A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man in August 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 of heart disease in August 2014 at HMP Whatton. He was 73 years old. I offer my condolences to his family and friends.

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

The man was sentenced to prison in 2007 and had been at HMP Whatton since August 2013. He was significantly overweight and had Type 2 diabetes, chronic obstructive pulmonary disease, a history of heart disease and a degenerative spinal condition. Healthcare staff at the prison managed these conditions well throughout his time at Whatton. Despite lifestyle advice, he put on several stone during his time in prison. He was five foot six tall and weighed over 18 stone at the time of his death.

At the beginning of August 2014, the man fell over in his cell a number of times. Officers were unable to get him back into bed and instead made him comfortable on a mattress on the floor. About an hour later, he began to have difficulty breathing. His cellmate gave him his inhaler, but he appeared not to be able to use it. At 11.30pm, the night patrol officer sought advice from the night manager who asked him to continue to monitor him, but did not seek medical advice. Shortly afterwards, his cellmate believed he had died. The night patrol officer, believed he could see his chest rising but did not go into the cell to check. He called the night manager again, who then called the duty doctor. Staff went into the cell at about 11.50pm. He was unresponsive and they called an ambulance. They tried to resuscitate him but paramedics pronounced him dead, shortly after they arrived.

The clinical reviewer was satisfied that, overall, the man received a good standard of care at Whatton, equivalent to that he could have expected in the community and I agree. However, I am concerned that no one sought medical advice or called an ambulance when he first had breathing difficulties and that the night patrol officer did not go straight into the cell to check his condition, or call an emergency code, when his cellmate believed he had stopped breathing. There was also a delay in getting paramedics to the cell, once the ambulance arrived at the prison. The clinical reviewer recognised that his death was not immediately predictable and that the staff on duty did their best in difficult circumstances. However, he also considered that it was possible that earlier medical intervention on the night of his death might have saved his life. There is an urgent need to improve emergency procedures at Whatton, a matter I have raised with the prison before.

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 **January 2015**

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SUMMARY

1. In April 2007, the man was sentenced to an indeterminate prison sentence, with a minimum term period to serve of four years. He was held first at HMP Exeter and transferred to HMP Whatton in August 2013.

2. The man had Type 2 diabetes, chronic obstructive pulmonary disease (COPD – lung disease) and spinal problems. He had a history of heart disease and took medication to control his blood pressure and cholesterol. He was significantly overweight and had previously been a heavy cigarette smoker.

3. Healthcare staff at Whatton saw the man frequently to review and manage his health conditions and he attended a number of hospital appointments. On 17 June 2014, he began a programme of diet and exercise to try to lose weight.

4. At the beginning of August, the man fell in the toilet area of his cell and officers helped him into a chair. Later that evening he needed the toilet but was unable to move due to back pain. Officers could not move him so instead gave him incontinence pants and a urine bottle. At about 10.30pm, he fell again while trying to stand up. The officers were unable to move him back to bed, so instead put a mattress on the floor of his cell and made a bed for him there.

5. At 11.19pm, the man's cellmate told the night patrol officer that he was having difficulty breathing and was unable to speak. The officer rang the night manager who advised him to monitor the situation and keep him informed. The night patrol officer went back to his cell, and noted that he was still on the floor. His cellmate said he thought that he was dead, but the officer said he could see chest movement. He left to update the night manager who asked the prison control room to contact the out of hours medical service.

6. The night manager arrived approximately 10 minutes later and he and another officer went into the man's cell. He did not appear to be breathing and they could not find a pulse. They used a defibrillator which found no shockable heart rhythm and so began cardiopulmonary resuscitation. At 11.53pm, the manager asked the control room to call an ambulance. The officers continued to try to resuscitate him until paramedics arrived at 12.17am. The paramedics confirmed his death at 12.39am.

7. We agree with the clinical reviewer that the care the man received at Whatton was equivalent to that he could have expected to receive in the community. However, we share his concern that staff should have sought medical advice and called an ambulance sooner on the night that he died. We make one recommendation.

