

Independent investigation into the death of Mr Ian Wilkin a prisoner at HMP Whatton on 29 August 2017

A report by the Prisons and Probation Ombudsman



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

Mr Ian Wilkin died on 29 August 2017 of a heart attack at HMP Whatton. He was 66 years old. We offer our condolences to Mr Wilkin's family and friends.

Mr Wilkin had not complained of any symptoms relating to his heart and I am satisfied that staff at Whatton could not have predicted the heart attack which resulted in his death. In that respect the care Mr Wilkin received at Whatton was equivalent to that which he could have expected to receive in the community.

However - although it did not contribute to Mr Wilkin's death - I am concerned that on two occasions clinical staff failed to identify in a timely manner that Mr Wilkin had not received an appointment after a referral to secondary care in connection with his cancer.

It is also concerning that prison staff attempted to resuscitate Mr Wilkin when there were clearly no signs of life.

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

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Summary

Events

1. On 6 February 2015, Mr Ian Wilkin was sentenced to six years in prison for sexual offences. He was sent to HMP Nottingham. On 8 April 2015, he was transferred to HMP Whatton.
2. Mr Wilkin had a complex medical history before entering prison. In September 2007, he was diagnosed with rectal cancer and gas gangrene and underwent surgery and the formation of a colostomy (when a section of the bowel is surgically diverted through the abdomen, allowing faeces to leave the body through an opening called a stoma). In 2008, when the cancer reoccurred, he had further surgery to remove one leg and half of his pelvis. At his initial health screen at Whatton, he said that he had been clear of cancer for five years.
3. On 30 April 2015, a prison GP referred Mr Wilkin to a colorectal specialist after he reported bloating and leakage from his stoma. Healthcare staff saw him on a regular basis but it was not until February 2016, after a routine check of patient appointments, that they realised that they had not arranged an appointment with the specialist. After consulting the GP and speaking to Mr Wilkin, staff sent a new referral.
4. Mr Wilkin had his first appointment with a colorectal consultant on 5 May. A CT scan was arranged and the results raised concerns that Mr Wilkin's cancer had returned. The information was sent by letter to prison healthcare staff but they did not share it with Mr Wilkin.
5. The consultant explained the test results to Mr Wilkin when she saw him again on 21 September, and said that, if his cancer had returned, there was no further active treatment available to him. The consultant discharged Mr Wilkin from her care but said his original surgeon planned to see him again.
6. This information was passed to the prison. Mr Wilkin was not sent an appointment to see his original surgeon and this was not noticed until he made an appointment to see the prison GP nine months later.
7. On 23 November 2016, a nurse referred Mr Wilkin to a prison GP when he reported swelling in his right leg. The doctor advised him to mobilise his leg as much as possible but to otherwise keep it elevated. The GP also arranged for compression stockings. Mr Wilkin did not report any further problems with his leg after this appointment.
8. On 5 June 2017, Mr Wilkin reported pain in his anus. A prison GP arranged blood tests and wrote to his original surgeon who, despite the referral some nine months earlier (in September 2016), had not seen him. Mr Wilkin saw a member of the surgeon's team on 14 August, who arranged a scan of his abdomen and bladder.
9. On 29 August 2017, shortly after 8.00am, a prison officer found Mr Wilkin unresponsive when she unlocked his cell. His skin was purple, he felt stiff and cold to touch. The officer got assistance and staff radioed a code blue medical

emergency. The control room immediately called for an emergency ambulance and healthcare staff made their way to the cell.

10. Officers applied a defibrillator to Mr Wilkin's chest and began chest compressions. Healthcare staff arrived at the cell seconds later and told them to stop because Mr Wilkin was dead. Paramedics arrived at 8.25am, and confirmed Mr Wilkin was dead.
11. A post mortem examination concluded that the immediate cause of Mr Wilkin's death was from coronary artery thrombosis (a blood clot inside a blood vessel of the heart). This was caused by coronary artery atheroma (commonly known as 'hardening' or 'furring up' of the arteries) which reduces the blood supply to the heart.
12. The post mortem report found no recurring tumour.

