

**Investigation into the circumstances surrounding
the death of a man 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 who died from apparently natural causes on 29 September 2006 at HMP Whatton. He was 56 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.

The investigation was undertaken by one of my investigators. Both he and I would like to thank the Governor of HMP Whatton and his staff for their participation and assistance.

A doctor was asked by Nottinghamshire County Teaching Primary Care Trust to undertake a review of the man's clinical care. I have drawn extensively upon the clinical review and judge it to be a thoughtful and comprehensive document.

The man was correctly identified as at risk of arterial problems leading to stroke or heart attack, and appropriate actions were taken by medical staff. I have made one recommendation, drawn from the clinical review, which concerns the sharing of all relevant clinical information when a prisoner moves from one prison to another.

Like many people in prison, the man was a heavy smoker with all the accompanying health hazards. As with so many premature deaths that I investigate, the death of the man while in his mid-50s is a reminder of the importance of health promotion in all prison establishments.

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 1956. He was 56 years old when he died on 29 September 2006 at HMP Whatton.

The man had been received into custody after being sentenced on 20 March 2006 to four years imprisonment. He was initially held at HMP Birmingham, before being transferred to Whatton on 6 June. During his first healthscreen, it was noted that the man had attempted suicide four months prior to his sentencing. It was also noted that he was registered blind, had arthritis and sciatica, and had previously experienced a minor stroke.

On the morning of 29 September 2006, the man's cell mate found him in bed, unconscious and cold. The cell mate alerted prison staff, who immediately came to the shared cell. As they could find no sign of life, they removed the cell mate from the cell and requested assistance. Medical staff from the prison and an ambulance crew attended and assessed that the man had been dead for some time. Rigor mortis had clearly set in. Paramedics were subsequently called and they pronounced death at 8:30am.

The clinical review concludes that the man's clinical care was appropriate and equivalent to that available in the community. I have endorsed the one recommendation in the clinical review that concerns the sharing of all medical information when a prisoner is transferred.

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, who is a Consultant in Public Health Medicine, to carry out a review of the man's clinical care. I am grateful to the reviewer for undertaking the review 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 to offer them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions they would like explored and addressed. The family were grateful for contact being made, but declined a visit at that time. I hope that this report addresses any concerns they may have about the circumstances surrounding the man's death.
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, who are all 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 (HMCI), 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." The prison was inspected again in 2007 but the report of this inspection has not yet been published.
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.
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KEY FINDINGS

11. The man was first held at HMP Birmingham. During the healthscreening procedure, his blindness, arthritis and sciatica were all noted, as was his suicide attempt some months earlier. It was also noted that the man had previously experienced a mild stroke. A few days after his reception, marks were found on his wrists which were treated as possible self-harm. An Assessment, Care in Custody and Teamwork (ACCT) self harm observation regime was started. This was appropriately closed soon after when the medical assessment identified that the risk of self-harm had abated and that the man had come to terms with his situation.
12. The man arrived at Whatton on 6 June 2006. He was prescribed a drug to reduce the levels of fat in his blood vessels, aspirin to prevent stroke, and co-codamol as a pain reliever for arthritic problems. He was also asked whether he wanted to continue his anti-depressant medication, but he declined. He was allowed to keep the medication in his possession for self management.
13. Due to the man's history of stroke, a number of blood tests were carried out. When the results were received it was clear that he had a high risk of arterial blockages. As a consequence, he was referred to the Queen's Medical Centre in Nottingham for clinical assessment. An appointment was made for the man to attend the out-patients department on 30 October 2006, but unfortunately he died before the appointment date.
14. On 28 September, at around 10:00pm, the man and his cellmate had a cup of tea. When interviewed, the cell mate recalled that the man awoke at 3:00am on 29 September to use the toilet. After a cigarette, he then went back to sleep. At around 07:30am, the cell mate tried to wake the man. Having received no response, he started to make a cup of tea. A few minutes later, the cell mate attempted to wake the man again and realised that he appeared to have died. He therefore rang the cell bell to alert staff. Around 7:50am, two Prison Officers who were in the centre office on Alpha Unit 6, when a cell bell was activated. The officers went to cell 01, the cell occupied by the man and his cell mate, on the second landing. One of the officers noticed that the cell mate was upset.
15. The officers entered the cell and found the cell mate in a distressed state because he could not wake the man. The man did not respond when the officers tried to rouse him and they could find no sign of breathing or a pulse. While one officer checked on the man, his colleague was talking to the cell mate to calm him down. The officers decided to take the cell mate to the centre office, as he was clearly still distressed. They locked the cell, leaving the man inside. When they arrived at the centre office, a call was made to the control room to tell them what had happened.

