



A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

**Investigation into the death of a man in March 2014  
at HMP Whitemoor**

## ***Our Vision***

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

This is the investigation report into the death of a man who died of a heart attack on 13 March 2014, at HMP Whitemoor. The man was 54 years old. I offer my condolences to his family and friends.

The investigator carried out the investigation. A clinical reviewer reviewed the man's clinical care at Whitemoor. The prison cooperated fully with the investigation.

The man was serving a life sentence and arrived at Whitemoor from HMP Frankland on 5 June 2013. He did not have a full health assessment that day, but a nurse, who did not see his medical record, arranged an appointment with a doctor six days later. The man lived in the Fens Unit at Whitemoor, a specialist unit for prisoners with personality disorders. He said he did not like seeing healthcare staff and frequently chose not to attend GP and hospital appointments. He did not attend the GP healthcare assessment and healthcare staff were not aware that he had been treated for high blood pressure at Frankland several years previously.

On the morning of 13 March 2014, two prisoners found the man unresponsive in his cell and alerted officers, who called an emergency response code. Healthcare staff attended and attempted resuscitation, although it was clear that the man had been dead for some time. The officer who had unlocked his cell that morning had not identified this. A prison GP pronounced the man dead shortly afterwards.

The clinical reviewer noted that the man's death was sudden and unexpected, and could not have been prevented. His care was also hampered by his frequent refusal to attend healthcare appointments. Nevertheless, I am concerned that the man did not have a full health assessment when he arrived at Whitemoor and his medical history was not summarised in his clinical record. As a result, his treatment for high blood pressure some years earlier was not identified. I am also concerned that the officer who unlocked the man's cell on the morning of 13 March, did not check on his welfare and identify that he was dead.

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**

**February 2015**

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## SUMMARY

1. The man was sentenced to life imprisonment on 15 December 2013. On 5 June 2013, he transferred from HMP Frankland to the Fens Unit at HMP Whitemoor, for prisoners with severe personality disorders.
2. Healthcare staff at Frankland had treated the man for high blood pressure and Crohn's disease. When he arrived at Whitemoor, a prison nurse carried out an initial health screen but did not have access to the man's electronic medical records. He did not report having any health conditions. She made an appointment for him to see a prison GP for a detailed healthcare assessment, but the man did not attend. The man was extremely anxious about seeing healthcare staff and frequently missed appointments. He discussed this with Fens Unit staff who accompanied him to some appointments.
3. No one at Whitemoor was aware of the man's previous history of high blood pressure and therefore did not monitor it. In September 2013, doctors investigated the man for weight loss, problems swallowing and coughing up blood, and referred him for tests under the two week cancer rule. The results were negative.
4. At 8.03am on 13 March 2014, an officer unlocked the man's cell but did not check him. At 8.44am, two prisoners found the man unresponsive in his cell. Healthcare staff attended and attempted resuscitation, although it appeared that the man had been dead for some time. A prison GP pronounced the man dead at 9.20am.
5. The man was able to make his own decisions about whether to attend healthcare appointments and frequently decided not to attend them. The unit staff often encouraged him to attend and accompanied him on occasions. However, we are concerned that healthcare staff never completed a full initial health screen for the man. This meant his high blood pressure was never monitored at Whitemoor. The officer who unlocked the man's cell on 13 March should have checked his welfare. Although this would not have affected the outcome for the man, it could be crucial in other circumstances. We also do not consider the healthcare staff should have felt obliged to attempt resuscitation, when the man was clearly dead. We make four recommendations.

## **THE INVESTIGATION PROCESS**

6. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact her. No one responded. The original post-mortem was 'inconclusive' and toxicology reports were requested. The Ombudsman's investigation was suspended until the results of toxicology tests (which were negative) and a cause of death was given. We are sorry for the delay this caused with the issue of this report.
7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She visited Whitemoor on 21 March 2014 and spoke to the Head of Healthcare and a member of the Independent Monitoring Board. After the investigation was re-opened, the investigator interviewed five members of staff at Whitemoor in October and spoke to two prisoners. She informed the Governor of the preliminary findings of the investigation.
8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
9. We informed HM Coroner for North and East Cambridgeshire of the investigation who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
10. The man's family did not wish to be involved in the investigation.
11. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

## **HMP WHITEMOOR**

12. HMP Whitemoor is a high security prison and holds over 450 category A and B prisoners serving long sentences. NHS East Anglia commissions healthcare services. The GP service is provided by Medacs and there is an on-call service for out of hours cover. Cambridgeshire and Peterborough NHS Foundation Trust manage the prison's mental health provision.
13. Fens Unit is a small unit for 62 men with severe personality disorders and regarded as dangerous. It is staffed by psychiatrists, mental health nurses and prison staff. The unit aims to address offending behaviour through the reduction of risk by targeting factors which lead to criminal behaviour while meeting mental health needs.

