



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 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 pneumonia, caused by lung cancer in July 2014 at hospital, while a prisoner at HMP Whatton. He was 81 years old. I offer my condolences to his friends.

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

The man had been in prison since 2006 and at Whatton since 2008. His initial health screen indicated that he suffered from a number of chronic health problems and poor mobility. He was a moderate smoker. He was admitted to hospital on several occasions with circulatory problems. However, he was able to live on a wing with support from a prisoner carer. Healthcare staff monitored him frequently, aided by comprehensive care plans.

The man's health deteriorated suddenly in June 2014 and staff moved him to a new unit with an adapted cell to aid his nursing care. The next day, 27 June, an officer found him lying on a mattress on the floor of his cell. He said that he was comfortable and resting, but later reported some pain and appeared confused. Nurses assessed him and decided he needed to go to hospital to be checked. The hospital admitted him for observation. His condition deteriorated in hospital. At the beginning of July, doctors diagnosed a bowel obstruction, pneumonia and secondary brain cancer, the primary site of which was unknown. He refused any treatment and died later that day.

The clinical reviewer found that the standard of healthcare the man received at Whatton was equivalent to that which he could have expected to receive in the community. I am satisfied that he received good support at the prison and his death could not have been foreseen or prevented.

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

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SUMMARY

1. In October 2006, the man received an indeterminate sentence for public protection with a minimum period to serve of two years. He was sent to HMP Shrewsbury. His medical history included heart problems, chronic obstructive pulmonary disease (COPD), limited mobility and arthritis. He moved to HMP Whatton in November 2008. Healthcare staff initiated comprehensive care plans and reviewed his chronic diseases frequently.
2. At around 9.00am on 27 June 2014, officers found that the man had moved his mattress onto his cell floor. He said that he was resting and comfortable. A nurse visited him around 30 minutes later and found him calm and relaxed. The nurse arranged for senior nurses to assess him later that morning.
3. The clinical matron and another senior nurse examined the man around 10.30am. He told them that he had pain in his left shoulder, but the nurses could not lift him back to his bed. He appeared to be confused, although his clinical observations were stable. The nurses decided that he should go to hospital for further assessment, and called an ambulance. Later that day, the hospital admitted him for tests and observation. Two officers escorted him, but they did not use restraints.
4. The man's condition deteriorated in hospital. At the beginning of July, the hospital notified prison healthcare staff that he had a blockage in his abdomen. At their request, the prison passed the hospital details of his next of kin. The next day hospital staff told the escort officers that he was very poorly and refusing treatment. Medical tests had indicated a bowel obstruction, pneumonia and cancer, which had probably spread to his brain. He died that night.
5. The clinical reviewer concluded that the standard of healthcare the man received at Whatton was equivalent to that he could have expected to receive in the community. He made two recommendations for improvement which the Head of Healthcare will need to address but are not repeated in this report. Overall, we are satisfied that he received an appropriate standard of care at Whatton.

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 care in prison.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She requested additional notes from two members of healthcare staff. She gave the Governor initial feedback about the preliminary findings of the investigation.
9. We informed HM Coroner for Nottinghamshire 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 friend, his nominated next of kin, to explain the investigation. His friend did not have any specific issues for the investigation to consider.
11. The man's next of kin was provided with a copy of the draft report. They did not make any comment on the factual accuracy of the report. The prison considered our draft report and noted one factual inaccuracy, which has been amended.

HMP WHATTON

12. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.
13. The healthcare centre is open Monday - Friday from 8.00am to 7.30pm and weekends there is nurse cover from 8.00am to 12.30pm. There is an out of hours service. There are no inpatient beds, but there is an end of life suite, known as The Retreat, alongside the healthcare facility.

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 to be generally good and staff were polite and responsive to prisoners' needs. Primary care was well organised and access to nurse-led, GP and dental services were good. 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 2012 - 2013, the IMB reported favourably on healthcare services.

