Investigation into the circumstances surrounding the death of a man in January 2011 at HMP Whatton

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report into the circumstances surrounding the death of a man at HMP Whatton in January 2011. His cell mate found him unresponsive on his bed. Wing staff were alerted and tried to resuscitate him until healthcare staff arrived and took over. When the paramedics arrived, they confirmed that he had died. He was 80 years old. I extend my sincere condolences to the man's family and friends.

A review of the man's clinical care was commissioned from NHS Nottinghamshire County. I am grateful to a doctor for that review, which is annexed to the report.

One of my investigators was appointed to carry out this investigation on my behalf. I would like to thank the Governor and her staff for their assistance with this investigation. I am particularly grateful to the liaison officer.

The man was an old man living in a prison with many elderly prisoners. However, his death was unexpected. The post mortem showed that he had a blood clot on his lung for which there were no obvious symptoms. I make no recommendations in this report. I acknowledge the professional teamwork of both healthcare, and prison staff, in their attempts to save the man's life.

In this final report there are eight minor amendments to factual inaccuracies, none of which change the basis of this report. The man's family have received a copy of the draft report and they have no comments to make with the content. A copy of this final report will be sent to them.

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

CONTENTS

SUMMARY

1. The man was 77 years old when he was sentenced to six years imprisonment in 2007, for serious offences. He was first sent to HMP Woodhill then transferred to HMP Whatton four months later. On his arrival at Whatton, he was seen and assessed by healthcare staff as having hypertension (high blood pressure) and raised cholesterol. The man's medication was reviewed and his prescription was continued to address his medical conditions. In the weeks that followed, he was diagnosed with kidney disease and mild diabetes.

2. From 2007 until 2011, the man went to a hypertension clinic to check his blood pressure. The doctor reviewed his medication regularly and he underwent regular blood tests for his kidney disease. The man also had extensive dental work.

3. In October 2008, the man was placed on the prison's self harm support and monitoring measures after mentioning that he intended to take all of his medication. However, he later denied thinking about harming himself and apologised to staff for making such a thoughtless remark. Two days later, the self harm monitoring measures were closed.

4. On 19 November 2010, the man was seen at a hospital, as an out patient for a skin lesion. The lesion was noted to be non cancerous and treated accordingly.

5. A nurse assessed the man on 21 January 2011, as he was short of breath and had tingling in his arm. The nurse referred the man to the doctor who examined him and prescribed steroid medication. The following morning, at around 6.30am, the man's cellmate noticed he was sleepy and had not taken his medication. The cellmate told the wing staff that the man did not seem well. An officer contacted the duty nurse and told her about the man. The nurse checked the man's medical notes and advised the officer to encourage the man to take his medication. At the time, she was tending to a prisoner who had recently been discharged from hospital following heart surgery and another having palliative care. Therefore, the nurse was unable to go straightaway to the wing.

6. Around 11.55am, the man's cell mate found that he was unresponsive on his bed. The cell mate went to the wing office and told an officer that he thought the man "had gone". The officers immediately went to the man's cell and, after checking his vital signs, started cardio pulmonary resuscitation (CPR). They radioed for emergency medical assistance and an emergency ambulance.

7. Healthcare staff arrived at the man's cell and used a defibrillator machine, to see if an electric shock was necessary to restart his heart rhythm. However, despite all attempts to save his life, the man's death was confirmed at 12.45pm after he was examined by paramedics.

8. I make no recommendations in this report and I acknowledge the good practice in the attempts to save the man's life.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened on 28 January 2011, when my investigator visited Whatton. She was met by the liaison officer and reviewed the man's prison files. Selected copies of documents held in those files were sent to my investigator. Later, my investigator spoke to a governor who also accompanied her to the man's cell on Charlie unit. She met the man's cellmate my investigator returned to Whatton on 8 March and interviewed two members of staff.

10. Notices and my terms of reference were sent to Whatton in advance of My investigator's visit. The Independent Monitoring Board (IMB) and the Prison Officers Association (POA) did not ask to see My investigator but her details were made available should they wish to contact her. (The IMB are volunteers drawn form the community who monitor the day to day life of the prison, its staff and prisoners. The POA is the trade union for prison officers.) At the time of circulating this report there have been no responses to those notices.

