

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE
DEATH OF MAN IN HOSPITAL, IN JUNE 2007 WHILST IN THE
CUSTODY OF HMP WHATTON**

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

April 2008

This is the report of an investigation into the death of a man in June 2007. He died of lung cancer in a specialist hospital, whilst in the custody of HMP Whatton. He was 72 years old.

I would like to add my personal condolences to those already expressed to the man's next of kin on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my colleagues. We would both like to thank the Governor of Whatton and his staff for their participation in the investigation. A medical practitioner was appointed by Nottinghamshire County Teaching Primary Care Trust to undertake a review of the man's clinical care, and I also appreciate his assistance.

As is the case with many of my investigations into deaths due to natural causes, the findings of the clinical review carry significant weight. In the case of this man, it appears that his overall medical care was acceptable. He was diagnosed with incurable cancer, and any difference in the treatment he received would not have made much difference to the overall outcome. However, there are some questions about the ongoing care of, and the correct location of, terminally ill prisoners which the prison and the Primary Care Trust will wish to address. I am pleased to note in this final version of my report that the Prison Service have accepted two of the recommendations and partially accepted the other.

I make three recommendations to the Governor and Primary Care Trust.

This report has been anonymised for publication on my website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2008

CONTENTS

Summary

The Investigation Process

HMP Whatton

- Healthcare
- Previous deaths at Whatton
- Her Majesty's Chief Inspector of Prisons

Key Findings

Issues

Recommendations

SUMMARY

The man was 72 years old when he died in hospital in June 2007. He had been sentenced in August 2006 to four years and six months' imprisonment and soon afterwards was allocated to HMP Whatton.

The man had previously been fitted with a pacemaker. At assessment on reception it was noted that he had a history of heart disease, asthma, and was taking various medications. He had some minor contact with healthcare but nothing serious until, in February 2007, he was suspected of being anaemic. He was admitted to hospital in March when he underwent a blood transfusion. His health did not improve and he continued to see the doctor in prison. In May, he had a chest X-ray followed by a scan. He complained of fatigue and shortness of breath, and was diagnosed as having lung cancer.

In early June, the man was admitted to hospital and commenced a course of chemotherapy. While he was in hospital the prison made arrangements for continuous oxygen to be available on his return. He was transferred back to prison on 15 June.

The man's health deteriorated and with it his ability to care for himself. By Saturday 23 June, staff and a prisoner who was helping him were becoming concerned whether he was in the best place, and plans were made to re-assess his care. However, Whatton does not have 24-hour healthcare cover at weekends and the review was scheduled for the Monday.

Sadly, this was too late. The man deteriorated further on Sunday, 24 June. He was returned to hospital, but died soon afterwards.

The man had expressed a wish to be cremated, and the prison's Governor and chaplain were the only attendees at his cremation. His ashes were then transferred to his home area for a further service. Once again, the Governor and chaplain attended. There were also two separate services held in the prison for his fellow prisoners.

THE INVESTIGATION PROCESS

1. My investigator visited Whatton and spoke to staff who had responsibility for the man during his time there. He interviewed five members of staff and notices were posted to staff and prisoners about the investigation, inviting contributions if necessary. None were received. The investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff. The investigator also visited the man's cell.
2. The Nottinghamshire County Teaching Primary Care Trust appointed a medical practitioner to carry out a review of the man's clinical care. I am grateful to the clinical reviewer for undertaking this review. My investigator discussed aspects of the man's treatment with both healthcare staff and the clinical reviewer.
3. My investigator contacted Her Majesty's Coroner for Nottinghamshire to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's listed next of kin to offer him the opportunity to raise any questions or concerns for the investigation to consider. He was also offered the opportunity to see my report at draft and final stages. At the time of contact he only asked about the return of some of the man's personal property (my investigator pursued this with the prison). My family liaison officer gave contact details for my office and advised that he was welcome to contact us at any stage in the future.

