

**Investigation into the circumstances surrounding the
death of a man at HMP Whitemoor
in March 2008**

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

February 2009

This is the report into the circumstances surrounding the death of a man. He died in his cell at HMP Whitemoor in the early hours of 6 March 2008. The cause of the man's death is recorded in the post mortem report as ischaemic heart disease due to arteriosclerosis. I extend my condolences to the man's family and friends, almost all of whom live in Turkey, and I apologise for the delay in publishing this report.

The man developed hypothyroidism whilst he was in prison and he needed to take medication to stabilise his condition. Unfortunately, he was reluctant to take the medication, and he became both physically and mentally unwell. He required a short stay in Rampton high security hospital on two occasions, to help him recover from mental health crises. I am pleased that prison doctors were able to arrange for the man to go to hospital and that his condition improved.

The man was a Turkish national serving a lengthy sentence for serious drug crimes. At the beginning of his time in prison he struggled to communicate because English was his second language. Towards the end of his life he felt he had served sufficient time in England, and asked to be repatriated to Turkey (he was due for deportation at the end of his sentence in any case). The Home Office, however, refused permission for technical reasons relating to early release schemes in Turkey.

The investigation was carried out by my colleague. A clinical review, for which I am most grateful, was undertaken by Cambridgeshire Primary Care Trust (PCT). I included the clinical review as an annex to the draft report.

I am indebted to the Governor of HMP Whitemoor, for his and his staff's support throughout this investigation. I would especially like to single out the service and support given by the Safer Custody Coordinator.

I do not make any recommendations within this report, although I have highlighted an area of good practice by staff who worked with the man, trying to persuade him to accept their clinical help. I request that the Governor passes on my observations.

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SUMMARY

The man was a Turkish national who was arrested and sentenced to 16 years imprisonment in 1998 for drug related offences. He was held in HMP Belmarsh, HMP Frankland and HMP Full Sutton before being transferred to Whitemoor in July 2004.

That same month, the man was diagnosed with hypothyroidism, a condition that can lead to many of the body's functions slowing down. This can have an effect on a person's metabolism, mood, weight, body temperature and skin condition. From this point on, the man's behaviour appears to have altered. Prior to this illness, the man had been physically and mentally well but after it was diagnosed he became aggressive, depressed, and distrustful. He often refused to comply with requests from medical staff regarding his medication which resulted in his admission to Rampton, a high security hospital. In June 2005, and again in August 2006, the man was sectioned under the Mental Health Act 1983 and admitted to Rampton Hospital for treatment. On both occasions he got better and returned to the prison, but he always remained reluctant to take his medication.

In April 2006, the man had an electro cardio graph test (ECG – an electrical trace of the hearts rhythm) as part of the care being provided to him. It showed that he had a normal heart rhythm, but indicated that he might have had minor heart attacks in the past. Repeat ECG's were done that day which showed more normal rhythms, but no referral to secondary care services was thought necessary.

On 6 March 2008, the man was discovered by the night patrol officer to be unresponsive in his cell when she made her early morning checks. Staff assistance was called and the Night Orderly Officer, together with supporting staff, went into the man's cell. A nurse checked the man for signs of life, but could find none. An ambulance was called and staff attempted to resuscitate him. The ambulance crew found no signs of life and therefore they pronounced life extent for the man at 5.48am.

The post mortem revealed that the man died from ischaemic heart disease and atherosclerosis, that is to say the blood vessels feeding his heart had hardened and narrowed, which led to him having a heart attack.

The man's family responded to the draft report, which is attached as an annex to the final report. Amongst other concerns they raised, the difficulty they had in connection with telephone communication is one that resonates with this office. There is therefore an additional section added at the end of the 'Issues' section of this report to endeavour to address this issue.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Whitemoor on 20 March 2008. He was given access to the man's prison records and shown around the prison, including the wing where the man was resident before his death. Notices of the investigation for staff and prisoners were sent to the governor in advance of my investigator's visit. No prisoners or staff asked to see him as a result of these notices.
2. Whilst visiting the prison my investigator met a member from the Independent Monitoring Board (IMB) who gave him the Board's report on the man's death. No matters of concern to the IMB were identified within their report. My investigator also met committee members from the local branch of the Prison Officers' Association.
3. Cambridgeshire Primary Care Trust (PCT) was asked to undertake a clinical review of the care the man received while in custody. A review was carried out on their behalf. My investigator asked the clinical reviewer to look at the entries in the man's clinical record and determine whether he received an appropriate level of care whilst in custody, equivalent to what he might have expected had he been at liberty.
4. One of the Ombudsman's Family Liaison Officers wrote to the man's family via the Turkish Embassy to explain the purpose of the investigation and invite them to raise any concerns they wished to be considered and addressed as part of the investigation. At the time of issuing the draft report the family had not expressed any issues or concerns. They subsequently wrote to me and I reflected their concerns within the Final report.

