noted that B wing had received notification of my investigation that day, and that interviews would take place on 23 August.
71. The Duty Governor told my investigator that the PLO found contact details for the man's daughter a few days after he died. On 26 April, the Duty Governor telephoned her to break the news and left a message on her answer machine to call him back. The man's daughter returned the Duty Governor's call shortly afterwards and agreed to act as next of kin. They discussed funeral arrangements. An offer from Winchester to assist with the arrangements and the financial cost was accepted. The Duty Governor then asked a member of the chaplaincy team to help with the arrangements and telephoned his sister to check that she was happy to be put in touch with his daughter. The man's sister confirmed that she was content with the arrangements.
72. The chaplain passed the details of the funeral to an administrative officer at Winchester on 14 May. The following day, the same member of staff liaised with the funeral directors and arranged for the relevant paperwork to be signed the prison's Governor. On 16 May, the man's daughter rang Winchester and spoke to the administrative officer. She explained that she wanted his property returned to her by post if possible. The administrative officer said that he would pass her request to the Duty Governor to discuss the best way to send it, and would telephone her back.

73. The Duty Governor told my investigator that, after co-ordinating the relevant death in custody paperwork, he gathered the man's property together and telephoned his daughter. He asked if she wanted the property returned to her. He also explained that there was a considerable amount of property to send. His daughter said she was happy for valuables to be sent by post. The Duty Governor arranged to bring the rest of his belongings to the funeral.
74. The man's funeral took place on 29 May and Winchester's chaplaincy team conducted the service. The Duty Governor attended and handed over his belongings, packed into boxes and Prison Service bags, to his daughter.

ISSUES

75. As I mention in my foreword to this report, the gaps in record keeping, particularly from a healthcare point of view, have made this a difficult story to tell accurately. In addition, the investigation process did not always run smoothly and my investigator experienced some organisational problems in securing a suitable time and place to interview staff.
76. The man was not picked up appropriately by the reception healthcare screening, designed to do exactly that. An opportunity to follow up his care with a secondary screening was also missed. Once in contact with healthcare, he went on to experience delays in his care, and his eventual transfer to hospital was, on paper, a mystery.
77. That said, the lack of continuity of care following his transfer, the failure to pick up his chronic disease history, and the delays in taking his blood and receiving his results would not have saved the man's life. His post mortem found evidence of advanced cancer. He presented as a man older than he was. This is possibly because he had been in the prison system for much of his adult life. His medical history was extensive with evidence of chronic disease and mental health problems.
78. Once the man was admitted to hospital, he was managed appropriately by Winchester's senior management and officers. After his death, the prison followed its own contingency plans for a death in custody and paid for his funeral. However, I have made numerous observations about the way Winchester followed up his death and these were raised with the Governor during the investigation itself. The recommendations I have made, based on these observations, will enable Winchester to strengthen its response in future. Additionally, the recommendations made by the clinical review panel are designed to better manage prisoner healthcare. I deal with these below.

The man's transfer, reception and induction

79. The man's transfer took place on the day he was due to see a doctor at HMP Kingston. This followed blood tests taken two days earlier. Transfer arrangements were made between the duty governors at Kingston and Winchester. Kingston's healthcare did not see him before he was moved to Winchester and therefore he was not assessed as fit to travel.
80. When the man arrived in Winchester's reception, he was seen by a HCO as evidenced by his CSRA. The HCO ticked the low risk box on his form which is surprising considering that sections 1 and 2 of the same CSRA considered him to be high risk and a single cell occupant only. It is particularly surprising given sections 1 and 2 are routinely completed before a prisoner sees a member of the healthcare team in reception. The HCO's assessment had no bearing on the man's location. Operational staff rightly placed him in a single cell and communicated through his wing history sheet that he remained high risk. Despite this, I remain concerned about the order in which this may have been

completed, and the lack of attention paid to important documentation affecting the security arrangements for a prisoner on arrival.

