

**Circumstances surrounding the death in April 2007 of a
man in hospital whilst a prisoner at HMP Whatton**

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

January 2008

This is the report of an investigation into the death of a man. The man died in the hospital, after collapsing in his cell at HMP Whatton in the early hours in April 2007.

A post mortem was held at the request of the Nottingham Coroner and it revealed that the man's death was due to natural causes. The cause of death was recorded as a myocardial infarction (heart attack).

I extend my sincere condolences to his family and friends.

I would like to thank the Governor at Whatton and his staff for their help and assistance to my investigator.

I also commissioned a clinical review of the care afforded to the man whilst he was in Whatton. This was carried out by a doctor on behalf of Nottinghamshire Primary Care Trust. I am grateful to the doctor for his review.

My report includes one recommendation. I also endorse one made in the clinical review dealing with medical emergencies at night. One recommendation has been accepted and the second recommendation has been partially accepted by the Governor and Head of Healthcare at HMP Whatton. The man's family acknowledge the findings of this report but remain dissatisfied with Derbyshire Probation Service handling of their brother's case.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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SUMMARY

The man was sentenced to two years imprisonment in June 2005 at Crown Court. He was released in October 2005 on licence with various conditions. The man was placed in a hostel in Derbyshire, near to his family. He had learning difficulties and other mental health problems.

The man was recalled to prison in February 2006 after breaking his licence conditions. He was re-released by the Parole Board in May to an approved premises (hostel) in Derby. In August, the man was again re-called to prison for breaking his licence conditions having entered an exclusion zone detailed on his licence.

The man was received into HMP Nottingham and later transferred to HMP Whatton in October 2006. The first reception health screen document noted his health problems, including hypothyroidism (under-active thyroid), epilepsy, gastritis, and his learning difficulties. It further noted that the man's parents had died of heart disease related illnesses. He was offered advice from healthcare staff on a healthier lifestyle as a means of preventing heart disease.

In January 2007, at an oral Parole Board hearing at Whatton, it was agreed that the man could be released once an assessment plan had been re-worked by his Probation Officer. The hearing was adjourned for six weeks until this happened. It was also noted by the Parole Board that the man was mentally impaired, possibly to the extent that he was unable to comprehend the conditions of his licence.

The man was an offender subject to Multi Agency Public Protection Arrangements (MAPPA) at level three (offenders who because of the offences they have committed are considered to pose a risk of serious harm to the public). Meetings were held to ensure that appropriate arrangements were being considered for his release, including providing the man with supported housing, assistance from Social Services and help from the Learning and Disabilities Team. At the time of the man's death, his probation officer was trying to ensure a full support package was in place before the man was released so that his risk could be safely managed in the community.

In the early morning of 23 April at 3:50am, the man rang his cell bell to tell staff that he was experiencing pain in his chest. The senior officer on duty was contacted and attended the man about 20 minutes later in his cell. He then called the emergency out of hours doctor service and was advised to call an emergency ambulance so that his heart rate could be monitored. An ambulance was called at about 4:15am.

Staff kept checking on the man and made enquires about his medical condition. The prison gates were opened in preparation for the arrival of the ambulance.

At around 4.20am, the man was found to be unresponsive in his cell. Staff called for immediate assistance, and the senior officer and an officer entered the cell. He did not respond and was sweating and struggling to breathe. The senior officer collected a defibrillator machine (this sends an electric shock to the heart) from the nearby healthcare centre and applied this alongside using Cardiac Pulmonary Resuscitation (CPR).

When the ambulance arrived, paramedics took over the resuscitation attempts. The man was then transferred to hospital, where he was pronounced dead shortly after arrival.

THE INVESTIGATION PROCESS

One of my investigators visited Whatton on the 3 May 2007. My investigator met with the deputy governor, and the prison's Family Liaison Officer. My investigator reviewed the man's medical records and prison file, and took copies of those documents. She then visited a wing and saw the man's cell.

A clinical review was commissioned from Nottinghamshire Primary Care Trust to assess the man's medical care whilst in prison. A doctor subsequently carried out this review and I am grateful to him for his report.

