# Investigation into the circumstances surrounding the death of a man in August 2010, in hospital while in the custody of HMP Whatton

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

**January 2011**

This is the report of the investigation into the circumstances surrounding the death of a man in hospital while in the custody of HMP Whatton. From birth, the man suffered from many disabilities including asthma, gastric abnormalities, a small bone structure and Pierre Robin Syndrome (a congenital facial condition, symptoms of which include a cleft palate). Following deterioration in his physical condition, the man was admitted to the hospital on 22 August. He died the following day at 3.22pm with his family at his bedside. The man was 47 years old. I extend my sincere condolences to his mother, brother, step father, family and friends.

Her Majesty's Coroner for Nottinghamshire requested a post mortem examination, which indicated that the man died of natural causes by idiopathic end stage lung disease (when the lungs can no longer keep the blood supplied with oxygen). NHS Nottinghamshire County Primary Care Trust (PCT) appointed a doctor to carry out a review of the medical care that the man received in prison. I am grateful to the doctor for that review, which is an annex to this investigation report.

One of my investigators was appointed to carry out this investigation. I would like to thank the Governor at HMP Whatton and her staff for the assistance throughout the investigation. I am especially grateful to the liaison officer.

In this report, I reflect on the continued compassion shown by healthcare and prison staff offered to prisoners suffering from chronic and terminal illnesses. I record as good practice the start of an application for a release on temporary licence and the dignity afforded to the man and his family. I make no recommendations.

This final report has been amended to include minor factual inaccuracies. Two paragraphs, 14 and 15, held in the HMP Whatton section of the report have been amended. These paragraphs now refer to an updated inspection report in 2010 by Her Majesty's Inspector of Prisons and an Independent Monitoring Board report dated 2009-2010. Furthermore, paragraph 22 has also been amended to include a revised description of Charlie Unit. The man's family have read the report and do not wish to add any further comments.

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **January 2011**

**CONTENTS**

## SUMMARY

The man was convicted in May 2008, and later sentenced to a minimum of four years imprisonment for sexual offences. When he arrived at HMP Nottingham, healthcare staff identified him as being in a poor physical condition. Although Nottingham does not have an inpatients' unit, staff arranged for him to be observed and cared for on a wing where he could be easily observed by healthcare staff. The man's medication was reviewed following liaison with his community doctor.

The man transferred to HMP Whatton and his care continued through regular consultations with nurses and doctors. He was urgently referred to an Ear, Nose and Throat specialist because of an ulcer in his throat and was seen two weeks later. The ulcer was not cancerous. A chronic cough was noted and the man was seen by a physiotherapist for exercises to help his breathing. Two months later, following a review by the doctor it was recorded that the man was still very underweight and having problems eating.

The man was seen at a hospital by a gastroenterologist (a specialist in abdominal medicine) and a percutaneous endoscopic gastrostomy (PEG) tube was discussed with him. (This is a surgical procedure and the tube is externally inserted directly into stomach to allow to nutrition into the body.) He was seriously underweight and it was hoped that this procedure would help him to maintain his weight. A nursing plan was opened to care for the man and he was visited daily by healthcare staff. Despite encouragement from staff, the man continued to smoke and his breathing became increasingly problematic.

The man told staff that he was considering asking for the PEG tube to be removed because it was causing pain. (In fact, the PEG tube remained in place until his death.) Healthcare and prison staff discussed a move to a wing which would provide an appropriate location for his deteriorating physical health. A week later, he moved to Charlie one wing (C1) where older and less able prisoners are located.

The man was seen by a nurse in the morning of 22 August, because he was having difficulty breathing. His condition failed to respond to medication and he was admitted to hospital later that evening. He was escorted by two officers and restraints were used.

A governor began to complete the risk assessment to release the man on temporary licence (ROTL) and the restraints were removed during the morning of 23 August. (A ROTL means the prisoner is temporarily released from custody.) The man's family arrived at the hospital and the bed watch officers moved away from his bedside. He died at 3.22pm with his family by his side.

