

**Investigation into the death of a man  
whilst in the custody of HMP Whatton  
in June 2011**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**March 2012**

This is the report of an investigation into the death of a prisoner at HMP Whatton. The man died, having collapsed in his cell. The cause of his death was found to be due to natural causes from bronchopneumonia, chronic obstructive lung disease (COPD) and hypertrophy of the left ventricle.

The man had lost contact with his family many years ago. However I offer my condolences to anyone affected by his death.

The investigation was led by my one of my investigators. I am grateful to NHS Nottinghamshire County for the appointment of the clinical reviewer and to the Governor and staff of HMP Whatton for their co-operation.

The review of the man's clinical care shows that he received good quality care whilst in Whatton. The man had serious health problems, with a history of chronic obstructive pulmonary disease (COPD) and high blood pressure. Both these conditions were well managed at Whatton, with appropriate investigations and treatment. This included excellent smoking cessation advice.

However, it is of concern that the investigation identifies a number of areas where the actions of discipline staff in response to the man's ill health were not of the expected standard. While there is no evidence that these weaknesses made a material difference to saving his life, the report makes four recommendations to ensure improvements in future. These relate to the use of medical emergency codes, accessing out of hour's medical services and documenting interactions with prisoners.

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.

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**Prisons and Probation Ombudsman**

**March 2012**

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## SUMMARY

1. At the time of his death, the man was serving a life sentence at HMP Whatton.
2. When he first arrived at Whatton on 19 May 2008, he was suffering from a long standing lung condition and high blood pressure. Healthcare staff confirmed with an outside hospital that he was not suffering from tuberculosis. A diagnosis of pulmonary sarcoidosis <sup>1</sup>was confirmed. However, no further treatment was required.
3. Whilst at Whatton, he was encouraged to accept smoking cessation advice and support and to participate in the 'New Leaf' programme<sup>2</sup>. However, the man's attempts to stop smoking were unsuccessful. He was also prescribed appropriate medication, which included steroid treatment <sup>3</sup>and inhalers.
4. On 18 June, he approached a member of wing staff on two occasions to express concern about his health. Despite asking to see healthcare on the second occasion, staff did not seek further assistance from the out of hour's medical service. His interaction with the member of wing staff was also not documented in his prison file.
5. The following morning, he was found to be unresponsive in his cell by a prison officer. The officer did not make a 'code blue' call over his radio because the man appeared to be breathing. Having contacted the control room to request the attendance of healthcare, a 'code blue' call was made.
6. Healthcare staff responded to the call for assistance and, working with prison staff, attempted to resuscitate the man. A defibrillator<sup>4</sup> was also attached but healthcare staff were unable to find a shockable rhythm. Paramedics arrived at the prison quickly and carried out their own

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<sup>1</sup> Pulmonary sarcoidosis is a rare disease that results from inflammation. Ninety percent of the cases of sarcoidosis are found in the lungs, but it can occur in almost any organ.

<sup>2</sup> New Leaf is the local stop smoking service for Nottinghamshire County Teaching PCT. The free service offers advice and support for smokers who want to quit.

<sup>3</sup> Corticosteroid drugs, called "steroids" for short, are potent chemical substances which can reduce swelling and inflammation quickly. These drugs are closely related to cortisol, a hormone produced on the cortex of the adrenal glands.

<sup>4</sup> A defibrillator is a machine used to shock the patient's heart and restore the heart's normal rhythmic patterns. It cannot however, restart the heart if a detectable rhythm cannot be found.

advanced life support procedures. After finding no signs of life the paramedics pronounced him dead.

7. This investigation has found that the man received a good standard of health care at Whatton. However, it includes four recommendations on areas of practice in need of improvement. These recommendations relate to the need for staff to follow local procedures and to ensure that they document key information in a prisoner's core record.