11. Her Majesty's Coroner for Nottinghamshire held a post mortem examination. The man's death was recorded as due to natural causes from a massive pulmonary embolism, (a blood clot in the lung) and deep vein thrombosis. A review of his clinical care was commissioned by NHS Nottinghamshire County and carried out by a doctor. The clinical reviewer is the first annex to this investigation report.

12. One of my family liaison officers wrote to the man's brother outlining the process of the investigation. During a subsequent telephone conversation the man's brother did not raise any specific issues that he wanted to be included in the investigation but has asked to see a copy of this report.

13. At the end of March, my investigator wrote a feedback letter to the Governor to inform her that no important issues had been identified during the initial part of the investigation.

HMP WHATTON

14. HMP 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 of escape.) Additionally, because of the extent of the healthcare provision (which I describe below), they must 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 system.

15. Whatton prison is located on a large site and therefore it takes a considerable amount of time to move between the prison wings. The regime includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes.

16. 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 6.00pm, the exception of weekends when there is minimal staff cover in the mornings only. Outside of these hours, Nottinghamshire Emergency Medical Services (NEMS) are contacted when required.

17. 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. (Triage clinics assess patient's symptoms to find out if their medical condition can be treated by a nurse or a doctor.) After an initial consultation, the nurse refers patients to the doctor or arranges appropriate prescriptions to be administered. Nurses take the lead in treating prisoners with different diseases, and they have various internal clinical specialists, including a palliative care nurse, to care for terminally ill patients. Occasionally, external specialist nurses come in. They include diabetic, chronic obstructive pulmonary disease (COPD) and tuberculosis (TB) nurses.

18. 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 six previous deaths from natural causes at Whatton over the last year, mainly from long term illnesses.

19. 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."

20. The most recent annual report published by the IMB 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."

21. Charlie unit is spilt into three wings and mainly accommodates older prisoners. The unit is positioned away from the main prison area. On 8 March 2011, a palliative suite was opened to provide an appropriate setting for prisoners with terminal illnesses. This suite offers facilities for prisoners to be cared for in a suitable and sensitive environment.

KEY EVENTS

22. The man was born in 1930 and was a retired driver, he served in the armed forces under National Service. In March 2007, the man was sentenced to six years imprisonment at a crown court. This was his first recorded offence. He participated in the Enhanced Thinking Skills course, to address his thoughts on his offending behaviour. However, the man did not want to proceed with the Sex Offender Treatment Programme.

23. On his arrival at HMP Woodhill, a first reception health screen document was completed to record his medical history. Later, he was seen by a reception doctor who noted that the man had hypertension (high blood pressure) and high cholesterol. His medication was reviewed and a new prescription issued to continue his present drug therapy. The man was moved to a double cell. A cell sharing risk assessment (CSRA) recorded him as low risk when sharing a cell. The man settled into the prison regime and was noted to be a quiet and compliant prisoner.

24. Following his transfer to Whatton on 20 July, the man's history of hypertension, with palpitations, occasional breathing difficulties and high cholesterol was noted again on his first reception health screen document. A plan was completed for the man to be seen by the doctor, the dentist and an appointment was made with the chronic disease clinic to keep a check on his hypertension.

25. Following an in possession medication assessment, the man was allowed to have his medication in his cell to take as he required. The assessment gauges the risk of allowing prisoners to have their medication in their possession as opposed to collecting it from a dispensary each day.

26. Two weeks later, the man was seen by a doctor and underwent a full physical examination. A urine test indicated that the man had protein in his urine, a symptom of kidney disease and mild diabetes. The doctor reviewed the man's medication and arranged for him to have a blood test.

27. A nurse saw the man for a blood pressure review on 21 August. His blood pressure reading was 130/52, an average reading is 130/80 and his pulse rate was 52 beats per minute (bpm), a normal reading is between 60-100 bpm. Two weeks later, a blood pressure check noted that the man's reading was low at 122/53. The man's blood pressure was checked monthly. No significant medical issues were recorded until October 2008, although he continued to have medication reviews and attend the hypertension clinic.

October 2008 – May 2010

28. The Assessment, Care in Custody and Teamwork (ACCT) support procedures were opened by an officer on 28 October 2008, after The man said that, "… he might as well take all his month's medication". (The ACCT procedures monitor and support prisoners assessed as at risk of suicide or self-harm.)

