

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Whittaker a prisoner at HMP Wandsworth on 9 September 2016

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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 Paul Whittaker, a prisoner at HMP Wandsworth, died in hospital on 9 September 2016 of a stroke. He was 67 years old. I offer my condolences to those who knew him.

Mr Whittaker's long-term health conditions were appropriately managed by healthcare staff at Wandsworth. However, the investigation found that prison GPs did not review Mr Whittaker's prescribed medication history, which showed that he had been prescribed anti-epileptic medication.

Mr Whittaker suffered an epileptic seizure on 2 July, which might have been prevented had prison GPs prescribed anti-epileptic medication earlier. While this did not affect the eventual outcome for Mr Whittaker, it is important that prison GPs review prisoners' clinical records.

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

October 2017

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Summary

Events

1. Mr Paul Whittaker was remanded in custody at HMP Wandsworth in June 2016. He had a number of long-term medical conditions and a history of substance misuse.
2. Mr Whittaker was located in the prison's inpatient unit, where care plans were put in place. Prison GPs prescribed methadone to him and the substance misuse team assessed him regularly. Mr Whittaker was incapable of attending to his personal care, so healthcare staff assisted him with activities of daily living, including personal hygiene.
3. On 2 July, Mr Whittaker had an epileptic seizure and was admitted to hospital. Doctors prescribed anti-epileptic medication and Mr Whittaker did not have another seizure before he died.
4. At 8.45am on 26 July, a nurse found Mr Whittaker unresponsive in his cell and called an emergency ambulance. He was readmitted to hospital and doctors diagnosed respiratory failure. Mr Whittaker continued to deteriorate and he died at 7.40am on 9 September from a stroke.

Findings

5. Prison GPs' failure to review Mr Whittaker's prescribed medication meant he was not prescribed anti-epileptic medication. Had this been prescribed earlier, it could have prevented Mr Whittaker's epileptic seizure on 2 July.
6. With the above exception, we are satisfied that the standard of care provided to Mr Whittaker was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that staff establish the identity of a prisoner's community GP and promptly request their clinical records to ensure continuity of healthcare in line with PSO 3050.
- The Head of Healthcare should ensure that GPs review a prisoner's medication history to ensure continuity of healthcare in line with PSO 3050.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. NHS England commissioned a clinical reviewer to review Mr Whittaker's clinical care at the prison. Our investigation was suspended until we received the clinical review report.
9. We informed HM Coroner for Inner West London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. There was no family involvement in this investigation. Mr Whittaker had no next of kin.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wandsworth

12. HMP Wandsworth is a local prison in London and holds up to 1,658 men in eight residential wings. St George's Healthcare Trust provides physical healthcare services at the prison. There is an inpatient unit for up to six prisoners (the Jones Unit), which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Wandsworth was in March 2015. Inspectors noted that primary care services had deteriorated due to staffing pressures. The management of long-term conditions was reasonable but health promotion was weak. Medicines management was adequate. The regime in the Jones Unit was unnecessarily restrictive and not individualised for the men held there. There was no regular review of the needs of prisoners with disabilities in the prison and insufficient activities for older prisoners, many of whom spent a lot of time locked in their cells.

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 2016, the IMB reported that nursing shortages had resulted in a high use of agency nurses in the Jones Unit. There were frequent complaints from prisoners about the limited amount of time they were unlocked.

Previous deaths at HMP Wandsworth

15. Mr Whittaker was the second prisoner to die of natural causes at HMP Wandsworth since January 2015. There were no similarities with the circumstances of Mr Whittaker's death.

Key Events

16. On 4 June 2016, Mr Paul Whittaker was remanded in custody for a violent offence and sent to Wandsworth. Mr Whittaker had served three previous short-term sentences at Wandsworth and prison and healthcare staff knew him well.
17. At an initial health screen, a nurse noted that Mr Whittaker had a history of substance misuse and alcoholic liver disease which had caused a cognitive impairment. Mr Whittaker suffered from epileptic seizures and had chronic lower leg ulcers, duodenal ulcers (these occur in part of the intestine beyond the stomach) and had tested positive for hepatitis C infection. Mr Whittaker had poor mobility and used a wheelchair. He told her he used methadone in the community but did not know the name of his GP. She made a referral to the prison's substance misuse service and a prison GP assessed Mr Whittaker and prescribed methadone. Mr Whittaker was moved to the prison's inpatient unit. Nurses created care plans to manage his medical conditions and an older person's care plan to ensure his personal and physical needs were met.
18. On 6 June, a substance misuse consultant psychiatrist assessed Mr Whittaker and noted that he said that his community GP had prescribed methadone. The substance misuse team continued to assess Mr Whittaker regularly.
19. On 7 June, Mr Whittaker moved to a wheelchair adapted cell. On 8 June, Mr Whittaker damaged his cell and became aggressive with prison officers. He refused to allow a prison nurse to change the dressings on his leg ulcers and was verbally abusive to healthcare staff. On 11 June, Mr Whittaker returned to the inpatient unit. Nurses saw Mr Whittaker daily in accordance with his care plans and he did not express any concerns.
20. On 28 June, Mr Whittaker complained to a nurse of chest pains. She recorded his pulse, oxygen saturation level and blood pressure as normal. She arranged for Mr Whittaker's transfer to hospital. Two officers accompanied him and did not use restraints. Mr Whittaker refused an assessment by hospital doctors and was returned to Wandsworth the same day.
21. On 29 June, a prison GP saw Mr Whittaker, who was aggressive and uncooperative. Mr Whittaker refused to discuss why he had discharged himself from hospital. The same day, Mr Whittaker refused to see the substance misuse consultant psychiatrist to discuss a methadone detoxification plan. The psychiatrist noted that the substance misuse team should continue to regularly assess Mr Whittaker.
22. At 3.15pm on 2 July, a nurse went to Mr Whittaker's cell to complete a routine assessment. Mr Whittaker was pale and unresponsive and appeared to be having a seizure. She radioed an emergency code blue (which is used to indicate a prisoner has chest pain and difficulty in breathing) and the control room immediately called an emergency ambulance. Another nurse arrived and gave Mr Whittaker oxygen therapy. She recorded Mr Whittaker's pulse and temperature as normal. At 3.25pm, the paramedics arrived and took control of Mr Whittaker's care. The paramedics diagnosed an epileptic seizure and took Mr Whittaker to hospital. Two officers went with Mr Whittaker in the ambulance and did not use restraints.

