

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Adam Willmott, a prisoner at HMP Whitemoor in April 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations such as this into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

This is the investigation report into the death of Mr Adam Willmott from a heart attack in April 2015, while a prisoner at HMP Whitemoor. He was 49 years old. I offer my condolences to Mr Willmott's family and friends.

The investigation found that the clinical care that Mr Willmott received at Whitemoor was equivalent to that he could have expected to receive in the community. I am satisfied that Mr Willmott received an appropriate standard of healthcare at Whitemoor. Although Mr Willmott could have reduced his risk of heart disease by lifestyle changes and following healthcare advice, staff at Whitemoor could not have predicted or prevented his sudden death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2015

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SUMMARY

Events

1. Mr Adam Willmott was sentenced to life imprisonment on 16 November 1998. He had been at HMP Whitemoor since September 2005.
2. Mr Willmott suffered from diabetes and had been dependent on insulin since 1998. He suffered from a skin disorder and used hearing aids. In 2011, he had been diagnosed with diabetic retinopathy (damage in the cells at the back of the eye). Mr Willmott had a family history of heart disease. He had problems with his joints. Healthcare staff treated and investigated these issues satisfactorily and referred him for a specialist opinion a number of times. They reviewed Mr Willmott's health frequently including regular diabetic care reviews. However, Mr Willmott did not monitor his blood sugar levels adequately and his diabetes was poorly controlled.
3. In April 2015, Mr Willmott went to work in the morning, but did not feel well and went back to his cell to rest. About two and a half hours later, shortly before 11.00am, another prisoner found Mr Willmott collapsed in his cell. He alerted staff and an officer radioed an emergency medical code. Two officers attended and tried to resuscitate Mr Willmott. Healthcare staff arrived quickly and took over the resuscitation attempt. At 11.20am, a prison GP pronounced Mr Willmott dead.

Findings

4. The investigation found that the clinical care that Mr Willmott received at Whitemoor was equivalent to that he could have expected to receive in the community. Healthcare staff examined, investigated and treated Mr Willmott's healthcare problems and reviewed his diabetes appropriately and frequently. The clinical reviewer commended the very comprehensive and detailed records the nurses kept. We are satisfied that staff at Whitemoor could not have predicted or prevented Mr Willmott's death. We make no recommendations.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
6. The investigator visited the prison on 14 April 2015 and obtained copies of relevant extracts from Mr Willmott's prison and medical records.
7. NHS England commissioned a clinical reviewer to review Mr Willmott's clinical care at the prison. The investigator and clinical reviewer interviewed four members of staff at Whitemoor on 29 May. The investigator also interviewed a prisoner. On 11 June, he interviewed two more staff at Whitemoor.
8. We informed HM Coroner for North and East Cambridgeshire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted Mr Willmott's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Willmott's mother was concerned that Mr Willmott did not receive a good standard of healthcare at the prison.
10. Mr Willmott's mother received a copy of the draft report. She did not raise any issues. The prison also received a copy of the draft report.

BACKGROUND INFORMATION

HMP Whitemoor

11. HMP Whitemoor is a high security prison, which holds over 450 men serving long sentences. NHS East Anglia commissions healthcare services.
12. The prison healthcare centre includes a nine bed in-patient unit. Primary Care, Drug Misuse Services (IDTS) and Mental Health services are now integrated. From 1 April 2015, Northamptonshire Healthcare NHS Foundation Trust became the healthcare provider at Whitemoor.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Whitemoor was in January 2014. Overall, inspectors found Whitemoor a safe, respectful and purposeful prison, which provided opportunities for prisoners serving long sentences to address their offending behaviour. The Inspectorate considered that relationships between staff and prisoner were better than at previous inspections and most prisoners said they had a member of staff they could turn to for help. Inspectors found that healthcare services were satisfactory with a good range of visiting services. There were substantial staffing challenges caused by recruitment difficulties and chronic disease clinics were limited. The GP service was clinically sound but many prisoners said they did not feel listened to or cared for.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2014, the IMB considered that the healthcare services were effective, especially with reduced permanent staff in the reporting year.