## **HM Inspectorate of Prisons**

14. The most recent inspection of Whitemoor was in January 2014. Overall, the Inspectorate considered the prison to be safe, respectful and purposeful. The Inspectorate assessed health services as reasonable, but said there were too many agency staff. The Inspectorate recommended that SystemOne (the computerised medical record system) should be accessible in the first reception screening room. There were limited chronic disease clinics, but a helpful blood pressure monitoring clinic had been introduced. Inspectors noted that the Fens Unit staff worked well with prisoners convicted of serious offences and with serious problems, in a challenging but supportive environment. The programme was impressive and prisoners were involved in intensive therapeutic work. The Fens Unit had a dedicated mental health team.

## **Independent Monitoring Board**

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers who help ensure that prisoners are treated fairly and decently. In its most recent published report, for the year to May 2013, the Board commented that healthcare was continuing to improve and was now at least as good as services in the community.

## **Previous deaths at Whitemoor**

16. The man was one of three prisoners to die from natural causes at Whitemoor since the start of 2014. We have previously raised the issue of checking the welfare of prisoners when unlocking cells.

## KEY EVENTS

17. The man was found guilty of a violent offence on 15 December 2003 and sentenced to life imprisonment. He spent time in a number of prisons and, on 5 June 2013, moved to HMP Whitemoor from HMP Frankland. At Frankland, healthcare staff had treated the man for high blood pressure and Crohn's disease.
18. A nurse carried out the man's initial health screen when he arrived at Whitemoor. The screening room has no computer and, therefore, the nurse did not have access to the man's medical records at the screen. The nurse did not record any observations or take his blood pressure. The man was concerned about his health because of his Crohn's disease, but he did not mention having treatment for high blood pressure. The nurse made an appointment for the man to see a GP on 11 June for a more detailed health screen. The man was considered fit for work and located on the Fens Unit.
19. The man did not attend the GP appointment on 11 June. A prison psychiatrist saw him that day in the Fens Unit for an initial psychiatric review. The man discussed his problems caused by Crohn's disease and his temporary colostomy. The man said he avoided seeing prison GPs and the psychiatrist encouraged him to attend. The record shows the man did not attend GP appointments on 18 and 27 June and 22 August. There is no record that anyone discussed this with him again or followed up why he did not attend.
20. On 4 September, the man told the psychiatrist he had chronic abdominal pain and, for the past eight months, had also experienced difficulty when swallowing and had coughed up blood. The man said he was very anxious about seeing the GP the next day. The psychiatrist advised and encouraged him to attend.
21. On 5 September, the man did not attend the appointment with the GP. Records show this was because Fens Unit staff would not allow him to leave the unit for health and safety reasons because his only footwear was a pair of slippers. On 12 September, the psychiatrist took him to his appointment in a wheelchair, as he still only had slippers to wear. This was his first GP appointment since he had arrived at Whitemoor.
22. The man told the GP that he had increasing pain in his throat and had coughed up blood several times. The GP noted the man had smoked cigarettes since the age of seven and had declined investigation into his throat problems at Frankland. He noted the man's throat and chest were clear and made an urgent two week referral to the ENT clinic at Peterborough City Hospital for suspected cancer. The man refused to