## THE INVESTIGATION PROCESS

8. The investigation into the man's death was opened on 23 June 2011, when the investigator visited Whatton. She was met by the liaison officer and reviewed the man's prison files. The investigator was provided with copies of documents she requested from those files. She also spoke to the Governor A regarding her role as the Prison's Family Liaison officer (FLO). The Governor also accompanied her to the man's cell. The investigator returned to Whatton on 15 July and interviewed three members of staff.
9. Notices and terms of reference for the investigation were sent to Whatton in advance of the investigator's visit. She met with a member of the Independent Monitoring Board (IMB)<sup>5</sup> and the Prison Officers Association (POA).<sup>6</sup> At the time of circulating this report there have been no responses to those notices.
10. Her Majesty's Coroner for Nottinghamshire held a post mortem examination. The man's death was recorded as due to natural causes from bronchopneumonia, chronic obstructive lung disease (COPD) and hypertrophy of the left ventricle. A review of his clinical care was commissioned by NHS Nottinghamshire County and carried out by the clinical reviewer. The clinical review is the first annex to this investigation report.
11. The man had not been in contact with his family since the early 1980s. Following his death, the Governor sought to establish his next of kin by examining his prison record. However, she was unable to find any information relating to either a friend or relative.
12. During the investigation, the investigator interviewed three members of prison staff. The clinical reviewer did not consider it necessary to interview any healthcare staff.
13. On 13 September, the investigator wrote a feedback letter to the Governor of Whatton to inform her that her initial enquiries had identified one area of concern.
14. The draft report was advance disclosed to the Prison Service due to criticism of a specific member of staff. A response was received, and has been included in the body of the report at the relevant sections.
15. The National Offender Management Service responded to the draft report. They identified no factual inaccuracies and we include their response to the recommendations at the end of the report.

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<sup>5</sup>The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners.

<sup>6</sup> The POA is the trade union for prison officers.

## The Man

16. The man was born in the Manchester area. He had not had any contact with his family since the early 1980s. Prior to coming into custody he had two long term relationships.
17. The man was initially located at HMP Manchester before being moved to HMP Wymott in May 2007. He was moved to HMP Whatton in November 2008 to allow him to continue to address his offending behaviour. During his time in prison he completed various offending behaviour programmes. He also gained various educational qualifications in numeracy and literacy. The man had achieved enhanced status under the Prison Service's incentives and earned privileges scheme (IEPS).<sup>7</sup>

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<sup>7</sup> The IEP scheme operates on three privilege levels: basic, standard and enhanced. The purpose of the scheme is to ensure that privileges above the minimum are earned by prisoners through good behaviour and are removed if they fail to maintain acceptable standards.

## HMP WHATTON

18. HMP Whatton is a specialist prison for adult male sex offenders to enable them to participate in sex offender treatment programmes to address their offending behaviour. It has increased its capacity by 500 over the last four years. All applicants for a place at Whatton must be adult males, category C and with a history of sexual offending.<sup>8</sup> Additionally, because of the extent of the healthcare provision, which is described below, they must not require the services of a full-time medical officer. The average age of the prisoners at Whatton is higher than elsewhere in the prison system.
19. Whatton prison is located on a large site and therefore it takes a considerable amount of time to move between the prison wings. The regime includes education, vocational training, industrial workshops and manufacturing, farms and gardening. A large range of offending behaviour programmes are available.
20. Whatton can accommodate older prisoners and those with chronic diseases and has considerable experience of working with this specific prisoner population. However, the prison does not have a 24 hour healthcare service. NHS Nottinghamshire County is responsible for healthcare provision within the prison. The healthcare centre is open daily, with healthcare staff on duty between 7.30am and 6.00pm. At weekends there is minimal staff cover in the mornings only. Outside of these hours, Nottinghamshire Emergency Medical Services (NEMS) are contacted when required.
21. The healthcare department at Whatton runs a walk-in centre and a nurse-led GP practice. It offers nurse-led triage clinics<sup>9</sup>, blood clinics, specialist clinics and follow up clinics. After an initial consultation, the nurse refers patients to the doctor or arranges appropriate prescriptions to be administered. Nurses take the lead in treating prisoners with different diseases, and they have various internal clinical specialists, including a palliative care nurse, to care for terminally ill patients. Occasionally, external specialist nurses come in. They include diabetic, chronic obstructive pulmonary disease (COPD) and tuberculosis (TB) nurses.
22. The prison manages prisoners suffering from complex physical conditions through their specialist clinics. The clinics continue to provide the relevant healthcare to manage and monitor a prisoner's health.
23. The then HM Chief Inspector of Prisons made an unannounced inspection of Whatton in 2010. An extract from that report said:

“There had been improvements in health services. The environment was spacious, clean and staffed by a dedicated team with the necessary skills mix. Access to the services was

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<sup>8</sup> Category C prisoners are assessed as being of medium risk of escape.