One of my own Family Liaison Officers made contact with the man's family informing them of our investigation. The man's sister-in-law, raised several points in relation to her brother in law's recall to prison and to Derbyshire Probation Area that I have dealt with in this report. The family were appreciative of the support and assistance from the prison.

On 1 June, my investigator visited Derby and spoke to the man's probation officer. On 6 June, my investigator returned to Whatton and interviewed members of staff and prisoners who knew the man.

On 12 June, my investigator met with a voluntary agency that had been part of the MAPPA panel. This panel met regularly to discuss his future release plans.

HMP WHATTON

Whatton is a category C prison that currently holds 761 adult male prisoners, primarily sex offenders. It first opened as a detention centre for juveniles, but its role changed in the early 1990s to that of a prison for vulnerable adult offenders. During this time, the prison developed as a specialist establishment for adult male sex offenders to enable them to participate in the Sex Offender Treatment Programme. Whatton has recently undergone a large expansion programme.

Whatton was last inspected by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, in February 2004. Ms Owers found that: "Whatton ... provided a respectful environment with good standards and cleanliness, food and healthcare. Staff-prisoner relationships were excellent which ... speaks volumes for the professionalism of the staff."

Healthcare within the prison is commissioned and provided by Nottinghamshire County Teaching Primary Care Trust. There is no 24 hour healthcare service in the prison, therefore no medical staff are on site during the night or weekends. If staff need a doctor out of normal healthcare unit times, contact is made with Nottingham Emergency Medical Service (NEMS).

Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their own possession. It is administered on a daily basis to other prisoners, when either they are considered to be at risk or the medication is considered unsuitable to be held in their possession.

KEY FINDINGS

The man was received into HMP Nottingham on remand in October 2004. He was sentenced to two years imprisonment in June 2005. The man was later transferred to HMP Lindholme and released, on licence, in October 2005. In February 2006, the man was recalled to prison following a breach of his licence conditions. He returned to Nottingham and was then transferred to HMP Stocken. In May, the man was released from Stocken following a Parole Board recommendation. The Board agreed that his recall had been appropriate but said that the man could be re-released into the community. He was released to a hostel in Derby, under the supervision of Derbyshire Probation Area.

In August 2006, the man was again recalled to prison following a breach of his licence conditions. He was received into HMP Nottingham, then transferred to Whatton in October and located on A wing. He settled well into the regime of the prison. Throughout the man's time in prison his mental health issues and learning difficulties were appropriately identified.

A first reception health screen document was completed. The document noted his medical conditions of hypothyroidism, epilepsy and gastritis. The document also noted that the man had suffered from depression associated with his alcohol use. His learning difficulties were also documented. The man's family history of heart disease was recorded; actions were taken in relation to these, and staff made plans to check his blood lipids and to review this with the GP. Thyroid function tests and a full blood count were also requested.

In November, a blood sample was taken to test the man's thyroid levels. In December, he underwent routine management of his thyroid problem and his medication levels were maintained.

When the man had first arrived, his medication had been administered to him on a daily basis due to his history of non-compliance. By the end of the year he was considered ready to keep his medication in his own possession and staff ensured he was able to take it correctly.

In January 2007, a Parole Board hearing at Whatton agreed that the man could be re-released after an assessment plan had been re-developed by his probation officer. The Parole Board noted that the man had learning difficulties and might have lacked understanding of his licence conditions. The probation officer was working with a multi-agency partnership to ensure the man was fully supported on his release.

In February 2007, following his blood test results, the man was seen in healthcare to discuss his diet and exercise. He had difficulty in reading so the nurse used pictorial information to explain the importance of a healthy lifestyle. The man was advised on a walking regime. He was not interested in smoking

cessation sessions. The man's thyroxin medication was increased to 50mcgs daily.

In February 2007, the man was transferred to B wing and started work in the manufacturing workshop. On 23 February, his thyroxin was further increased to 75mcgs daily. In 2 April, his medication was reviewed and it was noted that the man felt well on his present prescription. Finally, on 16 April, another blood sample was taken prior to a planned GP review.

