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 June 2014, while in the custody of 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 in June 2014, while in the custody of HMP Whatton. He died from heart disease, type 2 diabetes, pneumonia, urinary tract infection and dementia. He was 77 years old. I offer my condolences to his family and friends.

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

The man was sentenced to nine years in prison in 2009 and was transferred to Whatton shortly afterwards. At the time, he suffered from diabetes, rheumatoid arthritis and poor vision, for which healthcare staff saw him frequently. He developed further chronic health problems, including heart disease, and his general health and mobility gradually deteriorated. On 5 June, a prison GP noted that he appeared unwell and arranged for him to be admitted to hospital. The hospital diagnosed pneumonia. His condition deteriorated in hospital and he died a few days later.

I agree with the clinical reviewer that the standard of healthcare the man received at Whatton was at least equivalent to that he could have expected to receive in the community. However, I am concerned that the prison did not inform his next of kin when he was seriously ill. I am also concerned that, when he went to hospital, prison staff restrained him without a fully considered risk assessment, a matter I have raised in other cases at Whatton. In this instance, it is particularly unacceptable that an elderly, frail and immobile man was restrained until the point of death.

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** **December 2014**

**CONTENTS**

## SUMMARY

1. The man was sentenced to nine years in prison in March 2009 and transferred to Whatton in June that year. At an initial health screen, he reported a number of health problems including diabetes, reduced mobility, caused by rheumatoid arthritis, and problems with his vision. He smoked cigarettes, but did not want help to give up.

2. Healthcare staff reviewed and treated the man frequently for his medical conditions. A named nurse coordinated and monitored his care and a disability carer helped him with daily activities. Over time, his health deteriorated and he developed a number of other chronic conditions and his mobility became more limited.

3. From June 2013, healthcare staff treated the man for leg sores which caused him pain and discomfort. He suffered increasing memory loss and, in February 2014, doctors diagnosed moderate dementia.

4. On 3 June 2014, the man appeared unwell and confused. The next day, his condition had deteriorated further. On 5 June, a prison GP reviewed him and thought he might have a urinary tract infection. She sent him to hospital where he was also diagnosed with pneumonia. He asked the escorting officers to contact his brother but no one did this. His condition deteriorated in hospital and he died a few days later. He had been restrained by an escort chain in hospital up to the time he died.

5. The clinical reviewer considered that the care the man received at Whatton was equivalent to that he could have expected to receive in the community. We are concerned that he was inappropriately restrained in hospital and that the prison did not notify his brother that he had been taken to hospital. We make two recommendations.

## THE INVESTIGATION PROCESS

6. 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.

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

8. The investigator obtained copies of the man's prison medical records and extracts from his prison record. On 28 July, she interviewed three members of staff and a prisoner at Whatton and briefed the governor about her preliminary findings.

9. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation, who provided the results of the post-mortem examination. 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 friend, his nominated next of kin, who also acted on behalf of his brother, to explain the investigation. He did not have any specific issues for the investigation to consider.

11. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

## HMP WHATTON

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

13. Nottinghamshire Healthcare Foundation Trust runs 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 8.00am until 12.30pm. A local out of hours service provides cover at night and at weekends. Specialist clinics are held for older prisoners and those with chronic long conditions. There are no inpatient beds.

## HM Inspectorate of Prisons

14. The most recent inspection of Whatton was in February 2012. The Inspectorate found the prison was safe and decent. Health services were judged generally good and staff were respectful and responsive to prisoners' needs. Primary care was well organised and prisoners had good access to nurse-led clinics, GP and dental services. There was a wide range of chronic disease clinics and enablement therapies to meet the needs of the population.

## Independent Monitoring Board

15. Each prison 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 latest published report for the year to May 2013, the IMB reported favourably on healthcare services. The Board noted a large elderly population at the prison, which impacted on the healthcare department. However, the Board was satisfied that the clinical needs of all prisoners were met.

## Previous deaths at Whatton

16. The man's death was the sixth from natural causes at Whatton since January 2013. We have raised the issue of unjustified use of restraints for elderly prisoners in hospital before.

## KEY EVENTS

17. On 30 March 2009, the man was sentenced to nine years in prison. He went first to HMP Leicester, and then to HMP Lincoln. His medical history included type 2 diabetes and he had sight and hearing problems. Rheumatoid arthritis reduced his mobility. He was a moderate cigarette smoker.

