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 in July 2014, while in the custody of HMP Whitemoor

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 investigation report into the death of a man of heart failure in July 2014, while in the custody of HMP Whitemoor. He was 62 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at Whitemoor was conducted. The prison cooperated fully with the investigation.

In August 2008, the man was given a life sentence. He arrived at Whitemoor in May 2009. At the prison, he received frequent treatment for diabetes. He did not always follow healthcare staff advice and had difficulty controlling his diabetes, cholesterol and blood pressure.

In November 2013, the man had a small stroke. During his treatment, specialists discovered a brain aneurysm and he agreed to surgery to treat this. He had the surgery on 27 May 2014.

The man's condition deteriorated significantly after his operation and he was acutely unwell. His condition improved in June and he transferred to hospital for rehabilitation. However, his condition deteriorated again at the beginning of July and he developed severe gastric problems. He had surgery on 7 July, but died after a heart attack.

I agree with the clinical reviewer's conclusion that the man's standard of healthcare in prison was equivalent to that which he could have expected to receive in the community. Healthcare staff helped and advised him about his medical conditions, although he often did not follow their advice. When he first went to hospital, officers used an escort chain to restrain him. While I consider that his risk should have been fully reviewed a little earlier, I am pleased to note that the prison decided to remove restraints on 3 June and they were never used again, allowing him greater dignity in his last weeks of life.

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 **February 2015**

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SUMMARY

1. The man was given a life sentence for murder and kidnapping in August 2008. He had a number of previous convictions and had been in prison before. He was a heavy smoker, and had abused alcohol and drugs. His medical history included chronic depression and diabetes.

2. In May 2009, the man transferred to HMP Whitemoor. Healthcare staff frequently reviewed and advised him, but he had difficulty controlling his diabetes. He often refused advice about his medication, diet and smoking.

3. In November 2013, the man suffered a small stroke. After initially refusing treatment, he agreed to see specialists at hospital. Tests revealed a brain aneurysm, which was unrelated to his other medical problems. He agreed to an operation to treat the aneurysm.

4. In May 2014, the man had the operation at hospital. He had a stroke during the operation and became acutely unwell. After his condition improved in June, he transferred to another hospital for rehabilitation. However, he deteriorated again in July and developed severe gastric problems. He later died in hospital.

5. We agree with the clinical reviewer that the clinical care the man received at Whitemoor was equivalent to that which he could have expected to receive in the community. Healthcare staff frequently reviewed him, but he often refused their advice about managing his health problems. He continued to be restrained in hospital after his operation in May, when his condition deteriorated, without a further risk assessment. However, we welcome the fact that this was reviewed later and, after 3 June, restraints were not used again. We make no recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

7. NHS England commissioned a review of the man's clinical care in prison.

8. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed staff at Whitemoor in August and November 2014. He wrote to the Governor about the preliminary findings of the investigation.

9. We informed HM Coroner for North and East Cambridgeshire District of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. His sister, his nominated next of kin, did not have any specific issues for the investigation to consider, however said the prison treated him well and kept the family informed.

11. The family and the prison received a copy of the draft report. Both were content there were no factual inaccuracies.

HMP WHITEMOOR

12. HMP Whitemoor is a high security prison which holds over 450 men serving long sentences. NHS England commissions healthcare services. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision. The prison healthcare centre includes a 24-hour, nine bed in-patient unit. GP services are available between 9.00am and 5.00pm every weekday.

HM Inspectorate of Prisons

13. The most recent inspection of Whitemoor was in January 2014. Inspectors found Whitemoor to be a safe, respectful and purposeful prison which provided some constructive opportunities for prisoners serving long sentences to address their offending behaviour. Healthcare services were reasonable, but inspectors found that there were staffing challenges because agency staff covered around half the posts.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers who help ensure that prisoners are treated fairly and decently. In its most recent report for the year ending May 2014, the Board found that, despite reduced staffing levels, the healthcare department operated effectively. The Board commented that the standard of health care at the prison met that in the community.

Previous deaths at Whitemoor

15. The man was the third prisoner to die from natural causes in the custody of Whitemoor since the beginning of 2014. There were no significant similarities with issues identified in previous cases.

KEY EVENTS

16. The man was remanded to HMP Birmingham in August 2007. He transferred to HMP Woodhill in June 2008. In August 2008, he was given a life sentence for murder and kidnapping.

17. The man had a number of previous convictions and had been in prison before. He was a heavy cigarette smoker, and had abused alcohol and drugs. His medical history included chronic depression and diabetes.

18. In May 2009, the man transferred to HMP Whitemoor. At his initial health screen, a nurse noted his diabetes and asthma. Blood tests showed that he had poor diabetic control and high cholesterol (a fatty substance in blood). Healthcare staff prescribed simvastatin to reduce his cholesterol, and aspirin to prevent strokes and heart problems. He used an insulin pen for his diabetes, and quetiapine (an antipsychotic drug) to help manage his depression.

19. In June, a diabetic nurse specialist reviewed the man. She recorded that he had a good knowledge of diabetes and was using his insulin pen effectively.

