PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Whatton in November 2012

Our Vision

‘*To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision’*

This is the report of an investigation into the death of a man at HMP Whatton. He died in November 2012 from bronchopneumonia, chronic obstructive pulmonary disease (COPD), cerebral infarction and peripheral vascular disease. He was 74 years old. I offer my condolences to his family and friends.

A clinical review was conducted of the man's clinical care at Whatton. HMP Whatton cooperated fully with the investigation.

The man had been in prison for over eight years and had a number of chronic diseases, but rejected advice to stop smoking to help improve his health. He was monitored closely and seen daily in the months before his death. The clinical reviewer concludes that he received good medical care and support at HMP Whatton.

I am satisfied that the man received a good standard of care at the prison. But, as I have found in other recent investigations at Whatton, restraints were used inappropriately when he was taken to hospital. The Governor needs to ensure that security arrangements for escorts outside the prison properly reflect risk and individual circumstances.

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 my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2013**

CONTENTS

SUMMARY

1. The man was convicted of sexual offences on 28 July 2004, and subsequently sentenced to nine years in prison. He went to HMP Nottingham and them to HMP Whatton in 2006.

2. On 28 July 2010, the man was released from prison. After failing to adhere to the conditions of his release, he was recalled to prison the next day.

3. Throughout his time in prison, the man received frequent treatment for a number of medical conditions, including an irregular heartbeat. In 2008, he was diagnosed with chronic obstructive pulmonary disease (COPD). Despite these conditions, as well as regular help and advice from healthcare staff to assist him to stop smoking, he continued to smoke heavily. In the months leading up to his death, healthcare staff and carers saw him daily.

4. In November 2012, the man was found lying on the floor of his cell. At 9.20am, his carer took him to the healthcare department in a wheelchair. As they arrived, he had a cardio-respiratory arrest. Healthcare staff were on hand to attempt resuscitation immediately and requested an ambulance. Efforts to resuscitate him continued till 9.40am but were unsuccessful.

5. The man's family was notified promptly of his death and funeral expenses were offered. A post-mortem report concluded that he died from chronic obstructive pulmonary disease, cerebral infarction and peripheral vascular disease.

6. The investigation found that the man's health was managed well at Whatton but the prison was unable to facilitate out of hours GP visits at the weekend, so on one occasion he had to be taken to hospital. We have made a recommendation about this.

7. Despite being a wheelchair user judged to be a low risk of escape or harm to others, restraints were used while the man was in hospital. We believe that insufficient consideration was given to his health and mobility when staff assessed his risk and that the use of restraints was not justified. We are not satisfied that Whatton has implemented previous recommendations about the need to take account of a prisoner's health and mobility when making risk assessments for escort to hospital.

THE INVESTIGATION PROCESS

8. Notices were issued at Whatton announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

9. The investigator examined documents relating to the man's time in custody. He visited Whatton on 3 January 2013 and interviewed three members of staff and a prisoner. He gave preliminary feedback on the findings of the investigation to the Head of Residence.

10. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care. He was given all the relevant documents to assist his review.

11. A copy of the investigation report has been sent to the Coroner to assist his enquiries into the man's death.

12. One of the Ombudsman's family liaison officers contacted the man's family to let them know about the investigation and invited them to identify issues they wished the investigation to consider. The man's daughter was concerned that she was not told directly by Whatton that her father was in hospital.

HMP WHATTON

13. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 prisoners. All the prisoners are sex offenders.

14. Healthcare services are commissioned by NHS Nottinghamshire and provided by Nottinghamshire Community Health Trust. The healthcare centre is open daily from 8.00am to 7.30pm, with a local out of hours service providing cover at night and at weekends. Specialist clinics are provided for older prisoners and those with life long conditions. There are no inpatient beds at Whatton.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) last inspected Whatton during January and February 2012. The prison was found to be safe and decent. Health services were judged to be generally good with staff who were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led, GP and dental services was good. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population. Medication administration was found to be compromised by the lack of appropriate supervision of some medication.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and humanely. In its most recent report, for the period June 2011 to May 2012, the IMB at Whatton reported favourably on healthcare services. They were satisfied that the clinical needs of all the prisoners were met and noted that there was a high quality of care for prisoners with terminal illness in a new palliative care suite in the healthcare unit.