Previous deaths at HMP Whitemoor

15. Mr Willmott was the fourth prisoner to die from natural causes at Whitemoor since the start of 2013. There were no significant similarities with issues identified in previous cases.

KEY EVENTS

16. Mr Adam Willmott was sentenced to life imprisonment on 16 November 1998 and sent to HMP Full Sutton. On 13 September 2005, he transferred to HMP Whitemoor.
17. Mr Willmott was diagnosed with diabetes and was dependent on insulin since 1998. He suffered from a skin disorder. At Whitemoor, Mr Willmott used hearing aids. He smoked 15 cigarettes a day and declined help to stop smoking. In February 2011, an ophthalmologist diagnosed him with diabetic retinopathy (damage in the cells at the back of the eye). In May, Mr Willmott had an operation on his left shoulder. In October, a prison GP reviewed Mr Willmott and noted his father had had a heart attack when he was 21. The GP recorded that Mr Willmott had a 32.6% (high) chance of having a cardiovascular problem within the next 10 years and advised him about improving his diabetes control, which increased his risk. Mr Willmott had already stopped taking regular aspirin and refused medication to decrease his risk of future heart problems.
18. Healthcare staff regularly monitored Mr Willmott's diabetes and other health conditions. On 5 August 2013, a specialist diabetic nurse reviewed Mr Willmott and recorded that he had complained about his diet. She asked him to keep a food diary to help her assess if he was getting a balanced diet and advised him to improve his diabetes control to reduce the risk of progression of his retinopathy. Mr Willmott gave up keeping a food diary after two days. Over the following months, Mr Willmott did not have any major health issues.
19. On 17 February 2014, a prison GP examined Mr Willmott, who reported knee pain. The doctor diagnosed early osteoarthritis and ordered an X-ray, which showed no abnormality. On 10 March, a prison GP reviewed Mr Willmott and recorded an increase in his blood sugar level. He advised him to monitor it for two weeks but Mr Willmott refused. The GP referred Mr Willmott to a physiotherapist for a soft tissue injury to his left knee.
20. On 19 June, Mr Willmott was suffering pain and swelling of his right elbow and a prison GP prescribed an antibiotic. An X-ray showed no abnormality. On 27 August, the GP noted that Mr Willmott's blood tests showed poor diabetic control. The GP noted Mr Willmott's blood sugar levels remained high with minimal changes from the last tests and planned a further review with the specialist diabetic nurse. On 11 September, a nurse reviewed Mr Willmott's diabetes. His blood pressure and pulse were normal and she advised him about managing his diabetes effectively.
21. On 21 November, a prison GP noted that Mr Willmott's pain and swelling in the right elbow had gradually resolved, but he had ongoing pain in his left knee. The GP prescribed medication and referred him for assessment with an orthopaedic consultant (which took place on 17 February 2015). A scan of Mr Willmott's knee showed no abnormality.