18. In June 2009, the man moved to HMP Whatton. Because of his medical conditions, healthcare staff saw him frequently. Over time, his health deteriorated and he developed a number of further chronic health conditions, including heart disease, hypertension and kidney disease. His mobility was limited. A nurse coordinated and monitored his care which included specialist nursing treatment.

19. The man received warfarin (an anticoagulant, to prevent blood clots) daily. He had regular blood tests to monitor this and healthcare staff reviewed and adjusted his medication as required. From June 2013, his mobility gradually deteriorated and he had daily wound care treatment for leg ulcers.

20. On 23 September, the man told the nurse that he had fallen a number of times when he tried to stand up and was finding it difficult to get about. On 26 September, he fell during the night. She noted that this was his third fall in one week and referred him to the older persons' physiotherapy service for a priority assessment. After an assessment, he moved to an adapted cell on B wing, a general wing.

21. On 1 October, a prison GP reviewed the man and referred him to a doctor specialising in the care of elderly patients. On 4 October, he had a dementia test. A nurse noted that he believed it was 1985 and that he would need a further review, but no immediate changes to his care were necessary.

22. On 10 October, a nurse reviewed the man's location after wing staff reported that he was having difficulty moving around on B Wing. She considered that he would be better located on A Wing, where there were more experienced carers and suitable cells. She noted that he was able to care for himself, but found some daily activities difficult. She implemented a care plan to support him.

23. On 14 October, a nurse reviewed the man in his cell on B Wing, and noted that the sores on his legs made it difficult for him to move unaided safely. She considered that his bed was too high and too far from the toilet facilities. The room was dirty and full of clutter which was a trip hazard. She agreed with another nurse that he should be moved to an alternative disabled cell on another wing, which was better suited to his needs. Staff made arrangements for him to move to A wing.

24. A prison GP examined the man on 14 October. She found that the sores on his lower leg had deteriorated and she could not feel a pulse in the leg. He said he was in pain. The doctor prescribed antibiotics and arranged regular reviews of his leg.

25. An occupational therapist assessed the man on 21 November. She noted that he continued to need support from the disability carer to be able to move around safely and he was happy with the current arrangements.

26. Despite constant dressing, the man's leg wounds were painful. A doctor referred him to vascular surgeons and a tissue viability nurse. On 14 February 2014, healthcare staff adjusted his wound care plan, in line with advice from Nottingham City Tissue Viability Service.

27. On 21 February 2014, a community psychiatric nurse and a consultant in old age psychiatry reviewed the man. An assessment and CT scan showed that he had vascular dementia, probably due to hypertension and diabetes. The consultant's report said that he had moderate dementia and there was no medication for his condition.

28. A nurse from Nottingham City Tissue Viability Service visited the man on 7 March. She was satisfied that prison healthcare staff managed his leg sores well and discharged him from the service. On 8 April, a nurse noted he had several superficial abrasions to his legs with no sign of infection. By the end of May, the sores were healing and he reported that he was in less pain.

29. On 4 June, wing staff told a nurse that the man was incontinent and in a confused state. His disability carer said that he seemed less mobile. Later that afternoon, another nurse reviewed him and found he appeared to be frailer, had a raised heart rate and he was unable to give a urine sample. She noted he was not confused at the time and his leg wounds appeared to be improving.

30. On 5 June, a nurse found that the man was unwell and confused. She said he was unable to stand up without assistance. She noted that he appeared dehydrated and that it would be difficult to manage him in the prison. A doctor reviewed him at 12.28pm and noted he was immobile. She considered this was probably due to a urinary tract infection and sent him to hospital. Two officers escorted him and used an escort chain to restrain him in hospital. (An escort chain is a long length of chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

31. The man was admitted to hospital. One morning a few days later, he asked the escorting officers for his brother's telephone number and wanted prison staff to contact his brother on his behalf. No one did this.

32. Healthcare staff from the prison remained in contact with the hospital for updates on the man's condition. Hospital staff diagnosed pneumonia and treated him with antibiotics. His mobility remained poor.

33. At 5.45am the man began to have serious breathing difficulties. One of the escorting officers contacted the prison and asked for a review of the need for restraints, but the prison made no immediate change. He remained attached to an officer by an escort chain. At about 5.56am, he became unresponsive

and the officer removed the restraints. Hospital staff attempted resuscitation, but he did not respond and staff stopped all treatment at 6.10am. At 6.35am, a doctor certified his death.