<sup>9</sup> Triage clinics assess patient's symptoms to find out if their medical condition can be treated by a nurse or a doctor

good, as was GP support. There had been an appropriate focus on older prisoners and their needs.”

24. The most recent annual report published by the IMB covers the period from June 2009 to May 2010. The IMB drew attention to Whatton being of one of the few prisons where the average age of a prisoner was in the mid forties. The IMB said:

“As previously reported in Annual Reports, the Board continues to be extremely impressed by the overall proactive management of all aspects of healthcare, with the service provided being regarded by many as a ‘place of excellence’. The HMIP report on healthcare stated that much of the healthcare provision was classed as excellent, with the ‘end of life’ care provided by both prison officers and the healthcare team being described as of a very high quality by the Nottinghamshire Coroner. Whatton has one of the highest rates of death by natural causes within the prison system. Whilst this is to be expected with a significant number of prisoners over 65 years of age, nevertheless prison staff on wing A8 are to be commended for the great care and wellbeing offered to those in their care at the end of life.”

25. Since 2008, there have been thirteen deaths due to natural causes at Whatton, including the man. In one of the most recent death in custody investigations, the professional team work of healthcare and prison staff in their attempts to save the prisoner’s life, was acknowledged.

## KEY FINDINGS

26. The man was born and lived in the Manchester area. The man was convicted of a number of serious offences and sentenced to a life term, with a minimum tariff of four years and three months<sup>10</sup>. This expired on 3 January 2008. The man had a significant record of previous convictions for other serious offences and this was fifth custodial sentence.
27. Following sentencing, he was located at HMP Manchester. He participated in a number of programmes to address his offending behaviour, following which it was recommended that he needed to be moved to a prison the offered offending behaviour treatment which suited his learning style. He also attained some educational qualifications in both literacy and numeracy.
28. The man was moved to HMP Wymott on 11 May 2007. Following the expiration of his tariff, the Parole Board<sup>11</sup> considered the man's case for release or a move to open conditions. The panel concluded that he should remain in closed conditions to further address his areas of risk through further offending behaviour work.
29. On 19 November 2008, he was moved to HMP Whatton. A first reception health screen document was completed by Nurse A to record his medical history. Nurse A recommended that the man should live in a single cell until his health had been reviewed by a doctor. She also contacted Lancashire Teaching Hospital for further information regarding the man's medical history of possible tuberculosis (TB). A consultant in respiratory medicine hospital replied on the same day and confirmed that there was no evidence of chest malignancy or TB from his most recent CT scan and biopsies. The man was diagnosed with pulmonary sarcoidosis. However, the consultant said he did not require any treatment for this condition.
30. During a review with Prison Doctor A on 25 November, it was noted that the man had a history of chronic obstructive pulmonary disorder (COPD)<sup>12</sup> and hypertension<sup>13</sup>. A chest x-ray had revealed an extensive mass on his right lung in the upper lobe area. The doctor made a referral to a chest physician at the Queen's Medical Centre in Nottingham for further investigation into the man's lung condition.

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<sup>10</sup> In sentencing the courts will impose a minimum term (tariff) that the prisoner must serve before they can be considered for release by the Parole Board.

<sup>11</sup> The Parole Board is an independent body that works within the criminal justice system to protect the public by risk assessing prisoners to decide whether they can be safely released into the community.

<sup>12</sup> COPD stands for chronic obstructive pulmonary disease. This is a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.

<sup>13</sup> Hypertension is more commonly known as high blood pressure. It is a cardiac chronic medical condition in which the arterial blood pressure is elevated. This means that that the heart is having to work harder than it should to pump the blood around the body.

