Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John York a prisoner at HMP Whatton on 25 January 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*

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.

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.

Mr John York died in hospital of pneumonia on 25 January following a severe stroke, while a prisoner at HMP Whatton. Mr York was 77 years old. I offer my condolences to Mr York's family and friends.

I am satisfied that Mr York received a good standard of care and support at Whatton, equivalent to that which he could have expected in the community. However, I am concerned that the security risk assessment justifying the use of restraints on Mr York when he went to hospital did not take proper account of his advanced age and serious ill-health. It is disappointing to have to raise this matter with the prison again.

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 **August 2017**

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Summary

Events

1. Mr John York arrived at HMP Whatton on 21 September 2015, having been sentenced to five and a half years in prison.

2. Mr York was an elderly and frail man with limited mobility. He often presented as confused and disorientated. Healthcare staff reviewed him frequently and a trained prisoner carer helped him with everyday tasks. In October 2015, a nurse noted that Mr York's condition had deteriorated and she sent him to hospital where the general impression was one of depression or mild dementia. In November 2015, a social care assessment indicated that Mr York required daily support from a healthcare assistant and staff referred him to a community based dementia service.

3. In April 2016, a nurse recorded that Mr York continued to present with high blood pressure and booked him a GP review. A week later, a prison GP conducted an examination and prescribed a medication to lower his blood pressure. Over the next eight months, nurses monitored Mr York daily and doctors reviewed his blood test results when required. In December, a community psychiatric nurse saw Mr York for an assessment and confirmed a diagnosis of vascular dementia.

4. On 21 January 2017, at around 9am, a nurse reviewed Mr York and noted that he was lying on his bed breathing loudly and unable to communicate. An officer called an emergency code blue and Mr York was promptly taken to hospital by ambulance. Hospital staff confirmed that Mr York had suffered a severe stroke and that he had developed associated chest problems, which caused aspiration pneumonia. His condition did not improve and they started end of life care. Mr York died in hospital on 25 January, at 6.20am.

Findings

5. We agree with the clinical reviewer that Mr York received a good standard of clinical care at Whatton, equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately addressed his care needs and correctly identified and treated his high blood pressure.

6. However, we are concerned that the decision to use restraints when Mr York went to hospital in January did not take full account of his poor health and how this affected his level of risk.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr York's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr York's clinical care at the prison.

10. We informed HM Coroner for Nottinghamshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. The investigator wrote to Mr York's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

12. The initial report was shared with HM Prison Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Whatton

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

14. Nottinghamshire Healthcare Foundation Trust provides healthcare services at the prison. The healthcare centre is open seven days a week. GPs from a local practice provide specialist clinics for older prisoners and those with chronic conditions and there is an out-of-hours service. There are no inpatient beds, but there is a palliative care suite in the healthcare centre, called The Retreat, for end of life care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Whatton was in August 2016. Inspectors reported that the quality of health and social care was good, and waiting times for treatment were reasonable. Inspectors found that a mix of appropriately skilled staff, in well-integrated teams, provided health services, and that they provided polite and professional interactions with their patients. There was high demand for routine hospital appointments, though an increase in the number of available escort officers had significantly reduced the number of cancellations. They described the palliative care unit as excellent.

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 May 2016, the IMB reported that the elderly prison population was 37% and was a severe drain on prison resources. They said that the healthcare department struggled to care for the increasingly older population with their variety of complaints and conditions. They said that the healthcare facilities were not fit for purpose and compared badly with those in the community. Over the previous year, a business case to improve physical healthcare facilities was prepared, but was unsuccessful because funding from the NHS was no longer available.

Previous deaths at HMP Whatton

17. Mr York was the fifth person to die of natural causes at Whatton since January 2016. There has been a subsequent death from natural causes. We have previously raised concerns about shortcomings in the completion of risk assessments for hospital escorts.