HMP WHATTON

5. Whatton is a category C prison and holds adult male offenders. Its three wings are mainly single cell and have the capacity to hold 821 prisoners.
6. Prisoners coming to Whatton must be adult male category C offenders. The regime includes a wide range of learning and skills activities, including education, vocational training, industrial workshops and manufacturing, farms and gardens. There is also a range of offending behaviour programmes.
7. Wings A1 and A2, which included where the man was accommodated, make up the unit for older prisoners and those with particular social and palliative care needs.

Healthcare

8. Healthcare within the prison is commissioned and provided by the Nottinghamshire County Teaching Primary Care Trust (PCT). The PCT provides a range of services. Healthcare provision is available between the hours of 7.30 am and 5.45 pm Monday to Friday, and between 7.30 am and midday on Bank Holidays and at weekends. Out-of-hours care is provided by a contracted provider.

Previous deaths at HMP Whatton

9. Since my office took over the responsibility for investigating all deaths in custody on 1 April 2004, there have been ten deaths at HMP Whatton, eight of which were due to natural causes. My investigator has not identified any similarities between the investigations into these other deaths and the circumstances surrounding the death of this man.

Her Majesty's Chief Inspector of Prisons (HMCIP)

10. The most recent inspection of Whatton by HM Chief Inspector of Prisons took place in January 2007. Her subsequent report included a number of recommendations. The recently reorganised PCT had previously included the prison in its quality improvement group as part of the clinical governance arrangements. However, following the reorganisation, this had ceased to be the case. The Chief Inspector recommended that this should be resumed. Her report also recommended that the service level agreement for medical out-of-hours cover should be patient-focused and clearly state what was expected of the service. She went on to recommend that there should be information-sharing policies with appropriate agencies to ensure efficient exchange of relevant health and social care information.

KEY FINDINGS

11. The man was convicted at Crown Court in June 2006 and taken to HMP Pentonville. He was 71 years of age at the time. On 11 August, he was sentenced to four years and six months' imprisonment. He was transferred to Whatton on 1 September, went through the induction process and was allocated to A wing. No problems were reported.
12. On 13 September, the man went to healthcare, complaining of pain in his abdomen. After seeing the doctor the pain went away, and did not seem to recur. The same month his appeal against conviction was rejected but he was given leave to appeal against sentence which he did. (This appeal was heard in January 2007, but was also unsuccessful.) The man suffered an asthma attack in October 2006 when healthcare staff attended again.
13. The man had a number of contacts with healthcare and medical staff. He attended hospital on 26 January 2007. On 7 February, he had a standard check on his pacemaker which showed that it was working correctly. On 18 February, he collapsed while in the dining area. Healthcare attended, and advised him to see the doctor the following day, although his records do not indicate whether he did so. He saw healthcare staff on 22 and 23 February, when he told them that he had collapsed in his cell a few weeks previously but had not told anyone. Blood results indicated chronic kidney disease and a management plan was identified.
14. Blood tests also indicated that the man's blood count was low, and he was urgently admitted to hospital on 2 March. He remained in hospital for a week, during which time he had a blood transfusion and an endoscopy. He returned to Whatton on 9 March, but the prison doctor did not receive the hospital's discharge summary until 4 May. The summary indicated high blood pressure in the stomach region and a growth in his colon, and that this could have been causing the man's low blood count.
15. After the man's return to prison he was assessed by the psychology department for allocation to an offending-related treatment course. He was further assessed on 29 March, but on 18 May was told that he did not need to attend the programme while he was unwell.
16. On 30 April, when the man had complained of a productive cough, the prison doctor identified that he had a wheezy chest and a node on the left side of his neck. He considered whether an X-ray was necessary, but his medical notes do not indicate that one was taken.
17. The following month, on 11 May, the man was visited in his cell by healthcare staff because he felt unwell and the left side of his neck was swollen. Two days later, he attended healthcare complaining of shortness of breath, wheezing and chest pain. He had just begun an offending behaviour programme and it was thought that the stress might have been causing some of his health problems. However, the following day he again saw the doctor, complaining of chest pain. The doctor noted that the swelling on the man's

neck had increased, and that he still had not had a chest X-ray. He arranged for him to be admitted directly to hospital where he remained for three days. Whilst in hospital he had a chest X-ray and a computed tomography (CT) scan (a specialised X-ray test to give clear pictures of the inside of the body, particularly of the soft tissues).