81. Winchester could not provide a first or second healthcare screening. This is a document I would have expected to have seen in the man's medical records. Furthermore, there is no evidence to suggest that he received a healthcare screening at all. What I can say is that I have criticised the lack of routine healthcare screenings at Winchester in a previous report. One of the nurses told my investigator that both screenings would usually be carried out at the same time, rather than days apart. The Head of Healthcare said that conducting both screenings together was due to the tight staffing levels.
82. The Head of Healthcare also confirmed that she had recently circulated a number of protocols for reception, first and second healthcare screenings, continuity of healthcare and palliative care at Winchester. The protocols, forwarded to my office, were based on the best practice evident in other prisons. They provide clear guidance to staff in accordance with Prison Service Orders and other relevant documents. As I mentioned earlier in my report, the healthcare centre is also devising an older prisoner policy to tailor ongoing assessment towards the specific needs of this group. The policy draft is due in December 2007. The reception protocol was adopted by Winchester in September 2007. Whilst I am pleased to see that other mechanisms are theoretically in place to ensure a prisoner, like the man, experiences a smooth journey through the healthcare process in future, I am not aware of the timescales for implementation.
83. Healthcare screening forms an integral part of reception, induction and ongoing care. They are not something that can wait. Winchester has recognised where improvement needs to be made and already introduced new reception guidance to healthcare staff. For that reason, I will not repeat the recommendations I have made in previous reports. However, I do urge the Head of Healthcare to give the remaining protocols the highest priority for immediate implementation. I also urge the Head of Healthcare to add to the recently circulated memo on reception healthscreens that CSRA management checks will also be carried out by the duty healthcare manager.
84. If the man's medical record from Kingston did not arrive with him on 1 September 2006, Winchester received it the day afterwards. On 2 September, the man spoke to a nurse on A wing about his medication. The nurse appropriately recorded it in his medical record. It was written directly underneath the last two entries from Kingston about his pending doctor's appointment and blood test. The nurse made that entry and would, perhaps, have assumed that his blood test results and appointment at Kingston had already been picked up in reception at Winchester. That said, his record did not say that the reception HCO had seen him. This is a mandatory entry in medical records. In the absence of written confirmation, an opportunity to pick up his healthcare soon after his arrival was missed for a second time.
85. The man's experience of reception and induction is indicative of a breakdown in communication. The clinical review panel share my criticism of the reception

process and communication. With the new electronic system in mind, the panel repeat the recommendation they made following a previous death in custody at Winchester. The review says the following:

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. A comprehensive template for recording this assessment should be available on the computerised clinical system which is now in place at HMP Winchester. Healthcare staff should have access to this system where they undertake their work and not just in the Healthcare wing.

86. I endorse the panel's view. However, I remain concerned that Winchester could not provide my investigator with evidence of a secondary healthcare assessment whilst the man was being inducted on A wing. The absence of both a first and second healthcare screening, coupled with no entry in his medical record to confirm that he had been seen in reception, led to the two week delay in seeing a doctor. Another consequence was no follow up in relation to his overdue test results. In addition to the clinical review panel's recommendation, I make the following recommendation:

The Chief Executive of Hampshire PCT should conduct an audit into the policies and procedures around receiving both new receptions and prisoners on transfer to ensure effective, ongoing healthcare is afforded to individuals in a timely manner.

87. The clinical review panel recommend that medical records and a summary of a prisoner's healthcare should always be available in reception. Prison healthcare should, in the main, reflect the standard practices seen in the community, and I have said in a previous report that medical records are not automatically sent with a patient transferring from GP to GP as the man effectively did. The HCO did not necessarily have to see his full medical record to ascertain if there were any immediate concerns, but would have benefited from a summary of his care at Kingston. In any case, the HCO should have obtained immediate information from him during screening and married this up with his record when it did arrive.
88. The computer system is designed to capture the issues of concern that both myself and the clinical review panel have highlighted. Winchester's healthcare inherited the system in June 2007 and the Head of Healthcare is confident that it will improve screening, continuous care and medical information sharing when prisoners are transferred or released from the prison. Inevitably, a new IT system needs time to settle before it will be embedded into mainstream ways of working in healthcare. The clinical review panel make the following recommendations which I endorse:

All healthcare staff should be adequately trained in the use of the new computer clinical system for both the recording and summarising of entries. A comprehensive and up to date note summary should always be

available on the system to ensure that the doctors working in the healthcare team can easily identify relevant medical history when reviewing patients. All members of the healthcare team should understand the structure of the system and how it is to be used.

