

**Investigation into the death of a man  
on 18 May 2010 whilst in the custody of HMP Whatton**

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

**October 2010**

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

This is the report of an investigation into the death of a man, who was a prisoner at HMP Whatton, who died in hospital on 18 May 2010. The man was 73 years old. He was diagnosed with an incurable brain tumour in March 2010 and the prognosis was very poor. On 16 May, the man was taken to hospital after his condition deteriorated and he died there two days later.

I offer my sincere sympathies to the man's family and friends, and all those affected by his loss.

The investigation was undertaken by one of my colleagues. I would like to thank the Governor of Whatton and her staff for their assistance during the investigation. In particular, I am grateful to Mr A and Ms A for making the arrangements during the investigation. A clinical review into the man's medical care at Whatton was commissioned from NHS Nottinghamshire County Primary Care Trust. They appointed Dr A to conduct the review, and I am grateful to him for his timely report.

The clinical review carried out by Dr A concludes that the man's clinical care was comparable to that available in the community. I have noted the issues highlighted by Dr A and the recommendation he has made about acting upon advice given by external professionals.

I make no recommendations of my own.

**Thea Walton**  
**Acting Deputy Prisons and Probation Ombudsman**

**October 2010**

## **SUMMARY**

The man was born in 1936. He was 73 years old when he died on 18 May 2010 in hospital whilst in the custody of HMP Whatton. The man died of natural causes as a consequence of pneumonia, recurrent brain tumour and an infection in both of his kidneys (pyelonephritis).

The man was remanded into custody by a Magistrates' Court on 18 October 2007. He was sentenced on 28 November 2008 at Crown Court to 11 years imprisonment for sexual offences. After stays in HMP Bedford, HMP Leicester and HMP Lincoln, he transferred to HMP Whatton on 9 April 2009.

During the man's first reception health screening interviews, it was recorded that he had history of high blood pressure (hypertension). He was a smoker; assistance to help him stop smoking was offered but he chose not to take up the offer. On 4 March 2010, the man was diagnosed with a brain tumour. After an operation to reduce the size of the tumour he was informed that his prognosis was very poor as his condition was incurable.

On the morning of 16 May (a Sunday), staff were concerned about the man's well being when they unlocked his cell. They requested medical assistance and, after the man was seen by healthcare staff, an ambulance was called. After paramedics carried out an assessment he was taken to the Accident and Emergency (A&E) Department of a local hospital. The man was later admitted to the hospital.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that restraints were to be used and two officers remained at the man's bedside. The risk assessment was later revised and the restraints were removed and not re-applied.

During the early hours of 18 May, the officers on bedwatch noticed that the man had stopped breathing. They told hospital staff and he was pronounced dead by a hospital doctor at 2.20am.

The clinical review carried out by Dr A, on behalf of NHS Nottinghamshire County Primary Care Trust, considered the care provided for the man. In Dr A's view, the quality of care given to the man was equivalent to that he would expect in the community. In Dr A's opinion Whatton needs to be satisfied that their arrangements for dealing with out of hours healthcare interventions are sufficient for the demands placed on them. He made one recommendation concerning the recording of advice from an occupational therapist.

I make no other recommendations of my own.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 18 May 2010 by one of the Ombudsman's investigators. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event no one came forward.
2. My investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.
3. A clinical review was commissioned from NHS Nottinghamshire County Primary Care Trust into the care provided for the man during his time in custody. Dr A was appointed to lead the clinical review, and I am grateful for his timely report.
4. My investigator visited HMP Whatton on 21 May and spoke to the number one governor as well as staff involved in the care of the man. He returned on 19 July and interviewed an Assistant Practitioner and Mr B, a prisoner who was employed as a support worker on the man's wing.
5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.
6. One of my Family Liaison Officers contacted the man's family. They were able to discuss the purpose of the investigation and raise any concerns or questions that they wanted to be addressed. The family were concerned about the management of the man's medical care whilst he was in custody and the circumstances of his discovery on 16 May. They were also concerned about the presence of uniformed officers on bedwatch duty when the man was terminally ill in hospital. The family spoke very positively about the help and support they received from prison staff. They will have the opportunity to receive my report and comment on the findings. I hope my report helps them better understand the events leading to the man's death.

