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 at HMP Whatton

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, who died of bronchopneumonia on 13 July 2014, at HMP Whatton. He was 71 years old. I offer my condolences to his family and friends.

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

In April 2012, the man was remanded to HMP Leicester and sentenced to 18 years in prison the next month. He remained at Leicester. Before his imprisonment, he had been diagnosed with an irregular heartbeat and chronic obstructive pulmonary disease. His health deteriorated and he transferred to HMP Whatton on 2 July 2014, which was better suited to meet his clinical needs. On 12 July, he complained of breathlessness. A nurse who went to see him helped him used a nebuliser and he appeared to be better. She did not take his clinical observations. The next morning, an officer carrying out a roll check could not get a response from him and called the orderly officer. When the orderly officer arrived he went into the cell, he could find no signs of life and it was apparent that he had died. Paramedics attended and confirmed his death.

The clinical reviewer found that overall the man received a good standard of healthcare in prison which was equivalent to that he could have expected to receive in the community. I agree. However, I am concerned that the officer who found him unresponsive did not consider going into his cell to check his wellbeing but waited for the duty manager to attend. Although the delay did not affect the outcome for him, it could be crucial in other 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 **February 2015**

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SUMMARY

1. On 13 April 2012, the man was remanded to HMP Leicester. The next month, he was sentenced to 18 years in prison for sex offences. Before prison, he had been diagnosed with atrial fibrillation (an irregular heartbeat) and chronic obstructive pulmonary disease (COPD) resulting in frequent chest infections, for which he sometimes needed admission to hospital.

2. In June 2012, the man suffered a stroke which was appropriately treated and from which he recovered well. He moved to the enhanced care facility at Leicester and was largely self-caring but needed help with mobility. A respiratory consultant at hospital saw him twice in the next twelve months to review his COPD.

3. The man suffered with frequent chest infections and, in July 2013, was admitted to hospital with pneumonia. Doctors prescribed antibiotics and steroids. He was admitted to hospital again on 21 October with breathing difficulties. The hospital discharged him on 25 October with a diagnosis of congestive heart failure. A CT scan of his chest taken while in hospital ruled out any other underlying causes for the frequent exacerbations of his COPD and repeated chest infections.

4. The man transferred to HMP Whatton on 2 July 2014. On Saturday 12 July, he collected his daily medication from a nurse as usual and raised no concerns. About an hour later, an officer asked the medications nurse to see him as he was complaining he was short of breath. He told the nurse that he had not used his nebuliser that day and the nurse helped him with that, after which he seemed better. The nurse did not have her medical bag with her and did not take his clinical observations. She telephoned the wing later that day to check how he was. An officer told her that he had improved.

5. At 7.00am, an officer carrying out the morning roll check and a night patrol officer could not get a response from the man. They did not go into the cell but called the night orderly officer. When he arrived, he went in and checked for signs of life. It was clear to him that he had died as, among other signs, rigor mortis was present. The control room called an ambulance which arrived at 7.30am. Paramedics pronounced him dead at 7.34am.

6. We agree with the clinical reviewer that the man received a good standard of clinical care equivalent to that he could have expected to receive in the community. Although it would not have affected the outcome for him, we are concerned that the officer and operational support grade who found him unresponsive did not go into his cell immediately but waited for the night orderly officer to attend. In other circumstances such a delay could be crucial. We make one recommendation about this.

THE INVESTIGATION PROCESS

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

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed four members of staff at Whatton in September and October 2014. She informed the Governor's representative of the preliminary findings of the investigation, and followed this up in writing.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's brother, his nominated next of kin, to explain the investigation. He had no specific issues for the investigation to consider. However, the man's sister asked why her brother had moved prisons if he was so unwell, and whether hospital might have been a more appropriate place for him.

12. The man's brother and sister received a copy of the draft report. They did not make any comments.

13. The draft report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of this report.

HMP WHATTON

14. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 men convicted of sexual offences.

15. Nottinghamshire Healthcare Foundation Trust run health services at the prison. The healthcare centre is open during the week from 7.30am to 6.30pm. On Saturdays and Sundays, there is nurse cover from 8.30am until 1pm. A local out of hours service provides cover at night and at weekends. Specialist clinics are held for older prisoners and those with chronic life long conditions. There is a specially adapted palliative care suite to enable men to receive end of life care at the prison.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Whatton was in February 2012. The Inspectorate found that the quality of healthcare was generally very good. 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. Palliative care arrangements were particularly good.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2013, the IMB reported favourably on healthcare services.

