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 January 2015 while a prisoner at HMP Whatton

Our Vision

To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision.

This is the investigation report into the death of a man who died in January 2015, while a prisoner at HMP Whatton. The man died of viral pneumonia, cardiac arrest and heart disease, with underlying chronic obstructive pulmonary disease. He was 62 years old. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. A clinical reviewer reviewed the clinical care the man received at Whatton. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in May 1997 and had been at Whatton since 2011. The man had complained of chest pains since 2007, but investigations had shown that these were not caused by cardiac problems. In 2011, doctors concluded that gastric issues were causing the pain. The man continued to complain of chest pain during his time at Whatton but again investigations did not confirm the pain was cardiac related. He took medication for high blood pressure and to help reduce his cholesterol levels.

On 16 January 2015, a GP prescribed the man medication for a chest infection. On the evening of 21 January, the man was struggling to breathe and his cellmate alerted staff. A night patrol officer did not call an emergency code, but asked a manager to attend. The manager established from the man's records that he had heart problems and other health conditions and went to the cell. After assessing the man, he asked for an ambulance, which was called 15 minutes after the man's cellmate had first raised the alarm. Paramedics arrived and took the man to hospital. In the afternoon of 22 January, the man had a cardiac arrest. Doctors placed the man on life support. On 24 January, after discussions with his family, doctors withdrew the life support and the man died.

I agree with the clinical reviewer that the man's healthcare in prison was equivalent to that he could have expected to receive in the community. However, I consider that the night officer who found the man with breathing difficulties should have followed national emergency procedures and called an emergency code without waiting for the night manager to attend. This should have resulted in an ambulance being called immediately. While it does not appear that this affected the outcome for the man, the investigation found that night staff at Whatton routinely do not follow these mandatory emergency procedures, which the Governor needs to rectify.

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 **August 2015**

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SUMMARY

1. In May 1997, the man was sentenced to life imprisonment. He began experiencing chest pain in 2007 and investigations showed this was not cardiac in nature. In November 2011, specialists concluded that the man had chronic gastritis (inflamed stomach lining) which caused his chest pain.

2. The man moved to Whatton in December 2011. At his initial healthscreen, a nurse noted he had an extensive family history of ischaemic heart disease. He had high blood pressure, high cholesterol, angina, chronic obstructive pulmonary disease (COPD - lung disease), a stomach ulcer and he was overweight (almost 19 stone). In February 2012, the man first experienced chest pain at Whatton. The hospital diagnosed suspected sleep apnoea.

3. A heart scan in July 2012 showed nothing abnormal, but the man still frequently complained of pain in his chest. These incidents either resolved themselves or investigations concluded that the causes were gastric or not known. In 2013, the man unsuccessfully tried to lose weight. For a short period he stopped taking his medication, but started again, after advice from healthcare staff.

4. In November 2014, a prison GP noted that the man had not had any chest pain for four weeks. The GP said he would review his medication needs if the man experienced chest pain again.

5. On 16 January 2015, a doctor prescribed antibiotics when the man developed a chest infection. Just after 11.00pm on 21 January, the man was struggling to breathe. His cellmate became concerned and alerted the night patrol officer. The night officer did not use an emergency medical code, but asked the night manager to attend. The night manager checked the man's medical history and went to the cell to assess him. After five minutes he asked the night patrol officer to contact the control room to call an ambulance. Paramedics arrived, assessed the man and took him to hospital.

6. The man had a number of tests at the hospital and a doctor told him he probably had a mild infection. However, in the afternoon of 22 January he had a cardiac arrest and hospital staff resuscitated him. The man was placed on a life support machine but doctors considered he would not recover. The life support was removed and the man died on 24 January.

7. The clinical reviewer concluded 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, we are concerned that prison staff did not immediately use an emergency code and call an ambulance as soon as they were alerted to the man's breathing difficulties. Although this did not affect the outcome for the man, in other emergencies this could be crucial. 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 her. No one responded.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator interviewed four members of staff at Whatton on 24 February 2015.

10. NHS England commissioned the 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 cause of death. We have sent the coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation. She had some questions relating to the man's care in hospital, which is outside the remit of this investigation. The family liaison officer directed her to the Patient Advice and Liaison Service.

13. The man's family received a copy of the draft report. They did not raise any issues that the report does not already cover.

14. The prison also considered our draft and did not raise any factual inaccuracies. They submitted an action plan addressing our recommendation which is at the end of this report.

HMP WHATTON

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

16. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. There is a healthcare centre, which is open seven days a week from 7.30am to 6.30pm, Monday to Friday, and from 8.30am to 1.30pm at weekends, backed up 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

17. 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 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 to meet the needs of the population.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB noted that the high number of older prisoners put pressure on healthcare services.

Previous deaths at HMP Whatton

19. The man's death was the eleventh from natural causes at Whatton since the beginning of 2013, reflecting its relatively high proportion of older prisoners. We have raised the issue of emergency response procedures before.