## HMP WHATTON

7. Whatton 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 Sex Offender Treatment Programmes. Whatton has recently undergone large expansions in 2006 and 2008, increasing the capacity by 500 places. All applicants for a place at Whatton must be adult males and category C sex offenders. They should not require the services of a full-time medical officer. The average age of the prisoners at Whatton is higher than elsewhere in the Prison Service.
8. The regime at Whatton includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes, including both Living Skills and Sex Offender Treatment Programmes.
9. The NHS Nottinghamshire County Primary Care Trust (PCT) is responsible for healthcare provision within the prison. The healthcare centre is open daily, with healthcare staff on duty between 7.30am and 7.30pm. Outside of these hours, Nottinghamshire Emergency Medical Services (NEMS) are contacted when required. Despite the average age of the prisoners, the PCT has not provided any inpatient healthcare facilities.
10. The healthcare department at Whatton runs a walk-in centre and a nurse-led GP practice. It offers nurse-led triage clinics, blood clinics, specialist clinics and follow up clinics. After the initial consultation, the nurse refers patients to the doctors or arranges appropriate prescriptions to be made up. Nurses take the lead in different diseases, and they have various internal clinical specialists, including in palliative care. Occasionally, external specialist nurses come in. These include diabetic, COPD (chronic obstructive pulmonary disease) and TB (tuberculosis) nurses.
11. There is a portable automated defibrillator located on each wing. These machines can analyse the heart rhythm, diagnosing shockable rhythms and then charging to treat. Defibrillation consists of delivering a dose of electrical energy to the affected heart. This halts abnormal electrical activity in the heart and can allow a normal heartbeat to be re-established.
12. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. This determines the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch is carried out by a duty governor. Visits from the family may be allowed but they are closely monitored to ensure that they do not impinge on the security of the bedwatch.

13. The risk assessment will consider the following:
  - i. The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advise on any medical objections to the use of restraints.
  - ii. Behaviour in prison.
  - iii. Home circumstances.
  - iv. The nature of the offence (criminal history), the risk to the public and hospital staff, including the risk of hostage taking.
  - v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
  - vi. The physical security of the hospital.
  - vii. Assessment of visits restrictions.
  
14. According to the policy for performing hospital bedwatches in force when the man was in hospital, the following options were available to the Governor:
  - i. "Escort and bedwatch with two officers or more, with restraints.
  - ii. Escort and bedwatch with two officers or more, without restraints.
  - iii. Escort and bedwatch with one officer, without restraints.
  - iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
  - v. ... exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952)."

The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

15. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan is drawn up for the most serious offenders that benefits from the information, skills and resources provided by the individual agencies, including the police, co-ordinated through MAPPA.
  
16. There are three levels of MAPPA:
  - Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
  - Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
  - Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

## **Her Majesty's Chief Inspector of Prisons' Report**

17. The former HM Chief Inspector of Prisons made a full announced inspection of Whatton in January 2007. (There has been another, unannounced, inspection at Whatton since the man's death, but the report of that inspection has not yet been published.)
18. In the report of the 2007 inspection, the Chief Inspector noted that there was good practice in the health services provided. She wrote:

"There had been a comprehensive health needs assessment that had sought the views of patients, carers and staff as well as reviewing clinical records, and the results were being used to plan services."

## **Independent Monitoring Board (IMB) Report**

19. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. The Board monitors day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Whatton covers the period from June 2008 to May 2009. The IMB drew attention to Whatton being one of the few prisons where the average age of a prisoner was in the mid forties. The IMB said:

"The general adult male prison population has about 80% under the age of 40 whilst Whatton will regularly house some 60% to 70% of its 845 prisoners over the age of 40 years. Naturally, this brings a completely different dimension to the healthcare needs of those in Whatton to almost any other prison establishment. It is therefore inevitable that more prisoners will die of natural causes in Whatton with the resultant effect that the healthcare has been required to respond to major incidents from time to time, on the palliative care of individuals. It has done this and continues to do so with great staff dedication and in an extremely sensitive manner."

## **Performance ratings**

20. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being "serious concerns" and four "exceptional performance"). For the last four performance reports, HMP Whatton has been given a rating of three (or "good performance").
21. My investigator reviewed the reports into earlier deaths from natural causes at Whatton. He found that the issue of healthcare provision outside of normal hours has been raised in previous investigations.



