Circumstances surrounding the death of a man who was a prisoner at HMP Whatton in September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report of an investigation into the death of a man. The man, a prisoner at HMP Whatton, died from apparently natural causes on 5 September 2006 in outside hospital. He was 77 years old.

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

This investigation has been undertaken by one of my investigators. He and I would like to thank the Governor of HMP Whatton and his staff for their assistance. Nottinghamshire County Teaching Primary Care Trust identified a doctor and Public Health Assistant to undertake a review of the man's clinical care, and we also much appreciate their help.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical review. I have noted the issues highlighted by the clinical reviewers and there are clearly lessons to be learned in terms of the clinical management of patients in prison. I endorse the recommendations made in the clinical review and urge the prison health partnership to develop an action plan to address these in a timely manner.

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 the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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SUMMARY

The man was born in 1929. He was 77 years old when he died on 5 September 2006 in a hospital in Nottinghamshire.

The man was received into custody after being sentenced on 14 December 2005 to 18 months imprisonment. He was initially held at HMP High Down and HMP Lewes before being transferred to HMP Whatton on 6 June 2006. During his first health screen, it was noted that the man had an abdominal hernia (protrusion of organs through the abdominal wall) and had also previously undergone heart surgery for an aortic graft to improve the blood flow to his heart. The man was due to be released from prison on 13 September 2006.

During the early afternoon on 5 September 2006, the man complained that he was feeling unwell. He was taken to Whatton's healthcare centre for observation and, after he had been assessed, an ambulance was called. Paramedics took the man to hospital where doctors diagnosed a bleed from his aorta (the large vessel which opens out of the heart and carries blood to the rest of the body) which would require an operation. The man's family were advised of his condition and he was allowed to speak with them.

Whilst he was in hospital, a bedwatch was carried out by prison staff. The security risk assessment was that handcuffs were to be used. However, due to the man's deteriorating condition and the impending operation, the restraints were removed at 5:40pm and not reapplied.

At 7:30pm, the man was taken into the operating theatre. Prison staff waited in an adjacent room while the operation was performed. At around 10:40pm, doctors informed the prison staff that the man had not survived the operation.

The clinical review identifies areas for improvement and makes five recommendations that I support.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by prisoners and staff.

2. The Nottinghamshire County Teaching Primary Care Trust identified a doctor and a Public Health Assistant to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a most timely manner.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed. In the event, the family raised no specific matters of concern about the man's care and treatment whilst he was in custody.

5. My investigator discussed aspects of the man's treatment with staff and prisoners at Whatton and with the clinical reviewer.

HMP WHATTON

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

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

8. Due to the offending histories of prisoners held at Whatton, a protocol exists between the prison and local hospitals, which specifies the security measures that must be in place before a prisoner will be accepted for treatment. No prisoner would be left alone in hospital even if released on temporary licence.

9. Healthcare within the prison is commissioned and provided by Nottinghamshire County Teaching Primary Care Trust. The Primary Care Trust provides a range of primary care services including General Practitioner (GP) clinics. It contracts out of hours GP services to a private provider.

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

KEY FINDINGS

11. On 11 January 2006, the man was transferred from High Down to Lewes and, after induction, it was decided that he should be given Vulnerable Prisoner status because of his age and the nature of his offence.

12. The man arrived at Whatton on 6 June 2006. During the health screening procedure in reception it was noted that he had a hernia and that he walked with a stick as he had limited mobility. It was also noted that the man had previously undergone an aortic graft operation. A range of medications were prescribed to treat his various conditions and he was allowed to keep these in his possession for self medication.

13. The man was transferred to Whatton after the wing for vulnerable prisoners at Lewes was closed for refurbishment. Although the man arrived at Whatton on 6 June, it was not until three days later that a further health screening took place. The health screen form was completed satisfactorily by a nurse. However, there were actions present on the form which do not appear to have been completed. The nurse noted that the man should have a General Practitioner (GP) appointment. However, the section on the screening form to be completed by the GP is blank. There is also no record in the man's medical history of him having such an appointment. On 20 June, the man had a blood sample taken and tested. The results showed nothing untoward.