KEY EVENTS

20. In May 1997, the man was sentenced to life imprisonment for sexual offences, with a minimum time to serve of seven years before he could be considered for release. The man had experienced episodes of chest pain from 2007 but, after investigations, specialists concluded that the pains were non-cardiac and diagnosed chronic gastritis in November 2011. In December 2011, he transferred to Whatton. Sentence planning meetings recorded that the man remained a real risk to the public.

21. On 20 December 2011, at an initial health screen at Whatton, a nurse noted that he was a non-smoker with an extensive family history of ischaemic heart disease. The nurse recorded that the man weighed almost 19 stone. A prison GP re-prescribed a range of medications for high blood pressure, angina, high cholesterol, a stomach ulcer, chronic obstructive pulmonary disease (COPD – lung disease) and a skin condition. On 3 January 2012, at a second health screen, a doctor noted the man's health conditions and medication.

22. On 26 February, the man complained of chest pain for the first time since he had arrived at Whatton. He was admitted to hospital for tests and the hospital discharged him the next day, with a diagnosis of suspected sleep apnoea. After a severe angina attack on 7 May 2012, a hospital doctor referred him for a heart scan to see how well blood was flowing to his heart. The scan, carried out in July, showed nothing abnormal. In October, the GP reviewed the man's recent history and stopped his prescription for nicorandil and isosorbide mononitrate (both used to treat angina).

23. Between October 2012 and January 2015, records show the man experienced 11 episodes of chest pain. These usually resolved themselves quickly at the prison, but he was admitted to hospital three times. Investigations at hospital found the cause of the pain was inconclusive, gastric related or atypical chest pain.

24. The man attended a weight loss programme for a short time, but did not lose any weight. For a short period he did not take his medication, but started again after advice from the GP. Records show the man's blood pressure improved during this period.

25. On 26 November 2014, the GP saw the man for a medication review and the man asked for more GTN spray (glyceryl trinitrate, which eases angina symptoms). The doctor noted that, although he had a history of chest pain, he had not had any chest pain for four weeks. The GP said he would review The man again if he had further chest pain, but he did not re-prescribe the GTN spray.

26. On 16 January 2015, the nurse noted the man had a chest infection with a productive cough. She arranged for a doctor to prescribe antibiotics and gave them to the man that evening.

27. At approximately 11.00pm on 21 January, the man and his cellmate were watching television in their cell. The man's cellmate said that the man went purple and his feet started twitching. The man's cellmate banged on the cell door and rang the cell bell at 11.12pm.

28. An operational support grade (OSG) was the night patrol officer. Initially, he said he was not sure where the banging was coming from. When the man's cellmate rang the cell bell, The OSG attended immediately. He looked through the observation hatch and saw the man shaking, purple and clearly in some discomfort. He said the man repeatedly said 'Leave me alone. I want to die'.

29. The OSG told the man and the man's cellmate he would get help. He asked the man's cellmate to reassure the man and make him comfortable. He then went to the wing office to call the communications room. At 11.18pm, an operational support grade in the communications room took the OSG's call and ran to get the duty manager who was in a room nearby.

30. The duty manager asked the OSG in the control room to check the man's prison record for details of any recent health issues and he and an officer went to the man's cell. They arrived at approximately 11.22pm. In the meantime, the OSG had informed the duty manager that the man had a heart condition and asthma and had recently been treated for a chest infection.

31. The duty manager said the man was lying on his left hand side, facing the wall, breathing heavily and talking with difficulty. The man said that he was starting to feel a little better and the man's cellmate commented that his colour had improved. The man said he had heart problems and that he felt sick. The duty manager and an officer helped him into a sitting position and the OSG asked the control room to call an ambulance. Records show an ambulance was called at 11.27pm.

32. The duty manager spoke to the man, who was sitting on his bed. Although he was clearly not well, the man was conscious and able to have a conversation. At 11.50pm, the ambulance arrived and paramedics spent some time assessing the man's condition. He was able to walk to a stretcher on the wing corridor and the ambulance left the prison at 1.03am and took him to Queen's Medical Centre, Nottingham.

33. Two officers accompanied the man and used an escort chain to restrain him. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

34. The man had tests in hospital. At 6.00am on 22 January, an escort officer noted in the escort record that he was hot and clammy. A doctor gave the man morphine for lower back pain.

35. At 12.55pm, the man transferred to Nottingham City Hospital. At 2.20pm, a hospital doctor told the man he probably had a mild infection. Because of the move to another hospital, a manager had postponed a further review of the

need for restraints. Before that could happen, at 3.28pm, the man had a cardiac arrest. Officers removed the restraints immediately as hospital staff had to resuscitate him. They did not use restraints again.

36. At 5.00pm, doctors moved the man to the Intensive Care Unit and put him on a life support machine. On 23 January, the prison's Head of Security reduced the escort to one member of staff.

37. At 9.30pm on 24 January, after discussion with the man's family, doctors turned off the life support machine and he died at approximately 10.08pm. Members of his family were with him at the time.