## KEY EVENTS

22. The man was born in 1936 in Leicestershire. Prior to his arrival in custody he was retired. The man had previously worked as a brick layer, stone mason and as a retained firefighter.
23. The man was remanded into custody by a Magistrates' Court on 18 October 2007. He arrived at HMP Bedford the same day. It was his first time in prison. The man was sentenced at Crown Court on 28 November 2008 to 11 years imprisonment for sexual offences. The man later moved to HMP Leicester and HMP Lincoln. He transferred to HMP Whatton on 9 April 2009, and was located on Alpha Wing 5. When the man arrived at Bedford, he was assessed as MAPPA Level 1.
24. At the man's first reception health screen interviews, it was recorded that he had a hernia and history of hypertension (high blood pressure). The following medication was prescribed for the man: paracetamol (for pain relief), simvastatin (commonly known as a statin a medication which helps to reduce cholesterol and prevent heart disease in people at high risk and those who have already had a heart attacks or stroke), felodipine and rampril (for blood pressure) and dexamethasone (an anti-inflammatory medication). He was a smoker but chose not to accept help to stop.
25. The man was categorised as a category C prisoner. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape; Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult; Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt; and Category D: open conditions, prisoners who can be trusted not to try and escape.
26. On 2 June 2008, the man was granted enhanced prisoner status. The Incentive and Earned Privileges Scheme (IEPS) was introduced to prisons in 1995. It is designed to encourage prisoners to progress through their sentence plan, to undertake hard work or other purposeful activity and create a better and safer environment for prisoners and staff. There are three levels under IEPS – basic, standard and enhanced – with all new prisoners initially being on standard level. Changes to that level will then depend on their conduct and progress through their sentence plan.
27. At his review with the prison doctor, on 28 April 2009, it was noted that the man was still smoking and that his blood pressure was well controlled. It was also noted that the man had stopped taking his simvastatin medication because it made him feel nauseous.

28. On 10 June, the man attended a review with the prison doctor where they discussed his cholesterol levels and him resuming his simvastatin medication. They also discussed his chronic ankle pain, which was because of osteoarthritis, and a hernia in his scrotum, which had been there for a number of years but was not causing him pain.
29. At the man's review with prison doctor on 24 August, it was decided to increase his statin medication as his cholesterol level was quite high. Just over two weeks later, on 9 September, a check of the man's kidney function showed he had kidney disease without proteinuria (proteinuria is an indicator for chronic kidney disease).
30. The prison doctor carried out a review of the man's medication on 26 January 2010. It was noted that his blood pressure was much higher and it was decided to prescribe ramipril (at a dose of 1.25mg a day). A blood test was arranged to check kidney function.
31. On 12 February, staff on the wing told healthcare staff that the man had been vomiting. He did not attend his morning blood test but was seen in the afternoon by the prison doctor. The doctor recorded that the man was passing water up to four times during the night with a poor stream and often missed the toilet whilst urinating. The man denied any weight loss and said his bowels were normal. When he was examined an "enormous scrotal swelling" was noted and, on rectal examination, the doctor found that his prostate was enlarged. A plan was made to check the man's urine, carry out routine blood tests and repeat his blood pressure readings. In addition, because the man had commented that his memory was poor, the doctor arranged for a mini mental state examination (MMSE, or Folstein test, is a brief 30-point questionnaire test that is used to screen for cognitive impairment) and also a review by the nursing team to assess urinary continence. A referral was made to the general surgical team because of the scrotal swelling.
32. Six days later, on 18 February, the man was seen by a nurse after staff on the wing had raised concerns about his ability to look after and feed himself and his general well being. The man denied any problems with incontinence and said it was down to poor aim as a result of the scrotal swelling. It was also noted that he was forgetting to take his medication. A MMSE was carried out which came back with a low score. The nurse decided to refer the man back to the prison doctor and consideration would be given to moving him to Alpha Wing 8 (the Palliative Care Unit) where he would have more support from nursing staff and wing carers.
33. On the following day, 19 February, the man was seen by the prison doctor. It was recorded that his cholesterol levels had improved, blood pressure was a little better and his kidney function was stable. However, the man had a raised prostate hormone (prostate specific antigen, or PSA).
34. On 22 February, the man was visited in his cell by a nurse who recorded: "... is not managing at all, difficulty dressing and cannot hold things properly, tobacco all over the floor".