I do not make any recommendations and note the dignity afforded to the man during the final hours of his life.

## THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 1 September 2010, when my investigator visited Whatton. She met the Prison and Probation Liaison Officer and reviewed the man's prison and medical files. Copies of documents from those records were forwarded to Ms Gilbert. My investigator later met a governor, visited C wing and spoke informally to his personal officer. No members of the Independent Monitoring Board (IMB) or Prison Officer's Association asked to see her. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison and prisoners.)

2. The Ombudsman's notice of investigation and terms of reference were sent to Whatton in advance of my investigator's visit but there has not been any responses from prisoners or staff.

3. A clinical review of the man's medical care in custody was commissioned with NHS Nottinghamshire County PCT. A doctor undertook that review on behalf of the PCT which is annexed to the investigation report.

4. One of my family liaison officers wrote to the man's mother, to inform her of the investigation and any issues she would like to be considered. She has not raised any matters to be included in this report.

**HMP WHATTON**

5. Whatton is a specialist prison for adult male sex offenders to enable them to participate in Sex Offender Treatment Programmes, to address their offending behaviour. It has increased its capacity by 500 over the last four years. All applicants for a place at Whatton must be adult males, category C with a history of sexual offending. (Category C prisoners are assessed as being of medium risk to the public.) 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.

6. The regime at Whatton includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes.

7. Whatton can accommodate older prisoners and those with chronic diseases and has considerable experience of working with this specific prisoner population. However, the prison does not have a 24 hour healthcare service. NHS Nottinghamshire County 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.

8. 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 doctor or arranges appropriate prescriptions to be administered. Nurses take the lead in treating different diseases, and they have various internal clinical specialists, including palliative care. Occasionally, external specialist nurses come in. They include diabetic, COPD (chronic obstructive pulmonary disease) and TB (tuberculosis) nurses.

9. The former HM Chief Inspector of Prisons made an unannounced inspection of Whatton in 2010. An extract from that report said:

   > "There had been improvements in health services. The environment was spacious, clean and staffed by a dedicated team with the necessary skills mix. Access to the services was good, as was GP support. There had been an appropriate focus on older prisoners and their needs."

10. The most recent annual report published by the IMB at Whatton covers the period from June 2009 to May 2010. The IMB drew attention to Whatton being of one of the few prisons where the average age of a prisoner was in the mid forties. The IMB said:

> “As previously reported in Annual Reports, the Board continues to be extremely impressed by the overall proactive management of all aspects of healthcare, with the service provided being regarded by many as a ’place of excellence’. The HMIP report on healthcare stated that much of the healthcare provision was classed as excellent, with the ‘end of life’ care provided by both prison officers and the healthcare team being described as of a very high quality by the Nottinghamshire Coroner. Whatton has one of the highest rates of death by natural causes within the prison system. Whilst this is to be expected with a significant number of prisoners over 65 years of age, nevertheless prison staff on wing A8 are to be commended for the great care and wellbeing offered to those in their care at the end of life.”

11. The prison has effectively managed prisoners suffering from complex physical conditions through their specialist clinics. The clinics continue to provide the relevant healthcare to manage and monitor a prisoner’s health. There have been five previous deaths from natural causes at Whatton over the last year, mainly from long term illnesses.

## KEY FINDINGS

12. Following a court appearance in May 2008, the man was taken to HMP Nottingham. On his arrival at the prison, he was seen by a nurse. The nurse noted that the man was in poor physical health, underweight and had an outstanding appointment with a gastro-intestinal consultant at a hospital. He told the nurse that he needed oxygen to help his breathing whilst sleeping. It was further written that he was a smoker. The man's complex medication was prescribed by the doctor following information from his community general practitioner.