Organisational processes should be introduced to ensure medical records are complete and that all relevant medical correspondence, or summaries thereof, are included in the health records. This should ensure that all prisoners receive appropriate healthcare and enable the healthcare team to provide a summary of the healthcare record when transferring prisoners to other establishments.

89. A new IT system is not a cure-all that can remedy every issue highlighted in the man's case. It is incompatible with other IT systems currently being used across the prison estate, and the prison sits outside the local PCT where IT is concerned. This means that effective communication still needs to be maintained between Winchester and other clinical areas. Of course, any IT system is heavily reliant on the healthcare staff using it to input the correct data. Whilst it will in future prompt staff that blood tests are overdue, or that a prisoner has a doctor's appointment pending, it will only do so if the information has been entered onto the system at source. I make the following recommendation:

The Prison Health Partnership must satisfy themselves that the protocols and procedures around the use of computerised medical records does not negate the need for continued communication and dialogue between healthcare professionals, both internally and externally.

Delays in the man's ongoing healthcare

90. The man experienced a significant delay in getting to see a doctor. When he did see one, he had already been on A wing for approximately two weeks. The clinical review panel say that Winchester's healthcare team did not seem to know about his chronic illness history and recent health problems. Most notably, it was not mentioned in his medical records that the doctors at Winchester knew he had a history of cirrhosis of the liver. The doctor did recognise that he was receiving medication and continued his prescription in a timely way. The review panel say that his prescription charts were clearly annotated with the dose and strength of medication he was taking. The doctor also correctly identified his weight loss and recorded this. The man experienced two further delays to have his ears syringed and his blood taken. The first delay came in December 2006. The second delay came in March 2007. In relation to this latter delay, one of the nurses interviewed provided my investigator with an overview of both the old and new procedures for taking blood samples. The nurse also explained that she had suggested the setting up of a blood clinic every week to better manage the volume of tests requested. The nurse stressed that she was one of only two healthcare professionals qualified to take blood.

91. The clinical review panel comment negatively on the delays the man experienced. The panel focus particularly on the delay in taking his blood, and conclude that this was significant as his abnormal liver function could have been identified earlier. In a previous report at Winchester, I made a recommendation to the PCT to agree a protocol with the local GP Practice to follow up and review prisoners' test results. I repeat this recommendation and fully endorse the review panel's recommendation (which I have edited slightly):

The PCT should agree a protocol with the local GP Practice to follow up and review prisoners' test results.

Winchester should ensure that the healthcare team is adequately staffed and resourced to provide appropriate and timely healthcare to their population. Procedures should also be reviewed to ensure investigations are carried out when requested, or patient dissent documented.

Record keeping

92. The review panel conclude that the man's medical records were factual, consistent and accurate, but not comprehensive. They were written in a timely manner but did not necessarily provide current information about the care and condition of the patient. The records were not perfectly legible, nor accurately dated and timed. The records were respectful, consecutive, with a lack of jargon or abbreviations. They identified problems and the action to be taken. However, the timeliness of the actions identified was very poor. I agree with these comments. I have already said that it is surprising to see no entry relating to his reception by the HCO. I am also surprised that his medical record did not document his admission to hospital, provide a summary of why he was admitted, or why it was not married up with the referral letter by the referral doctor, that presumably accompanied the man to hospital. The IT system is designed to improve the quality and consistency of record keeping in future but is reliant on the staff accessing the system to enter the correct information. I have reworded the clinical review panel's recommendation:

The Head of Healthcare should remind staff that medical records should always be kept in chronological order and updated appropriately. Medical records should include appropriate sections for the continuous healthcare record, test results, medical correspondence and medical charts.