35. Just under a week later, on 1 March, staff on the wing requested that healthcare visit the man. He was found on the floor of his cell, unsteady on his feet but with no signs of head trauma. The man's blood pressure was taken later in the morning and was found to be quite high. It was recorded that his cell was untidy, that he had been incontinent overnight, could not dress or feed himself, could not use the toilet and had limited use of his left arm. The nurse recorded that "the man is not aware of anything that goes on around him" and that he was not coping at all well. Later in the afternoon, the man was seen by the prison doctor who noted his blood pressure was still high and that his MMSE had deteriorated. The doctor made urgent referral to the stroke service and further referrals to urology, for psychogeriatric input and for an occupational therapy assessment. The man moved to Alpha Wing 8 on 2 March and was located on the ground floor (the 1s) in cell 14.
36. On the following day, on 3 March, the man was reviewed by the nurse and prison doctor on the wing. During the examination, the man was leaning heavily to the left, was covered in vomit, gazing to the right side and had weakness affecting his left arm and leg. These were recognised as physical signs consistent with brain disorder. A diagnosis of a cerebrovascular accident (CVA or stroke) or space occupying lesion (SOL or brain tumour) was made.
37. The man was immediately taken by ambulance to a Stroke Unit at a local hospital. He was moved to another hospital on 4 March and a Consultant Neurosurgeon diagnosed that the man had a brain tumour (Grade 4 right-sided temporoparietal glioblastoma).
38. There are various types of primary malignant brain tumour. The different types develop from different types of cell in the brain. As a general guide, each type is graded on a scale 1-4. Grade 1 and 2 tumours are said to be 'low grade' and grade 3 and 4 'high grade'. The higher the grade, the more 'aggressive' the tumour tends to be and the faster it tends to grow. The treatment options and outlook (prognosis) can vary depending on the type and grade of the tumour.
39. On 5 March, emergency surgery was carried out to relieve the pressure on the man's brain being caused by the tumour. He remained an inpatient at the hospital until he was discharged on 12 March.
40. There was regular liaison between healthcare at Whatton and the hospital to coordinate a safe discharge and return to prison. There were some concerns about premature discharge and healthcare staff visited the hospital on 10 March to assess the man's suitability to return to Whatton. The nurse found that the man was catheterised (a catheter is used to drain urine from the bladder – the man had an unsuccessful trial without a catheter), was able to move around his bed independently but was not orientated in time and place. A decision was made not to receive him back to Whatton until after the oncology multi-disciplinary meeting on 12 March. Significant pressure was placed on the healthcare team at Whatton by the hospital to accept the man back into prison as soon as possible. However, given his social needs at the time, namely needing 24-hour care, healthcare staff managed to defer this for a

few more days until he was managing more independently. The man was attended by a Consultant Clinical Oncologist who observed that his condition had improved following his operation and:

“... currently he has got a poor memory but seems to understand the discussion today ... he is mobile unaided, although hasn't undertaken self-care duties yet ... I have explained to the man that he has a high-grade brain tumour which will be incurable, but which we could perhaps control for a short time with radiotherapy.”

41. On 12 March, the man was discharged from the hospital and returned to Whatton. It was recorded by healthcare staff he appeared to be aware of his surroundings and he was observed emptying his catheter independently. An inspection of his operation scar was made and it was healing well.
42. At a nurse review on the following day, 13 March, it was recorded that overnight, the man had, with force, pulled out his catheter. His carer had to put incontinence pads on him. It was also noted that the man had not taken any of his medication but had eaten his breakfast. The wing staff and carers were asked to monitor all of his food and fluid intake. Officer A made the following entry in The man's personal record on the same day:

“He was only with us here (Alpha Wing 8) for a day before being taken to hospital. He returned from hospital March 12th. He is still quite ill and requires increased medical support ... he has spent nearly all of his time sleeping.”