29. The officer interviewed the man for the ACCT assessment. The officer noted that he had inadvertently spoken of self harm following a disagreement with his cell mate over his snoring during the night. The man apologised for his words and he said that he was not thinking about harming himself. Although he was deemed to be of low risk of self harm, his in possession medication was reviewed and he was required to collect it from the dispensary instead of keeping it himself.

30. Two days later, an ACCT case review was held with the man who was described as being in "high spirits". He told staff that he wished he had thought more carefully before speaking about self harm and agreed to carry on sharing with his cellmate. The ACCT was closed and a post closure review was held on 4 November. The man felt well and was looking forward to sharing with a new cell mate in two weeks time. He was allowed to have his medication in his possession again.

31. A nurse attended the man's cell after he had fainted on 28 April 2009. He told the nurse that he was having problems eating because of tooth abscesses. The man's blood pressure was recorded at 126/57 and pulse rate at 56 bpm. The nurse wrote that the problems with dental abscesses were being treated by a dentist. She advised the man to try to eat, drink fluids and asked wing staff to monitor his well being.

32. The man continued to have regular blood pressure checks along with blood and urine tests. He regularly attended the healthcare unit for medication reviews with the doctor.

May 2010 – January 2011

33. On 20 May 2010, a nurse saw the man in the healthcare unit. He had been suffering from chest pain for several weeks, which became worse when inhaling. The man told the nurse about his family history of heart disease. The nurse carried out an electrocardiograph (ECG) procedure to measure his heart rate and rhythm. Later, a doctor reviewed the ECG reading and noted that there were no abnormalities in the man's heart rate.

34. A doctor saw the man on 2 November and noted that he had a five centimetre skin lesion on his left hip. The lesion was irregular and the doctor referred the man for a hospital appointment under the two week rule. (The two week rule is an urgent request for an appointment with a specialist, when a cancer might be suspected.)

35. The man was seen by a consultant dermatologist at a hospital on 19 November. The lesion was non cancerous and medication was prescribed. A follow up appointment was made for three months later.

36. A nurse saw the man on 21 January 2011, in the healthcare unit. The nurse noted that he was suffering from tightness in his chest with tingling "pins and needles" in his right arm. His blood oxygen level was low at 90%, a normal reading would be 100 -98%. The man was given a Salbutamol inhaler to assist

his breathing and she made an appointment for him to see the doctor during the afternoon surgery.

37. At 3.36pm, a doctor examined the man and wrote that, whilst he was short of breath, with a dry cough, his chest was clear. The man's blood pressure was noted as 127/80. The doctor prescribed Prednisolone, a steroid to help control asthma.

22 January

38. On Saturday 22 January, the nursing cover for the day was from 8.30am to 1.00pm. A Registered General Nurse (RGN) and a Healthcare Assistant (HCA) were the two members of healthcare staff on duty. Part of the nurse's duties for that morning was to attend to two prisoners, one who had recently been discharged from hospital after cardiac surgery and another needing palliative care nursing.

39. The man's cell mate, told my investigator that he made him a cup of tea at 6.30am on 22 January. The cell mate reminded the man to take his medication, however, the cell mate noticed that he went back to sleep without taking his tablets or drinking his tea. About 10.25am, the cell mate went to the wing office and told an officer that the man had fallen on the floor. The officer went to the cell and asked the man what had happened but he could not remember. The man was helped back to bed by two prisoners and the officer went to the wing office to contact healthcare staff.

40. The officer spoke to two members of the healthcare staff, the nurse and the HCA who were not in the healthcare unit but on another wing, she told them that the man had fallen. The nurse was tending to the cardiac care prisoner on another wing which was a distance from Charlie Unit. At interview, the nurse explained that she had to spend time with this prisoner to check his post operative care and medication, then visit the prisoner who was having palliative care.

41. The healthcare staff told the officer that they would return to the healthcare unit, around a ten minute walk away, where they could read the man's medical notes. The nurse read the man's medical notes and saw that the doctor had prescribed medication for asthma the night before. The nurse rang the wing office and advised an officer that the man had seen the doctor the previous day and should be encouraged to take his medication as prescribed. The nurse then returned to her cardiac patient.