Liaison with the man's family

38. At 11.00am on 22 January, the prison informed the man's sister, his next of kin, that he was in hospital. Later that day, after the man's cardiac arrest, the Head of Security phoned his sister to let her know he was critically ill. The man's sister and other members of his family went to the hospital.

39. On 24 January, the prison appointed a prison manager as the family liaison officer, the prison manager and another prison manager went to the hospital at 6.45pm that evening, introduced themselves to the man's sister and other family members and offered support and advice.

40. The prison manager maintained contact with the man's family after his death. The man's funeral was on 26 February, and the prison contributed to the funeral costs in line with national policy.

Support for staff and prisoners

41. A senior manager debriefed the staff who had been involved in the man's care on the night he died and made sure they were aware of the support available from the care team and other services. A Governor's notice informed staff and prisoners of the man's death and the support available. Officers told the man's cell mate personally and offered him the support of Listeners (prisoners trained by the Samaritans to give other prisoners emotional support).

Cause of death

42. The Coroner did not request a post-mortem. The hospital gave the cause of death as 1(a) Influenza Pneumonitis (b) Ventricular Fibrillation Cardiac Arrest (c) Ischaemic Heart Disease and 2) Chronic Obstructive Pulmonary Disease.

ISSUES

Clinical Care

43. The clinical reviewer concluded that the man's care in prison was at least equivalent to that he could have expected to receive in the community. He said staff investigated, diagnosed and treated the man's conditions (which included high blood pressure, high cholesterol and obesity) appropriately. When necessary healthcare staff referred him to hospital for assessment and investigations.

44. When the man developed the symptoms of a chest infection in January 2015, a nurse assessed him and arranged for a doctor to prescribe antibiotics. The clinical reviewer was satisfied that the man received appropriate treatment for his chest infection. Healthcare staff were not on duty at the time the man became ill on 21 January, so they were not involved in the emergency response.

45. We agree with the clinical reviewer's assessment of the standard of the man's care in prison, and we are satisfied that he received appropriate support and treatment.

Emergency response

46. The OSG, the night patrol officer, attended the man's cell, between 11.12pm and 11.18pm. He described the man as purple, shaking and in some discomfort but also told us that the man was able to communicate, and told the OSG to leave him alone. The OSG told us that Whatton's local policy dictated that officers could only enter a single cell, on their own, with the authority of the Night Orderly Officer, and must never enter a double cell on their own.

47. In fact, Whatton's local policy allows a single member of staff to enter any cell (whether single or double) in an emergency, when a prisoner's life is in danger. This reflects national Prison Service instructions, which indicates that this should be where there is immediate danger to life, subject to a personal risk assessment and should not put anyone else at risk. While it is a concern that the OSG was not aware of this, it is apparent that he did not consider the OSG's life was in immediate danger at the time and there was little he could have done to help him, had he opened the cell. However, we consider that The OSG should have radioed a medical emergency response code.

48. Prison Service Instruction (PSI) 03/2013 - Medical Emergency Response Codes, issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently communicating the nature of any medical emergency. It directs that staff should use a code blue (or code one) for any emergency where a prisoner has symptoms including chest pain and difficulty in breathing.

49. Use of an emergency code should ensure that staff take the right equipment to an incident and the control room or communications room should call an ambulance immediately, without waiting for further information. Whatton has an appropriate local protocol, but staff did not follow it.

50. When the OSG decided to summon assistance, he phoned staff in the communications room. He told us that this is because he knew the wing had radio black spots. However, he did not use an emergency code. The OSG knew about the emergency codes but was not aware that broadcasting either of these codes would alert staff in the communications room to call an ambulance immediately.

51. The OSG and the duty manager told us that it was unusual for staff to use emergency codes at night and that staff tended to ask the night manager to assess the situation before calling an ambulance. The man collapsed at 11.12pm, but an ambulance was not called until 11.27pm, 15 minutes later. While it does not appear that the delay affected the outcome for the man, in other cases this could be crucial. The PSI makes it clear that "if staff are in any doubt …they must call an ambulance. It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required." We make the following recommendation:

The Governor should ensure that prison staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner and that the communications room calls an ambulance immediately an emergency code is received.

RECOMMENDATION

The Governor should ensure that prison staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner and that the communications room calls an ambulance immediately an emergency code is received.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that prison staff use the appropriate emergency code whenever there are serious concerns about the health of a prisoner and that the communications room calls an ambulance immediately an emergency code is received.	Accepted	A medical emergency response local protocol has been issued to remind staff of code red and code blue response codes in line with Prison Service Instruction (PSI) 03/2013 - *Medical Emergency Response Codes*, to make sure there are no delays in calling an ambulance. A system has been put in place whereby the Custodial Manager for each set of nights is briefed by the Head of Safer Custody on the correct procedures, which are then communicated to the night staff. A member of the senior management team completes a night visit each month to check on systems and processes; this also covers the medical emergency protocols and entering a cell to preserve life.	Completed Head of Safer Custody