13. The man was taken to a cell on F wing. (There are cells on F wing which allows healthcare staff easier accessibility to observe and monitor prisoners. Nottingham does not have a dedicated healthcare inpatient unit.) On 31 May, a nurse wrote that the man seemed vague during a consultation and it was difficult to conduct his secondary health screen. (This health screen, completed several days after arrival at the prison, assesses the prisoner's full medical history and observations.)

14. A nurse saw the man on 3 June and wrote that he had a palate, that is an insert, in his upper mouth which made his speech difficult to understand. The nurse faxed the man's community doctor for more information on his condition. The next day, a doctor reviewed the man's complex medication regime. Following the receipt of a full medication list from his community doctor, the man's prescription was updated.

15. Healthcare staff re-arranged the man's hospital appointment for September, having noted that he should have attended prior to his arrival at Nottingham. The appointment was to investigate his gastro-intestinal issues. The man's condition continued to vary and he was treated for infections, gastric and breathing problems over the next few months. He remained on F wing and was closely monitored by healthcare staff.

16. In September, the man was seen at a hospital, as an outpatient in the Digestive Disease Centre. The doctors noted that he was malnourished and had previously been fitted with a percutaneous endoscopic gastrostomy (PEG) tube. The hospital doctor made the decision that a PEG tube would be the appropriate treatment for the man.

17. The man was transferred to HMP Whatton on 23 December and his medical notes continued through the PCT's electronic system. This allowed healthcare staff at Whatton to access the man's treatments, medication and current physical condition with immediate effect. Following his induction, the man was allocated a cell on the Charlie

Unit, where infirm and elderly prisoners are located as this is the least secure accommodation at Whatton.

**January – July 2009**

18. A doctor saw the man for a medication and physical health review on 13 January 2009. She noted his long standing medical conditions and advised healthcare administration staff to contact the hospital to notify them of the man's transfer to Whatton. It was further noted that he should be urgently referred to an Ear, Nose and Throat (ENT) consultant, as she noticed an ulcer in his throat.

19. On 4 February, the man was seen at the hospital by an ENT registrar. Following an examination of his throat, the registrar wrote that whilst the man was malnourished, and his palate showed no signs of ulceration or a malignancy in his throat. The man started physiotherapy later that month to help his breathing and mobility.

20. The man was escorted to hospital on 12 March for an outpatient appointment. He agreed to have a PEG feeding tube inserted again and, because he was at Whatton, the hospital transferred his surgical care to another hospital. On 14 April, the man was admitted to this hospital for abdominal pain, as an emergency. He was discharged the following day and it was recommended that his pain relief of co-dydramol should stop, to be replaced with paracetamol.

21. A consultant in gastroenterology (abdominal medicine) wrote to the man's doctor at Whatton on 22 April, for assurance that the prison and healthcare staff could appropriately manage his care after the PEG tube procedure. The doctor further added that there might be problems with his breathing following the surgical procedure. He wrote that prison staff should be aware of the medical assistance the man would need in addition to an extended stay in hospital to recover from the operation.

22. Two days later, a doctor examined the man and discussed the PEG procedure with him. A nurse saw him on 29 April and again spoke to the man about the procedure. The nurse then contacted the consultant at the hospital to discuss the issues around the surgical procedure and its management at Whatton.

23. The man was admitted to hospital on 30 June for the PEG procedure. Following the operation he was taken to the high dependency unit for monitoring. He was escorted by two officers and an escort chain was applied, although this was removed for the operation. (An escort chain is a 1.8 metre of chain with one cuff attached to the prisoner and the other to an officer.) A nurse wrote in his medical notes that a PEG feeding training session had been arranged for the following day for the prison nursing team.

24. Three days later, the man was discharged from hospital and returned to Whatton. The nurse visited him on 3 July and noted that he was able to administer his feeds into his PEG tube. A care plan was started for the man. He was to be seen daily and the tube thoroughly cleaned during each visit. Additionally, provision was made for an adequate supply of feeding syringes. He was prescribed a nutritional drink and the care plan required that his weight was to be recorded weekly. Contact details of a nutrition nurse at the hospital was sent to the prison's communications room, in case of an emergency with the man's feeding tube. On 9 July, his weight was 37kgms.