- attend for a chest X-ray on 17 September. The man's weight was 69.2kg. The doctor did not complete a full health assessment or look at the man's medical history which had not been summarised on the medical record.
23. On 30 September, the man refused to attend the ENT clinic appointment and the GP made another urgent referral. On 3 October, healthcare and Fens Unit staff discussed the man's refusal to attend hospital appointments. Fens Unit staff agreed that someone would accompany him to future appointments for support.
  24. On 9 October, the GP saw the man and noted that he was aware of a probable cancer diagnosis but was anxious about attending hospital. His weight was recorded as 70.8kg.
  25. On 11 October, an ENT specialist saw the man at Peterborough City Hospital. A mental health nurse from the Fens Unit accompanied him. The man refused to have a nasal endoscope as he was afraid of intrusive procedures. The ENT specialist advised that the man should have a barium swallow test (which can show more clearly if there are any problems in the oesophagus, stomach, and duodenum) and stop smoking. The man had the barium swallow test on 24 October. The results did not show any abnormalities.
  26. The man continued to complain about difficulties in swallowing and weight loss. On 29 November, his weight was recorded as 66.4kg. The doctor prescribed high calorie drinks and omeprazole for acid reflux. On 13 December, the GP made another urgent referral for suspected cancer to a gastroenterologist. The man refused to attend an appointment with the GP on 17 December, but on 20 December saw the doctor and complained of on-going neck pain, coughing up blood and weight loss. He weighed 67kg. The doctor arranged a chest X-ray for 6 January 2014, but the man was abusive to the radiographer who refused to continue.
  27. The man refused to attend healthcare appointments four times in January. He had a chest X-ray on 21 January and the results received on 5 February showed an infection in his right lung. The doctor prescribed antibiotics and referred the man to the respiratory department at Peterborough City Hospital. On 20 February, the man signed a disclaimer which said he would not attend future hospital appointments. He was assessed as having the mental capacity to make this decision.
  28. At approximately 8.03am on 13 March, an officer unlocked the man's cell. He told us that he looked in the cell and the man's light and television were on. The man was lying on the bed, which appeared to be made, with his head on his pillow towards the TV. The officer told us the man's eyes

were open and he thought he looked perfectly well, but he did not try to get a response from the man.

29. At 8.56am, two prisoners found the man unresponsive in his cell. One prisoner tried to find a pulse but could not move the man's arm because rigor mortis was present. The prisoner said the man looked like he had been dead for some time. Another prisoner informed another two officers who went to the man's cell. The officer called a code blue (an emergency medical code indicating a prisoner has breathing difficulties or is unresponsive) and the control room called an ambulance. A few minutes later two nurses arrived. They noted that the man was in bed, lying on his right hand side and was not responding. The nurse asked the two officers to move the man onto the floor to help emergency treatment.
30. A nurse arrived at 9.10am with the emergency equipment and she and the nurse began cardiopulmonary resuscitation. The man's body was difficult to move because rigor mortis was present. The nurse was unable to insert an airway because the man's jaw was clenched tight. As an alternative, an ambu-bag (a hand held manual resuscitator) was used to administer oxygen. They attached a defibrillator which did not detect a heart rhythm. The nurse told us it was clear that the man had been dead for some time, but continued to attempt resuscitation until the GP arrived at about 9.15am and pronounced the man dead shortly afterwards. Paramedics arrived, but were not needed as the doctor had already recognised the man's death.

#### **Liaison with the man's family**

31. The man did not have any contact with his family due to the circumstances of his offence. A custodial manager liaised with the police who contacted the man's family and informed them of his death. The man's family said they did not want to be contacted by the prison or the Ombudsman's family liaison officer. The prison arranged the man's funeral, which took place on 1 April.

#### **Support for staff and prisoners**

32. A Governor's notice informed prisoners and staff that the man had died. A briefing for the staff on Fens Unit took place at 10.00am. Staff reviewed prisoners being monitored as at risk of suicide and self-harm, in case they had been adversely affected by the man's death. Staff also offered other prisoners additional support, in particular, the two prisoners who had found the man unresponsive. A debrief for the staff involved in the emergency response was held at 2.00pm.

#### **Cause of death**

33. A post-mortem examination found the cause of death was myocardial ischaemia (poor blood supply to the heart), left ventricular dilatation (usually caused by high blood pressure) and coronary artery atheroma (the most common type of heart disease and cause of heart attacks). The toxicology results found no evidence of illicit drugs.