HMP WHITEMOOR

5. HMP Whitemoor is part of the High Security Estate. It accepts Category A and B prisoners and those serving four years or more. The maximum number of prisoners Whitemoor can hold is 458.
6. Healthcare provision is the responsibility of Cambridgeshire Primary Care Trust (PCT). The healthcare centre is on two floors. The lower floor has the treatment rooms and in-patient services, and the upper floor has more treatment rooms and offices. There are x-ray facilities, dentistry, podiatry and optician services available on this floor. There is one full time doctor employed and nursing staff provide 24 hour nursing cover to the whole prison. The “Out of Hours service” is provided by Suffolk Doctors On Call (SUFDOC).
7. The medical records system has recently been updated to an electronic record system called System 1. This has been slowly introduced since March 2008, and is currently being built up to manage all patients’ health records electronically, as well as appointments systems and audit processes. There is a Special Interest Group whose role is to ensure the strategic implementation of this system across all the prisons in the Eastern region. It is hoped this will go a long way to improving the quality of prisoner-patient clinical records.
8. HM Chief Inspector of Prisons, Ms Anne Owers, wrote in her report following an unannounced follow up visit in June 2008, that the prison showed signs of difficult relationships between staff and Muslim prisoners. Her report goes on to say “Staff appeared to have little idea of, and to have been given no support in, how to relate to this group [Muslim prisoners]”. Ms Owers described the fundamental problem as being that relationships between staff and prisoners generally were “distant and distrustful”.
9. In the latest published IMB report of 2006 – 2007, the issue of diversity and race awareness is highlighted, as is the issue of caring and coping with mental illness in prison. In respect of black and ethnic minority prisoners, the Board is critical of the culture that has existed, but recognises that there have been significant improvements. In regard to mental health services, the Board are highly critical of the PCT commissioning services, in particular the in-reach services.
10. There have been nine other deaths at HMP Whitemoor since 2004 when the Ombudsman became responsible for investigating all deaths in custody. Apart from the issue of poor medical records, there are no issues identified in the man’s death that occurred in the other investigations that have been conducted.

RAMPTON HOSPITAL

11. Rampton Hospital is one of three high security hospitals in England. Patients are admitted to Rampton under the Mental Health Act, 1983, after doctors certify they need treatment under secure conditions on account of their “dangerous, violent or criminal tendencies”. The level of security at Rampton is equivalent to that which can be found in a Category B prison.
12. The man was transferred to Rampton Hospital under Section 47 of the Mental Health Act, 1983 (MHA). Section 47 is used to transfer a sentenced prisoner with a severe and treatable mental illness to a National Health Service hospital.

KEY FINDINGS

13. The man was born in 1964 in Turkey. Little is known about his arrival in the United Kingdom, until he was arrested on 15 January 1998 for conspiracy to supply heroin. He was convicted of that offence on 8 December 1998 at Kingston Crown Court and sentenced to 16 years imprisonment. A deportation order for his return to Turkey on release from prison was imposed on 14 February 2000. In 1999, a Confiscation Order was served on him in respect of assets deemed to have been acquired from supplying drugs. On 29 November 2001, the man was sentenced to a further three years imprisonment as a punishment for failing to fulfil the Confiscation Order. The three year additional sentence was to be served at the end of his original sentence.
14. The man was transferred to HMP Full Sutton from HMP Belmarsh on 21 January 1999, and from Full Sutton to HMP Frankland on 17 August 2000. There was nothing of significance recorded in either his medical or security files from Full Sutton or Frankland save that he was a Category A prisoner (the highest security category) due to the nature of his offence.
15. Whilst at Frankland, the man began to feel depressed and complained of being unable to sleep properly and that he had ideas of harming himself from March 2004. He was prescribed an anti-depressant (Cipramil) and underwent some routine blood tests. He was found to be suffering from a thyroid condition, hypothyroidism. (This is a condition where the thyroid gland is underactive and does not produce enough thyroxine. Lack of thyroxine causes many of the body's functions to slow down.)
16. In June 2004, the man began to behave in a more aggressive and unpredictable manner. He believed that the medication he was taking for his hypothyroidism (Thyroxine) was "messing with his thoughts". He became violent and aggressive towards others (there were two assaults on other prisoners) and he was put into the segregation unit.
17. The following month, on 16 July, the man was transferred to HMP Whitemoor where he continued to be monitored for depression and feeling low. An F2052SH document was opened. (The F2052SH system was a process in place at the time. It was designed to ensure that as much help as possible is given to a prisoner during a difficult period when they may be at risk of self-harm or suicide.)
18. The man cut his wrist on 6 August, and required minimal treatment for his wounds. The staff on his unit increased their level of observations as he seemed to be depressed, but was unable to explain why he felt like that. On 7 August, another prisoner told staff that the man was depressed because of "family reasons". His behaviour is recorded within the F2052SH as being "odd" in that he spent long periods of time standing and staring, not talking to anyone who asked him anything. The F2052SH was closed on 13 August 2004.