93. The man's health was mostly managed on the wing and he was never admitted as an inpatient. He did go to the triage clinic on one occasion and left his cell to see the doctors. Aside from that, he came into contact with nurses on the wing. His wing history said little about his interactions on the wing and the events leading up to his transfer to hospital. Entries made were generally in relation to his quiet and polite mood and his conformity to the wing regime. His personal officer, told my investigator that he chose not to speak to her personally about his health. The officer made regular entries as did other officers on B wing. All entries were management checked in line with the personal officer scheme requirements. In fact, were it not for his personal officer's entries on 4 and 18

April, his wing history would not have reflected that he went into hospital. The officer was not on duty when the man died. Unfortunately, his wing history stopped with the entry dated 18 April.

94. B wing's observation book, in place to record events on the wing, mentioned the man on one occasion four months after he died. This single entry said less about his death and more about my investigation. The entry, dated 21 August, confirms that notices about my investigation into his death were received on that day and that my terms of reference were being circulated on B wing. This was two days before my investigator was scheduled to interview staff. However, of more concern is the apparent under-use of the B wing observation book in his case. There were incidences involving the man that I would have expected to see recorded, particularly his fall on the wing, his transfer to hospital and his death. Wing observation books are a useful vehicle for sharing both positive and negative information about prisoners. Similarly, a wing history sheet is a record of a prisoner's time on that wing, and should not be used purely to record conformity or non-conformity to a wing regime.
95. HM Chief Inspector of Prisons, made a recommendation to address this issue in her last report on Winchester. The recommendation centred on the personal officer scheme (as mentioned on page 9 of this report). I make no formal recommendation about the scheme. However, I do urge the Governor to remind staff of the purpose of wing history and wing observation books and the expected quality of entries, both positive and negative.
96. The man's bedwatch logs were generally thorough with clear and regular updates. Bedwatch officers were particularly conscientious in carrying out their duties at the hospital. From the records, it is clear that some officers had to manage his challenging behaviour when his health deteriorated further. I have no doubt that this must have been stressful for officers at times. The importance of good quality bedwatch logs was significant in this case. They became invaluable for the purposes of both my investigation and the clinical review panel. Without such a thorough log of the man's stay in the hospital, and in the absence of any updated medical records, I would not have been able to talk about the last two weeks of his life. I would be grateful if the Governor could share these views with the staff concerned.

Risk assessment and bedwatch

97. The man stayed in hospital for approximately 17 days before he died. A prolonged bedwatch, such as his, puts severe pressure on staffing levels for an individual prison. His first risk assessment for transfer to hospital on 3 April stated that he would be escorted by two officers and attached to one officer at all times. The document was authorised by the appropriate members of staff in healthcare, the security department and the duty governor. Winchester deployed its own officers and drew on volunteer officers from other prisons to manage his security arrangements. This worked well.
98. The security arrangements were reviewed by a Duty Governor on 6 April as part of his duty governor role that day. The Governor appropriately recognised

that the man's health had deteriorated and had, in turn, reduced his security risk. The Governor updated his risk assessment and authorised removal of his restraints with the proviso that this should be reviewed if his health improved. It did not, and on 10 April a further bedwatch management check and review of his risk reduced his security arrangements further. Again, this was in light of his deteriorating health.

99. With immediate effect, the man's bedwatch was reduced from two officers to one and this lower level of security remained in place until he died. His risk assessment differed from the previous one in that the healthcare section was not completed by a member of the healthcare team but by a prison officer. I am concerned that a member of operational staff completed a section meant for medically trained staff.
100. That said, the completion of the risk assessment had no bearing on the man's risk management in an outside hospital which was both regular, considered and well documented. I make no formal recommendation, but ask the Governor to remind senior managers who authorise risk assessments to ensure that individual sections are completed by the correct staff in future.