18. The day after his return to prison on 18 May, he again complained of fatigue and shortness of breath. His medical notes at this point contain an entry confirming the presence of potentially cancerous signals following earlier tests.
19. On 30 May, the man went to an appointment at the Combined Lung Oncology Clinic at the hospital. The prison had previously asked him if he wanted them to arrange for a family member to attend the appointment with him, but the man had said that he would attend alone. At this visit the man was informed that he had lung cancer. He visited the hospital on 1 June and was admitted the following day, remaining until 15 June. During this time, prison healthcare were in regular contact with the hospital. The man began his course of chemotherapy whilst in hospital, and was told that his prognosis was that he only had months to live.
20. While the man was in hospital, prison healthcare were in contact with the hospital over the further care he would need. This included the continuous provision of oxygen. Machines to provide this oxygen were obtained and located in the man's cell. He received the oxygen via a long tube, so the machinery could be permanently stationed without him needing to shift it in order to move around the room. Uniformed staff were not trained how to operate the machinery, but were given telephone numbers to contact in the event of assistance being required. The man was also provided with portable cylinders so he could continue to move around the prison.
21. The man was given his first dose of chemotherapy at the prison on 19 June. When he went to healthcare for a bath on 21 June it was noted that his weight had dropped and that his appetite was poor. Special arrangements were made with the kitchen for food and dietary supplements to be made available to him. However, on 23 June it was noted that the man was suffering from diarrhoea and vomiting, and that he was eating poorly.
22. A staff nurse who worked in Whatton's healthcare centre was involved with the man's healthcare up to and throughout his diagnosis with cancer. She had also been involved in a good deal of work to prepare for the provision of oxygen equipment for him in his cell. In the nurse's opinion, the man was properly accommodated in the prison. He had not needed to be a hospital in-patient or any specific outside care, and a transfer out of Whatton was, in her opinion, unnecessary.
23. A prison officer was the man's personal officer, a role which involves offering support, being first port of call for queries, and generally keeping a watch on the prisoner and his well-being. She had known the man since October 2006, and had regular contact with him. When she first knew him he was in a

reasonable state of health and mobility for his age. As his health deteriorated, the officer did not think that the wing could provide the care a man in his condition seemed to need, despite the best efforts of staff.

24. The Senior Officer (SO) on the man's wing shared the personal officer's opinion that it was not appropriate that someone needing oxygen machines in his cell should be held on the prison wing. When speaking to my investigator, the SO commented that in his opinion, staff on A2 who were involved in caring for the man acted very professionally, and went beyond the normal level of duty. Nevertheless, he felt that the man should have been in a hospice or somewhere he could receive the right level of care.
25. The SO had raised his concerns over the man's care with the Prison Officers' Association (POA) and with his Principal Officer (PO). The PO had in turn raised this with the Governor. The Governor was aware of the man's situation, but as the hospital had discharged him and said that there was nowhere that they could locate him, the prison had no option but to take him back.
26. On the morning of Saturday 23 June, as the wing officer unlocked the cells on A wing, the man asked him not to come inside his cell as it was too much of a mess. The man had soiled his bed. The officer asked a member of healthcare staff to attend, and the wing nurse came and spoke to the man and the wing officer. She assessed the man and noted that he was receiving oral medication and suffering from incontinence. She did not think that anybody should be in contact with his bodily fluids unless they were aware of the hazards. She commented in the unit observation book that his needs ought to be reviewed as soon as possible on the following Monday.
27. Whatton operates a system whereby some prisoners are employed to care for other prisoners who need higher levels of care. Another prisoner on A wing, who was also the prisoners' wing representative, had been acting as a carer and looking after the man. On 23 June, this prisoner wrote to the Governor saying that he felt he was no longer able to do so, and that the man was not in an environment providing the care he needed.
28. That afternoon, a prison officer sent an e-mail to a number of members of staff including his senior officer, the residential governor of A wing, the overall residential governor, the head of healthcare, and a POA representative. He raised the question of how the man needed to be cared for and quoted the entry from the unit observation book by the wing nurse.