## ISSUES

### Clinical care

34. The clinical reviewer noted that the man's death was not foreseeable or preventable and he had never complained of any symptoms directly related to his heart. He found that, while there some good areas of care at Whitemoor, there were also some gaps.
35. The clinical reviewer was concerned that while the man, and other prisoners on the Fens Unit, received intensive mental health care there was less attention paid to their physical health and poor communication between general healthcare staff and staff in the Fens Unit. Procedures for prescribing were paper based, rather than the computer based SystmOne healthcare record used in the rest of the prison, and this was potentially unsafe. The clinical reviewer made a number of detailed recommendations about the model for the delivery of healthcare in the Fens Unit which the Head of Healthcare will need to address. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners in the Fens Unit have routine health monitoring and promotion and healthcare services which are fully integrated with those in the rest of the prison.**

36. When the man arrived at Whitemoor on 5 June, the nurse saw him to assess his immediate healthcare needs. The nurse did not have any information about his past medical history because she did not have access to the man's electronic medical record, as there is no computer in the first reception screening room. She had not checked his record in advance. The nurse did not record any basic observations about the man's weight, height, blood pressure, smoking habits or family history. She told us that the doctor would record this information during the more detailed health assessment she booked for the man on 11 June. The man did not attend this appointment and did not have a full health screen at any time at Whitemoor.
37. The clinical reviewer was concerned that, because the man's medical records were not summarised when he arrived at Whitemoor, staff were not aware that he had been treated for high blood pressure at Frankland until 2011. Had they known, this might have led to monitoring. The man frequently refused to attend healthcare appointments and, when he eventually saw a doctor on 12 September, the focus was on symptoms that indicated possible cancer. No one checked his blood pressure at any time while he was at Whitemoor.

38. The man shared his anxiety about attending healthcare appointments with his psychiatrist, who advised and encouraged him to attend. Fens Unit staff attended hospital appointments with him for support and, on at least one occasion, the psychiatrist took him to a GP appointment. The man had full capacity to make decisions about his healthcare and we are satisfied that staff made efforts to persuade the man to attend appointments. However, we are concerned that he never had a full health screen and the reception nurse did not have access to his full medical record, a matter about which HM Inspectorate of Prisons has previously made a recommendation.
39. Prison Service Order (PSO) 3050 Continuity of Healthcare says that an initial assessment of the health needs of all newly arrived prisoners should take place within 24 hours of their arrival at the prison. The purpose of this is to identify any existing health problems and plan any subsequent care. A second general health assessment should take place within the week. While the man refused to attend his secondary assessment there is no record that any further attempt was made to complete a health screen. We make the following recommendation:

**The Head of Healthcare should ensure that all prisoners have an appropriate health screen when they arrive at Whitemoor. Reception nurses should have access to SystemOne records for initial screens and prisoners' medical histories should be summarised on their records with chronic and serious conditions highlighted.**

#### **Unlock procedures**

40. The officer told us that, when he unlocked the man's cell on the morning of 13 March, he was lying on the bed apparently watching television. He said that he thought the man looked perfectly well. The officer said that he thought that the man had replied to him when he spoke to him. At 8.44am, two prisoners found the man unresponsive and alerted staff. It was clear he had been dead some time, and would have been so when the office unlocked his cell.
41. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells. Prison Service Instruction (PSI) 10/2011, paragraph 2.3 clarifies the responsibility of the unlocking officer:

“Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”

42. While we understand that the officer originally believed that the man was alive when he unlocked the cell, it is evident that he did not get a response from him. This would not have changed the outcome for the man, who had been dead for some time, but in other circumstances it could ensure that a prisoner who is unwell gets prompt medical attention. It would also have avoided other prisoners the distress of finding the man dead. We have raised this matter before and the prison undertook to remind staff of their responsibilities when unlocking prisoners. We make the same recommendation:

**The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the well-being of the prisoner and that there are no immediate issues that need attention.**

### **Emergency response**

43. It was apparent from the evidence of the prisoners and staff who found the man that he had been dead for sometime. The nurse said it was difficult to move the man's body because of rigor mortis and other signs of death. She told us she was not comfortable about trying to resuscitate him but believed she was expected to do so.

44. We consider that it was inappropriate to attempt to resuscitate the man and was unnecessarily distressing for those involved. The European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...". The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.**

## **RECOMMENDATIONS**

- 1 The Head of Healthcare should ensure that prisoners in the Fens Unit have routine health monitoring and promotion and healthcare services which are fully integrated with those in the rest of the prison.
- 2 The Head of Healthcare should ensure that all prisoners have an appropriate health screen when they arrive at Whitemoor. Reception nurses should have access to SystmOne records for initial screens and prisoners' medical histories should be summarised on their records with chronic and serious conditions highlighted.
3. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the well-being of the prisoner and that there are no immediate issues that need attention.
4. The Governor and Head of Healthcare should ensure that all staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