On 23 April at 3:50am, the man rang his cell bell on the wing. Operational Support Grade (OSG) Officers attended his cell. The man told the officers he had pains in his left arm and centre of his chest, but he did not display other signs of distress. The officers immediately notified the Night Orderly Officer (NOO) who was on the wing. The NOO then radioed an officer who was in the Control Room, to join him on the wing. During night time patrol, two officers would need to be present to unlock a cell. (The Control Room is away from the wing.)

At approximately 04:10am, the NOO and the officer visited the man in his cell so they could observe his physical symptoms and make a decision on what medical action to take. The man told the NOO he had been having pain for about two hours and that he had taken medication for his epilepsy the night before. The man was sitting up on his bed. He was pale in colour and sweating even though the cell window was open and it was cold. The NOO asked the OSGs to check on the man every five minutes.

In the meantime, the NNO contacted Nottingham Emergency Medical Services (NEMS), a doctors out of hours service. He spoke to a doctor who advised him to call for an emergency ambulance and ask the paramedics to carry out an Electrocardiograph (ECG) when they reached the man. At about 4:15am, the NOO ensured an ambulance was requested through the communications room. He then asked the officer to enquire about family medical history with the man. He told the officer that both his parents had died as a result of heart conditions. The man said he felt a little bit better. The officer proceeded to make arrangements for an escort for the ambulance when it arrived.

About 4:20am, one of the OSGs checked on the man and found he had collapsed on his bed. His eyes were shut, his skin had a grey colour and he was struggling to breathe. The OSG immediately called for assistance.

The NOO and the officer returned immediately and entered the man's cell. They checked for a pulse and attempted to open his airway. His breathing was very shallow. The NOO left the cell to get the defibrillator machine from the healthcare centre which was very near to the Wing. He then followed the instructions on the defibrillator and commenced Cardio Pulmonary Resuscitation (CPR) until the paramedics arrived at 4:45am.

The paramedics continued CPR for around 40 minutes. The man was then transferred to hospital by emergency ambulance with an officer escort. On arrival at the hospital, the man was pronounced dead.

The man's family was informed of his death by Derbyshire Police that morning. On 24 April, the prison's Family Liaison Officer visited the man's family at their home.

A memorial service for the man was held in the prison's chapel. The Governor, attended the man's funeral. His family told my colleagues that they were extremely grateful to the staff at Whatton and appreciated their support and assistance with funeral expenses.

ISSUES

Clinical Review of the man's care at Whatton

Nottinghamshire PCT was commissioned to carry out a review of the man's medical care. A doctor carried out this review on behalf of the PCT. He concluded that the man's medical care in Whatton was appropriate. A comprehensive health screen was carried out and plans were made regarding the man's ongoing care. His cardiovascular risks were identified and his blood lipids were checked. With his learning difficulties in mind, Whatton healthcare staff went to great lengths to educate him to adopt positive lifestyle changes to prevent death from cardiovascular disease.

The clinical reviewer also commented that there was a 25 minute delay before an emergency ambulance was called. This time period reflects the procedural delays involved in alerting the NOO, the arrival of a second officer to open the man's cell, and the time taken to seek advice from emergency services and then acting on it in accordance with local policy.

The NOO needed to enter the man's cell to be able fully to observe his physical symptoms. But when the prison is on night patrol status, two officers are required to be present for a cell to be unlocked and entered. (This is a local security policy guideline.) The man had complained of chest pain and tingling in his arms but did not display any signs of distress. The NOO followed correct local procedure by waiting for the officer. The two officers entered the man's cell and observed his physical condition. From their observations, the NOO contacted the emergency out of hours doctor for advice who, in turn, advised that an emergency ambulance should attend. This was done and the ambulance was called at around 4.15am.

The distance from Whatton to the hospital is almost 16 miles by road and the ambulance took around 30 minutes to arrive. The man suffered a cardio-respiratory arrest and died of an acute myocardial infarction despite timely attempts at resuscitation.

The man's death at the age of 30 years was premature, but was from natural causes. In the doctor's opinion, the man could not have been saved. His review said, "This incident occurred in the middle of the night. This is a common time for heart attacks to occur. There were no healthcare personnel on duty, as Whatton does not have a 24-hour healthcare facility."