16. A Principal Officer was in the control room when the call was received by an Operational Support Grade. The Principal Officer immediately informed the Duty Governor who gave instructions that an ambulance should be called. They then both proceeded to Alpha Unit 6, accompanied by a Senior Officer.
17. They arrived at the man's cell around 8:00am. The two prison officers were waiting for them. They were joined at 8:03am by two nurses, who were accompanied by the ambulance crew. After the ambulance crew had examined the man and the electro cardio gram (ECG) had shown no output, they left the cell at 8:10am. Death was pronounced at 8:30am.
18. A Senior Officer was appointed as the prison's family liaison officer. She maintained contact with the family and helped with the arrangements for the funeral. The prison provided financial assistance towards the funeral costs. A memorial service was later held by the prison chaplain at the prison. The man's popularity was further demonstrated by the fact that prisoners on his wing collected £120 after his death. This is to be used to purchase a memorial plaque to be placed on a bench in the grounds of the prison.
19. The post mortem report records the man's death as being due to natural causes, as a consequence of an acute myocardial insufficiency, caused by thrombotic and atheromatous occlusion of the right coronary artery. This is a condition where there is ineffective pumping of the heart leading to heart failure.

CLINICAL REVIEW

20. A review of the man's medical care was undertaken by a doctor on behalf of Nottinghamshire County Teaching Primary Care Trust. The reviewer found that the man had suffered from significant long-term chronic heart disease and noted that his condition had been managed by prescribing aspirin to prevent stroke. Pain relief for sciatica was also prescribed.
21. The man's cell mate expressed his concern that the man apparently had to wait up to a week without medication. He was also concerned that the man was located on the first floor even though he had problems with his sight and was experiencing pain in his arm, particularly in the week before he died. A doctor reviewed the dispensing records. These indicated that medication was dispensed on the same day as prescribed, although there was a delay of four days in July and of 13 days in August between the medication being dispensed and being collected by the man. A doctor found no indication that this was other than the man postponing the collection of his medication. My investigator asked the reviewer if he found it surprising that healthcare staff took no action to remind the man that he had not collected his medication for almost two weeks. The reviewer's view was that it was up to the man to take responsibility for collecting and taking his medication. If he chose not to, there was little prison staff could do except ensure he knew the potential consequences.
22. The medications that the man was taking for his heart were for long term prevention and the reviewer was confident that, even if no drugs were taken for the entire periods of four and 13 days, there would have been no material effect on the man's health in the short term. Nevertheless, in other circumstances it is possible that such delays could have more serious consequences. Although I have no recommendation to make in this respect, I draw the issue to the healthcare manager's attention, to consider if further monitoring would be appropriate.
23. The man was aware that elderly prisoners with physical disabilities are located on wings A1 and A2 and have their medication dispensed on the wing. He did not complain to staff about his location and seemed settled there. Consequently, the reviewer judged that the man was content with being located in a first floor cell despite his problems with vision. The reviewer found no record of the man having reported pain or tingling in his arms before his death.
24. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to appropriate secondary care services. The clinical reviewer concluded that the man received an appropriate standard of care and support during his time in prison. There was no indication that his care was at any time less than would have been expected in the general community.

25. The clinical reviewer judged that the medical records for the man provided a clear account of his care throughout his time in custody. However, there were a few details about the care the man received at Birmingham which were not recorded.

26. The reviewer makes the following recommendation which I endorse:

The Prison Service should consider ways of ensuring that prisoners' full medical records accompany them when they relocate to another establishment.

CONCLUSIONS

27. The man had arrived in prison with a history of chronic health problems. He moved to Whatton on 19 May 2006, and died there of apparently natural causes.
28. Given the generous collection following his death, and from comments made by staff and prisoners at Whatton, it appears the man was a respected and well liked prisoner.
29. In light of the findings of the clinical review and my own investigation, I conclude that the man's medical care was both appropriate and satisfactory. I have endorsed the one recommendation from the clinical review which needs to be addressed by the Prison Service in partnership with the Department of Health.
30. Family liaison and other matters relating to the aftermath of a death in custody appear to have been handled well. The Governor of Whatton may wish to share that conclusion with the staff concerned.
31. Like many prisoners, the man was a heavy smoker with all the health hazards that brings. I do not know if the man himself would have responded positively to help to quit smoking, but his death is a reminder of the importance of health promotion in all prison establishments.

RECOMMENDATIONS

Medical

The Prison Service should consider ways of ensuring that prisoners' full medical records accompany them when they relocate to another establishment.