

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Mapp a prisoner at HMP Hewell on 27 July 2017

A report by the Prisons and Probation Ombudsman

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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 into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr William Mapp died in hospital on 27 July 2017 of heart failure while a prisoner at HMP Hewell. Mr Mapp was 87 years old. We offer our condolences to Mr Mapp's family and friends.

We are satisfied that Mr Mapp received a good standard of care at Hewell, equivalent to that which he could have expected to receive in the community. We are concerned however, that Mr Mapp's next of kin was informed of his death over the telephone instead of in person.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 15 December 2016, Mr William Mapp was sentenced to two years and six months in prison for sexual offences and was sent to HMP Hewell. This was his first time in prison. He had a number of chronic health conditions including heart and lung problems and limited mobility.
2. On 14 January 2017, Mr Mapp fell in his cell and was taken to hospital. The next day he had an operation to repair a fractured hip. He returned to prison on 30 January. The following day he slipped in his cell and hurt his affected side. He was returned to hospital where he remained until 21 April.
3. On his return to Hewell, prison healthcare staff put care plans in place for Mr Mapp and he was assisted by carers who attended his cell three times per day. On 29 May, staff found Mr Mapp slumped in his cell. He was taken to hospital but was returned to Hewell the following day. At an outpatient appointment on 9 June, it was confirmed that he had experienced a mini stroke.
4. In June, Mr Mapp received treatment for a urine infection and showed signs of confusion. On 2 July, his carers found him to be pale with shallow breathing and he was taken to hospital. On 27 July, the hospital placed Mr Mapp on an end of life pathway. He died later that day.
5. Following Mr Mapp's death, a prison chaplain telephoned his next of kin, his brother-in-law, to inform him that Mr Mapp had died.

Findings

6. Mr Mapp arrived at Hewell with a number of chronic health conditions. We agree with the clinical reviewer that Mr Mapp received a good standard of care at Hewell equivalent to that which he could have expected to receive in the community.
7. We are concerned that Mr Mapp's next of kin was informed of his death over the telephone rather than in person. We make one recommendation.

Recommendations

- The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff in line with national guidance.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Mapp's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Mapp's clinical care at the prison.
11. We informed HM Coroner for Worcestershire of the investigation who notified us of Mr Mapp's cause of death. We have sent the coroner a copy of this report.
12. The investigator contacted Mr Mapp's next of kin, his brother-in-law, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. We received no reply.
13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Hewell

14. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Mapp was at the Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK provide health services and there is an 18 bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that the prison had many challenges and areas of serious concern. On healthcare, inspectors acknowledged that Care UK had inherited a poor service but, while they had made some improvement, significant work was still needed. Healthcare staff shortages had significantly affected service delivery. However, agency staff had been recruited to cover shortages and recruitment campaigns had been run to fill vacancies. Areas in healthcare, including the inpatient area, were dirty and poorly ventilated. The waiting area for vulnerable prisoners had prominent racist and violent graffiti and what appeared to be blood on the walls. The high rate of 'failure to attend' healthcare appointments had shown recent improvement.

Independent Monitoring Board

16. 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 30 September 2016, the Board was concerned that the newly appointed healthcare providers had not been able to provide the promised, acceptable standard of care. Late provision of regular medication on the house blocks had caused considerable disruption and the use of a large number of agency nurses had led to a lack of continuity in patient care.

Previous deaths at HMP Hewell

17. Mr Mapp was the fifth prisoner to die from natural causes at Hewell since January 2015. There were no similarities with the circumstances of the previous deaths.

Key Events

18. On 15 December 2016, Mr William Mapp was sentenced to two years and six months in prison for sexual offences and was sent to HMP Hewell. This was his first time in prison. Mr Mapp had diagnoses of various long-term conditions including chronic obstructive pulmonary disease (COPD – a collection of lung diseases, including chronic bronchitis and emphysema), hypertension, atrial fibrillation (irregular and fast heart beat), heart conditions, stage three kidney failure, osteoarthritis of the spine and high cholesterol. He had poor mobility and used a walking frame. A prison GP assessed Mr Mapp and prescribed him the medication he received in the community.
19. On 14 January 2017, Mr Mapp slipped and fell in his cell. A nurse responded to a code blue emergency call (which indicates a prisoner is unconscious, not breathing or having breathing difficulties) and found Mr Mapp sitting on his bed and communicating well. His blood pressure was low and she advised Mr Mapp to continue to drink. He reported pain in his elbow where he fell. She told Mr Mapp to ask for help if he felt the pain was getting worse. Later that afternoon she returned to Mr Mapp's cell because he reported pain in his hip and said he had fallen on his hip earlier. Mr Mapp was taken by ambulance to hospital for investigation of a possible hip fracture. No restraints were used because Mr Mapp was unable to walk independently. Restraints were not used at any time when Mr Mapp was taken to hospital.
20. On 15 January, Mr Mapp underwent surgery to repair his fractured hip. On 17 January, a nurse heard from the hospital that Mr Mapp was likely to be in recovery for over 12 weeks. A nurse visited Mr Mapp in hospital on 30 January and discussed his suitability for discharge. Mr Mapp returned to the lower level of the healthcare unit at Hewell later that day.
21. On 31 January, Mr Mapp fell in his cell and hurt his head and hip on the previously affected side. Staff arranged for Mr Mapp to be taken to hospital. He was discharged the same day, but readmitted on 2 February as healthcare staff felt that his condition was deteriorating.
22. Mr Mapp stayed in hospital until 21 April. During his stay prison healthcare staff made regular contact with the hospital and prison nurses visited him on three occasions. Prior to his discharge, healthcare staff liaised with the hospital and ensured that the right equipment and social care were in place when Mr Mapp was returned to Hewell. On his return, care plans were put in place and carers attended to Mr Mapp three times per day.
23. On 8 May, a prison GP reviewed Mr Mapp and requested an urgent physiotherapy referral. He also discussed advance care planning with Mr Mapp and his wishes for end of life care. Mr Mapp wanted to discuss this with his sister. On 28 June, Mr Mapp said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
24. On 17 May, a physiotherapist met Mr Mapp and planned to see him weekly to assist him with standing and using his walking frame.