31. Nurse B reviewed the man's health needs on 9 December. He was identified as needing a vaccination course for hepatitis B and tested negative for both HIV and TB.
32. On 22 January 2009, the man presented with a chest infection. He was given smoking cessation advice and placed on the waiting list for the 'New Leaf' programme. The man's risk of being diagnosed with heart disease over a ten year period was assessed using the information obtained during the Framingham Heart Study.<sup>14</sup> His risk was recorded as 38 per cent. This showed he was at a high risk of developing cardio-vascular diseases.
33. During a review of his medication on 13 February, the man said since he had started taking statins<sup>15</sup> he had been experiencing pins and needles in his hands. He expressed concern about continuing with the medication which was subsequently stopped. A month later, he agreed to try a lower dose of medication to assist with the prevention of primary heart disease.
34. On 15 April, he man was seen by a consultant in respiratory medicine at the Queen's Medical Centre. The consultant concluded that he should undergo further imaging investigations of the upper lobe mass in his right lung. This took place on 20 July. No changes to his condition were identified.
35. Throughout April and May the man continued to receive smoking cessation advice. Despite initially telling healthcare staff that he was willing to participate in the 'New Leaf' programme, he continued to smoke regularly.
36. Nurse A undertook a review of the man's respiratory disease on 30 September. She noted that despite being fully aware of the risks to his health, he continued to smoke. Nurse A recorded that a wheeze could be heard on the right side of his chest. During an appointment with the prison doctor on 1 October, he was prescribed anti-biotics for increasing tightness in his chest. The doctor noted that the man was still 'smoking like a chimney'. The man was offered further support to help him stop smoking. He was encouraged to try alternative medication after his previous attempts had failed.
37. On 19 January 2010, Nurse C noted that the man had applied to undertake the 'New Leaf' programme for the fourth time. The man said he struggled to walk distances over 100 metres and was experiencing difficulty in eating large meals. An exercise tolerance test took place on 26 March.

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<sup>14</sup> The Framingham Heart Study has contributed importantly to understanding of the causes of coronary heart disease (CHD), stroke, and other cardiovascular diseases. Framingham research has helped define the quantitative and additive nature of these causes or, as they are now called, "cardiovascular risk factors."

<sup>15</sup> Statins are drugs which lower the level of cholesterol in the blood. They are also prescribed to patients who are at a high risk of developing cardiovascular disease.

38. A consultant physician at the Queen's Medical Centre saw the man on 1 February. Whilst he would be considered a candidate for lung volume reduction surgery or a lung transplant, none of these options were considered sensible at that time. A chest x-ray confirmed bullous disease<sup>16</sup> in the upper lobes of his lungs with no change in the scarring and bronchiectasis<sup>17</sup> on his right lung.
39. An entry in the man's medical records on 7 April notes that he had successfully stopped smoking. He continued to be monitored by healthcare staff and was regularly offered smoking cessation support over the next few months.
40. On 26 April, the man told Prison Doctor B that he had suffered an assault on his nose when he was in his 40s. He asked for a referral to the Ears, Nose and Throat (ENT) clinic to help improve his breathing. On 4 June, he told the doctor that he was keen to discuss with the ENT clinic if an operation would be helpful. At this point the doctor made a referral to the ENT clinic.
41. The man was seen by an ENT consultant on 16 August. He was listed for an operation to alleviate his symptoms of nasal obstruction.
42. During an appointment with the respiratory medicine team at the Queen's Medical Centre on 3 August, the results of the man's previous lung function tests were noted. His lung function was found to be only 31 per cent of that predicted for a man of his age. He was referred for a CT scan which took place on 3 September.
43. On 17 August, he was prescribed steroids for wheezing and a productive cough. A month later healthcare staff noted that he was on week five of the 'New Leaf' programme and continued to refrain from smoking. However, on 14 October, an entry in his medical record showed that he had started smoking again. Over the following months healthcare staff continued to offer smoking cessation advice in the hope that he would stop smoking once again.
44. The man was discharged from the respiratory team at the Queen's Medical Centre on 13 December because the results of the CT scan had shown there had been no further changes in the mass on his right upper lung lobe.
45. On 17 February, the man was seen at hospital for an operation on his nose. However, the anaesthetist decided that he was not suitable for

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<sup>16</sup> Bullous Lung Disease is the most common form of emphysema, a long-term, progressive disease of the lungs that primarily causes shortness of breath. It is a disease that is characterized by abnormal and enlarged air spaces within the lungs, along with the deterioration of alveolar tissue, which is basically lung tissue that makes up the walls between air sacs. The disease is located in the upper part of the lungs.