THE INVESTIGATION PROCESS

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

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. Another investigator spoke to prison staff and the man's cell mate at Whatton on 7 August. The investigator visited Whatton on 9 September and interviewed five members of staff. He informed the prison of the preliminary findings of the investigation.

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

11. 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.

12. One of the Ombudsman's family liaison officers contacted Kent Adult Social Services who care for the man's partner, his nominated next of kin. He informed them of the investigation process. After discussion and advice from social services, we agreed not to contact the partner further.

13. The prison has 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

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

15. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week from 7.30am to 6.30pm Monday to Friday and 8.30am to 13.30pm at weekends, with other cover provided by an out of hours service. There are specialist clinics for older prisoners and those with chronic conditions. There are no inpatient beds.

HM Inspectorate of Prisons

16. 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 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

Independent Monitoring Board

17. 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 2014, the IMB reported favourably on healthcare services. The Board noted there were weekly dental, physiotherapy, optical and podiatry clinics, and the services of visiting GPs. An increase in staff meant a reduction in waiting times. The Board noted the high number of elderly prisoners at Whatton and that staff managed an increasing number of prisoners with limited mobility.

Previous deaths at HMP Whatton

18. The man's death was the ninth from natural causes at Whatton since January 2013. One person has died since. We have raised the issue of emergency response procedures before.

KEY EVENTS

19. On 16 April 2007, the man received an indeterminate sentence for public protection with a minimum term period to serve of four years before he cold be considered for release. He went initially to HMP Exeter and, on 7 August 2013, transferred to HMP Whatton.

20. At an initial health screen, the man told a nurse that doctors had diagnosed him with Type 2 diabetes seven years earlier. He also suffered from chronic obstructive pulmonary disease and a degenerative spinal condition that caused back pain and affected his mobility. The nurse noted he had a history of heart disease for which he took a number of risk reducing medications, although he had had no recent symptoms. These included aspirin, bisoprolol (for cardiovascular disease), rampiril (for high blood pressure) and simvastatin to lower his cholesterol. He was significantly overweight, and had previously been a heavy cigarette smoker. He used a walking stick. A prison GP examined him and confirmed his medications.

21. On 17 September, a prison GP examined the man, who had reported feeling exhausted. She gave him a vitamin (B12) injection and took a blood sample. Results showed slightly high blood glucose levels and slightly reduced renal function. She arranged urine protein testing to check his kidney function. The results were normal. He had regular blood tests and further vitamin injections during his time in prison.

22. On 14 October, a nurse reviewed the man's diabetes control, which she recorded as satisfactory. His blood pressure and cholesterol levels were within an acceptable range.

23. On 29 October, the man told a GP that he had woken up that morning with slurred speech, a tingling in his left arm and a weakness in his left leg. She examined him and suspected a stroke. She sent him to hospital where doctors discounted a stroke and diagnosed degeneration in the musculoskeletal system which had caused the sensation of tingling and weakness. (A later scan confirmed he had not had stroke.)

24. On 7 January 2014, the GP reviewed the man and his medications. She adjusted his diabetes medication and they discussed the management of his musculoskeletal problems. She referred him to a spinal surgeon.

25. On 30 January, the man told a nurse that he felt generally unwell and had passed out earlier that morning. He said that his blood sugar levels had been low but that he had eaten more to correct this. He was short of breath, but told her this was normal and improved when he used his inhaler. She told him to rest, continue to monitor his blood glucose levels and inform healthcare staff if his symptoms worsened. She arranged a GP appointment for 10 February. He did not attend this appointment. The records do not show why.

26. The man’s mobility continued to deteriorate and, on 14 March, a physiotherapist examined him and noted that he had difficulty bending and could not stand without support. She arranged a walking aid, a helping hand pick-up instrument and a stool to use in the shower. Later in the month, an occupational therapist gave him a four wheeled walker. She instructed him in its use and encouraged him gradually to increase his mobility.

27. On 25 March, the man attended an appointment at the spinal unit at hospital. A consultant noted he had multiple problems and general poor health. She arranged a whole spine MRI scan, which was booked for 2 July.