**July 2009 – 11 August 2010**

25. Over the following three months, the man was closely monitored by healthcare staff on a day by day basis and by a nurse in particular. Despite some initial problems with his PEG tube, the man managed to use it appropriately with support from the nursing staff. A visiting dietician advised on extra nutrition to increase his weight. However, his breathing continued to pose problems and was prescribed steroids and inhalers with occasional oxygen therapy. The man continued to smoke despite advice from nurses.

26. The man was seen at an outpatient appointment on 29 September. The consultant in gastroenterology noted that the PEG tube was working well although his low weight was still a cause for concern. The consultant arranged for the dietician to remain involved in his care and offer advice on increasing his calorie intake. The man was discharged from the gastroenterology clinic.

27. In October, the man was provided with a repose mattress, to reduce pressure sores, an adjustable back rest and extra pillows. On 8 October, he was admitted to hospital with shortness of breath, a cough and a wheeze. He was discharged four days later, following treatment with antibiotics, steroids and a nebuliser, to assist his breathing. He continued to receive daily nursing visits and regular appointments with the doctor.

28. On 31 March 2010, the man was admitted overnight to hospital as the site of his PEG feeding tube had become infected. After treatment, he was discharged with a follow up visit arranged for by a specialist wound care nurse. The man's physical health was deteriorating, particularly his breathing was deteriorating, however he continued to smoke. The requirements of his care plan continued to monitor his physical health, weight and breathing.

29. In June, it was noted by healthcare staff that the man was finding the PEG tube intolerable and was considering asking for it to be removed. Healthcare staff and the doctors advised against this and he was encouraged to continue to use the tube with support from staff. The area around the PEG tube was cleaned and dressed daily.

**11 August – 23 August**

30. A nurse discussed with a Senior Officer (SO) a move for the man to C1 wing, where he could have single cell in a more suitable environment to manage his deteriorating health. (C1 wing has an older population of prisoner.) The SO raised concerns about the man using the shower facilities as staff would not be able to observe him. The nurse told the senior officer that the man did not use a shower due to his breathing problems. A healthcare assistant would assist him with a weekly shower and he could manage a daily strip wash himself.

31. The move to C1 would further benefit the man, as he was well known to the officers on this wing and had friends of a similar age living there. He was shown round C1 wing by the nurse and agreed to move there. He could keep his medication in his possession in a dossette box. (In possession medication indicates that the prisoner has been risk assessed to have his medication in his cell and take responsibility for administering it as per instructions. A dossette box holds individual medication in daily quantities.)

32. The man moved to C1 wing on 18 August and settled in his cell. An officer, who had known him for several years, became his personal officer. Two days later, a doctor saw the man and, following the results of a blood test, referred him to an outside hospital to be assessed by a metabolic bone team following an abnormal blood test. (The test indicated a problem with the man's bone structures however, the referral could not take place as he was admitted to hospital.)

33. A nurse visited the man in his cell on the morning of 22 August and saw that he was struggling to breath. His blood oxygen saturation rate was low at 89 percent, (a rate of 100 percent is favourable). He was given antibiotics and steroids to improve his breathing. During the afternoon it was recorded that his condition had not improved. The nurse contacted the out of hour's doctor who advised that the man should be taken to hospital.

34. The man was escorted to hospital with two officers, on an escort chain, at 4.30pm. After an assessment, he was transferred to a general ward for observation. A nurse passed information to the hospital regarding the man's current medication and was told that, despite his serious condition, he was showing signs of improvement.