Previous deaths at Whatton

16. The man was the fourth prisoner to die from natural causes at Whatton since the start of 2014. There are no similarities between these deaths and that of his.

KEY EVENTS

17. On 26 October 2006, the man received an indeterminate prison sentence for public protection with a minimum period of two years before he could be considered for release. He was sent to HMP Shrewsbury. His medical history included two heart attacks, heart disease, chronic obstructive pulmonary disease (COPD), limited mobility and arthritis. He was a moderate smoker, but declined offers of help to give up.
18. The man transferred to HMP Whatton on 26 November 2008. He had a full health screen on arrival, including a medication review. Healthcare staff developed care plans to ensure they monitored his medical conditions effectively. He had frequent contact with healthcare staff. He was admitted to hospital several times for circulatory problems, and he had frequent assessments by a physiotherapist.
19. On 19 November 2013, the man was unable to move out of his wheelchair into a taxi to attend an outpatient hospital appointment. The appointment was cancelled, as there was no appropriate transport. Staff noted on his clinical record that future hospital transport needed to be suitable for a wheelchair. On 21 November, his clinical records indicates that he weighed 111.7kg, which was morbidly obese. Healthcare staff continued to monitor him.
20. On 28 April 2014, a nurse examined the man and noted his blood pressure was low and he had an irregular pulse. A prison GP carried out an electrocardiogram (ECG) test, and ordered blood tests. On 30 April, the blood tests showed he had a low sodium level and too much water in his blood. Healthcare staff arranged further blood tests to monitor his sodium levels.
21. On 20 May, a GP reviewed the man's medication and stopped lansoprazole (an ant-acid medication) in case this was causing his low sodium levels.
22. The man refused to attend a hospital appointment, for an X-ray on 6 June, as the prison had not ordered a wheelchair taxi. There is no record to show whether staff arranged another appointment with appropriate transport. While unfortunate, this would not have affected the outcome for him.
23. On 14 June, healthcare staff examined the man after he fell in his cell. He had no obvious injuries and was able to mobilise as normal. Staff noted that he should have an occupational therapist and a physiotherapist should assess him.
24. A blood test, taken on 23 June, showed that the man's sodium levels were normal. Healthcare and prison staff met to discuss his needs and arranged for him to move to an adapted cell on Alpha Wing, which could accommodate his wheelchair and was more accessible for nursing care.
25. On 24 June, an occupational therapist assessed the man. She developed a plan for his care, for occupational therapy and healthcare staff to manage together.

26. On 26 June, when preparing for the man's move to Alpha Wing, healthcare staff found large quantities of unused medication in his cell, some of which was some years out of date. Healthcare staff gave him a dosette box set to store his repeat prescriptions and disposed of the old medication.
27. Healthcare staff assessed the man as bedbound and after his move to Alpha Wing on 26 June were developing a new care plan to reflect the additional nursing care required. Staff had ordered a hospital bed for him to assist in his nursing.
28. On 27 June at around 9am, officers found the man on the floor of his cell, lying on his mattress, which he had taken off his bed. An officer telephoned the healthcare unit to inform them, but told a nurse that he was not in danger and they did not need an immediate medical response. She arranged with senior nurses that she would visit him on her normal wing round. The clinical matron and a senior nurse agreed to go and see him later that morning.
29. A nurse went to see the man, who was comfortable and calm on his mattress on the floor, and able to communicate with her. She told him that two more nurses would be visiting him later, and he should let wing staff know if he needed anything.
30. At around 11am, the clinical matron and senior nurse examined him, who was still on the mattress on the floor. He said he had some pain in his left shoulder, but he could move his legs and otherwise appeared physically well. However, he seemed confused about why he was on the floor. The nurses could not get him off the floor to his bed. His medical observations were stable, but the nurses considered he should go to hospital for assessment and requested an ambulance.
31. The senior nurse remained with the man until the ambulance arrived at 1pm. The ambulance took him to hospital. Two officers accompanied, but they did not use restraints.
32. The hospital admitted the man for tests and observation. Prison healthcare staff telephoned the hospital each day for an update on his condition. At the beginning of July, hospital staff informed them that he had a blockage in his abdomen and he needed further tests. His condition deteriorated in hospital and doctors diagnosed a bowel obstruction, pneumonia with possible secondary brain cancer (primary site unknown) and a spinal cord lesion (compression of the spinal nerves). Doctors decided that, because of his condition, it would not be appropriate to attempt resuscitation in the event of a cardiac or respiratory arrest.
33. The clinical matron and a prison operational manager visited the man the next day. The clinical matron noted in his medical record that he was refusing treatment and drifting in and out of consciousness. At 6.50pm, a prison family liaison telephoned a friend of the man's who he had nominated as his next of