Findings

13. There is no evidence that Mr Wilkin reported any symptoms in relation to his heart at any time. The clinical reviewer was satisfied that healthcare staff could not have predicted Mr Wilkin's heart attack and that, in that respect, the care he received at Whatton was equivalent to that which he could have expected to receive in the community.
14. However - although this did not contribute to Mr Wilkin's death - on two occasions clinical staff failed to identify in a timely manner that Mr Wilkin had not received an appointment after a referral to secondary care in connection with his cancer.
15. In addition, prison healthcare staff did not speak to Mr Wilkin to offer emotional support after the hospital told him that his previous cancer might have returned.
16. Prison staff attempted to resuscitate Mr Wilkin despite the fact that there were clearly no signs of life.

Recommendations

- The Head of Healthcare should ensure that there is a robust system in place at HMP Whatton to ensure that referrals to specialist and secondary care are not missed.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in accordance with European Resuscitation Council Guidelines.

The Investigation Process

17. 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.
18. He visited Whatton on 6 September. He obtained copies of relevant extracts from Mr Wilkin's prison and medical records.
19. NHS England commissioned a clinical reviewer to review Mr Wilkin's clinical care at the prison.
20. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The investigator wrote to Mr Wilkin's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Whatton

23. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 men convicted of sex offences.
24. Since 1 April 2017, MITIE Care and Custody Health have provided healthcare services. The healthcare centre is open from 7.30am to 6.30pm Monday to Friday and from 8.00am to 1.30pm on weekends and bank holidays. There is an out-of-hours service at other times. There are no inpatient beds, but there is a palliative care suite in the healthcare centre for end of life care.

HM Inspectorate of Prisons

25. 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 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. The inspectors described the palliative care unit as excellent.

Independent Monitoring Board

26. 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 2017, the board reported its extreme concern about the provision of healthcare since the appointment of MITIE, particularly in relation to pharmacy and mental health.
27. The board highlighted the high number of older prisoners with significantly different and more costly healthcare needs, including social care.
28. Staff shortages together with the increasing demand for hospital escorts and bed watches, resulted in a significant reduction in 'out of cell' time and the board considered that the current pressure on staff was unsustainable.

Previous deaths at HMP Whatton

29. Mr Wilkin's death was the tenth from natural causes since September 2015. There are no significant similarities with those previous deaths.

Key Events

30. In September 2007, Mr Ian Wilkin was diagnosed with rectal cancer and gas gangrene (a bacterial infection causing gas to form in tissue where the lack of blood supply has caused the tissue to die.) He had surgery and the formation of a colostomy (where a section of the bowel is surgically diverted through the abdomen and an appliance called a stoma bag attached to allow faeces and urine to leave the body). He had had chemotherapy and radiotherapy treatment.
31. Mr Wilkin needed more surgery in 2008 and underwent a hindquarter amputation (where the entire leg and half the pelvis were removed). He had further treatment in 2009 and a scan in 2012, which showed no evidence of recurrent disease.
32. On 6 February 2015, Mr Wilkin was sentenced to six years in prison for sexual offences. He was sent to HMP Nottingham. On 8 April 2015, he was transferred to HMP Whatton.
33. At his initial health screen at Whatton, Mr Wilkin told a nurse that he had been clear of cancer for five years. His blood pressure was slightly high but otherwise there were no concerns. Staff offered Mr Wilkin smoking cessation advice and though initially reluctant, he gradually cut down the number of cigarettes he smoked and eventually stopped.
34. On 30 April, a nurse examined Mr Wilkin who reported bloating and leakage from his stoma. She referred him to the prison GP. The prison GP saw him the same day and referred him to a colorectal surgeon for review. Prison administration staff sent the referral on 11 May.
35. During his first few weeks at Whatton, both the occupational therapy service and a community-based physiotherapist saw Mr Wilkin to assess his needs. He underwent a tissue viability assessment and had a hospital bed and pressure-relieving mattress provided. Due to his limited mobility, staff recognised the likelihood of him developing pressure sores and kept this under regular assessment and review.
36. In February 2016, after a routine review of patient appointments, staff realised that Mr Wilkin's referral, sent ten months earlier, had not been responded to and no appointment had been received. On 29 February, a nurse spoke to him at the request of a prison GP, to discuss his continued need for a colorectal referral. Mr Wilkin said that he still had the problem, though not as bad. The prison re-sent the referral on 2 May.
37. On 5 May, Mr Wilkin attended hospital to see a colorectal consultant, who arranged for a computerised tomography (CT) scan. This is a scan that uses a computer to take data from several X-ray images and convert them into pictures on a monitor. The colorectal consultant reviewed Mr Wilkin's previous treatment and noted that she would speak to his original surgeon.
38. The colorectal consultant wrote to the prison GP at the prison on 19 July, and said that the CT scan raised concerns that Mr Wilkin's cancer had returned. She also said that surgical intervention would be risky and challenging. She said she