Previous deaths at HMP Whatton

18. The man's death was the eighth death from natural causes at Whatton since 2013. There were no significant similarities with the circumstances of this case.

KEY EVENTS

19. On 13 April 2012, the man was remanded to HMP Leicester, charged with sexual offences. At a reception health screen that day, he told a nurse that he had a lung disease, chronic obstructive pulmonary disease (COPD), which reduced his mobility. He had also been diagnosed with an atrial flutter (an abnormal heart rhythm) three months earlier. He took warfarin (to thin his blood) and digoxin (to slow his heart rate), and two different types of asthma inhalers for his COPD. The nurse noted that he was suitable for a normal wing but should have a bottom bunk due to his age and mobility problems. On 28 May he was sentenced to 18 years in prison. He remained at Leicester.

20. On 4 June 2013, records show the man suffered a stroke from which he recovered well. He moved to the enhanced care facility at Leicester and was largely self-caring but needed help with mobility. A respiratory consultant at hospital saw him twice between June 2012 and July 2013 to review his COPD.

21. On 9 July 2013, a physiotherapist at hospital reviewed the man. She noted he had regained mobility and was able to walk up a flight of stairs. However, he got breathless because of his COPD. She advised him to continue with his exercise programme and the stroke clinic discharged him that day.

22. On 26 July, the man was taken to hospital with breathing difficulties. Hospital staff diagnosed pneumonia and prescribed antibiotics. He returned to the prison that evening.

23. A prison doctor examined the man on 22 August when he complained of a tight chest. He had a cough, producing green sputum. The doctor prescribed a course of prednisilone (a steroid) to help relieve his COPD symptoms. He continued to have frequent chest infections and doctors prescribed antibiotics, steroids and a nebuliser. (A nebuliser is a machine that creates a mist of medicine, which is breathed in through a mask or mouthpiece.)

24. On 21 October, the man was admitted to hospital with breathing difficulties. The hospital discharged him back to prison on 25 October with a diagnosis of congestive heart failure. A CT scan of his chest taken while in hospital ruled out any other underlying causes for his frequent exacerbations of COPD and repeated chest infections.

25. On 2 January 2014, the man was admitted to hospital with breathing difficulties. The hospital discharged him on 10 January with a prescription for carbocisteine (to help reduce mucus). Hospital staff told him that his condition could not be cured, and apart from treating his symptoms there was little more they could do.

26. On 17 February, a prison doctor reviewed the man and discussed whether he wanted resuscitation to be attempted if he had a cardiac or respiratory arrest. The doctor explained that his condition meant that it would be unlikely that a resuscitation attempt would be successful. He reassured him that if he signed an order indicating he did not wish to be resuscitated, he would still receive

full treatment and be admitted to hospital if necessary, if he became unwell. He said he would discuss with his family before making a decision. He signed an order on 11 March. Healthcare and prison staff working on his wing were informed of this.

27. On 16 April, the man asked to see the prison's physiotherapist. He explained that due to his COPD he found it difficult to walk any distance. This made him not want to mobilise and he felt that as a result his body was becoming weaker. The physiotherapist gave him some breathing and chair exercises he could do in his cell.

28. The man's health declined and staff at Leicester agreed that he should transfer to HMP Whatton, which was more suited for his needs. On 26 June, a nurse telephoned another nurse at Whatton and gave a full handover about him and his health conditions.

29. The man transferred to Whatton on 2 July and a nurse completed a reception health screen. She noted he was short of breath but that staff at Leicester had said this was normal. She noted his wishes about resuscitation and asked the prison doctor to review him. Prison staff gave him a ground floor single cell.

30. On 3 July, a prison GP reviewed the man, who again agreed that he did not want resuscitation to be attempted. He signed a new order to record this. He did not have any other specific concerns about his health at this time. An occupational therapist carried out an occupational therapy assessment and observed him mobilising around the wing. She noted that he was able to walk independently with a walking frame. She gave him a wedge pillow to support his breathing at night and a chair to enable him to use the shower safely.

31. On 8 July, a nurse visited the man in his cell. He had a cough which produced green sputum, which he said was normal for him. She noticed that his inhaler technique was poor and the aero-chamber (used to help with the inhaler) was dirty. She cleaned it and advised him how to use it properly. She suggested using a mouthpiece rather than a face mask, but he did not want to change.

32. At 9.24am on Saturday 12 July, the man collected his daily medication from a nurse. He did not report any concerns. However, at 10.30am an officer asked the nurse to see him in his cell as he had said he was short of breath. He told her that he had not used his nebuliser that day and she helped him with this. She did not examine him or take his clinical observations as she did not have her medical bag with her. She noted that he looked no different to how he normally did and was not in any distress so she had no particular concerns about him.