43. On 14 March, it was decided to leave the catheter out as the man was witnessed successfully passing water in the toilet. When he was visited in his cell by the nurse on the following day, 15 March, it was noted that his cell was untidy and the man was unkempt. The nurse was not sure whether this was a physical problem or more to do with cognitive impairment. He was seen by the prison doctor later that same day. The doctor found that the man had no recall over events or awareness of his diagnosis. It was also recorded that his incontinence was a continuing problem and he continued to fall out of bed. Urgent occupational therapy was sought to try to improve safety within his cell but the occupational therapist advised that they were only contracted for one visit per month.
44. When healthcare staff saw the man on 16 March, they found that he had been incontinent again. They decided to replace the catheter. He was later observed enjoying a cup of tea.
45. On the following day, healthcare staff reported some problems with the catheter and a urine sample was sent for analysis which indicated that bacteria had grown on the catheter. Some concerns were noted about how much the man was drinking and the urine specific gravity (an analysis to measure kidney function) was checked and was found to be satisfactory. The prison doctor also discussed the man's prognosis with the neurosurgical team and whether radiotherapy was appropriate.

46. On 18 March, nurses visited the man in his cell and noted it was tidy. They visited again after he had fallen. The nurses did not detect any injuries and helped him onto the toilet to open his bowels. Later, the prison doctor visited the man and noted he had marked cognitive impairment, could not transfer alone (move from his bed to toilet) and had fallen three times because he could not stand up without support on the left side. The doctor described the man as being very dependent and requiring “quite intense nursing input” and discussed speaking to his family so that they were aware of the prognosis. A steroid medication and dexamethasone were prescribed by the prison doctor. He also contacted the occupational therapist to expedite an assessment and this resulted in some negotiation over future planned visits.
47. Later the same day, the man was given a full strip wash and his catheter bag was drained. He was not in distress. The occupational therapist visited later in afternoon and commented that his balance was “severely compromised” and that he had “poor insight into dangers of transferring, and conceded that this may have been the reason for at least one of his many falls since returning from hospital”. An adjustable chair was ordered but the bed and mattress were considered to be appropriate. Additionally, the following comments were recorded: “[The man] stated he was more than happy with his level of care” and “that all transfers and mobility needs to be supervised”. It was decided, therefore, that a walking frame was not appropriate as it would add to his risks.
48. A case conference to discuss the man’s care was held on 23 March. The following were present: Dr C, prison doctor, Head of Residential, Head of Residential, Nurse A, Palliative Care Nurse, and Senior Officer (SO) A, from the Alpha Wing 8. The case conference was called to see how the prison and healthcare could work closely together to provide for the man’s ongoing needs. The following was recorded in the minutes of the case conference:
- “Recently had a malignant brain tumour removed. Part of tumour remains and this will mean prognosis of three/six months life expectancy. If further treatment such as radiotherapy is viable this may lengthen life expectancy a little. He has left side vision impairment and reduced mobility. He has cognitive impairment and is at risk of falls.”
49. The Head of Residential agreed to explore the possibility of compassionate release with consideration also being given to release on temporary licence (ROTL). In his written response to my investigator, the Head of Residential said:
- “You are aware this [compassionate release] was discussed at the case conference in March. Shortly after this review took place he [the man] responded well to medication and made significant progress, which in turn enabled radiotherapy to be considered by the GP, this improved his prognosis and therefore the position per compassionate release was put on hold”