<sup>17</sup> Bronchiectasis is a lung disorder characterised by the irreversible damage of large airways called the bronchi resulting in their loss of elasticity and abnormal widening.

surgery because he was still smoking and showing signs of a wheeze and shortness of breath. The man was prescribed steroids and told that the operation would be re-scheduled.

46. The man's chronic health problems were considered severe enough for the doctor to medically retire him from his job in the prison workshops on 22 February. He started a smoking cessation course again on 22 March. The man was returned to hospital for the operation on his nose on 6 April. Once again the operation was cancelled due to his poor health. An entry in his medical record shows that the man was keen to have the operation but accepted that it was unlikely to go ahead because of his COPD.
47. Despite continuing to receive smoking cessation support, on 19 April The man walked out of the session and told healthcare staff he would not be attending again.
48. On 14 June, whilst walking to education the man experienced a shortness of breath. He was reviewed by Nurse C who noted that he continued to smoke excessively. The oxygen levels in his lungs were reported as being only 89 per cent and there was no improvement following the administration of salbutamol.<sup>18</sup> Following a discussion with Prison Doctor A, a further course of steroids were prescribed.

## **18 June 2011**

49. As part of the investigation, the Investigator interviewed Officer A. During his interview the officer told the Investigator that on the morning the day before the man's death, he had made a routine visit to his cell. The man said he was not feeling too good, in particular he was light headed and off his food.
50. The man told the officer that he was using a new spray which helped to 'open up his lungs'. The officer told the Investigator he had looked at the man's in-possession medication, in particular whether there were any side effects. The man told him he did not wish to attend healthcare but was aware that he should contact the officer if this changed.
51. At approximately 3pm, the man approached the officer and said he was still feeling unwell. He asked the officer to contact healthcare in order that they could visit him to check that everything was alright. Having made enquiries with the control room, the officer established that Healthcare had already left the prison for the day. The man said he did not want the officer to take any further action and was aware that he should speak to wing staff or press his cell bell if he felt unwell.

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<sup>18</sup> Salbutamol works on the receptors in the lungs and is used for the relief of bronchospasm in conditions such as asthma and chronic obstructive pulmonary disease. It is marketed as Ventolin among other brand names.

52. In response to the advance disclosure of the draft report Officer A said that he explained to the man about the services offered by NEMS and that they were available throughout the night. However, during his earlier interview with the investigator, the officer was asked about the other options available when healthcare are unavailable. The officer said that he had advised the man to use his cell bell to gain the attention of staff.
53. The officer told the Investigator that, when he was arriving for work on 19 June, he spoke to Nurse D from healthcare about the concerns the man had about his medication. The nurse said she would visit the man. Officer A said he did not make any written record of his conversations with the man or the nurse despite having access to P-NOMIS<sup>19</sup> and a wing observation book. In addition, he could not recall if he had informed wing staff about the man's concerns.
54. The Investigator sought further information from the healthcare practice manager. He explained that during the weekends healthcare staff are available between the hours of 8.30am and 12.30pm. Outside of these hours, medical advice is provided by Nottingham Emergency Medical Services (NEMS)<sup>20</sup> out of hours care. He said that prison staff should be aware of the availability of this service. and should access the service by contacting the control room.