28. On 28 March, the man had blood on his sheets which he said came from a small tear in his swollen testicles. He declined treatment but on 31 March the condition worsened and a GP prescribed antibiotics. On 3 April, after reporting significant pain, he went to hospital, where a doctor diagnosed cellulitis (a bacterial infection) and prescribed further antibiotics.

29. A nurse saw the man on 16 June to review his COPD. She noted his weight had increased but his symptoms were otherwise unchanged. He appeared to be managing his condition well with the use of inhalers. She stressed the importance of exercise. The next day, he saw another nurse and agreed to take part in a weight management, diet and exercise course, which he began on 2 July.

30. Also on 2 July, the man attended hospital for an MRI scan. On 4 July, when he returned to the hospital, a doctor told him they needed to repeat the scan due to the poor quality of the original image and scheduled this for 14 August.

31. The physiotherapist saw the man on 17 July to review his mobility. Prison officers told her he rarely left his cell despite being advised to take more exercise. She encouraged him to take more exercise and offered to help him that day, but he said it was too hot.

32. On 27 July, the man complained to officers about his back pain and said he could not get out of bed. Nurses advised that he should take pain killers and attempt gradual movement. A nurse reviewed him the next day and noted his symptoms appeared worse. They discussed the possibility of acupuncture and attending a pain support group. She noted he was still waiting for an MRI scan and arranged to review him after the scan. He said he had fallen a number of times and spent most of his time in a wheelchair.

33. On 2 August, a nurse saw the man in his cell after he had fallen onto a chair and hurt his back. He told the nurse he felt dizzy and continued to complain of back pain. She advised him to contact healthcare staff if he had any further problems.

Events leading up to the incident

34. At 6.00pm an officer responded to a cell bell from the man's cell. He found him collapsed in the toilet area, wedged between the toilet and the wall. He radioed for help and a custodial manager and several other officers joined him. The man told them his legs had given way, causing him to fall. The officers managed to lift him and sit him in a chair. He told them he was not hurt.

35. Another custodial manager was the night orderly officer on 3 August (in charge of the prison overnight). He started work at approximately 8.30pm. The day custodial manager briefed him about the man's fall and that she had told him to contact healthcare staff in the morning.

36. At 9.11pm, an operational support grade (OSG), the night patrol officer on the man's wing, responded to a cell bell. The cellmate told him that the man needed to use the toilet, but could not get there himself as his legs would not hold his weight. The OSG called for help and, at about 9.20pm, the night orderly officer and an officer joined him. The man was lying on his bed and told the officers he needed help getting to the toilet. He said he could not move his legs without considerable pain and did not have enough energy.

37. The night orderly officer got the man a mobility aid but he could not get up from the bed. After discussion with him, the officers agreed it would be unsafe to try to lift him to the toilet. As an alternative, the orderly officer gave him incontinence pants and a urine bottle. The officers left him on his bed in a sitting position supported with pillows.

38. At 10.03pm, the OSG responded to another bell from the man's cell. The cellmate said the man had fallen out of bed. The OSG could see that he was on the floor. He contacted the night orderly officer, who arrived with an officer at 10.19pm. They went into the cell but concluded they were unable to lift him back into bed. Instead the officers put a mattress onto the floor together with pillows and bedding to provide a makeshift bed.

39. The man told the officers he was content with this arrangement and just wanted to rest. The night orderly officer asked his cellmate to alert staff if there were any further problems and asked the OSG to check him during his regular patrols. The orderly officer said the man was coherent and aware of his situation.

40. At 11.19pm, the man's cellmate rang the cell bell. The OSG attended and spoke to the man through the observation hatch. He was having difficulty breathing and the OSG found it difficult to understand him. With the help of his cellmate, he established that he needed his inhaler, and his cellmate gave this to him. The OSG said he stayed outside the cell and tried to reassure him.

41. At 11.30pm, the OSG left the cell and telephoned the night orderly officer. He told him the man was having difficulty breathing but had been given his

inhaler. He told him to monitor the situation with regular checks and keep him informed.

42. The OSG returned to the cell a few minutes later. He noted that the man was still on the floor and that his cellmate and was helping him with his inhaler by putting the inhaler into his hand. However, it fell out of his hand. His cellmate said his chest was not moving and he was just staring up at the ceiling. He said he could not find a pulse and told the OSG he thought he was dead. However, the OSG told the investigator that he saw his chest moving and that his cellmate had agreed with him.