50. In the meantime, the man's bed was moved so that he could reach a wall bracket with his good right side (which helped his mobility) and healthcare staff visited him three times a day. He was sleeping well but this was monitored in case overnight care provision became necessary in the future. During the weekend, an additional agency carer was employed from 8.00am to 8.00pm (as healthcare staff do not work all day at the weekend).
51. There are three Disability Awareness Co-ordinators (DACs) on the wing who are prisoners who used to be cleaners but now act as support workers. Senior Officer A gave the DACs strict guidance on the support the man required. The DACs collected food and drink for him, and reminded the man to eat and drink.
52. When interviewed as part of this investigation, Mr B, who is employed as a DAC, said The man was:
- “... a very jovial kind of guy really. He knew he was unwell. He knew he needed help as in to do everyday tasks but when he first came into the wing yes he was a very, I wouldn't say happy-go-lucky, nevertheless you know he'd sooner laugh with you than anything else.”
53. Mr B confirmed that he would bring the man's meals to him and supply him with drinks. He also confirmed that the man was well liked by other prisoners. Mr B said:
- “On a regular basis on the way to healthcare or visits more often than not we'd actually stop on the way or on the way back when somebody would say “Hi, how are you” and just generally pass the time of day with him. I mean I was quite surprised just how many people knew the guy. I took him to reception once which is a like stone's throw from here and we stopped twice on the way back.”
54. Mr B also confirmed that he had no concerns about the care provided to the man: He said:
- “... if ‘the man’ said something was wrong either myself or one of the other two DACs would immediately go to staff and say the man's having problems with this and they'd ... pick up the phone and say this is Officer X on Alpha 8, we need ... to get the emergency team down and ... healthcare would be here. There was never been any problems with that side of things. ‘The man’ was a very well looked after guy because he had auxiliaries down here on a daily basis to help clean him up, to wash him, shower him, to dress him, to make sure he had his breakfast in front of them, to make sure he had something to drink.”
55. When my investigator visited the Alpha Wing 8 he met Officer B. Officer B had returned to duty on 18 May after two weeks leave. Before he went on leave he said that although the man was poorly he was quite mobile. Officer B said that the man was not well when he came onto the wing but perked up after his operation. He said that the man was quite happy on the wing and never made any complaints when he saw him. He would often come out off his cell and talk

to other prisoners. However, the man did not go into other prisoner's cells and had no particular friends that Officer B was aware of. He pointed out that the man's movements were restricted due his catheter. Officer B confirmed that at weekends an outside carer would come onto the wing, after the healthcare staff had left the prison, and they stayed until 8.00pm. The carer would make sure the man was dressed for bed and was comfortable.

56. On 25 March, it was recorded that the man had made a telephone call to his daughter and appeared to be in good spirits. When he saw the prison doctor it was noted that his overall condition had generally improved since the introduction of steroids, he was moving around better and his mental faculty had also improved. It was also recorded that the man was now willing to participate with all treatment options and, as a result, a letter was faxed to the hospital with regard to radiotherapy treatment.
57. After he was unlocked on the following day, 26 March, healthcare staff cleaned and reconnected the man's catheter. It had become disconnected during the night and drained over the bed and floor of his cell. Over the next couple of days, healthcare staff were concerned about the catheter drain tap being left in an open position. However, the man was able to deal with spillages.
58. The man attended an outpatient appointment at the local hospital on 29 March. He appeared to be in a good mood and had managed to wash and dress himself beforehand. The following day, 30 March, it was recorded that the man's urine was strong and dark. He was encouraged to drink more fluids. On 1 April, it was noted that the man was drinking well. However, the catheter bag was replaced after becoming disconnected.
59. During the morning of 2 April, it was recorded that the man's urine was draining freely and was less concentrated. He told staff that he was "feeling well this morning". However, during the late afternoon, Nottingham Emergency Medical Services (NEMS - the out of hours medical service for Whatton) were called to change the man's catheter as it had become blocked.
60. Five days later, on 7 April, nurses recorded that the man had left the tap open on his catheter which had drained onto the floor of the cell. The same thing happened two days later, on 9 April.
61. On 13 April, the occupational therapist carried out a functional ability review for the man and set his adjustable chair to the correct height (as originally stated at the appointment on 18 March). Following a physiotherapist assessment on 20 April, it was recorded that the man was "functioning at a much higher level than last time".
62. The man started on a course of radiotherapy treatment on 22 April. However, he declined to attend on 10 and 13 May. His first refusal was because he had a visit organised. On the second occasion, the following entry was made in his record: "I am not convinced that the man understood the need to attend". He was otherwise reported to be in good spirits and was assisted with his daily needs.