22. On 25 February 2015, a prison GP carried out full blood tests, which showed that Mr Willmott had good cholesterol levels and a normal kidney function but his sugar levels remained high. On 11 March, two nurses examined Mr Willmott. They discussed his blood sugar levels and control with Mr Willmott and noted he appeared not to be concerned about this and had not measured his blood sugar levels. Mr Willmott agreed to test his blood sugar before every meal and before going to sleep for the next two weeks. Because of his poor diabetic control, the specialist diabetic nurse recommended a change in his type of insulin to one that he could use more flexibly. She changed his needles to a smaller size, as Mr Willmott appeared to be injecting his insulin into muscle rather than fatty tissue, which meant the insulin would not be absorbed properly.
23. On 27 March, a prison GP noted Mr Willmott was not monitoring his blood sugar regularly and told him that healthcare staff could only advise him on diabetic control if he did this. He recorded that Mr Willmott was not happy about this and left the consultation voluntarily. The GP referred Mr Willmott to the diabetic medicine department at the hospital and a nurse created a diabetes care plan for him. Healthcare staff did not record any further healthcare issues after this.
24. One morning in April, Mr Willmott went to his job in a prison workshop, refurbishing computers for schools in Africa. When he got there, he told two officers that he felt unwell, but did not explain in what way. An officer took him back to his cell at approximately 9.30am. She asked Mr Willmott whether he wanted a nurse to check him, but he declined. She left his cell door open in case he needed any help and went about her duties on the wing. She checked Mr Willmott again at 10.00am and 10.15am and he said he was fine.
25. From about 10.43am to 10.50am a prisoner was talking to a friend at the friend's cell door, which was next to Mr Willmott's. He said that while he was talking to his friend he heard some noises coming from Mr Willmott's cell but did not think it was anything serious.
26. At 10.56am, the prisoner was coming back along the landing and said that something made him decide to check that Mr Willmott's was all right. He knocked on his door, which was unlocked but not ajar. He got no response and saw through a gap in the door that Mr Willmott had collapsed and his face appeared blue. Mr Willmott's body was obstructing the door. The prisoner shouted for help and three officers responded. An officer called a code blue at 10.57am. (A code blue is a medical emergency code, which indicates a prisoner is unconscious, not breathing, or is having breathing difficulties.) The control room called an ambulance quickly after the code blue was called.
27. Mr Willmott was lying face down on the floor with his head against the inside of the cell door. An officer managed to get into the cell and moved Mr Willmott away from the door. He noted Mr Willmott was unresponsive, not breathing and had no pulse. An officer started cardiopulmonary resuscitation until nurses arrived shortly afterwards at 11.00am and took over. The nurses attached a defibrillator, which showed no shockable heart rhythm. A prison

GP also arrived. The healthcare staff continued to attempt resuscitation until, at 11.20am, the GP pronounced Mr Willmott dead. Paramedics arrived a minute later.

Contact with Mr Willmott's family

28. A family liaison officer visited Mr Willmott's mother that day, informed her of his death and offered condolences and support. The prison contributed towards the costs of Mr Willmott's funeral, in line with national policy.

Support for prisoners and staff

29. After Mr Willmott's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support, including from the staff care team.
30. The prison posted notices informing other prisoners of the man's death and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Willmott's death. Officers, healthcare staff and members of the chaplaincy team supported the prisoner who found Mr Willmott in the days after the incident.

Post-mortem report

31. A post-mortem examination indicated that Mr Willmott had suffered an unreported myocardial infarction (heart attack) in the past and established that the cause of Mr Willmott's death was ischaemic heart disease and diabetes.

FINDINGS

Clinical Care

32. The clinical reviewer considered that Mr Willmott's death was not foreseeable and there was nothing staff at Whitemoor could have done to prevent it. There was no indication that Mr Willmott had a heart condition, and although the post-mortem indicated that he had had a heart attack in the past, there is no record that he ever presented with any symptoms. However, Mr Willmott could have reduced his risk of heart problems by controlling his diabetes more effectively, stopping smoking and taking advised medication.

33. Despite Mr Willmott's reluctance to address his poorly controlled diabetes, the clinical reviewer was satisfied that healthcare staff at Whitemoor provided good care. Mr Willmott had daily access to nurses and a prison GP saw him frequently for a variety of medical issues. Healthcare staff and specialists regularly advised him about improving the management of his diabetes and there was no delay in examining, investigating, and treating Mr Willmott's healthcare issues, including his diabetes. The clinical reviewer commended the very comprehensive and detailed healthcare records. He noted that healthcare staff rarely used a diabetic template and did not create an active care plan for Mr Willmott. While this did not affect the standard of Mr Willmott's care, he made some recommendations about these matters, which the Head of Healthcare will need to address.