23. While in hospital, Mr Whittaker had a chest X-ray, electrocardiogram (ECG - a test that checks the electrical activity of the heart) and a CT scan, with normal results. Hospital doctors prescribed anti-epileptic medication and Mr Whittaker returned to Wandsworth on 4 July.
24. On 5 July, a prison GP assessed Mr Whittaker and noted he had a history of epileptic seizures and had been prescribed anti-epileptic medication at Wandsworth in April 2016.
25. On 13 July, a consultant psychiatrist completed a cognitive function assessment. The results showed that Mr Whittaker had severe cognitive impairment. He concluded that this was due to a personality disorder and his history of substance misuse. He noted that medication or therapy would not improve Mr Whittaker's mental state.

Events on 26 July 2017

26. At 8.45am on 26 July, a nurse went to Mr Whittaker's cell to complete a routine assessment. Mr Whittaker was drowsy and unresponsive. He radioed an emergency code blue and the control room immediately called an emergency ambulance. He recorded Mr Whittaker's oxygen saturation level at 83% (low) and gave him oxygen therapy. The paramedics arrived at 9.04am and took control of Mr Whittaker's care. Mr Whittaker's oxygen saturation level increased to 95% but he was unresponsive to pain or voice. At 9.47am, the paramedics left the prison for hospital. Two officers went with Mr Whittaker in the ambulance and did not use restraints.
27. Hospital doctors diagnosed respiratory failure and treated Mr Whittaker with oxygen therapy and intravenous antibiotics and fluids. Mr Whittaker's condition continued to deteriorate and he died at 7.40am on 9 September.

Contact with Mr Whittaker's family

28. On 26 July 2017, the prison appointed a senior prison officer as the family liaison officer. She was unable to identify a next of kin for Mr Whittaker. Mr Whittaker had previously told prison staff that he had no contact with anyone in the community. The prison paid for and arranged Mr Whittaker's funeral which took place on 23 January 2017.

Support for prisoners and staff

29. The prison posted notices informing other prisoners of Mr Whittaker'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 Whittaker's death.
30. The prison offered support to the escort officers who were with Mr Whittaker when he died.

Post-mortem report

31. The coroner concluded that the cause of death was a stroke due to a right middle cerebral artery infarction.

Findings

Clinical care

32. The clinical reviewer commented that Mr Whittaker presented a considerable challenge to healthcare staff, both in terms of the extensive nature of his health problems and his behaviour. He considered that healthcare staff appropriately managed Mr Whittaker's complex health problems. The clinical reviewer concluded that the clinical care provided to Mr Whittaker was equivalent to that which he could have expected to receive in the community.
33. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, says that healthcare staff should make efforts to retrieve any information required from the prisoner's GP or other relevant service with which he has recently been in contact. This includes records from their community GP and previous periods in custody.
34. When Mr Whittaker arrived at Wandsworth on 4 June, a nurse completed an initial health screen. Mr Whittaker said his community GP had prescribed methadone to him but he could not recall his GP's name. A prison GP prescribed methadone to Mr Whittaker, but there was no evidence that healthcare staff made any effort to establish the details of his community GP in order to obtain his community clinical records. We make the following recommendation:

The Head of Healthcare should ensure that staff establish the identity of a prisoner's community GP and promptly request their clinical records to ensure continuity of healthcare in line with PSO 3050.

35. Mr Whittaker had a history of epileptic seizures and had been prescribed anti-epileptic medication at Wandsworth in April 2016. When he returned to Wandsworth on 4 June, there was no evidence that prison GPs reviewed his medication history. Mr Whittaker was not prescribed anti-epileptic medication and he had an epileptic seizure on 2 July. The clinical reviewer considered that had anti-epileptic medication been prescribed earlier, this could have prevented Mr Whittaker's epileptic seizure. We make the following recommendation:

The Head of Healthcare should ensure that GPs review a prisoner's medication history to ensure continuity of healthcare in line with PSO 3050.

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