33. At 12.46pm the same day, the nurse telephoned the man's wing. An officer told her that he had improved since using his nebuliser. She asked if he became unwell later in the day they should call The Gables, the medical out of hours service. (Healthcare staff finish at 1pm on weekends). The out of hours service was not required and there is no record that his condition deteriorated later that day or during the night.

34. At 7.00am, the night patrol officer handed over to an officer. The night patrol officer raised no concerns about the man's welfare. The officer started a roll check of the wing to ensure that all prisoners were present. When she arrived at his cell, she opened the observation panel in the door and saw him lying on the bed, apparently watching television. She noticed he did not move so called his name and rattled the door, but he did not respond. She decided to finish the roll check and come back to check a few minutes later.

35. When she had finished the roll count she went back to the man's cell but she could still not get a response. She asked another officer to check, but she was also unable to get a response from him.

36. The prison was still in night state when all prisoners are locked in their cells and the number of staff is much lower than during the day. The officer radioed the night orderly, the custodial manager in charge of the prison and asked him to attend. He arrived shortly after and went into the man's cell and checked him for signs of life. He was aware that he had asked not be resuscitated, but said it was clear that he had died as rigor mortis was present. He briefed the control room who called an ambulance at about 7.10am. The ambulance arrived at 7.30am and paramedics pronounced him dead at 7.34am. They noted that he had requested that resuscitation should not be attempted.

Liaison with the man's family

37. That day, a prison family liaison officer went to the man's brother's home to inform him of his death. His brother said that they had been aware that he was very ill and did not wish to be resuscitated. He was pleased that the prison staff had considered his brother's wishes. The prison held a memorial service for him on 24 July. The funeral was on 14 August 2014. The prison contributed towards the funeral costs, in line with national policy.

Support for staff and prisoners

38. A Governor's notice informed staff and prisoners of the man's death. A senior manager debriefed staff involved in the emergency response and offered them the support of the prison's care team. Staff offered prisoners on his wing appropriate support and access to the Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners). Prisoners considered at risk of self-harm or suicide were checked in case they had been affected by his death.

Post-mortem

39. A post-mortem showed that the man died from acute bronchopneumonia and chronic obstructive pulmonary disease.

ISSUES

Clinical Care

40. The man died of bronchopneumonia, which is a form of chest infection caused by either a virus or bacteria. The clinical reviewer explained that if it progresses, it can lead to overwhelming infection and death. Bronchopneumonia is more common in patients with COPD and other chronic lung diseases, and is always a potential risk for people who experience frequent exacerbations of their lung disease, or have worsening disease. He had frequent chest infections, which were appropriately treated with antibiotics and he was referred to hospital when necessary. The clinical reviewer said it can be difficult to distinguish between an exacerbation of COPD and an episode of bronchopneumonia as they are both infections of the chest.

41. The clinical reviewer identified some areas for improvement which the Head of Healthcare at HMP Leicester and HMP Whatton will need to address, but overall he considered that the man received a good standard of care in prison. While it would have been preferable for a nurse who saw him on the morning of 12 July, to have carried out clinical observations, she considered that he appeared little different from usual and his condition improved after using his nebuliser. It is possible that further clinical examination would have detected that he was developing pneumonia, but it is not possible to know. No member of staff had any further concerns about him that day, to lead them to call the out of hours service, which the nurse had advised should his condition deteriorate. We agree with the clinical reviewer that he received an appropriate standard of care at Whatton and Leicester.

Emergency Response

42. When the officer was unable to get a response from the man she did not go into his cell, although she had a full set of keys. She and another officer waited for the duty manager to attend. She said the prison was still in night state and she did not think the prison allowed officers to enter cells alone during night state. (Although another officer was also with her.) We consider that, although the man did not want to be resuscitated, she should have checked his wellbeing when he did not respond. There is a local instruction at Whatton about opening cells during night state, which says “where there is, or appears to be immediate danger to life, cells may be unlocked with one member of staff”. On this occasion, the delay did not affect the outcome as it appears that he had been dead for some time. However, in other circumstances any delay could be crucial. We make the following recommendation,

    The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there are serious concerns about the health of a prisoner.

RECOMMENDATION

The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there are serious concerns about the health of a prisoner.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there are serious concerns about the health of a prisoner.	Accepted	A notice to staff will be issued reminding staff that, subject to a personal risk assessment, they should enter a cell at night if there are serious concerns about a prisoner's health.	31 December 2014 Head of Safer Custody