Key Events

18. On 4 September 2015, Mr John York was sentenced to five years and a half years imprisonment for sexual offences and sent to HMP Leicester. He was moved to HMP Whatton on 21 September.

19. On 27 September, a nurse conducted a health screen and noted Mr York had a history of kyphoscoliosis (an abnormal curvature of the spine). The same day, prison staff reported that Mr York was not eating, had urinary incontinence and was confused. A nurse saw him for a review and recorded that he did not know where he was, did not make eye contact and could not recall the details of his community GP. She requested a urine sample and an urgent memory test. Prison staff moved Mr York to a single cell to make it easier for healthcare staff to access and monitor him.

20. On 5 October, a prison GP saw Mr York for an examination and recorded that he suffered from memory problems. She requested a series of blood tests, an occupational health referral and his community GP record. The next day, a mental health assistant conducted a memory test and suggested that Mr York should have a mental health assessment to rule out depression or any other mental illness.

21. On 14 October, a nurse reviewed Mr York in his cell and noted that a social care advocate (another prisoner trained to help him with everyday tasks) reported that he had difficulty getting dressed. Mr York had limited mobility and presented as confused and disengaged with his surroundings. She arranged for the mental health assistant to see him for a follow up appointment and she recorded that he was not aware of the time or where he was. The mental health assistant noted that Mr York's community medical record did not contain any significant medical history and indicated that he had not seen a GP since 2013. The next day, an occupational therapist saw Mr York to establish what equipment and level of support he required.

22. On 16 October, a nurse created a personal hygiene care plan and reviewed Mr York on the wing. She noted that he had lost weight and continued to present as confused and withdrawn. Concerned that his condition may deteriorate further, she sent him by taxi to hospital. Hospital staff initially treated Mr York for dehydration but the general impression was one of depression or mild dementia that required follow up by the community mental health team. Mr York returned to Whatton on 21 October and the nurse noted that he presented as more alert and aware of his surroundings.

23. On 29 October, a prison GP examined Mr York and recorded that he still had a very odd presentation. He had difficulty engaging in conversation and she considered that it could be a caused by dementia or depression. She prescribed citalopram (an antidepressant) and requested blood tests and a referral to the community mental health team. On 2 November, a social care assessment indicated that Mr York required daily support from a healthcare assistant to support his personal care needs. Two days later, she reviewed Mr York's blood test results and prescribed a vitamin D supplement.

24. The prison referred Mr York to a community based dementia service on 7 November, but there was an unexplained delay. Therefore, on 31 December, they referred him directly to mental health services for older people at the hospital. Over the next four months, Mr York's general health stabilised and his weight increased. His carers met all his personal hygiene needs and nurses saw him for reviews and to issue his medication daily.

25. On 12 April, a healthcare assistant recorded that Mr York's blood pressure remained high (177/72 mmHg) and she booked him a GP appointment. A week later, a prison GP diagnosed Mr York with hypertensive disease and prescribed amlodipine (a medication to lower blood pressure). Over the next five months, healthcare staff monitored his blood pressure frequently and documented that it had returned to within the normal range. Mr York's carers supported his personal care needs and nurses monitored and reviewed him daily.

26. On 29 September, the occupational therapist saw Mr York for a review and observed him using a Zimmer frame to mobilise. Three weeks later, she discharged him from occupational therapy given the unlikelihood of him being able to look after himself and as he was receiving suitable support from his carers. Nurses monitored him daily and GPs conducted examinations and reviewed his blood test results when required. A community psychiatric nurse saw Mr York for an assessment on 19 December and confirmed a diagnosis of vascular dementia.

27. On 11 January 2017, a nurse reviewed York's multiple care plans and issued his medication. On 18 January, a nurse noted that Mr York had been sick overnight and chose to chew his medication instead of taking it with fluids. Two days later, a nurse examined Mr York and noted that all his clinical observations were within the normal range, other than his temperature (38.4 degrees Celsius), for which she issued paracetamol.