25. On 26 May, a prison GP reviewed Mr Mapp at the request of a nurse because he was not feeling well. He found him to be breathless and pale and requested an ambulance. Mr Mapp told paramedics that he felt better and did not want to go to hospital. On 29 May, staff found Mr Mapp slumped on his commode, blue and with low blood pressure. They called an emergency ambulance and Mr Mapp was taken to hospital but was returned to Hewell later that day. A nurse sent Mr Mapp back to hospital because she considered him still to be unwell. The hospital called the healthcare unit to say that Mr Mapp was well enough to return to prison. He returned at 2am. On 9 June, a hospital consultant concluded that Mr Mapp had experienced a transient ischaemic attack (TIA – mini stroke).
26. On 15 June, a health care assistant found Mr Mapp to be confused and a urine test showed he had an infection. On 1 July, Mr Mapp appeared confused again and a urine test showed signs of an infection. On 2 July, Mr Mapp's carers found him to be pale and staring with shallow breathing. Mr Mapp was taken to hospital as an emergency.
27. Prison healthcare staff made regular contact with the hospital and had discussions about how to plan Mr Mapp's discharge to prison. On 25 July, a staff nurse visited Mr Mapp in hospital. She was told by hospital staff that he had been eating and drinking very little and Mr Mapp told her that he had given up.
28. On 27 July, a nurse received a call from the hospital to say that Mr Mapp had been placed on end of life care. The prison was informed that Mr Mapp died at 10.30pm.

Contact with Mr Mapp's family

29. On 2 July 2017, an officer was appointed as family liaison officer and made contact with Mr Mapp's sister to let her know he had been taken to hospital and was very unwell. The officer arranged a taxi for Mr Mapp's sister to attend the hospital and met her on arrival to explain his condition.
30. On 17 July, another officer took over as family liaison officer. On 19 July, she attempted to make contact with Mr Mapp's brother-in-law (who became Mr Mapp's next of kin after his sister had died) but was unable to get hold of him. After Mr Mapp died, a chaplain called Mr Mapp's brother-in-law to tell him that he had died. The chaplain told the investigator she could not remember why she called him instead of telling him in person.
31. The funeral took place on 17 August and the prison contributed towards the funeral costs in line with national policy.

Support for prisoners and staff

32. The prison posted notices informing other prisoners of Mr Mapp's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Mapp's death.

Post-mortem report

33. A post-mortem investigation was not completed as the Coroner accepted the hospital clinician's cause of death as severe aortic stenosis (heart valve disease)

and congestive cardiac failure (heart failure) contributed to by COPD, atrial fibrillation and peripheral vascular disease (a blood circulation disorder).

Findings

Clinical Care

34. Mr Mapp entered custody with a number of chronic health conditions. The clinical reviewer found that the care provided to Mr Mapp at HMP Hewell was equivalent to that which he could have expected to receive in the community and we agree.
35. The clinical reviewer makes three recommendations that the Head of Healthcare will want to consider.

Family Contact

36. The prison chaplain telephoned Mr Mapp's brother-in-law to inform him that Mr Mapp had died. She was unable to recall why she telephoned instead of visiting him in person. The family liaison officer told the investigator that the chaplain was informed of Mr Mapp's death as part of her role in the staff care team and that she was not asked to tell Mr Mapp's family. A deputy family liaison officer and the chaplain visited Mr Mapp's brother-in-law at home on 1 August.
37. PSI 64/2011 on Safer Custody, states, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death". Prison Service Order 1400 on Incident Management states that the prison should try to deliver the news themselves or at the very least via prison staff from a prison local to the next of kin.
38. As the PSI states, it is preferable for prisoners' families to be informed of their deaths in person from Prison Service staff. We make the following recommendation:

The Governor should ensure that in the event of a death, prisoners' families are informed in person by a member of Prison Service staff in line with national guidance.

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