42. The officer went to see the man in his cell at 11.05am. He was in bed and the officer saw that he was asleep but had taken two tablets. The officer asked the cell mate to stay with the man and try to persuade him to take all his medication. The cell mate agreed to keep "an eye on him".

43. About 11.30am, the cell mate called to the man to ask if he was alright and told him to take his tablets. The man said he would take them later. The cell mate collected his own lunch and returned to the cell to eat it. As he was eating, he called out to the man to check on him. Getting no reply, he went over to the man

and saw that he was not breathing and that there was an unpleasant odour coming from his mouth. The cell mate left his cell and called for another prisoner to come and see the man.

44. The prisoner went into the cell and took the man's pulse. He could not find a pulse and the man was unresponsive, so he told the cell mate that he thought the man had died. The cell mate went straight to the wing office and said to an officer "he's gone". The officer asked the cell mate to explain himself and he repeated, "he's gone I think he has gone". Two officers then ran to the man's cell, which was about 20 metres away, while another officer locked the wing office and joined her colleagues in the cell.

45. On arrival at the man's cell, the officers found him in bed on his left hand side, one officer checked his neck pulse and could not detect a beat. He used his radio to call a code blue urgent medical assistance. (A code blue indicates a medical emergency where there is no sign of breathing.) Another officer went back to the wing office and telephoned the communications room for them to call an emergency ambulance.

46. The officer turned the man over onto his back and placed a resusci shield, a face guard, over the man's mouth to start resuscitation. A second officer started chest compressions. The officers were joined by a Senior Officer (SO) who assisted with the CPR. The nurse responded to the emergency call from B wing and collected the emergency bag and the HCA from the healthcare unit, on her way to the man's cell.

47. The nurse attached a defibrillator to the man's chest and used the machine twice. It indicated that there was no heart rhythm and so a shock to his heart was unnecessary. The officers and nurses continued with the CPR until the paramedics arrived. They reached the man's cell at 12.45pm and moved him on to the floor. They took over the resuscitation attempts and confirmed his death at 12.48pm.

48. A hot de-brief was held for all staff involved in the emergency, led by a Developing Prison Service Manager (DPSM). The prisoners on Charlie wing were told of the man's death by the SO and the DPSM during the afternoon. Arrangements were made for Listeners to be brought onto the wing. (Listeners are prisoners trained by the Samaritans to support prisoners in times of crisis.) The cell mate was moved to a cell on another wing to be supported by a prisoner. A memorial service was held in the chapel for prisoners to pay their respects to the man.

49. Two family liaison officers visited the man's brother later that afternoon to inform him of his death. The man's family were grateful for the offer of funeral expenses but declined any financial assistance. One of the officers continued to support the family and attended the man's funeral with the Governor.

ISSUES

Clinical care

50. A review of the man's healthcare was commissioned from NHS Nottinghamshire County. A general practitioner, doctor carried out that review on behalf of the NHS. He assessed the man's medical files and statements made by prison and healthcare staff.

51. The doctor noted that the man's general medical and nursing care at Whatton was completely appropriate. He attended a clinic for regular checks on his hypertension and had frequent medication reviews. The recording of entries in his medical records was satisfactory.

Blood clot on the man's lung

52. The man complained of tightness in the chest and breathlessness health on 21 January. He attended the healthcare unit and was referred to the doctor following an assessment by a nurse. A doctor examined the man, confirmed that he was breathless and prescribed appropriate steroid medication. the doctor says in his review,

> "It is reasonable to assume that smaller clots had already formed on the man's lungs and that is why he complained of chest tightness and wheeze and why low oxygen saturations were recorded. In addition, along clot causing irritation of the diaphragm, may well have been the origin of the 'pins and needles in the right arm'."

53. The post mortem confirmed that the man's death was caused by a massive blood clot on the lung and the doctor notes that this is a fatal condition. The blood clot started from a clot in his lower limb but there is nothing in his clinical records to suggest that the man complained of pain or swellings in his legs at any time. The doctor concludes:

> "Therefore there would have been no opportunity to save his life by treating the clot in the leg before it moved. Resuscitation would not have been successful once such a large clot had formed in the lungs."