kin, and informed her of his condition. The friend did not want to visit and they agreed that the hospital would keep her updated by telephone.

34. At around 10.05pm, the two prison officers supervising the man at the hospital noticed that he had stopped breathing and told hospital staff. At 10.30pm, a doctor certified that he had died. The hospital telephoned his friend and informed her of his death.

Family contact

35. Prison Service Instruction (PSI) 64/2011 states prison staff should inform the nominated next of kin of a death, preferably in person. However, the man's friend had requested that the hospital should update her by telephone. We are satisfied the prison kept her informed when his condition deteriorated significantly, and that there was appropriate contact after he died.
36. On 3 July, the family liaison officer telephoned the man's friend to offer his condolences and support. She did not want him to visit her that day. He arranged to visit on 8 July.
37. The family liaison officer and a prison chaplain visited the man's friend on 8 July, and helped with the funeral arrangements. He had no known family, so the prison arranged for the funeral to be held in his hometown, which allowed his friend to attend the service. The prison arranged the service and the prison chaplain officiated. The prison paid funeral expenses, in line with national guidelines.

Support for staff and prisoners

38. The night orderly officer debriefed the escorting officers who were with the man at the time of his death and offered support. A Governor's notice informed prisoners and staff at Whatton of his death and offered support to anyone who might have been affected

Post-mortem report

39. A post-mortem examination concluded that the man died from aspiration pneumonia and (non-small cell carcinoma of lung) fast growing lung cancer).

ISSUES

Clinical Care

40. The clinical reviewer noted that the man was morbidly obese and had smoked for over 70 years. His medical record indicated that he had refused treatment in hospital and in fact died 'on his own terms'. During his time at Whatton, he had had considerable healthcare input – the clinical reviewer noted 179 healthcare appointments since his reception. In the last year of his life, healthcare staff started to see him daily for medication and nursing care. He had all expected health checks and vaccinations and lifestyle counselling. The clinical reviewer was satisfied that chronic disease management and medication reviews were all performed to maximise his chances of long-term survival.
41. The clinical reviewer found medical record keeping was entirely satisfactory. His review of the man's medical notes showed that there were no entries by healthcare staff to suggest that increased observations were required. He considered that his admission to hospital on 27 June was appropriate and could not have been made earlier. While he was frail and aging, his sudden deterioration in June 2014 could not have been anticipated.
42. The clinical reviewer noted two areas for improvement in relation to medicines management for older non-compliant prisoners to reduce the risk of stockpiling and the need to mark clinical records clearly when prisoners need transport suitable for wheelchairs. We do not repeat the clinical reviewer's recommendations in this report as they were not major matters, and not directly related to his death, but the Head of Healthcare will need to address them.
43. Overall, the clinical reviewer concluded that there was no opportunity for healthcare staff to have intervened earlier and changed the outcome for the man. In his opinion, his clinical care at Whatton was equivalent to that which he would have received in the community. We agree with the clinical reviewer's assessment of the standard of his care in prison and are satisfied that he received appropriate support at Whatton.