Continuity of Care

101. As I have mentioned above, the man's care at the hospital was recorded by operational staff for security reasons. There is nothing in his documentation to evidence that he was additionally managed by healthcare staff, remotely or through visits to the hospital. His medical record did not record that he had been transferred to hospital and why. A referral letter or summary of it from the doctor to the hospital was not married up with his prison medical record. Throughout his stay in the hospital, just one entry was made by the Head of Healthcare (on the day he died). A nurse told my investigator that she was not aware that healthcare staff had a duty to maintain regular contact with outside hospitals when a prisoner was on bedwatch. Anecdotally, the nurse said that there was no requirement for healthcare staff to visit the prisoner externally, and where contact had been made in the past it had been difficult to obtain a suitable update from prison officers due to medical in confidence issues.
102. PSO 3050 'Continuity of Care of Prisoners' sets out the expectations for maintaining contact with hospitals following a prisoner's admission. The PSO stipulates that daily contact must be made between healthcare staff and hospital staff and updates should be appropriately recorded. Elsewhere in this report, I have said that the Head of Healthcare has adopted a protocol taken from the best practice at another prison where it is already in operation. The protocol will remove any misunderstanding or ambiguity over the role of healthcare staff in future. It will also require doctors to copy referral letters into a prisoner's medical record for audit purposes. I urge the Head of Healthcare to implement the protocol as soon as practicable and make the following recommendation to capture all planned improvements to healthcare services at Winchester:

The Head of Healthcare should incorporate all protocols into the induction programme for new members of healthcare staff.

Contingency plans and family liaison

103. The Duty Governor on 20 April, was already on his way to the hospital to carry out a management check when the bedwatch SO reported that the man had died. On arrival at the hospital, the Duty Governor spoke to the SO and asked him to make a statement, recording what had happened, before going off duty. A previous Ombudsman's report following the death of another man at Winchester was issued in August 2007. This commented that staff statements were not made available to my investigator. I made a recommendation at that time, and I am pleased to see that the Duty Governor ensured that the SO provided a written statement as soon as possible after the man died.
104. The Duty Governor then made his way back to the prison and began to follow the incident log which forms part of contingency plans for a death in custody. He notified the appropriate members of staff and external agencies. He then contacted the man's next of kin by telephone and told her that he had died. My investigator asked the Duty Governor for a copy of the contingency plans and was told that the incident log was all that was available. He also said that there were no local instructions for deaths in custody and that Winchester took its guidance directly from Prison Service Order 2710 'Follow up to deaths in custody'.
105. There is no mandatory requirement placed on Governors to localise the instructions and guidance set out in Prison Service Orders. Governors have the discretion to issue local instructions to staff, specific to their own prisons, or to follow the national guidelines. I do not underestimate the importance of maintaining discretion in these matters. However, it is considered good practice to develop full contingency plans tailored specifically to individual prison environments. Winchester's plan consisted of one action sheet which instructs control room staff and the Duty Governor in what to do immediately following a death. The instruction to the Duty Governor to 'Consider contacting next of kin yourself' does not appear to reflect the philosophy behind PSO 2710, which is to consider who should contact next of kin. My investigator raised this issue, as part of her feedback on the investigation, with the Governor of Winchester. The Governor explained that he had since tasked one of his senior managers with drafting local instructions for deaths in custody to staff. I am grateful to The Governor for his speed in identifying a senior member of staff to take this work forward. For this reason, I make no recommendation.
106. The duty Governor contacted the man's sister in accordance with the instructions I have mentioned above. Further down the incident log, another instruction asks the Duty Governor to arrange a meeting between the prison chaplaincy, a nominated governor and a prisoner's next of kin if the next of kin are 'within reasonable travelling distance'. The Duty Governor told my investigator that one of the reasons he telephoned the man's sister was because she lived more than an hour away from the prison. The Duty

Governor further explained that, as Duty Governor for a death in custody, it would not have been practical for him to travel further away from the prison to inform the man's next of kin in person. Likewise, when his daughter was contacted, the Duty Governor left a message on her answer machine to contact him. She also lived over an hour from Winchester.