54. The doctor does not find any failings in the care the man received at Whatton. In his opinion the man's standard of care was comparable to that within the community.

22 January

55. A nurse was on duty on Saturday 22 January with a HCA. The staffing levels are reduced during the weekends at Whatton and there is reduced healthcare cover between 8.00am and 12.30pm. The nurse was the only qualified nurse on duty. Besides carrying out her normal duties, such as administering medication, the nurse was also looking after two post operative and palliative care prisoners.

56. When she first received a telephone message that the man was unwell, she recalled seeing him the previous day and referring him to the doctor. The nurse returned to the healthcare unit to check the man's medical notes. After reading the notes, she called the Charlie wing officers telling them to ensure that the man took his prescribed medication. She said that she would try to come to see him once she had completed the care of the post operative and palliative prisoners. Unfortunately the man's condition deteriorated rapidly that morning and the nurse was unable to see him before she responded to the emergency call for assistance.

57. As the only qualified nurse on duty, I fully appreciate that the nurse had to prioritise her workload for the 22 January. I acknowledge her decision not to visit the man when she was first alerted to his poor health and support her judgment on giving interim advice to wing officers for the man to be encouraged, to take his medication. I do not think that the nurse could have known the seriousness of his condition at the time. Although I make no recommendation on this occasion, the Governor and healthcare manager will want to monitor the staffing levels carefully. Whilst I applaud the prison's prize winning initiative to open a palliative care suite, they will need to make sure that the needs of those prisoners are not detrimental to those of others. As I have said, Whatton prison has many older prisoners and I do not think that the man was an exception. On this occasion, I am satisfied that he was properly looked after and the Governor and healthcare manager will want to be satisfied that this remains the case.

58. I am also satisfied that the response to the man's collapse was carried out professionally with a team effort between the wing staff and healthcare staff. CPR was carried out on the man's bed. Whilst it is preferable for CPR to be carried out on a hard surface, there was no space within the cell to lay the man on the floor. Furthermore, in terms of maintaining his dignity, I think that moving him on to the landing would have been undignified as prisoners were using landing areas during the lunch time period. I therefore judge that staff carried out CPR appropriately and the defibrillator was used correctly.

59. I acknowledge that there was a time lapse between the first call for an emergency ambulance to its arrival at Whatton. The ambulance was called as soon as staff knew there was a problem. However, it should be recognised that Whatton is an isolated prison located midway between Nottingham and Grantham. In previous death in custody reports, I have noted that ambulances may be delayed due to the distance they have to travel.

Charlie unit

60. My investigator has visited Charlie unit, designated as an older prisoner accommodation, on this and previous death in custody investigations. She has been impressed by the care afforded to the prisoners by locating them in a suitable and supportive environment. The support which prisoners give to each other is evident and pleasing to note.

61. The cell mate shared a cell with the man for six months and they became good friends during that time. At interview the cell mate, also an elderly man,

demonstrated the care which he gave to the man especially during the days preceding his death. I hope that the man's family will be comforted that their brother was looked after not only by the prison and healthcare staff, but also by the cell mate, who showed compassion towards his friend.

CONCLUSION

62. The man was an elderly man with a medical history that included hypertension, kidney disease and high cholesterol. These medical conditions were identified at Whatton and treated correctly. He was seen for regular medication reviews and attended a special clinic for his hypertension.

63. The day before he died, the man had been examined by a doctor and prescribed medication for his presenting symptoms. The clinical reviewer judges that this was appropriate. On the day the man died, there was only one qualified nurse on duty and she had to decide what her priorities were for that day. The nurse advised wing staff over the telephone when she was told that the man was poorly and she then consulted his medical record to check on her advice. It is unfortunate that his condition deteriorated before she could see him in person. Although I make no recommendation about the healthcare staffing levels in a rural prison with many older prisoners, I am sure that the Governor and healthcare manager will want to remain satisfied that they are sufficient.

64. The attempt to resuscitate the man was carried by both wing and healthcare staff and I acknowledge their professionalism. The clinical review clearly notes that the blood clot on he man's lung was a fatal condition and his life could not have been saved. Furthermore, the clinical reviewer records that the man received equitable medical care to that within the community.

65. I make no recommendations in this report.

ANNEXES

1. Documents considered during the investigation