I appreciate the need for correct unlocking procedures to be adhered to in the interest of security, particularly at night. However, due to the lack of healthcare at Whatton at night, there needs to be a level of flexibility to deal with emergencies promptly. I understand that Whatton is a large prison and it would have taken some time for the officer to have reached the wing to help unlock the

cell. However, considering his own proximity to the man's cell I consider that it might have been appropriate for the NOO to have made a cursory check on the man, and to have spoken to him about his symptoms through the cell door hatch. In the event, there was a 20 minutes delay before he was seen by the NOO and the officer and before medical advice was sought. However, I agree with the clinical reviewer that this would not have affected the ultimate outcome. Once the NOO reached the man, the response was swift and effective.

The Governor and the Head of Healthcare should ensure that local procedures allow for medical emergencies at night to be dealt with as soon as possible.

The clinical reviewer has also commented that prison staff, with their worthy attempts at resuscitation, did everything they could to keep the man alive following his heart attack. However, I am concerned by the risks that are apparent in every prison without 24 hour healthcare if there is any delay in commencing resuscitation attempts. I endorse the clinical reviewer's recommendation:

In the absence of duty healthcare personnel, there should always be on duty officers trained in Cardio Pulmonary Resuscitation and the use of the automated defibrillator.

Other clinical issues

The man had been in a number of prisons over the preceding few years. A review of his previous medical records show no apparent consideration of his family history of heart disease and therefore his heightened risk.

The man did not have a healthy life-style. He was known to abuse drugs and alcohol as well as to smoke. There is no documentary evidence to show that, at any time prior to his final period in Whatton, any health promotion advice was given to him. Neither does there appear to have been any consideration given to monitoring the man as part of a chronic disease management programme.

Whilst it is unlikely to have had an effect on the outcome for the man, the promotion of a healthy life-style and appropriate chronic disease management may well reduce the risk to others.

Family Issues

The man's family had a number of questions which I have considered individually:

Why did it take so long for the revised release plan to be completed and submitted to the Parole Board?

The man was recalled to prison on two occasions following his release from Lindholme in October 2005. His licence conditions included two specific points. He was not to make any contact with his ex-wife or her children, and he was not allowed to enter an area in Derbyshire, where his ex-wife lived with her children.

In August 2006, the man was seen by a community worker in the exclusion area. This person was aware of the man's licence conditions and knew he was in the exclusion zone. The community worker made a statement to the police on his observation of the man being in that area. The man's probation officer immediately applied for a revocation of licence in respect of the man. He was arrested and received into HMP Nottingham. The man was later transferred to Whatton.

The man's family raised issues around his recall to prison. They were concerned that the recall was unfair. As noted, he was recalled for being in an exclusion zone detailed in his licence conditions. The man's family felt that he had gone to the exclusion zone to find his family, as they had not been able to collect him from the hostel that day. His family believed that he had no intention of contacting his ex-wife or her family.

In January 2007, an oral hearing of the Parole Board took place at Whatton. The Board agreed the recall to prison was appropriate. They accepted that the man had not entered the exclusion zone with the purpose of contacting his ex-wife, although they agreed that simply being in the area heightened his risk, particularly if he were to use alcohol or drugs. Given that he had breached a core licence condition, there were grounds for believing his risk was increasing. The man was present at this hearing, along with his solicitor, his sister-in-law and his probation officer. The Board agreed to the man being released when a re-worked assessment plan had been completed for him. The Board adjourned for six weeks to allow that to happen.

The probation officer commenced work on the plan to ensure all the services that the man would need would be in place on his release, thus to avoid the possibility of a further recall to prison. The plan involved a multi-agency partnership of South Derbyshire Learning and Disabilities Team, South Derbyshire District Council, and Social Services. The identification of suitable release accommodation tailored to the man's special needs proved to be difficult. The man also wanted to live near to his family, and this was supported by them. He and his family turned down any alternative areas for accommodation. Funding for a support package, tailored to the man's special needs, was also being sought through the multi-agency partnership.