107. Chapter 4 of PSO 2710 sets out the role of the Family Liaison Officer (FLO). In relation to contacting a prisoner's next of kin, it is considered good practice to break the news in person as far as possible. There are a number of circumstances where this may not be possible. One of these is the distance a Governor and Family Liaison Officer may have to travel. Where this is the case, Chapter 4 provides guidance on contacting the nearest prison to where a family live and asking a FLO from that prison to make a personal visit. The man's sister lived in the South West of England and had already been contacted by another Governor at Winchester prior to his death. During the telephone conversation she was prepared for the man's death, and I am sure that when the Duty Governor broke the news this was not a shock to her. However, I am not entirely certain that the man's daughter was equally prepared. I remain concerned that breaking such difficult news by telephone is being used first, rather than a last resort.
108. The Duty Governor was assisted by the chaplaincy team and an administrative officer when making arrangements for the man's funeral. His offer to help both arrange and assist with the financial cost of the funeral was appropriate, timely and in accordance with PSO 2710. Ongoing contact with his family, and liaison with the funeral directors, was recorded by the administrative officer on a sheet forwarded to my investigator. The Duty Governor told my investigator that he did not keep a family liaison log and that this was the only record of contact on file.
109. The man's property was then returned in two stages. Having spoken to his daughter by telephone, the Duty Governor arranged to send his valuables by post and to bring the remainder of his property to the funeral. He told my investigator that the man's daughter was happy with the arrangement. When the Duty Governor attended the funeral on behalf of Winchester, he presented the man's daughter with the property in boxes and Prison Service bags. Despite the prior arrangements made with his next of kin, I do not consider that Prison Service bags are a suitable receptacle for returning property. Nor do I consider a funeral to be a suitable time and place to return property. Chapter 4 sets out how to make arrangements to return a prisoner's belongings. Paragraph 4.25 says:

"The Family Liaison Officer should consult the family about how they would like to retrieve their relative's belongings. Some families like to collect them themselves from the prison, others appreciate having them delivered to their home. This can be an emotional time for them when the Family Liaison Officer should be prepared to listen to reminiscences. Some families like to have clothes laundered, others want them just as they are. In either event, pack them neatly in a suitable bag or container, not a black sack or a bag recognisable as prison issue."

110. My investigator asked for a copy of Winchester's local policy on the role of the Family Liaison Officer. The role, embedded in PSO 2710, forms a large part of handling a death in custody. The Duty Governor confirmed that Winchester did not have a local policy and that Duty Governors usually assumed the role of Family Liaison Officer. However, one of the problems in allocating FLO responsibilities to Duty Governors is the capacity to carry out both roles effectively. Duty Governors are central to deaths in custody and have specific responsibilities to carry out. It is not impossible, but certainly difficult, for a Duty Governor to then be released from duty in order to remain the single point of contact and support for the bereaved family.

111. I accept that chapter 4 of PSO 2710 says:

"Family Liaison Officers are not a mandatory or prescriptive requirement for individual prisons. This is to allow governors the discretion in decision-making and local practice."

The only mandatory requirement is the following:

"Governors/Directors of contracted prisons must have in place a local protocol explaining what support will be offered to a family bereaved by a death in custody."

112. It is also important to recognise that the role is still relatively new and was introduced after my office took over responsibility for investigating deaths in custody in April 2004. Since then, many prisons have adopted local policies to identify, train and deploy Family Liaison Officers to provide an uninterrupted service to bereaved families.

113. The man had not been in contact with his family for many years. Once contacted by the Duty Governor, the man's sister stressed that she did not want next of kin responsibilities. The Governor respected her request and contacted his daughter who took over responsibility. From then on, his funeral was arranged with the costs met. I am aware that the man's family were happy with the service Winchester provided and raised no concerns with my office. However, I feel that the prison can only benefit from having a local FLO policy in place to improve its service to bereaved families in future. I make the following recommendation:

The Governor should consider implementing a local policy on the role of Family Liaison Officer in accordance with Chapter 4 of PSO 2710.

The Governor should consider placing suitable volunteers on the Family Liaison Officer training course waiting list as soon as practicable to ensure that there are dedicated staff available to carry out the role when a local policy is implemented.