Previous deaths at Whatton

17. We have investigated a number of deaths at Whatton. The man was the eighth prisoner to die there since January 2011. Like him, all the other prisoners had long-term medical conditions. Recent investigations at Whatton found there were occasions when the use of restraints for hospital appointments was inappropriate. There are similar concerns in this case.

KEY EVENTS

18. On 28 July 2004, the man was convicted of sexual offences against a member of his family and subsequently sentenced to nine years imprisonment. He was 66 years old. He went to HMP Nottingham where, on arrival, one of the GPs noted that he had arthritis, dry skin and that due to mobility problems he should have a ground floor cell. He transferred to HMP Whatton in April 2006.

19. On 21 August 2006, the man had an electrocardiogram (ECG - a test that measures the electrical output of the heart and is used to check for irregular heartbeats). The results showed that he had arterial fibrillation (a condition that affects the pace or regularity of an individual's heartbeat). He was referred to an anticoagulant clinic where he was prescribed warfarin, to prevent clotting in the blood vessels and digoxin, which is used to treat heart rhythm disorders.

20. The man had little further contact with the health services at the prison until April 2008, when he was reported to be suffering from breathlessness and coughing and had to use a wheelchair. He was diagnosed with chronic obstructive pulmonary disease (COPD) and a salbutamol inhaler was prescribed. He was helped to stop smoking, through a smoking cessation course but continued to smoke and eventually stopped attending. He told healthcare staff that he had smoked cigarettes for 60 years and found it difficult to stop despite their continued efforts to help him. Between 2008 and 2010, he attended healthcare appointments for a number of medical conditions.

21. The man was released from prison on licence on 28 July 2010, but did not comply with his licence conditions and was recalled to HMP Nottingham the next day. When he arrived a nurse noted that he looked "old and frail". He had minimal contact with healthcare staff during the remainder of his time at Nottingham. On 2 February 2011, he transferred to Whatton, where reception healthcare staff noted that he was "generally unwell". They recorded that he was a chronic smoker and identified relevant health monitoring.

22. On 22 February, one of the GPs at Whatton discussed with the man how smoking made his COPD worse. He told her that giving up smoking had killed both of his brothers and that he intended to smoke "as much as possible". He said that he got about by using a wheelchair around the wing and a stick in his cell.

23. On 26 April, a nurse recorded that the man had blood streaked sputum when coughing. She referred him for a chest X-ray which was carried out on 3 May. It is not clear what the outcome was.

24. The man saw prison nurses and doctors on several occasions over the following months, mostly for routine health matters. On 20 October, healthcare staff were called to his cell as he believed he had had a stroke but when examined, other than slightly raised blood pressure, his observations were normal.

25. On 28 February 2012, the man again reported that he believed he had suffered a stroke. His speech was slurred and he had weakness in his left arm. Paramedics were called but his condition improved before they arrived. The next day, another GP diagnosed a possible Transient Ischemic Attack (TIA - when blood flow to a part of the brain stops for a brief period of time). He contacted the TIA clinic at hospital and made an appointment for a CT scan for the following day. The scan identified evidence of a previous stroke and also of vascular disease (a narrowing of the arteries) in multiple areas of the brain. A follow-up appointment was made for 6 March, with a consultant vascular surgeon at the hospital.

26. The consultant vascular surgeon considered that the best treatment option for the man would be a carotid endarterectomy (a surgical procedure used to prevent strokes by correcting the narrowing in the common carotid artery). However, she was concerned that due to his poor health there would be an increased risk of complication if he had the operation. He was given time to consider his options but did not reach a decision before his death.

27. The man had no significant further contact with the healthcare department until 2 May, when a nurse went to his cell because he had reported being short of breath. The nurse recorded that he was in bed and appeared to be breathing normally. She established that he had not used his prescribed inhalers that day and thought that was the cause of the feeling of tightness in his chest. She explained the importance of the medication and the need for regular use of his inhalers.