20. In July, healthcare staff gave the man advice to help him stop smoking, but he did not give up. Staff frequently offered further advice. He was aware of the risks of smoking, but continued to smoke.

21. A prison GP reviewed the man in November. She recorded that he had leg pain caused by poor blood flow. He told her that he had smoked since the age of 14, and had a family history of diabetes and lower limb amputations. She told him that he was at high risk of having a heart attack or stroke. She also noted that he was suffering from chronic obstructive pulmonary disease (COPD, lung disease). An ECG showed a previous heart attack. She referred him to a cardiologist. (It is not clear from the record whether he saw a specialist.)

22. In December, the man had another diabetic review with the diabetic nurse. She told him that he had poor diabetic control and needed to lose weight. She gave him advice about his insulin regime, but he refused to change this.

23. During 2010, the man continued to have frequent reviews, but had difficulty controlling his diabetes. He rarely exercised, did not comply with dietary advice and refused to change his insulin regime.

24. In March 2011, the man told the diabetic nurse he sometimes forgot to take his insulin and continued to smoke, despite advice to stop. She asked him to keep a diary to help monitor his diabetic regime, but he did not complete this. She added metformin to his diabetic medication, but he continued to have difficulty managing his diabetes.

25. Over the following months, healthcare staff continued to review the man frequently. His diabetic control remained poor, and he often had high blood

pressure and high cholesterol. Staff continued to give him advice about his diet, exercise and smoking. He also suffered from skin problems, exacerbated by diabetes.

26. By the end of 2012, the man's diabetic control started to improve. In October, he told a prison GP that he had started exercising and monitoring his blood sugar levels. Blood tests in November showed that his blood sugar levels had improved.

27. On 8 January 2013, the GP reviewed the man again. He told the GP that he had stopped taking metformin and increased his insulin dose. The GP was pleased with his diabetic readings, but noted that he had stopped exercising and encouraged him to start again. However, he did not start exercising and his diabetic control deteriorated.

28. The GP next reviewed the man on 6 February. The GP noted that he smoked 30 cigarettes a day and no longer exercised. The GP advised him to stop smoking and ordered blood tests. The results showed high cholesterol, high blood sugar and poor diabetic control.

29. Two nurses reviewed the man on 29 April. He said that he had improved his diet, but was suffering from low blood pressure in the mornings. The nurses noted that he had poor diabetic control and high cholesterol. They suggested changes to his insulin regime, which he refused. He told the nurses that he had lost motivation to exercise. The nurses reminded him that regular exercise would help improve his diabetes.

30. Over the following months, healthcare staff continued to review the man frequently, and he had treatment for skin problems related to his diabetes. In May a mental health assessment did not identify any concerns.

31. On 2 September, the man met a GP to discuss the results of recent blood tests, which showed his diabetic control had improved. He told the GP that he had made changes to his diet, but he was not interested in exercising. He often forgot to take his regular medication, so the GP gave him a weekly blister pack to help him remember.

32. On 21 November, the man had difficulty speaking during a family visit. Later that afternoon, he told the GP that he had a headache but no other problems, and felt that he was recovering. He said that he had not taken aspirin regularly for the last three days, which he should have been taking.

33. The GP diagnosed a possible transient ischaemic attack (TIA, a small stroke causing minor and temporary symptoms). He told him that he was at risk of having a further stroke, which could lead to disability or death. He refused to go to hospital, or to stay in the prison's healthcare unit overnight for assessment. He also refused medication to lower his blood pressure. He told him to take aspirin, on the advice of a specialist at the hospital, and referred him to a TIA clinic at the hospital.

34. Later that evening, a nurse reviewed the man on his wing. She recorded that he was coherent, but had difficulty speaking and had some weakness on the left side of his face. He told her he wanted to stay on the wing. She asked officers to check him every two hours.

35. A GP reviewed the man the next morning. He recorded that his speech was still slightly slurred. An ECG test showed no heart problems. He encouraged him to go to hospital for a specialist assessment. He was initially reluctant, but eventually agreed to attend an out-patient appointment. The GP prescribed amlodipine to reduce his blood pressure.

36. On 26 November, the man told the GP that he had experienced no more slurred speech or facial weakness. The GP noted that he was still at high risk of having another stroke. He increased the dose of amlodipine.

37. The man attended a TIA clinic at hospital on 2 December. A CT scan showed that he had clots in blood vessels on his brain which caused the TIA. The scan also showed a small lesion close to an artery on his brain. A specialist referred him for another scan to find out if it was a tumour or an aneurysm (swollen artery).

38. On 10 December, a nurse recorded that the man was taking a lower dose of amlodipine than the GP had prescribed. Over the following weeks, he refused to increase his dose of amlodipine. He also chose not to follow advice from the GP to reduce his cholesterol levels. However, he agreed to start taking medication to help him stop smoking.

39. On 3 February, the man had an MRI scan at hospital. The results indicated that he had a brain aneurysm and the specialist referred him to a neurosurgeon at another hospital. Following an appointment on 17 March, a neurosurgeon (brain specialist) confirmed that he had an aneurysm, which was unrelated to his other medical problems. He explained to him the risks associated with an aneurysm, and offered him surgery to treat it.