### **The day the man died**

55. At 7.30am on the day the man died, he man was checked by Officer B as part of the morning roll check procedures. During an interview with the Investigator, the officer said she had opened the flap in the man's cell door. Having said good morning to him she observed him move his left foot. The officer noted that that the television in the man's cell was on. She explained that prisoners were expected to give a physical response to staff during morning. During the weekend a more relaxed approach was taken and prisoners were unlocked at 8.15am.
56. The man's cell door was unlocked by Officer C at approximately 8.30am. In a statement provided following the man's death, the officer said he opened the cell door slightly but did not look inside before walking away. The officer was also interviewed by the Investigator. He explained that because it was a weekend prisoners were not required to be up and dressed. The officer said it was not unusual for prisoners not to respond to wing staff or to come out of their cells.
57. When Officer A arrived at the man's cell at approximately 8.30am he saw that he was lying on his bed. He attempted to get a response by raising his voice. The officer observed that there was some movement in the

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<sup>19</sup> P-NOMIS is an electronic database which s being introduced to support the management of offenders by having one custodial record for life. It will enable standardisation and increased efficiency of prison procedures and assists in the safe and effective management of offenders through their time in custody.

<sup>20</sup> NEMS provides prison staff with medical advice and assistance in cases where urgent medical advice is required.

man's chest area but he was unable to get any response. For this reason he went to the wing office and telephoned the control room to request that healthcare attend the wing. The officer said he did not make a 'code blue'<sup>21</sup> call on his radio because there were observations of life. Having returned to the man's cell, the officer continued to try and wake him but was unsuccessful.

58. In response to the advance disclosure of the draft report Officer A wrote that he told the control room that healthcare were required immediately. He noted he was asked to confirm if he meant a 'code blue', to which he replied 'yes'. During his earlier interview with the investigator the officer said that he had not made a 'code blue' call when he found the man collapsed in his cell because he had observed signs of life, in particular that his chest was moving.
59. The control room log shows that a code blue call was made by control room staff to healthcare at 8.35am. An ambulance was also called. Nurse D and Nurse B arrived at the man's cell five minutes later where they found the SO, Officer D and Officer A carrying out cardio pulmonary resuscitation (CPR). The man was moved from his bed to the floor and Nurse D and Nurse B continued with CPR. Defibrillator pads were positioned on the man's chest but the machine was unable to detect a shockable rhythm.
60. Ambulance service staff arrived at the man's cell at approximately 9.06am. The paramedics carried out their own advanced life support checks. The man was pronounced dead at 9.10am.

### **Following the man's death**

61. Following the man's death, a hot debrief<sup>22</sup> was held by Governor B, the Safer Custody Manager, which was attended by uniformed and healthcare staff. Staff were offered access to the prison's staff care and welfare team.
62. A notice to prisoners was issued on 20 June to inform prisoners about the man's death. Prisoners were reminded that support was available from prison Listeners,<sup>23</sup> the Chaplaincy team and the Samaritans<sup>24</sup>. A memorial service was held in the prison chapel on 29 June.

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<sup>21</sup> A 'code blue' is called when there is a medical emergency. This indicates to staff that the patient is experiencing breathing or respiratory difficulties.

<sup>22</sup> A hot debrief should be held as soon as possible after the incident. The purpose of the hot debrief is to allow those involved to discuss any issues or concerns. The hot debrief should focus on reassurance, information sharing and how staff can support each other.

<sup>23</sup> The Listener Support Scheme is a peer support scheme where selected prisoners are trained to listen in confidence to prisoners who may be experiencing feelings of distress, including those which may lead to self harm or suicide.

<sup>24</sup> The Samaritans provide confidential emotional support on a 24 hour basis and are most commonly contacted via the telephone.

63. Her Majesty's Coroner for Nottinghamshire held a post mortem examination. The man's death was recorded as due to natural causes from bronchopneumonia, chronic obstructive lung disease (COPD) and hypertrophy of the left ventricle.
64. Governor A was appointed as the prison's family liaison officer (FLO) but was unable to establish a next of kin for the man. The Governor examined the man's core prison record and contacted his Probation Officer. The man had not been in contact with his family since the early 1980s.
65. Governor B told the Investigator that it was not unusual for prisoners at Whatton to lose contact with their families. Due to the nature of their offences, prisoners often maintained little contact with the outside world. The Governor said the Coroner was satisfied that a next of kin could not be found and was content for his funeral to take place.
66. The man's funeral took place on 21 July. The Prison Chaplain conducted the funeral service and the prison paid the full cost of the funeral in accordance with the guidance given in Prison Service Order 2510, Follow up to Deaths in Custody.