43. At 11.40pm, the OSG telephoned and updated the night orderly officer. The orderly officer radioed the control room to call the out of hours doctor, and he and an officer went to the wing. Record show the control room contacted the out of hour duty doctor line at 11.46pm and at 11.48pm the reply went through directly to the OSG. He was on the line to the doctor when the orderly officer and officer arrived on the wing at 11.50pm.

44. The man was on his back and was not breathing. The night orderly officer could not find a pulse. He attached a defibrillator to the man's chest, which found no shockable rhythm and he and the officer began cardiopulmonary resuscitation. At 11.53pm, the orderly officer radioed the control room to call an emergency ambulance.

45. The first ambulance arrived at the prison at 12.07am followed by a second ten minutes later. There are five locked vehicle gates between the prison entrance and the man's wing and it took over 11 minutes to arrive at the cell. Paramedics took over emergency treatment, but at 12.39am they confirmed he had died.

Liaison with the man's family

46. The man's partner, his nominated next of kin, lived a considerable distance from the prison, a journey time of at least three hours. The on-call duty governor considered requesting the assistance of a nearby prison to deliver the news to his partner, but was concerned that night staffing levels would cause a delay and might make this impractical. Therefore, in consultation with police (it is usual for the police to attend following a death in prison custody) she asked the local police inform his partner of his death.

47. The prison appointed a family liaison officer after the man's death. He called the man's partner the next day and realised that she had significant learning difficulties. He then contacted her key social worker for advice about ongoing contact.

48. The family liaison officer maintained regular contact with the man's partner and social worker. On 13 August, he visited her with a senior manager to return the man's property. A social worker was also present. They discussed funeral arrangements and he explained the role of the Coroner and the

Ombudsman's investigation. The funeral was on 2 September. The prison arranged and paid for the funeral, in line with national guidance.

Support for prisoners and staff

49. The Governor issued a notice to prisoners and staff informing them of the man's death. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been adversely affected by his death. Staff offered the cellmate individual support and the services of a Listener (a prisoner trained by the Samaritans to support other prisoners).

50. A senior manager debriefed the prison staff involved in the emergency response and spoke to healthcare staff the next morning about what had happened. All staff were offered appropriate support.

Post-mortem report

51. A post-mortem report concluded that the man died of ischaemic heart disease and coronary artery atheroma (fatty deposits in the artery).

ISSUES

Clinical Care

52. We agree with the clinical reviewer that the clinical care the man received at Whatton was of a good standard and that his overall care was equivalent to that he might have expected to receive in the community. He concluded that healthcare staff at the prison managed his various health conditions well and he received appropriate treatment when needed.

53. While he was at Whatton, the man had chronic disease management checks and regular reviews of his lung disease and diabetes. He had received help in prison to stop smoking and had begun a weight management programme. When he showed possible signs of a stroke, the prison GP made appropriate and timely referrals to secondary care. Physiotherapy, podiatry and occupational therapy were available to him to assist him with his limited mobility.

54. The man fell several times in his cell during the evening leading up to his death. Officers found it difficult to lift him, who was very overweight, (and with his agreement) gave him incontinence aids rather than risk injury to him or themselves by trying to get him to the toilet. After he fell again and could not get to his bed, officers made a bed for him on the floor. They intended that healthcare staff would review him the next morning. We are satisfied that the staff acted pragmatically in a difficult situation.

55. However, the clinical reviewer considered that the man's shortness of breath later could have related to his acute cardiac condition rather than his chronic lung disease. He noted that untrained prison staff could not have been expected to be aware of this. However, he considered, and we agree, that the staff should have sought medical advice when he showed signs of breathing difficulties and especially when his cellmate thought that he had died.

Emergency Response

56. At 11.19pm the OSG responded when the man had difficulty breathing. He communicated through the cell observation hatch, but had difficulty understanding him. He established that he needed his inhaler and his cellmate gave it to him, but he does not appear to have been able to use it. The OSG did not go into the cell or radio an emergency medical code, even when his cellmate thought he had died.

57. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, notes that an "NHS Ambulance guide for use in the community states that an ambulance should be called when there are signs of chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking, fitting or concussion, severe allergic reactions or a suspected

stroke. This must also be the case for prisoners". The instruction makes it clear that if there is any doubt about a situation it is better to act with caution and request an ambulance.

58. The OSG said he did not call an emergency code or go into the cell to check the man as he did not recognise that there was any immediate danger to his life. He was aware that he could go into the cell in an emergency but did not think this was one, even when his cellmate thought that he was dead. We are concerned that the OSG relied on his observations from outside the cell, rather than those of his cellmate who was alongside him. We understand that such judgements can be difficult, but we consider that he should have gone into the cell. At the very least, he or the night orderly officer should have called an emergency code at that stage.

59. After the OSG contacted the night orderly officer for the second time, the orderly officer radioed the control room and asked them to call the out of hours doctor for advice. After this, it took a few minutes for him to reach the cell, realise the seriousness of the situation and ask for an ambulance. The control room called an ambulance at 11.53pm. This was over half an hour after the man's cellmate first reported he was having difficulty breathing and approximately fifteen minutes after his cellmate thought that he might have died.

60. PSI 3/2013 requires Governors to have a medical emergency response code protocol which states how staff communicate the nature of a medical emergency and that the control room calls an ambulance immediately a code is used. It requires no "unnecessary delay in escorting ambulances and paramedics to the patient or discharging them from the prison, including during the night state".

61. HMP Whatton has a local medical emergency protocol dated 2010 and this is supported by a Governor's Notice dated 2012. Both pre-date PSI 03/2013. There is a separate instruction for managing the entry and exit of vehicles, including ambulances dated 2011. None of these documents reflect the requirements of PSI 03/2013.

62. The first ambulance arrived at the prison at 12.07am followed by a second one ten minutes later. An officer escorted the ambulance from the gate to the wing, unlocking and relocking each of five gates on the way. This took 11 minutes. We consider that this is too long and not within the expectation of the PSI which says that access to the prison and the individual prisoner should not be delayed. Whatton's local instruction about the entry and exit of vehicles, including emergency vehicles, does not specify any particular procedures for emergency access. In an emergency, other prisons make sure that internal gates are opened in advance to allow ambulance quick access to wings.

63. We consider that staff missed several opportunities to obtain medical help for the man. They did not assess him sufficiently thoroughly, did not use an emergency code to call an ambulance immediately, and did not contact the

out of hours service at an early enough stage. There was also a delay in getting the ambulance to his wing.

64. The prison needs to ensure that all staff understand the importance of a swift emergency response whenever there are serious concerns about the health of a prisoner. We cannot know whether earlier intervention would have changed the outcome for the man but the clinical reviewer does not discount this possibility. We make the following recommendation:

The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which gives staff guidance about when and how use an emergency code; when to enter a cell; and which ensures there are no delays in calling an ambulance and in ambulance staff getting to the individual prisoner.

RECOMMENDATION

The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which gives staff guidance about when and how use an emergency code; when to enter a cell; and which ensures there are no delays in calling an ambulance and in ambulance staff getting to the individual prisoner.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that all prison staff are aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and that Whatton has a Medical Emergency Response Code protocol which gives staff guidance about when and how use an emergency code; when to enter a cell; and which ensures there are no delays in calling an ambulance and in ambulance staff getting to the individual prisoner.	Accepted	A Notice to Staff (NTS) has been issued to remind staff of code red and code blue response codes in line with PSI 03/2013 and to ensure there are no delays in calling an ambulance. A NTS has also been issued to remind operational staff of their responsibility when to enter a cell and to ensure there are no delays in calling an ambulance. The staff group that manage night orderly officers have been instructed to ensure the two NTS are included with night Instructions and referred to by staff on nights regularly. Night orderly officers have been advised that where possible they must ensure there are no delays in getting ambulance staff to the individual prisoner. Night instructions will be adjusted to take account of this and the level of resource and security implications considered and balanced correctly to ensure this can be facilitated.	Completed Completed Completed 28 February 2015 Head of Operations