19. Later that month, the man was seen by the mental health in-reach team and assessed as suffering from depression secondary to his hypothyroidism (in other words, his hypothyroidism was thought to be partly responsible for his depression).
20. The man received a letter, dated 20 December 2004, from the Cross Border Transfer Section of the Home Office regarding his request for repatriation. The letter told the man that his request had been refused because:

“the Secretary of State is of the opinion that it would not be appropriate for you to avoid serving any part of the three year sentence imposed in default of a Confiscation Order solely as a consequence of transferring to Turkey”.

The Turkish authorities were of the view that the additional three year sentence was incompatible with Turkish law and they would not therefore enforce that part of the man’s sentence.

21. The man was sent to the segregation unit again in January 2005, after fighting with another prisoner. When he arrived there he went on hunger strike for nine days. He was moved to the healthcare unit in February and it was reported that he was taking his Thyroxine intermittently. During April he refused to take his medication at all. He said that “people were playing mind games” with him. He was hearing voices and messages both on the radio and through the ventilation system.
22. A Consultant Forensic Psychiatrist from the Norvic Clinic in Norwich, diagnosed that he was suffering from a paranoid psychosis (that is to say, he was mentally ill). Due to the seriousness of his offence, and the belief that he had been involved with a large gang supplying heroin, the Home Office insisted that the man, should he require treatment at an NHS mental hospital, would need to go to one of the secure hospitals in the country. He was assessed and offered a place at Rampton Hospital in June 2005.
23. The man was admitted to Rampton Hospital on 18 June. He had been refusing his medication and had eaten and drunk very little over the preceding few weeks. He deteriorated rapidly when he first arrived at Rampton and continued without food and fluids, until doctors decided that the severity of his condition warranted emergency treatment. They arranged his admission to the local hospital (Bassetlaw District General Hospital, Nottingham). Doctors at Bassetlaw Hospital sedated the man and treated him with intravenous fluids and Thyroxine. He recovered sufficiently to return to Rampton on 24 June, where he remained until he returned to Whitemoor on 10 October.
24. On 10 November, the psychiatrist requested that blood tests and an ECG should be carried out. The man started to become unwell again in February 2006, and had to be admitted to the in-patient unit at Whitemoor on 23 February. He believed that staff were conspiring against him and that he could hear voices again. He was refusing to take his Thyroxine and would not take any anti-psychotic medication.