would discuss this with Mr Wilkin at his next appointment. There is nothing in the medical record to show that prison healthcare staff shared the results of the CT scan with Mr Wilkin.

39. On 1 August, a nurse spoke to Mr Wilkin to discuss his ongoing treatment. Mr Wilkin said that he was expecting to have surgery. She explained that the latest correspondence from the colorectal team suggested they would prefer to attempt something less invasive.
40. A prison GP saw Mr Wilkin again on 21 September; she told him that there was a possibility that his cancer had returned and that, if this was the case, due to his previous surgery and chemo-radiotherapy, he would not be suitable for further treatment. Mr Wilkin said that he was keen to explore a surgical option and the prison GP said that the original surgeon planned to see him about this. She discharged Mr Wilkin from her care.
41. The colorectal consultant wrote to the prison on 21 September, setting out the details of the meeting with Mr Wilkin, but there is nothing in the medical record to indicate that healthcare staff at the prison spoke to him to offer emotional support or to discuss palliative care. Mr Wilkin was not sent an appointment to see his original surgeon as expected and there was no further investigation or discussion about the possibility of his cancer returning.
42. On 23 November, a nurse examined Mr Wilkin in the healthcare unit after he reported swelling in his right leg. She referred him to the GP and a GP saw him two days later. He advised Mr Wilkin to mobilise his leg as much as possible but to otherwise keep it elevated. He also arranged for compression stockings. Mr Wilkin reported no further problems with his leg after this.
43. On 5 June 2017, a nurse examined Mr Wilkin on the wing after he reported internal pain in his anus and blood in his urine. She referred him to the GP and a GP saw him on 9 June, and arranged blood tests. The results prompted further tests and a referral for an ultrasound scan (a scan that uses high-frequency sound waves to create an image of part of the inside of the body) of Mr Wilkin's liver. She also wrote to the original surgeon who, despite the colorectal consultant indicating that he planned to see him (nine months earlier in September 2016) still had not done so.
44. On 14 August, Mr Wilkin saw a member of the colorectal team. A prison GP reviewed him after he returned to the prison. Mr Wilkin told her that the hospital planned to do a CT scan of his abdomen and to examine his bladder and to wait for the results before deciding on further treatment.

Events of 29 August 2017

45. On 29 August 2017, shortly after 8.00am, Prisoner Officer D unlocked Mr Wilkin's cell and called "good morning". When Mr Wilkin did not reply the officer went into the cell where she saw him lying on his bed. She immediately noticed that his skin was purple in colour. She called his name out loudly and shook his arm but Mr Wilkin did not respond. She described Mr Wilkin as extremely cold and starting to feel stiff. She believed that he was dead and probably had been for some time.

46. She did not have a radio as not all officers on the wing carry them. She left the cell to get assistance from other officers on the wing. At 8.05am, Prison Officer E radioed an emergency code blue (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties). The control room immediately called for an emergency ambulance and healthcare staff made their way to the cell.
47. Officer D went to the wing office to collect the defibrillator. She returned to the cell with the custodial manager. A Supervising Officer and Officer G joined them moments later.
48. The officers attempted to get Mr Wilkin onto his back. Officer G said Mr Wilkin was cold and rigid and moving him was difficult. They applied the defibrillator pads to Mr Wilkin's chest and followed the instructions of the machine. No heart rhythm was detected and no shocks given. Officer D began chest compressions as directed by the machine but after only two compressions, healthcare staff were on scene.
49. A nurse entered the cell at 8.09am. She saw Mr Wilkin lying on the bed with his eyes open. She described him as purple in colour and cold to touch. His right arm was raised. She told the officers to stop chest compressions as there were no signs of life.
50. Paramedics arrived at the cell at 8.25am and confirmed that Mr Wilkin was dead.