35. A duty governor spoke to the hospital the following day. He was told that the man was now gravely ill and so he began the process of applying for release on temporary licence (ROTL). (A ROTL means the prisoner is temporarily released from custody.) The escort chain was removed. The man's mother was told of her son's deteriorating condition and made her way to the hospital. The escorting officers moved away from the bedside to allow privacy for his family.

36. The man died at 3.22pm, with his family by his side. There was not enough time for the application for a ROTL to be completed before his death.

37. Following the man's death, an officer told his particular friends about it as they gathered to collect their evening meals. All the prisoners were told that staff would be available should they need support.

44. An officer acted as family liaison officer and contacted the man's mother following the death of her son to offer support and assistance. On 31 August, his family visited Whatton to attend a memorial service in the prison chapel and meet his friends. Funeral expenses were offered to the family.

## ISSUES

### Clinical care

38. A review of the man's clinical care whilst in custody was commissioned by NHS Nottinghamshire County. A doctor carried out that review on behalf of the PCT. The doctor based his review on the man's medical notes in liaison with my investigator.

39. From the man's reception into prison, the medical screening identified his clinical issues appropriately and he received medication relevant to his physical condition.

40. Following his transfer to Whatton, the man was seen in excess of 200 times by healthcare staff. In spite of encouragement from staff and support from the smoking cessation clinic, he did not stop smoking. The man's lung function was extremely poor therefore his continued smoking and his failure to comply with all his therapies, added to the risk of chronic illness.

41. The clinical reviewer noted that the man suffered from poor physical health since birth. The surgical procedure to insert the PEG feeding tube helped to maintain his low weight and keep it from dropping further. However, it caused him some discomfort and the insertion site of the tube did not heal. Although the man was considering its removal, he was advised against this by healthcare staff so that he could receive better nutrition and maintain his already low weight.

42. The recording of all medical interventions by healthcare staff was noted, by the clinical reviewer, to be satisfactory with helpful and concise nursing care plans.

43. In conclusion, the clinical reviewer said:

> "There were many examples of good practice surrounding the care of this man. Attention was made to where he would be best located, equipment and expert advice was sought to relieve the suffering from his chronic conditions. He required and received reassurance on many occasions when he had difficulty breathing. Above all, the nursing team remained optimistic and attended to chronic problems, which were never going to get any better.
>
> "In my opinion, I cannot find any shortcomings in how the man was managed whilst serving his sentence at HMP Whatton and can confirm that in my opinion, his standard of care was comparable to that of a NHS patient in the community. I make no recommendations."

**The man's support at Whatton**

44. The man was supported by officers, healthcare staff and fellow prisoners during his time at Whatton. Disabled and chronically sick prisoners make up a significant part of Whatton's prisoner population. They continued to provide a safe and compassionate regime for the man who had longstanding and complex needs.

45. The application for a release on temporary licence could not be completed before the man died. The respectful conduct of the bed watch officers allowed privacy for his family during the final hours of his life. Both these actions are noted as good practice.

46. I am also pleased that the risk assessment was reviewed and the restraints were removed before the man reached the end of his life, meaning that he died without the indignity of being chained to a prison officer.

## CONCLUSION

47. The man was born with many serious medical conditions and spent much of his childhood in hospital. Following his conviction in May 2008, he was taken to Nottingham where his medical conditions were identified and treated appropriately. This high quality healthcare continued following his transfer to Whatton where he was seen over 200 times by healthcare staff during his eight months at the prison.

48. Following a surgical procedure to insert a feeding tube to assist his nutrition and maintain his weight, a nursing care plan was opened and he was seen daily by healthcare staff. The man continued to smoke despite advice which impacted on his already chronic lung disease.

49. A deterioration in his health was seen on 22 August and he was admitted to hospital. An application for ROTL was started the following day and bed watch staff removed the restraints when it was clear that he was chronically ill. The man died with his family at his bedside on 23 August.

50. I judge that staff at Whatton continued to care for the man with compassion and afforded him dignity in the final hours of his life. I do not make any recommendations.