63. When healthcare staff checked on the man on 14 and 15 May, he was found to have already showered independently and he told staff that he had already emptied his catheter. Around lunchtime on 14 May, the man was re-catherised as he was in pain and urine was bypassing the catheter. It was noted on both days that there was some urine in the catheter and although it was suggested that this would be reviewed there is no record of this taking place.
64. When wing staff unlocked the man on 16 May (a Sunday), they were concerned about his condition. They contacted healthcare and asked for assistance. Practice Nurses B and C visited the man at around 8.55am. They felt that he should be taken to hospital immediately. They were concerned about his pallor, shortness of breath, obvious signs of pain and his general deterioration from the previous day. An ambulance was called and the paramedics arrived at 9.25am.
65. The paramedics agreed that the man should be taken to hospital and the ambulance left the prison at 10.35am. He was escorted by Officer B and Officer C in the ambulance and taken to the Accident and Emergency (A&E) Department at the local hospital. He was admitted and moved to a side room in a ward at the hospital.
66. Staff from the A&E Department telephoned Whatton for further information about the man. The reply recorded in the notes included the following comment: "... that he was not checked by healthcare overnight as we are not a 24hr healthcare department".
67. Whilst the man was in the hospital, the initial risk assessment was completed by the duty governor, Mrs A, Deputy Head of Residential. She judged that restraints (a pair of handcuffs linked by a chain) were to be used and two officers should remain on duty at his bedside (this is known as a 'bedwatch'). A log of activities was maintained by the officers on bedwatch duty, and this was checked on a regular basis by a visiting duty governor.
68. Around 11.10am (on 16 May), hospital staff asked that the restraints be removed whilst the man's condition was diagnosed. The restraints were re-applied at 12.10pm once the bedwatch staff were advised that his condition had stabilised. Mrs A revised the risk assessment at 12.50pm and the restraints were removed and not re-applied.
69. The following entry was recorded in the bedwatch record at 6.30pm: "Seen by consultant, Dr C. He gave a time frame for death as tomorrow morning. Visitors still here attending bedside".
70. Around 6.50pm on 17 May, Senior Officer B and Officer C took over the bedwatch duty. Around 1.55am, on 18 May, the bedwatch staff noticed that the man had stopped breathing. They immediately informed hospital staff. Just over twenty minutes later, at 2.20am, a hospital doctor pronounced that the man was dead.

71. After the man died, the prison activated its death in custody contingency plan. The police visited the hospital and found no suspicious circumstances.
72. Hospital staff contacted the family to inform them of the death. Whatton also appointed Senior Officer A as the prison's family liaison officer. He maintained contact with the family and assisted with the funeral arrangements. Whatton also offered financial assistance with the costs of the man's funeral. The man's funeral took place in June 2010.
73. Prisoners were informed of the man's death after they were unlocked on 18 May. They were also asked whether they required any support or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) All the prisoners on the Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime were reviewed. (ACCT is the Prison Service's procedure for supporting and monitoring prisoners believed to be at risk of suicide or self-harm.) When the officers on bedwatch duty returned to Whatton, they were offered support from the prison's care team.
74. The post mortem report records the man's death as being due to natural causes, as a consequence of pneumonia, recurrent brain tumour and an infection in both of his kidneys.

## ISSUES CONSIDERED

### Clinical care

75. As noted, a review of the man's medical care was undertaken by Dr A on behalf of NHS Nottinghamshire County Primary Care Trust.
76. Dr A found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In his review, Dr A wrote:

“Record keeping was on the whole satisfactory, and where it was not, when fluid balance records were not kept up to date, the shortcomings were identified and efforts made to rectify them. When the man was ready for discharge from hospital after his brain surgery, the HMP Whatton healthcare staff quite rightly identified potential problems and managed to defer his discharge for a few more days until he was managing more independently. The prison was put under some pressure to accommodate the discharge before they were ready, presumably because of the demands on hospital beds.”

77. In his review, Dr A noted that providing comprehensive care in a prison setting can be difficult. This was especially an issue at Whatton with regard to access to an occupational therapist whose contract was limited to one visit per month. It required some effective negotiation to secure more frequent assessments. Dr A drew attention to an adjustable chair which was ordered after the man was visited by the occupational therapist. It was not until a further review by the therapist some time later that it was noted that the chair was set at the wrong height. In Dr A's opinion, getting the view of outside professionals in prisons (for example, occupational therapists) can be difficult and their recommendations, when given, should be readily identifiable in the medical record for the benefit of the whole care team, and acted upon if appropriate.