28. On 21 January, at around 9am, a nurse went to see Mr York for a review and noted that he was lying on his bed breathing loudly and unable to communicate. At 9.05am, an officer called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and an ambulance was called immediately. Paramedics arrived at the prison at 9.21am and took Mr York by ambulance to hospital. Two officers escorted him and restrained him with an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer).

29. Hospital staff confirmed that Mr York had suffered a severe stroke and that records indicated he had suffered a stroke previously. Mr York developed chest problems due to the stroke, which caused aspiration pneumonia (a lung infection that develops after food, liquid or vomit is inhaled into the lungs). His condition did not improve and hospital staff started end of life care. Prison healthcare staff kept in daily touch with the hospital for updates on Mr York's condition.

30. On 25 January, hospital doctors decided to withdraw all active treatment and Mr York died at 6.20am.

Contact with York's family

31. On 21 January, the prison appointed an officer as family liaison officer. He noted that although Mr York had not nominated a next of kin, he had listed two friends. A prison manager asked the police for help tracing Mr York's next of kin and the officer arranged to meet his friends, one of whom was an ex-partner, at the hospital on 23 January. His ex-partner confirmed that he had three daughters from a previous relationship, but was unable to provide any more information. On 25 January, at 1.10pm, the officer contacted Mr York's ex-partner to tell her that he had died.

32. On 26 January, at 8.45am, the police informed the officer that they had located one of Mr York's daughters in Doncaster. The next day, he received notification that the police had advised her of her father's death. He wrote to Mr York's daughter on two occasions to request her input in to the funeral before proceeding with the arrangements.

33. Mr York's funeral was held on 14 March and the prison contributed towards the costs, in line with national policy.

Support for prisoners and staff

34. After Mr York's death, a prison manager debriefed the escort officers at the hospital to ensure that they had the opportunity to discuss any matters arising and to offer support. The staff care team also offered support.

35. The prison posted notices informing other prisoners of Mr York'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 York's death.

Post-mortem report

36. The coroner confirmed that Mr York died of aspiration pneumonia following a severe stroke. A previous stroke was a contributory factor.

Findings

Clinical care

37. Mr York was an elderly man with a number of chronic conditions, including hypertension and dementia. When he arrived at Whatton, his initial presentation was challenging and healthcare staff appropriately addressed his care needs. The clinical reviewer considered that the 13 month delay in Mr York having a community mental health assessment did not have a significant impact on his well-being as staff managed his care well. She also considered that healthcare staff correctly diagnosed and treated him for high blood pressure. We agree with the clinical reviewer that Mr York's second stroke could not have been foreseen or prevented.

38. We are satisfied that, overall, the level of care Mr York received at Whatton was good and was equivalent to that which he could have expected to receive in the community.

Restraints, security and escorts

39. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change

40. When Mr York went to hospital on 21 January, a prison manager signed a risk assessment indicating that he presented a medium risk to females and hospital staff. The assessment identified that his condition had an impact on his ability to escape, but the medical information section, including whether there were any objections to the use of restraints, was not complete. The prison manager who despatched the escort could not recall the specific incident, but told us that the prison's priority is to focus on the preservation of life and the security of the escort. Within minutes of Mr York's arrival at hospital, he reviewed the risk assessment and authorised the removal of his restraints. They were not used again for the remaining four days of Mr York's life.

41. While we recognise that the prison manager made the appropriate decision to remove the restraints shortly after Mr York's arrival at hospital, we consider that the use of restraints during the transfer was not justified. Mr York was an elderly and frail man with dementia who, at the time he was taken to hospital, was clearly very seriously ill. The risk assessment used was primarily based on the prison's view of his offence with little evidence of any consideration of how Mr York's age, health and mobility affected this risk, as the 2007 High Court judgment requires. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments, justifying the use of restraints on prisoners taken to hospital, understand the legal position; and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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