25. The psychiatrist expressed her concern to staff that they needed to be more firm in their encouragement of the man to take his medication. He remained reluctant but was well enough to be discharged from the in-patient unit back to his own cell on 22 March.
26. There are notes in the continuous medical record that the man refused his medication, despite staff encouragement, throughout the rest of March and April. On 13 April, the man was seen by the community psychiatric nurse together with another prisoner who was a friend. The nurse noted that the man's speech was slurred, his complexion was grey and that he refused to have his pulse checked. The man was adamant that he did not need his Thyroxine.
27. On 22 April, the man had an ECG which initially showed that he had a normal heart rhythm, but might have had a recent minor heart attack. A repeat ECG showed the heart was working normally at that time.
28. Throughout May and June, the man was seen by clinical staff and it was clear to them that he was becoming increasingly unwell. He was refusing his medication, which in turn was having a negative impact on his health. He was grey, his face was getting puffy and he appeared to be putting on weight. He started to become aggressive, irritable, showed signs of feeling like he was being persecuted and having auditory hallucinations again. He was transferred back to Rampton Hospital on 31 August.
29. The man went back to Whitemoor three months later on 20 November, having been prescribed Thyroxine and Zuclopenthixol. (Zuclopenthixol is an anti-psychotic medication that was to be given in a long lasting injection. It has a tranquilizing effect on the patient.)
30. On 16 January, 2007, the man was seen by a second psychiatrist. The man refused to go to the healthcare centre, so the second psychiatrist went to his cell. Prison officers on the unit (B wing) told the second psychiatrist that they believed that the man was over sedated. The second psychiatrist therefore reduced the frequency of the depot injection from once every three weeks, to once every four weeks. The next injection was due on 29 January.
31. According to the medical record, the man had the depot injection on 28 January. The next entry in the record reads "prisoner refused to attend healthcare yesterday for his prescribed injection. Seen in education where he agreed with [the community psychiatric nurse] to attend healthcare. Agreed to give prisoner injection". The entry dated 31 January reads "prisoner stated that he was well but looked unkempt at this time. He did appear more cheerful than when I last spoke with him. Zuclopenthixol diconate 300mgs given. Next due 28 February".
32. On 6 March at 5.05am, a prison officer was making her morning unlock checks of prisoners on B wing. Her written report to the Governor said that, when she looked through the observation panel of the man's cell, he seemed an unusual colour. The officer tried to rouse the man by calling to him,

switching on the lights and rattling the door, but gained no response. The officer contacted a principal officer (PO) who was the most senior officer on duty that night (codenamed Oscar 1). The principal officer and his assistant, a senior officer (SO), together with the nurse on night duty, went to B wing.

33. The principal officer, senior officer and night duty nurse arrived at approximately 5.20am and under the principal officer's instruction, all four staff entered the man's cell. The night duty nurse checked for signs of life, including breathing, pulse and blood pressure, but was unable to find any. Nevertheless, the principal officer asked for an ambulance to be called and the night duty nurse began cardiopulmonary resuscitation (CPR).
34. The paramedics arrived at the man's cell at approximately 5.47am. After a brief assessment of the man's condition, the paramedics at 5.48am pronounced that he had died.
35. The duty governor and the Independent Monitoring Board (IMB), police and care team were all told of the man's death. The prison's death in custody contingency plans were put into place, and before any staff left the prison they were seen by the care team and asked to complete statements about what had happened. The deputy governor, held a hot debrief (a meeting of all those staff involved in the events surrounding the man's death) before they went off duty. The man's next of kin were informed of his death by the Turkish Embassy in London.

ISSUES

The man's health

36. The man was sentenced in December 1998 and until early 2004 showed no signs of any problems either from a custodial or health perspective. His early days in custody were defined by his security status of a category A prisoner, whose first language was not English – but aside from those difficulties, it does not appear the man had any other concerns.
37. In March 2004, the man began to complain of feeling tired, depressed and having thoughts of harming himself. He was diagnosed with hypothyroidism. He transferred to Whitemoor the following July.
38. When the man showed signs of being depressed and at risk of self-harm, Whitemoor instigated the procedure for keeping people safe, using the F2052SH system. From examination of the F2052SH documents, it appears that prison staff acted appropriately and caringly on each occasion they thought the man was approaching a crisis. The only evidence of self harm appears to have been in August 2004, not long after his arrival at Whitemoor.
39. The man does not seem to have accepted his diagnosis of hypothyroidism, or at least the need to take medication for his condition. This appears to have led to behaviour that prison staff found difficult to manage. He was seen and supported by mental health in-reach services on a regular basis. They encouraged him to take the medication that he was prescribed.
40. It is difficult to determine whether it was the man's hypothyroidism or the mental illness that developed separately to his physical condition, that caused his feelings of distrust, paranoia and persecution. Either way, there was a crisis in June 2005 and again in August 2006, such that he had to be transferred to Rampton Hospital under a MHA Section order. Indeed, in June 2005, he was so ill that he had to be forcibly sedated for his own good whilst life saving treatment was provided. I believe that the perseverance of staff at Whitemoor, in particular mental health services, deserves recognition for work well done.
41. Before the man left Rampton Hospital in October 2005, a multidisciplinary team meeting was held with the team who had been looking after him. It is recorded in the notes of that meeting that the man had been seen by a doctor from Rampton as part of his treatment. In interview the man told the doctor that he did not like to take Thyroxine "because it was a hormone and [he] considered that hormones are usually given to women and therefore [he] considered himself to be less of a man. She [the doctor] considered therefore that his reluctance to take the Thyroxine was related to cultural issues". I can find only this one explicit mention of this belief in the man's records, yet I would consider this an important consideration in his care. Although there is no suggestion in this report that the man was discriminated against on grounds of race, he thought that staff were "persecuting" him at times. It is open to debate as to whether the man's culture led to his belief that his

treatment, which contained hormones, affected his sense of his masculinity and was sufficiently understood.