28. On 9 August, the man was admitted to hospital for a planned exploration of his bladder and pelvis. As is standard practice, staff carried out a risk assessment to consider what security was needed. It was noted on the risk assessment that he required a wheelchair due to poor mobility and this restricted his ability to escape unaided. He was assessed as a low risk of escape (on a scale of low, medium, high) and low risk to staff and the general public. The risk assessment was authorised by security and operations manager, who instructed that two staff accompany him and that an escort chain (a chain with a handcuff at each end attached to the prisoner and an officer) be used.

29. On 13 August, a nurse examined the man in his cell after an officer told her that he was becoming “increasingly immobile, taking an hour to get out of bed in the morning, not eating properly and needed to be prompted to take medication”. The nurse noted that it was very difficult to hold a conversation

with him as he seemed disinterested and vague. He had also become incontinent. His increasing frailty and confusion was discussed at a healthcare team meeting later that day.

30. The next day, a doctor suspected that he was suffering from a urinary tract infection and planned for him to be admitted to hospital. However, his condition improved significantly so it was decided to carry out blood tests rather than take him to hospital.

31. A nurse reviewed the man's condition on 15 August. She noted that he was again incontinent and had a pressure sore caused by the amount of time that he was spending in bed. She considered that a move to a cell with a hospital type bed and a commode would benefit him. On 16 August, she discussed his condition with a doctor, who agreed to review him the next day.

32. On 17 August, a doctor noted that the man's condition had deteriorated. He was extremely vague and unable to care for himself. She arranged for an emergency admission to hospital for assessment and observation. The security risk assessment was the same as previously and he was accompanied by two prison officers restrained by an escort chain in hospital.

33. On 23 August, a nurse from Whatton telephoned a doctor at the hospital to discuss the man. The doctor said that he was now unable to care for himself at all. Two nurses were needed to assist him in and out of bed, he needed care for pressure sores and he was doubly incontinent. The doctor added that the hospital was planning to discharge him later that day. The nurse explained that Whatton did not have the facilities to provide the 24 hour care that he needed, so the doctor agreed to postpone the planned discharge until more suitable accommodation could be found.

34. The next day, a nurse and an occupational therapist visited the hospital to assess the man's needs. The nurse noted that he was unable to care for himself or transfer independently between his bed and chair, he was only taking small amounts of food, required a beaker with a lid when drinking and was incontinent. Due to the level of care required, it was decided to transfer him to another hospital, which specialised in rehabilitation. He remained at the hospital until a bed became available.

35. On 24 August, an operational manager and the Head of Offender Management at Whatton carried out a routine daily management visit. He noted on the escort log that the man was "tired and confused, a frail elderly man who has deteriorated since my last visit". He concluded that the use of an escort chain to restrain him while he was in hospital was no longer necessary and the presence of two prison officers would be sufficient. However, he decided that a single standard handcuff should be used if he moved from the hospital.

36. On 29 August, the man transferred to another hospital. Healthcare staff at Whatton liaised regularly with the hospital for updates about his nursing care needs and future care package. On 5 September, the hospital informed healthcare staff that he had suffered a prolonged period of delirium and that he was significantly functionally and cognitively impaired. On 18 September, he had an episode of haematemesis (vomiting of blood caused by bleeding in the oesophagus, stomach or duodenum). This required an urgent endoscopy (a procedure where a thin flexible camera is inserted into the stomach through the oesophagus) which was carried out at another hospital.

37. Before the man could return to Whatton, a multidisciplinary review panel was held at Whatton to discuss his future nursing care needs. It was decided to use agency carers to provide him with the 24 hour care necessary and he returned to Whatton on 20 September.

38. On 27 September, a community based occupational therapist carried out a full review of the man's condition. She recorded that Whatton had supplied him with a hospital style bed, a high backed chair with a deep cushion and a commode. She felt that this equipment was sufficient for him at the time. However, she commented that after his discharge from hospital he had "low client motivation to maintain function and relinquish the support of his carers" and "carers are not proactively promoting independence with personal care tasks". She also noted that he was smoking despite continued efforts by Whatton to assist him to stop. She discussed her findings with healthcare staff and they devised a care plan to help him become more independent. A follow-up review was planned to assess his progress.