14. On 5 September 2006 at around 1:30pm**,** a Prison Officer was approached by a prisoner who told him to look in on the man as he was not feeling very well. The officer went into the man's cell and saw him sitting at his desk. The officer asked the man how he felt. The man told him that he had pains in his stomach and, although he had taken some 'Rennie' (an anti-acid preparation), he did not feel any better. The officer judged that the man's colouring and demeanour suggested that he was in pain and decided that he should be immediately taken to the prison's healthcare centre. The officer arranged for his colleague to take the man to the healthcare centre, and a wheelchair was used to facilitate the journey.

15. The man was met in the healthcare centre by the Practice Nurse. The nurse immediately informed the prison doctor that the man had arrived and commenced her assessment. The man was able to co-operate with the assessment process and told the nurse that the pains he was experiencing in his stomach were like "trapped wind". He said that if he could just "burp" he would be alright. The nurse completed her assessment and informed the duty manager she thought that the man was likely to need an ambulance. After the prison doctor completed a thorough examination of the man, he asked the nurse to call for an ambulance.

16. An ambulance was called at 3:00pm. While waiting for the ambulance to arrive, the man was lucid and able to engage in conversation. He discussed his impending release on 13 September 2006, and said that he came from Kent.

17. A support paramedic arrived before the ambulance crew and, after he had carried out an assessment, the ambulance left the prison around 3:55pm. The man was taken to hospital, accompanied by two officers.

18. Doctors at the hospital diagnosed a bleed from the man's aorta which would require an operation. The man's family was immediately advised of his condition and he was allowed to speak with them on the telephone.

19. Whilst the man was at the hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. However, these were removed at 5:40pm after a further security assessment when the man's condition started to deteriorate and also due to his impending operation.

20. Two new officers relieved their colleagues at 7:00pm and were briefed about the man's situation. Around 7:30pm, the man was taken into the operating theatre. The escort staff waited in an adjacent room while the operation was performed. At around 10:40pm, a doctor from the hospital informed the staff that the man had died during the operation.

21. The prison contacted the man's family to inform them of his death and to offer condolences and support. A Senior Officer was appointed as the prison's family liaison officer. She maintained contact with the family and assisted with the arrangements for the funeral. The Governor also attended the funeral. The prison provided financial assistance for the funeral and a memorial service was also held by the prison chaplain.

22. The post mortem report records the cause of death as due to natural causes, as a consequence of a massive intra thoracic haemorrhage caused by a ruptured thoracic aortic aneurysm (dangerous ballooning of the aorta, the main artery leaving the heart, which is caused by disease in the artery's wall).

Clinical Review

23. As previously noted, the clinical review was undertaken by a doctor and Public Health Assistant on behalf of Nottinghamshire County Teaching Primary Care Trust. The reviewers found that the man had suffered from significant long-term chronic diseases.

24. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical review concludes that there are no circumstances indicating that death could have been anticipated or prevented, but makes recommendations for improvements to clinical practice.

25. The reviewers judge that the prison should develop a system for ensuring that prisoners with health problems undergo priority screening. The review notes that the health screening for the man took place three days after his arrival at Whatton. The reviewers draw attention to the fact that, due to his age and the

five different medications he was prescribed, the man should have been a priority for health screening.

The prison health partnership should develop a system for ensuring priority screening for prisoners with health problems.

26. They also judge that a policy should be developed to ensure the correct and timely referral of prisoners to the General Practitioner (GP) clinic, disability office and other relevant services. The reviewers say there must be documentary evidence in a prisoner's medical records to support the offer of the appointment and any subsequent actions or interventions.

Healthcare should develop a policy to ensure the correct and timely referral of a patient to the General Practitioner (GP) clinic, disability office and other relevant health and social care services. There should be documentary evidence in the prisoners' medical records of attempts to invite prisoners to appointments. Clear lines of responsibility for those involved in screening should be in place and actions noted on the medical records file for the relevant prisoner.