**Liaison with the man's family**

34. On the day of the man's death, an operational manager at the prison went to see the man's nominated next of kin, a friend, and told him that he had died. In September 2013, he had told prison staff that his twin brother suffered from ill health so he had nominated his friend to act as his next of kin, to support him. The operational manager and the man's friend went to see the man's brother, but he was not at home. The friend then rang him and told him that his brother had died.

35. The man's brother and friend attended a memorial service held at the prison on 18 June 2014. His funeral was on 30 June. The prison arranged and paid for the funeral, in line with national guidance.

**Support for staff and prisoners**

36. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. Staff reviewed prisoners identified as at risk of suicide and self-harm in case they had been adversely affected by the news of his death.

**Post-mortem report**

37. A post-mortem examination concluded that the man died of ischaemic heart disease (reduced blood supply to the heart), coronary artery disease, type 2 diabetes, pneumonia, urinary tract infection and dementia.

## ISSUES

### Clinical Care

38. When the man arrived at Whatton, he was 72 and had a number of chronic health problems. He gradually became frailer and developed a number of additional chronic conditions, including heart disease, hypertension, kidney disease and dementia. The clinical reviewer found that healthcare staff at Whatton appropriately reviewed and managed these conditions.

39. The clinical reviewer concluded that the man's clinical care in prison was equivalent to that which he could have expected to receive in the community. We agree with the clinical reviewer's assessment and are satisfied that he received an appropriate standard of care and support at the prison.

### Liaison with the man's family

40. When the man was in hospital, he asked for his brother's telephone number and wanted officers to contact him on his behalf. There is no record that this happened. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.

41. We consider that when the man was admitted to hospital on 5 June, the prison should have informed his next of kin. We are also concerned that when he specifically requested someone to inform his brother, no one did so. This meant that neither his brother nor his friend had the opportunity to visit and spend time with him before his death. We make the following recommendation:

    **The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.**

### Restraints, security and escorts

42. 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.

43. When the man was taken to hospital on 5 June, an escort risk assessment indicated that he was a low risk to the public, potential to escape and of further offending. A nurse completed the healthcare part and said that there were no medical objections to the use of restraints, but pointed out that he used crutches or a wheelchair and that his medical condition meant that he was unable to mobilise and was very confused. She noted "at best only able to mobile with frame a few steps".

44. An operational manager recommended that the man should be restrained by an escort chain and accompanied by at least one male officer, because of his immobility. Another manager authorised the use of restraints. At the time he was admitted to hospital, escort records show that he had a high temperature, leg sores and low blood pressure. He was confined to bed and not mobile. The next day, the operational manager reviewed the risk assessment but made no change.

45. The man remained restrained until the early morning of his death, when an escorting officer removed his escort chain at the time he became unresponsive. Sadly, he could not be resuscitated and it was apparent that he had died. The officer had called the prison to request permission to remove restraints shortly before, but this was not agreed.

46. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity. We are not satisfied that the initial risk assessment fully took into account the man's condition. Although a nurse made it clear that he was immobile, she did not object to the use of restraints. As the assessment indicated that he was low risk of escape and that his health and mobility was poor it is difficult to understand how managers concluded that restraints were necessary. At the very least, the escort chain should have been removed when the officer called the prison not long before he died.

47. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility impacts on the risk of escape and any objections to the use of restraints. It is unacceptable that a very ill and immobile old man should be chained to an officer until he died. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed.**

## RECOMMENDATIONS

1. The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

2. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed**.**

**ACTION PLAN**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible |
|---|---|---|---|---|
| 1 | The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill. | Accepted | Relevant Managers have been reminded of the requirement to notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.<br><br>A proactive Family Liaison Officer system is in place to offer appropriate support. | Completed and ongoing |
| 2 | The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed**.** | Accepted | Staff involved in the completion of risk assessments are advised of each prisoner's condition and mobility to ensure that any decision taken about the use of restraints is appropriate. This information is disseminated during operational briefings and the functional head also feeds this back at Senior Management Team meetings.<br><br>Risk assessments for prisoners taken to hospital are based on consideration of the individual's circumstances and the actual risk the prisoner presents at the time. There is an underpinning regard to not only the individual's risk of escape but also their risk to the public.<br><br>Risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed, as necessary, to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of | Completed and ongoing |

| | | | | |
|---|---|---|---|---|
| | | | risk by the escorting staff in attendance. | |