40. On 27 March, the man told the GP that he had decided to have surgery to treat the aneurysm. Over the following weeks, healthcare staff saw him often and discussed the operation with him. Healthcare staff continued to advise him about managing his blood pressure and cholesterol, but he refused to change his medication regime.

41. On 26 May, the man transferred to hospital for surgery. Four prison officers accompanied him and used an escort chain to restrain him in hospital. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) He had surgery the next day. Prison staff removed the escort chain while he was under anaesthetic, and reapplied it after the operation.

42. The man struggled to recover after the operation. He reacted badly to blood pressure medication and hospital staff admitted him to the high dependency unit. He was drowsy and weak, and had help with all his care including

feeding. Prison officers recorded that he was in a “semi-conscious, half-paralysed” state at the time. A CT scan showed that he had probably suffered a stroke during the operation.

43. On 3 June, the man started treatment for pneumonia. Prison managers agreed to remove the escort chain and he was not restrained again. The prison assigned a trained family liaison officer (FLO) to support his family. Hospital specialists confirmed that he had suffered a stroke and had a blood clot in his head. They said that he required 24 hour care and was unlikely to have full independence again.

44. Healthcare staff remained in contact with the hospital for updates on the man’s condition. His family visited him in hospital with support from the FLO. On 8 June, he contracted a chest infection and was placed on a ventilator (a machine to support breathing). He had an operation to remove a blood clot on 18 June, during which he had a heart attack. His condition improved after the operation and he transferred to another hospital for rehabilitation on 28 June.

45. In July, the man’s condition deteriorated again and he developed severe gastric problems. He had an operation to stop bleeding in his lower intestine. He had a heart attack the next day and died at 11.40am.

46. A Governor’s notice informed prisoners and staff at Whitemoor of the man’s death and offered support to those who might have been affected.

47. Hospital staff informed the man’s family of his death. The FLO continued to support his family after his death. In line with national guidance, the prison contributed to the funeral costs.

48. The Coroner confirmed that the man died from cardiac failure (heart failure), a myocardial infarction (heart attack) and a duodenal haemorrhage (intestinal bleeding). The pathologist also noted the impact of his stroke on 27 May.

ISSUES

Clinical care

49. The clinical reviewer concluded that the man's care in prison was equivalent to that which he could have expected to receive in the community. He found that he had full access to help and advice about his medical problems, and healthcare staff reviewed him frequently.

50. The clinical reviewer noted that the man had a rigid view of his treatment. He failed to attend a number of diabetic reviews, and often did not follow advice from staff about his medication regime, smoking and exercise. As a result, he had difficulty in maintaining good diabetic control or managing his high cholesterol and high blood pressure effectively. After the TIA in November 2013, he did not take medication to reduce blood pressure as directed by the GP.

51. The clinical reviewer was satisfied that the man understood the risks of the operation to treat the aneurysm in May 2014, and that staff discussed this with him. The clinical reviewer considered that the root causes of his problems were complications from his poorly controlled diabetes, high blood pressure and a lifetime of smoking.

52. We agree with the clinical reviewer's assessment of the standard of the man's care in prison, and we are satisfied that he received appropriate support.

53. The clinical reviewer found that entries made by healthcare staff in the man's medical record were generally of a good quality, but made a recommendation for improvement which the Head of Healthcare will need to address.

Restraints, security and escorts

54. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 about the prisoner's ability to escape must be considered as part of the assessment process and that risk should be reviewed when circumstances changed.

55. The man was a category A prisoner, meaning his escape would be highly dangerous to the public. On 26 May, when he went to hospital for his operation, he was mobile and not acutely unwell. A GP completed the

medical section of the escort risk assessment. He said that officers should remove any handcuffs from him while he was under anaesthetic.

56. The man went to hospital in double handcuffs. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is standard for moving category A prisoners.) Officers restrained him with an escort chain on the hospital ward. They removed the chain during the operation and replaced it afterwards. We are satisfied that these decisions were appropriate.

57. The man suffered a stroke during the operation and his health deteriorated significantly. The next day, the prison completed an updated risk assessment and reduced the number of officers escorting him from four to three. A manager noted that he was unresponsive and undergoing further medical investigation. The risk assessment contained no new healthcare input to say how his condition affected his risk of escape.

58. On 3 June, the prison completed an updated risk assessment. A prison GP said that the man's medical condition restricted his ability to escape unaided. A prison manager agreed that officers could remove the restraints because of his medical condition, noting the High Court Judgement. He was never restrained again.

59. To comply fully with the High Court judgement, the prison should have fully reviewed the man's risk on 29 May, but instead used the medical assessment the GP had completed before his stroke. While it is likely that a new risk assessment on 29 May would have resulted in the restraints being removed earlier, we recognise the efforts that Whitemoor, as a high secure prison, has begun to make to comply with these requirements, so do not make a formal recommendation. We welcome the fact that restraints were removed on 3 June, which meant that he spent the rest of his time in hospital, the remaining weeks of his life, in more dignified conditions.