24 June

29. On the morning of 24 June, the wing SO went into the man's cell and thought that he looked extremely ill. He contacted healthcare and asked for someone to come and assess him. He also made contact with the second PO and with the duty governor, as he felt that a discussion was required as to whether the man was in the right environment. The wing nurse attended from healthcare

at 11.00am and said that the man needed to be in hospital. An ambulance was called.

30. The first escort officer was on the rota to provide escort duty and, just after lunchtime, he and the second escort officer were called to escort the man to hospital in a blue-light ambulance. The duty governor agreed that it was not necessary for the man to be handcuffed neither whilst in the ambulance nor while he was being medically treated.

31. The man was conscious during the journey to hospital, but only spoke to respond to questions from medical staff. On arrival at the hospital he was taken to a ward, and escorting officers remained with him while he was treated. Shortly before 4.30pm, medical staff asked the escorting officers to leave the room. They did so, remaining where they could still see the man. Within approximately two minutes medical staff came out and told them that the man had died. The escort officers informed the prison and remained at the hospital until the second PO arrived and formally identified the body. They then returned to the prison.

After the man's death

32. As noted above, the man had been closely involved in the chapel at Whatton. When he had realised how ill he was, he had asked the chaplain if she would visit him in hospital. When she heard that the man was being readmitted to hospital on 24 June, the chaplain drove to the hospital. Sadly, she arrived ten minutes after his death. The chaplain subsequently telephoned the man's next of kin, whom she knew from previous contact, to pass on the news.

33. Just after 4.30pm, the wing SO was informed that the man had died. A short debrief session was held, and appropriate support was offered to staff. Prisoners were advised of the man's death by a notice which offered support if they felt they would like it. Some prisoners close to the man, such as the man who had provided care for him, were told individually.

34. The man's personal officer was not on duty when he died. She did not find out about his death until she came in to work the following Wednesday when she noticed the roll numbers were one down. She queried this and a colleague explained why. The news came as rather a shock to her and she told my investigator that, as his personal officer, she would have appreciated a telephone call. Returning to work three days after the death, the officer was not offered any formal support, though her immediate colleagues were supportive.

35. The chaplain subsequently liaised with the man's next of kin over the arrangements for the funeral. The man had expressed a wish to be cremated, and it was agreed that he would be cremated in Nottingham. His ashes were then transferred to Croydon, where he had lived, for a service there. In addition, two services were held in Whatton for the man's friends: one on the wing and one in the chapel.

36. The only people present at the cremation service in Nottingham were the chaplain and the Governor. They also travelled to Croydon for the service there, and brought with them the man's personal effects to hand to his next of kin. Very properly, they used an ordinary holdall rather than Prison Service-marked bags.

Post Mortem

37. The post mortem gave the cause of death as:

- 1a disseminated poorly differentiated squamous carcinoma of lung
- 2 ischemic heart disease.