39. A doctor reviewed the man on 1 October. She felt that his deteriorating condition and need for 24-hour agency care could not be sustained indefinitely at Whatton. She planned to review him two weeks later with a view to recommending a transfer to a prison that would be able to provide the level of care that he required.

40. On 16 October, it was noted that the man's condition had improved and that he was able to move around his cell with a walking frame. He was also more independent and able to feed and dress himself with little assistance. The services of an overnight carer were stopped but he still had an agency carer between 7.00am and 7.00pm.

41. By 18 October, the man was eating and drinking independently, able to go to the toilet unaided and dress himself with the assistance of a Disability Assist Co-ordinator (DAC). (DACs are prisoners who volunteer to take on the role of social carer and assist other prisoners such as him with a variety of everyday tasks.) After a further review, it was decided that agency carer service would

be replaced by 22 October with a combination of scheduled visits by healthcare staff and the use of DACs.

42. At 10.36am on Saturday 27 October, a nurse visited the man as part of her daily rounds. She recorded that he was feeling unwell and had vomited overnight, and again that morning. At 11.20am, she contacted a GP with the Emergency Medical Services for advice, who advised that he needed to physically examine him. She told the doctor that healthcare staff were only on duty until 12.30pm, and that after midday there was no facility to escort a visiting doctor in the prison. He therefore concluded that a visit to Whatton was not feasible and asked that he be taken to their centre in Nottingham to be examined by a GP. She said that for security reasons this was not possible and asked if the doctor would admit him to hospital. The doctor was unable to do so without seeing him, so advised that he should be taken to the accident and emergency department at hospital. The security risk assessment carried out before he went to hospital noted that he was bedridden and that an escort chain should be used during the escort.

43. On 2 November, the man was informed that an application he had previously made for release on parole had not been approved. He nodded and said that he had "served enough time".

44. An assistant practitioner (healthcare assistant) was called to the man's cell a couple of weeks later after he was found lying on the floor. She found no evidence of any injury but arranged for a GP to examine him. A prisoner disability helper took him to the healthcare centre in a wheelchair. At 9.20am, as they arrived at the entrance, an officer, who was assisting healthcare staff that day, said he noticed he "throw back his head and take a very long breath".

45. The officer called for assistance and a nurse and healthcare assistant came immediately. After examining the man, the nurse called for another nurse to bring the oxygen and grab bags which contain emergency equipment. A doctor attended immediately and, after checking his vital signs, suspected that he had suffered a cardio-respiratory arrest. She asked that the control room request an emergency ambulance.

46. The man was then taken to The Retreat (the palliative care suite, which was not in use at that time) and both nurses and the healthcare assistant attempted cardiopulmonary resuscitation (CPR) in rotation. The doctor attached an automated defibrillator to him. It advised to shock once. After they delivered the shock, the doctor checked his vital signs but there were no heart sounds or pulse. CPR continued until 9.40am, when paramedics arrived. The healthcare staff and paramedics discussed the situation and decided to stop CPR. Death was confirmed by the doctor at 9.45am.

47. After the man's death healthcare staff spent time supporting the prisoner disability helper before taking him back to his houseblock.

48. Later that day, at 1pm, the prison's family liaison officer visited the home of the man's son to break the news of his father's death. A Senior Officer accompanied her. The man's son was not there so they went to see his daughter instead. The man's son later contacted them.

49. A post-mortem examination concluded that the man died from chronic obstructive pulmonary disease, cerebral infarction and peripheral vascular disease. A memorial service was held at Whatton on 29 November. The funeral was held on 7 December. Representatives from Whatton attended and the prison paid the funeral costs.

ISSUES

Clinical care

50. The clinical reviewer comments that the man required a substantial amount of medical and nursing care at Whatton. Within the last 12 months of his life, 235 planned appointments were recorded with the healthcare department but there was actually much more informal contact. In the months leading up to his death, he was seen every day and the clinical reviewer is satisfied that staff put in place a comprehensive plan for his health and social needs.