**The Head of Healthcare at HMP Whatton should ensure that recommendations made by outside professionals are clearly recorded in a prisoner's medical record and acted upon if appropriate.**

78. Dr A recognised that there had been problems relating to the management of the man's catheter. It appears that the man was “at times able to manage his catheter but at other times his efforts made things worse”. He frequently left the tap open on his catheter and accidentally pulled it out causing trauma and bleeding to the urethra (the tube in the penis). The catheter was also changed twice by doctors from the out of hours medical service (NEMS - Nottinghamshire Emergency Medical Services). Dr A wrote: “Catheters invariably require emergency changing outside of usual hours and, in my opinion, HMP Whatton has to be satisfied with their current arrangements for this common nursing procedure”.

79. Both my investigator and Dr A noted that in the final few days before his death, the man enjoyed more independence and was even able to take a shower on his own. The man was re-catheterised after he was feeling uncomfortable and only small amounts of urine were noted in the draining bag. The comment was made in the notes to check how much was draining later in the day but there is no record that this happened. On the following day, 15 May, the nurse noted that the man had already emptied the catheter bag but that there was some urine in it and again the comment was made to check later in the day. This may well have been done but there was no record in the man's medical record

80. Dr A also wrote:

“The fact is, urine production would have been reduced in the presence of an acute pyelonephritis (kidney infection), and this may have been the reason for the absence of significant quantities of urine in the bag, and not because of a blocked catheter from blood and pus.”

81. Dr A noted that there were several examples of reliance on non-core staff to provide out of hours care (agency carers and doctors from NEMS). Dr A wrote:

“In my opinion, since a significant proportion (if not the majority) of critical healthcare interventions happen during out of hours supervision, HMP Whatton needs to be satisfied that the arrangements they have in place are sufficient for the regular and expected demands placed on them.”

82. I have investigated many deaths at Whatton in the past, and have commented on the provision of medical services there. In the overwhelming majority of cases, I have found that the level of care given was equivalent to, or often better than, that on offer in the community. However, while not making a recommendation of my own, I would encourage the Governor and Head of Healthcare to constantly assess whether the current level of provision remains appropriate or whether a different model should be considered. From previous investigations, I am aware of the Governor's view on this issue. However, given the facts of the man's case, and Dr A's comments, I believe there is merit in bringing the matter to her attention again.

### **Use of restraints**

83. As previously mentioned, whilst the man was in hospital the initial risk assessment was for restraints to be used and for two officers to remain with him. It was in line with standard procedures that the man was handcuffed in the first instance. At the time the handcuffs were first applied, the man was conscious and could reasonably have been judged to pose a security risk.

84. The risk assessment for the man was reviewed and revised soon after he was admitted to hospital. During the evening of 16 May, the staff on bedwatch duty were informed that the man was not expected to survive for more than a day. Two officers remained on bedwatch duty at a discreet distance but the man's family felt that their uniformed presence was unnecessary.

85. My investigator has looked at this and found that the action taken by Whatton was appropriate. In previous deaths this office has investigated, at other establishments, the escort has been at the prisoner's bedside and family members have not had an opportunity to spend time alone with their loved one. This was not the case with the man's family, although I appreciate that they may have been distressed by having the officers present nearby.
86. My investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Whatton. The Governor may wish to share my assessment with her managers and staff.

## CONCLUSION

87. The man arrived at HMP Whatton on 9 April 2009. He was diagnosed with an incurable brain tumour on 4 March 2010. Just over two months later, on 16 May, he was found collapsed in his cell and was taken to a local hospital. The man passed away in hospital two days later on 18 May.
88. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were also in line with current policy and expectations.
89. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. In his clinical review, Dr A drew attention to comments made in the man's record about out of hours medical provision at Whatton. This related to the entry in the medical record on 16 May 2010: "That he was not checked by healthcare overnight as we are not a 24hr healthcare department". Dr A has made one recommendation, concerning recording of information from outside professionals which I endorse.

## **RECOMMENDATION**

1. The Head of Healthcare at HMP Whatton should ensure that recommendations made by outside professionals are clearly recorded in a prisoner's medical record and acted upon if appropriate.

*Recommendation accepted - All professionals should document in a patients medical notes and the care plans for those patients should be clearly marked and shared with the clinical team. All professionals working within the health team will be forwarded the record keeping operating procedure and be required to sign up to this.*