The man was subject to MAPPA at level two. Subsequently, meetings at MAPPA level three were held. It was a priority for MAPPA that those accommodation arrangements ensured the victim's safety and were under the exclusion zone. Additional licence conditions were also under consideration. Adult services were making an assessment of support services to help the man following his release.

Due to the complexities of these plans, his release was delayed. Following the Parole Board hearing, the man's release unfortunately did not take place before his death. Whilst I acknowledge his family's distress that he was still in prison at the time of his death, I consider that the delay and the reasons for it were reasonable under the circumstances.

Why were the family excluded from meetings between the man and outside agencies despite the fact his brother was his legal guardian?

The man's family felt that his probation officer had failed to engage with them and had little time for him before his impending release. The family thought that all communication had broken down with Derbyshire Probation Area.

The man's family indicated that they had raised the issue regarding the lack of involvement with their brother's probation officer with a senior manager at Derbyshire Probation Area. The family were unhappy at the manager's response.

The man's sister in law spoke about their love and concern for their brother and their wish to help him. I am unable to comment in this report on the dynamics of the relationship between Derbyshire Probation Area and the man's family, but I highlight their concern. Whilst understanding that his family felt marginalised, it is also important to point out that the Probation Area was trying to engage with agencies to ensure the man was offered opportunities on his release that would be able to support his individual needs. His family were an integral part of his life, but their home location was also within the location of his victim's home, and part of the exclusion zone related to his licence conditions.

It would not have been appropriate for the man to live with his family on release. He was a MAPPA three level offender. The inclusion of the family at those meetings would have been inappropriate due to the confidential nature of the issues for discussion.

The man's family had attended supervision meetings before his recall to prison when he had been living in the hostel. According to his probation officer, the attendance of his family had tailed off. The family disagree with this and maintain that a member of the family attended every probation appointment when the man was being seen at the probation office and that they were not always informed of appointments in Derby.

The man's family felt that the Probation Service did not acknowledge how much they cared about his future, and the support the family were able to offer. When the family were not present, the man's key worker attended the meetings to support him. The man's probation officer told my investigator that, after every supervision session with her client, she repeated his licence conditions and ensured that he understood what was said to him.

In light of the family's concerns, I have arranged for a copy of this report to be sent to Derbyshire Probation for their consideration.

Other Issues

An officer was the man's personal officer for a short time. She told my investigator that the man was quiet. He complied with the prison regime and, despite his obvious learning difficulties, understood prison rules. The man worked in the manufacturing workshop which he enjoyed.

Two friends of the man, who knew him well whilst at Whatton, told my investigator that he was 'buying' prescription drugs from other prisoners. There is no other evidence to substantiate this, and the man's post mortem report did not indicate that there were any drugs in his system other than those prescribed to him. The man's friends indicated to my investigator that he would purchase the prescribed drugs with tobacco or food items. Following the man's death, two prisoners were questioned about these accusations by staff at Whatton. There was no evidence to substantiate the accusations and no further action was taken by the prison.

RECOMMENDATIONS

1. **The Governor and the Head of Healthcare should ensure that local procedures allow for medical emergencies at night to be dealt with as soon as possible.**

Accepted – The procedures followed by the night staff led by the NOO, as described in the report, were appropriate. When the man's condition deteriorated suddenly, the NOO displayed excellent leadership in commencing CPR. But the insights offered by the report and the experience of staff that night could properly be used as the basis for a review of Whatton's night procedures in partnership with Nottinghamshire County Teaching PCT. The recommendation will be placed on the agenda for the Partnership Board which will oversee the review.

2. **In the absence of duty healthcare personnel, there should always be on duty officers trained in Cardio Pulmonary Resuscitation and the use of the automated defibrillator.**

Partially accepted – Nationally all establishments are required to have staff trained in first aid, including resuscitation, in place. The implications for having all staff trained in the use of defibrillators on duty in all prisons will be considered but at present a risk assessment approach is used at a local level to reflect population and resources available. Locally this is currently the position, but the resilience of HMP Whatton's procedures will be reviewed by February 2008