51. The clinical reviewer draws attention to a delay in arranging a chest X-ray on 3 May 2011, but felt that this did not impact adversely on the man's management.

52. The man did not accept all the advice and help given by healthcare staff, particularly in relation to his continued smoking. Healthcare staff were frequently called to his cell after reports of him feeling unwell. These events were sometimes significant but at other times he was in his bed smoking when they arrived. Despite repeated attempts to encourage him to stop he smoked, in his own words, "as much as he could" up until his death.

53. The clinical reviewer states:

> "The use of agency carers was also appropriate and filled that care gap of not having 24 hour HMP Whatton nursing staff on duty…there was some comment about carers doing too much for the man but this did not impact on his recovery. "

54. He concludes that there were no shortcomings in the man's care and management at Whatton. He considers that the standard of care he received was "comparable to that of any NHS patient treated in the community" and "maintained his life until the end" and we agree.

Out of hours healthcare

55. On the morning of Saturday 27 October, the man was unwell. He had been vomiting that morning and the previous night. As this occurred at the weekend, there was no GP on duty at Whatton, so healthcare staff used the NEMS out of hours service. The doctor at the Emergency Medical Service thought that he should be assessed by a GP but the nurse explained that there was no healthcare cover after 12.30pm at the weekend and they could not facilitate a visit by a doctor and neither could they take him to the centre. The doctor advised the nurse to send him to hospital by emergency ambulance to be examined by a doctor.

56. The clinical reviewer was concerned about the arrangements for out of hours healthcare and considers that Whatton should avoid taking unwell prisoners to accident and emergency departments for assessment. We agree and make the following recommendation

The Governor and Head of Healthcare should ensure that out of hours GPs are able to visit prisoners when required.

Emergency response

57. The man collapsed just as he arrived at the healthcare centre. An officer who was working in the healthcare centre called for help and a nurse and healthcare assistant responded immediately. They also called for a doctor to assist and requested paramedics. Despite the quick response, he showed no signs of life and resuscitation attempts stopped as the paramedics arrived at 9.40am. The doctor confirmed his death at 9.45am. As he was already at the healthcare centre, qualified staff were immediately on hand to assist him. We are satisfied that nothing more could have been done by healthcare staff to change the outcome.

Restraints, security and bedwatch

58. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

59. The man attended hospital as an outpatient and for extended stays. On each occasion, the risk assessments consistently assessed him as a low risk of escape and a low risk to staff and the public. Despite this an escort chain was used on each occasion, apart from his inpatient stay at the hospital from 24 August and later at another hospital, when it was decided that restraints were no longer necessary, due to his deteriorating physical condition.

60. Prison Service guidance states that restraints are not normally necessary when the prisoner's mobility is severely limited. As the man used a wheelchair, that would apply in his case. There is no evidence to suggest that he presented a risk of escape that could not be managed by a two officer escort. Given his age, physical condition and lack of mobility, we do not think that the use of an escort chain was necessary or justified.

61. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The man had been assessed as a low risk of escape and a low risk to staff and the public should he do so. We do not consider the risk he presented warranted the use of an escort chain during these hospital visits. This is a matter we have raised with Whatton before and we repeat the same recommendation made in other cases.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

Family liaison

62. The man's daughter was concerned that she had been notified her father was in hospital by her social worker, rather than the prison. However, as his next of kin was listed as his son, staff at Whatton correctly contacted his son to inform him of his father's condition.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that out of hours GPs are able to visit prisoners when required.

   Accepted. In their response to the draft report, the prison indicated that our view of the out of hours provision was inaccurate. Nevertheless, they have accepted the recommendation and commented as follows. "The recommendation is accepted however, current practice dictates that out of hours doctors are able to visit prisoners and this happens on a regular basis."

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   Accepted. "The recommendation is accepted. However, in the case of the man, we believe that a risk assessment was properly completed based on current behaviour as well as his ill health."