## ISSUES

### Clinical care

67. A clinical review was undertaken by the clinical reviewer on behalf of NHS Nottinghamshire County. The clinical reviewer concludes that the man readily accessed the healthcare department at Whatton. He notes that the man completed a patient involvement and feedback form which recorded his own opinion of the healthcare services provided as being, "...the best one I have been to in the six years I have been in". The clinical reviewer considers that the man's medical care was comparable to that expected in the community.
68. On arrival at Whatton, the man was known to suffer from COPD and hypertension (high blood pressure). His healthcare needs were appropriately assessed during his initial reception health screen. This included further investigation into his medical history with the Queen's Medical Centre.
69. The clinical reviewer has commented:
- "The man had chronic lung disease and his lung function was only 31 per cent of what it should have been for his age. He also had a mass in the upper lobe of his ring lung and although this was not TB or cancer (and later diagnosed as sarcoidosis), this required extensive investigations, including CT scans, PET scans<sup>25</sup>, bronchoscopy<sup>26</sup>, mediastinoscopy<sup>27</sup> and on-going surveillance between 2007 and 2010 when he was discharged from further follow-up."
70. Throughout his time at Whatton, the man was offered continuous support to help him stop smoking. He was encouraged to participate in the 'New Leaf' smoking cessation programme and, despite some initial success, he remained a heavy smoker to the day he died.
71. On 14 June, the man complained of experiencing a shortness of breath and was prescribed a course of steroid treatment. The clinical reviewer has commented that, considering the post mortem report confirmed that the man died from bronchopneumonia, a prescription of antibiotics may have had some positive effect. He writes:

"However, this has to be seen in the context of a man with chronic lung disease whose 5 year life expectancy with uncorrected chronic

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<sup>25</sup> PET scanning is most commonly used in the diagnosis and assessment of cancer.

<sup>26</sup> A bronchoscopy is a procedure which can help to diagnose some conditions of the airways (bronchi) and lungs.

<sup>27</sup> A mediastinoscopy is a surgical procedure to examine the inside of the upper chest between and in front of the lungs.

hypoxia<sup>28</sup> and impaired heart function (as confirmed by the post mortem) was less than 50%”

72. The clinical reviewer considers that the man’s premature death, although unexpected, was entirely understandable given his poor physical health. The Ombudsman shares his view.

### **Response following the man’s collapse**

73. Following the discovery of the man in his cell, Officer A asked the control room over the telephone to request the attendance of healthcare staff. He told the investigator that he did not make a ‘code blue’ call on his radio because he could still see signs of life, despite being unable to get a physical response to his attempts to rouse the man. Although the officer responded to the advance disclosure of the draft report to say that he had said healthcare staff were required immediately, it is apparent that he did not use his radio to raise the alarm which would have been quicker.
74. The purpose of a ‘code blue’ call is to indicate to both prison and healthcare staff that a prisoner is experiencing difficulties in breathing. The use of emergency codes is intended to convey essential information quickly with the aim of reducing the possibility of misunderstandings amongst staff. In the circumstances, having discovered the man unresponsive in his cell, Officer A should have made a ‘code blue’ call. However, it is noted that the control room appropriately interpreted the information provided by the officer and did in fact make a ‘code blue’ call to healthcare staff.

### **The Governor should ensure that all staff are aware of the importance of using the appropriate emergency codes.**

75. The response of prison and healthcare staff once they arrived at the man’s cell was co-ordinated and efficient. The clinical reviewer has commented that Nurse D and Nurse B correctly assessed the man’s condition and commenced CPR. This was followed by the use of the appropriate medical equipment. On arrival at the prison the paramedics were quickly taken to the man’s cell where they were able to commence their advanced life support procedures.