RECOMMENDATIONS

To the 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. A comprehensive template for recording this assessment should be available on the VISION computerised clinical system which is now in place at HMP Winchester. Healthcare staff should have access to this system where they undertake their work and not just in the Healthcare wing.

The prison service accepted the recommendation. In response, they said:

Already have a system in place. Audited on a daily basis by the manager on duty. Healthcare manager to ensure that the quality of assessment is to the required standard. Healthcare manager to put filing system in place for management check list. Templates are being reviewed along with reception protocol. Vision system in place in all areas of healthcare.

2. The Chief Executive of Hampshire PCT should conduct an audit into the policies and procedures around receiving both new receptions and prisoners on transfer to ensure effective, ongoing healthcare is afforded to individuals in a timely manner.

The prison service partially accepted the recommendation. In response, they said:

Reception protocols reviewed and redrafted.

3. All healthcare staff should be adequately trained in the use of the new computer clinical system for both the recording and summarising of entries. A comprehensive and up to date note summary should always be available on the system to ensure that the doctors working in the healthcare team can easily identify relevant medical history when reviewing patients. All members of the healthcare team should understand the structure of the IT system and how it is to be used.

The prison service accepted the recommendation. In response, they said:

Reception protocol to be amended to include summarising. To ensure that training is included in staff induction.

4. Organisational processes should be introduced to ensure medical records are complete and that all relevant medical correspondence, or summaries thereof, are included in the health records. This should ensure that all prisoners receive appropriate healthcare and enable the healthcare team to provide a summary of the healthcare record when transferring prisoners to other establishments.

The prison service accepted this recommendation. In response, they said:

Vision IT system is in place and all medical correspondence is scanned into medical records. Transfer protocol drafted, to be disseminated to all healthcare staff.

5. The Prison Health Partnership must satisfy themselves that the protocols and procedures around the use of computerised medical records does not negate the need for continued communication and dialogue between healthcare professionals, both internally and externally.

The prison service accepted the recommendation. In response, they said:

Develop the role of administration staff. Improve communication between healthcare departments in other prisons by sharing the recommendations and action plan with HMP Kingston. To develop wing based nurses to improve continuity of care and promote accountability.

6. The PCT should agree a protocol with the local GP Practice to follow up and review prisoners' test results.

The prison service accepted the recommendation. In response, they said:

Arrange a meeting to discuss with the local GP Practice.

7. Winchester should ensure that the healthcare team is adequately staffed and resourced to provide appropriate and timely healthcare to their population. Procedures should also be reviewed to ensure investigations are carried out when requested, or patient dissent documented.

The prison service accepted the recommendation. In response, they said:

Profile has been reviewed and recruitment is underway. A training plan in place to address the medical needs of prison population. Protocol to be drafted to ensure investigations are carried out when requested or patient dissent documented.

8. The Head of Healthcare should remind staff that medical records should always be kept in chronological order and updated appropriately. Medical records should include appropriate sections for the continuous healthcare record, test results, medical correspondence and medical charts.

The prison service accepted the recommendation. In response, they said:

The Vision IT system does this automatically. PCT supporting Head of Healthcare in accessing relevant reed codes from the local GP Practice.

9. The Head of Healthcare should incorporate all protocols into the induction programme for new members of healthcare staff.

The prison service accepted the recommendation. In response, they said:

Already included in the secondary healthcare screening pack. Healthcare manager to ensure that this is in place.

To the Governor

10. The Governor should consider implementing a local policy on the role of Family Liaison Officer in accordance with Chapter 4 of PSO 2710.

The prison service accepted the recommendation. In response, they said:

Policy drafted and implemented.

11. The Governor should consider placing suitable volunteers on the Family Liaison Officer training course waiting list as soon as practicable to ensure that there are dedicated staff available to carry out the role when a local policy is implemented.

The prison service accepted the recommendation. In response, they said:

Volunteers are being sought to fill the role. Training to commence in the new year.