42. The man had an ECG in April 2006, which initially indicated that he might have suffered some minor heart attacks in the past. He had repeat ECGs at the time which showed normal heart rhythms. The abnormal readings were therefore attributed to what are known as artefacts, that is relating to the machine, rather than the man's heart.

Record keeping

43. The man was discharged from Rampton Hospital on an anti-psychotic medication, Zuclopenthixol. He was initially supposed to have this injection every three weeks but the second psychiatrist, decided that this dose was too high for him. Arrangements were made to reduce the frequency this was given to once every four weeks.
44. On 31 January, the medical record says that the man was given his injection. There then follows an entry that says 28 January "Depot given this am. Next due 27 March 2008". The clinical reviewer says "It is possible that the wrong month has been recorded but I am unable to comment further as I cannot find any evidence to say one way or other". It does seem logical that the entry dated 28 January, should indeed read 28 February. It does, after all, appear in the clinical record after the entry made 31 January.
45. However, this highlights an issue that is not peculiar to this man's record, but is a feature of other investigation reports by the Ombudsman. The clinical reviewer found it extraordinarily difficult to complete his report because of the poor state of the clinical record held by Whitemoor. He had some initial difficulty following the content of the clinical record because there was no summary of medical conditions, some records were missing and there were poorly written entries in the medical notes. The missing records were eventually resolved, but had resulted in a time delay for the clinical reviewer. This may, in part be due to the fact that most of it is in handwritten format rather than electronically recorded. It may, in part be due to the fact that the man had recently been a patient at Rampton, and transferring records around the health system can have its effect on them. Nevertheless, the clinical reviewer records in the clinical review in a number of different ways that he could not comment about matters because "a considerable part of the inmate medical record was missing". I trust, with the introduction of a computerised medical records system, that this will not be an issue in future clinical reviews relating to Whitemoor.

Telephone communications with the man's family

46. Foreign National Prisoners (FNP) often do not receive visits whilst they are in prison. The Prison Service therefore makes arrangements for foreign national prisoners to receive additional phone calls so that they can maintain family ties. Whitemoor has a process whereby they give extra money to a prisoners

pin phone account to facilitate this. They also have a means for cheaper overseas phone calls to be made.

47. There is also a need to consider protection of victims in foreign countries. Whitemoor has a policy of speaking first with a prisoner's nominated telephone contact using the services of a translator. This is to ensure that the person at the other end of the telephone call is a bone fide contact of the prisoner. This is only done the first time a prisoner makes contact with the nominated person. It is a way of preventing potential harm to innocent third parties (it gives the recipient of the call the opportunity to say 'no, I do not want to receive calls from this person'). I believe this to be an appropriate safeguard to have in place, but understand the difficulties this might on occasions cause for genuine family contacts.

After the man's death

48. After the man's death, the principal officer instigated the death in custody protocol in line with Whitemoor's local instructions. It seems clear from the records that much was done to ensure staff were properly supported. Whitemoor's local contingency plan structures seemed to work well and the hot debrief identified some useful learning for the establishment.

49. The clinical review concludes that the man died of natural causes. The clinical reviewer says that:

"Post mortem shows that his arteries were 80 percent occluded and this would clinically indicate that the heart had difficulty pumping oxygenated blood around the system. This would have resulted in the heart becoming over worked and ultimately resulted in the man's heart stopping. There is a high incidence of fatal heart attacks in men under 50 years of age who have occlusions of this nature; often the first sign of such atherosclerosis in young men is their death".

GOOD PRACTICE

50. I commend the work of staff at HMP Whitemoor, particularly mental health staff, in their tireless efforts to manage the man's physical and mental health condition. To encourage a man who is ill and remains reluctant to receive medicines that will help him is a difficult task. It would have been all too easy for staff to consider the man's decision not to take medication as his own choice and take no further action. Instead, they chose to persevere and were determined to ensure, as best they could, that the man should receive the care and medication he needed.