ISSUES

Clinical care

38. The clinical reviewer says that the man received adequate care whilst in prison. His reception screening was comprehensive and ongoing care plans were set in place. It was also impressive that prison staff worked to ensure that, when he returned from hospital, he had proper access to continuous oxygen, and that the man was asked if he wanted a family member to attend the oncology clinic with him in May 2007. The man died of an incurable lung cancer and any differences in his treatment would not have affected the final outcome.
39. The clinical reviewer expresses some concerns about communication to the prison's healthcare centre and the care the man received when in hospital. When the man spent some time in hospital in March 2007, his discharge summary was not received by the prison doctor for two months. Although he was an in-patient for seven days, no chest X-rays were taken which the reviewer believes led to the diagnosis being delayed.
40. The clinical reviewer also comments on the number of occasions when the man was either admitted to hospital on a Friday or discharged back to the prison on a Friday. Hospitals are under pressure to clear beds before the weekend, and the reviewer suggests that prison healthcare seems to be under a similar pressure to reduce the number of prisoners requiring nursing care over the weekend. He warns that the situation will be repeated, and the Governor and healthcare manager should be satisfied that arrangements are adequate. Although the man's care was adequate and his symptoms were controlled, the reviewer remains concerned about the adequacy of weekend nursing care.

The Governor and Primary Care Trust should review the provision of weekend nursing care, particularly in respect of terminally ill prisoners.

41. Further to this, there do seem to be some issues regarding the care that patients in prison require. The Governor told my investigator that, in the light of the man's death, they have been working to ensure that other prisoners requiring specific care are able to receive it. This includes actions such as widening cell doors and installing equipment to assist with washing. It is commendable that the prison is proactively seeking to ensure that future prisoners with specific healthcare needs are more likely to have them met.
42. After the man was diagnosed with lung cancer, officers and a prisoner were not confident that he was in the right environment to be properly cared for. The clinical reviewer considers that on his discharge from hospital it was reasonable for the man to return to Whatton, even though there is no 24 hour healthcare provision.
43. The healthcare nurse thought that the man did not require specialised medical care in another location, but did arrange an early review of his needs. As lung

cancer is such a short-prognosis illness, his care should have been kept under constant review. That a terminally ill prisoner had to be cleaned by a fellow prisoner after suffering diarrhoea and nausea is not dignified. When he became unable to look after himself, the level of care the man received should have been altered accordingly, whether by increasing his care in the prison or considering an alternative location.

The Governor and the Chief Executive of the PCT should develop a protocol to ensure that patients with palliative care needs are able to have those needs met in prison.

Informing staff

44. Informing staff of the death of a prisoner whom they knew is a sensitive issue that is easy to get wrong. Some staff who are off-duty when a death occurs may not want to have their rest-time interrupted with potentially upsetting news, whereas others would prefer to know. In this case, the man's personal officer, only found out about his death on returning to work when she noticed the roll count was low and asked why. She was not offered any formal support.

The Governor should consider putting in place a sensitive system for ensuring that staff returning to work are informed of the death of prisoners, and that support is available if required.

RECOMMENDATIONS

1. The Governor and Primary Care Trust should review the provision of weekend nursing care, particularly in respect of terminally ill prisoners.

The Prison Service has accepted this recommendation. Whatton now works with the PCT to ensure that when patients require night or weekend nursing and appropriate palliative care, it is provided.

2. The Governor and the Chief Executive of the PCT should develop a protocol to ensure that patients with palliative care needs are able to have those needs met in prison.

The Prison Service has accepted this recommendation. As stated above, Whatton and the PCT now liaise to ensure appropriate care is available.

3. The Governor should consider putting in place a sensitive system for ensuring that staff returning to work are informed of the death of prisoners, and that support is available if required.

The Prison Service have partially accepted this recommendation. They state that the policy in place notifies all staff when a prisoner has died, offering support and the use and facilities of the care team. Unit managers brief their staff on any prisoner who has died on their unit, but there will be occasions when staff that have to be off duty for a long period of time are not updated. This recommendation would be difficult to apply across the prison unless it is known specifically who is very close to the prisoner. Operationally this would be extremely difficult.