### **Other issues relating to the investigation**

76. At approximately 8.30am on the morning the man died Officer D unlocked the man’s cell but did not look inside. Whatton’s operational instructions for night staff say.... “The relief morning staff will be required to gain a physical or verbal response from each individual prisoner.” The purpose of this is both to check on the welfare of the prisoner and to protect the member of staff. We therefore make the following recommendation:

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<sup>28</sup> Hypoxia is a condition in which the body as a whole (generalized hypoxia) or a region of the body (tissue hypoxia) is deprived of an adequate oxygen supply.

**The Governor should ensure that all staff are aware of the correct procedure to be followed when a prisoner's cell is un-locked.**

77. The man spoke to Officer A on the morning before he died and told him that he was feeling unwell. However, he did not wish to be seen by healthcare staff. During the afternoon, the man approached Officer A again and said he was still feeling unwell. He asked if a member of healthcare could come and see him. The officer contacted the control room who told him that healthcare had already left the prison.
78. At weekends an out of hour's medical advice service is provided by NEMS. After Officer A had spoken to the control room he should have sought further medical advice from this service. This would have provided access to a nurse or other medical professional who would have been able to consider the man's symptoms and concerns. The officer, in response to the advance disclosure of the draft report, said that he had told the man about the service offered by NEMS. Although it is impossible to ascertain now whether this happened, his statements during interview regarding the use of the cell bell suggest that staff would benefit from a greater understanding of the facilities available.

**The Head of Healthcare should ensure that prison staff are aware of the services provided by NEMS and how they can be contacted when healthcare staff are unavailable.**

79. Having spoken to the man on two occasions, it is concerning that Officer A did not document the conversations on either P-NOMIS or the wing observation book. This meant there was no record in the man's core prison record that he had expressed concern about his health. In addition, Officer A did not make a record that he had asked Nurse D to visit the man in his cell. The following is therefore recommended:

**The Governor should ensure that wing staff are aware of the importance of documenting interactions with prisoners, in particular in circumstances when it concerns a prisoner's medical condition. Information of this nature should also be communicated to healthcare staff.**

## **CONCLUSION**

80. The man was a man in poor physical health who was suffering from a serious respiratory condition. Despite being offered continuous support from healthcare staff regarding smoking cessation he continued to be a heavy smoker until the day he died.
81. The clinical reviewer has found that the man was able to effectively access the healthcare services provided by Whatton and received a standard of care that was comparable to a patient treated in the community.
82. Following his collapse the man was treated appropriately and efficiently by healthcare staff. However, there are a number of areas where the actions of members of discipline staff were not of the expected standard. While there is no evidence that these weaknesses made a material difference to saving the man's life, the report includes four recommendations to improve staff responses in future.

## RECOMMENDATIONS

1. The Governor should ensure that all staff are aware of the importance of using the appropriate emergency codes.

The National Offender Management Service accepted this recommendation:

“A Notice to Staff has been published reminding all staff of our current Code Red/Code Blue system along with instructions of when to use it. (NTS 075 – 2012).”

2. The Governor should ensure that all staff are aware of correct procedure to be followed when a prisoner’s cell is un-locked.

The National Offender Management Service accepted this recommendation:

“A Notice to Staff has been published that reflects our policy for Accounting and Supervision of Prisoners (NTS 076 – 2012).”

3. The Head of Healthcare should ensure that prison staff are aware of the services provided by NEMS and how they can be contacted when healthcare staff are unavailable.

The National Offender Management Service accepted this recommendation:

“We have a direct speed dial to NEMS and staff in the Control Room are aware of how and when to access their services. A Notice to Staff has been published to remind all staff of the NEMS facility (NTS 079 – 2012).”

4. The Governor should ensure that wing staff are aware of the importance of documenting interactions with prisoners, in particular in circumstances when it concerns a prisoner’s medical condition. Information of this nature should also be communicated to healthcare staff.

The National Offender Management Service accepted this recommendation:

“A Notice to Staff has been published which highlights staff responsibility in regard to documenting their concerns about a prisoner’s medical condition. It outlines how to record and report their concern as well as the Managers’ follow-up check to ensure this has been dealt with and actioned appropriately (NTS 077 – 2012).”