27. The reviewers recommend that a review of health policies should be undertaken when prisoners fail to turn up for scheduled appointments, or do not collect their medication. This issue is related to the point that documentary evidence should be recorded of actions taken in relation to a prisoner's medical care. However, the reviewers say that, if a prisoner has been invited to an appointment, the onus should be on the prisoner to take responsibility to contact healthcare to re-arrange missed appointments. The policy review may also include requesting that residential prison staff should be asked by health professionals to check up on prisoners who fail to attend or miss appointments and when medication is not collected.

A review of health policies should be undertaken when prisoners fail to show up for appointments or to collect medication.

28. The clinical reviewers also say there should be a policy on whom and under which circumstances prison staff can access prisoner medical records.

There should be a clear PCT policy on whom and under what circumstances prison officers can gain access to the medical records of prisoners.

29. Looking at the medication prescribed to the man, the review noted that on one occasion medication had been prescribed to the man without a doctor's authorisation. The medicine concerned, Rinatec Nasal Spray, is a type known as an antimuscarinic or anticholinergic. It is used for many purposes, but when applied into the nose is used to treat runny noses that are a result of allergic or non-allergic inflammation in the nose. While in this case the medication was a nasal spray, in another case a different prisoner could be given an inappropriate and potentially damaging medicine.

There must be an appropriate PCT policy in place to ensure medications are not prescribed without the appropriate authorisation of a prescribing clinician.

30. Prisoners raised a concern that, since the increase in the size of Whatton and the influx of new prisoners, there had been a cut back in services. For example, they said that nurses who had been based on wings had been withdrawn, and disabled and elderly prisoners were being forced to travel to reception or healthcare for treatment. The review concluded that these concerns are unfounded; indeed, that since the number of prisoners has increased there has been an increase in staffing levels. The reviewer noted that there had never been a 'wing based' service, with the exception of elderly prisoners. The elderly prisoners are all based on one wing and clinical care is taken to them.

31. The suggestion that prisoners are experiencing delays in getting appointments for dental and chiropody services has been investigated as part of a health needs assessment. The number of dental appointments has been doubled from the start of 2007 and the chiropody service will be provided directly by the Primary Care Trust. The reviewers state that, as the prison has expanded since February 2006, the mix of prisoners has consequently changed. The Public Health team at Nottinghamshire County Teaching Primary Care Trust is currently undertaking a Health Care Needs Assessment (HCNA) which is looking at all aspects of healthcare. This work includes asking prisoners to fill in a questionnaire on a range of health issues and reviewing their medical records. From the results of this information and data gathering exercises, the level of health need will be understood better and this will include dental and chiropody services. I welcome this initiative.

CONCLUSION

32. The man moved to Whatton on 19 May 2006. He died of apparently natural causes in September 2006.

33. The man had arrived in prison with a history of chronic health problems. He was due to be released from prison the week after his death and it is sad that he was unable to spend his final days at home with his family.

34. From comments made by staff and prisoners at Whatton, the man was a respected and well liked prisoner. His popularity was further demonstrated by a collection by prisoners on his wing which raised £85. This was used to buy a wreath, with the remainder given to charity.

35. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with sensitivity. The decision to remove mechanical restraints, following a risk assessment, was entirely appropriate given the circumstances. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.

36. The clinical review makes five recommendations designed to improve practice that I endorse. These should be addressed by the Nottinghamshire County Teaching Primary Care Trust in partnership with the Governor of Whatton.

37. I commend the good level of communication between prison officers and the healthcare staff which helped to ensure the man was attended to quickly and appropriately.

RECOMMENDATIONS

Medical

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1. **The prison health partnership should develop a system for ensuring priority screening for prisoners with health problems.**

2. **Healthcare should develop a policy to ensure the correct and timely referral of a patient to the General Practitioner (GP) clinic, disability office and other relevant health and social care services. There should be documentary evidence in the prisoners' medical records of attempts to invite prisoners to appointments. Clear lines of responsibility for those involved in screening should be in place and actions noted on the medical records file for the relevant prisoner.**

3. **A review of health policies should be undertaken when prisoners fail to show for appointments or to collect medication.**

4. **There should be a clear PCT policy on whom and under what circumstances prison officers can gain access to the medical records of prisoners.**

5. **There must be an appropriate PCT policy in place to ensure medications are not prescribed without the appropriate authorisation of a prescribing clinician.**