Contact with Mr Wilkin's family

51. Immediately after Mr Wilkin's death the prison appointed, a trained member of the prison civilian staff as the family liaison officer (FLO). Mr Wilkin's son, his nominated next of kin, lived more than 130 miles from the prison. After a discussion at senior manager level, the prison asked the local police to inform Mr Wilkin's son of his death.
52. Mr Wilkin's son telephoned the prison at 2.15pm and spoke to the FLO who offered her condolences. They discussed the procedures that would follow, including funeral arrangements and the collection of Mr Wilkin's property. Mr Wilkin's son explained that he had not been in contact with his father for several years and did not want to be involved in the funeral. He said he would inform the other family members of the death, some on whom still lived in the Nottingham area.
53. The FLO telephoned Mr Wilkin's son on 31 August. He said that he had spoken to Mr Wilkin's sister who did not want to be involved in the funeral but who had agreed to attend the prison to collect his property.
54. Mr Wilkin's sister and two other family members attended the prison on 6 September to collect Mr Wilkin's property and were given the opportunity to attend the wing.
55. Mr Wilkin's funeral was held on 2 October 2017. The prison contributed towards the cost on line with prison service instructions.

Support for prisoners and staff

56. After Mr Wilkin's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
57. The prison posted notices informing other prisoners of Mr Wilkin'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 Wilkin's death.

Post-mortem report

58. A post-mortem examination concluded that the immediate cause of Mr Wilkin's death was coronary artery thrombosis (a blood clot inside a blood vessel of the heart), caused by coronary artery atheroma ('hardening' or 'furring up' of the arteries). No recurring tumour was seen.

Findings

Clinical care

59. The clinical reviewer is satisfied that healthcare staff at Whatton could not have predicted the heart attack that Mr Wilkin sustained in August 2017, which resulted in his death and that, in that respect, the care he received at Whatton, was equivalent to that which he could have expected to receive in the community.
60. However, though not related to his death, on two occasions clinical staff failed to identify in a timely manner that Mr Wilkin had not received an appointment after a referral to secondary care.
61. On the first occasion in April 2015, a prison GP referred Mr Wilkin to a colorectal consultant but the lack of an appointment went unnoticed for ten months. On the second, in September 2016, the colorectal consultant referred Mr Wilkin to the surgeon who had treated him previously. No appointment was received and this went unnoticed for nine months.
62. The head of healthcare said that the usual process for referrals to secondary care is to run a weekly report for urgent cases and a quarterly report for non-urgent cases to ensure they get appointments within the expected time frames. However, there is no evidence to show that this happened.
63. The head of healthcare could not say why the quarterly checks were not completed as required, but did say that, on average, they have approximately 40 referrals to secondary care per month and that, during the period in question, they had staff vacancies and a lack of capacity. We make the following recommendation,

The Head of Healthcare should ensure that there is a robust system in place at HMP Whatton to ensure that referrals to specialist and secondary care are not missed.

64. On 19 July 2016, prison healthcare staff were informed in a letter from his consultant, that, following tests, a possibility existed that Mr Wilkin's cancer had returned and that if this was the case, no further active treatment could be offered. Healthcare staff did not discuss or share this information with Mr Wilkin and it was another two months before he was told (at the next appointment with his consultant).
65. Following the consultant appointment, prison healthcare staff still did not speak to Mr Wilkin about the possibility of his cancer returning and to offer emotional support or to discuss palliative care.
66. The head of healthcare told the clinical reviewer that since Mr Wilkin's death the prison have put in post a registered nurse with a special interest in palliative care. The nurse will be aware of all patients with a diagnosis of cancer and has responsibility for the management of their care. Appropriate access to clinical

supervision and appropriate training is planned. We therefore make no recommendation.

Resuscitation

67. Officer D described Mr Wilkin as extremely cold and starting to feel stiff when she discovered him unresponsive in his cell. She believed that he was dead and probably had been for some time. Officer G described him as cold and rigid and that moving him was difficult. None the less the officers attempted resuscitation.
68. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised, but staff should understand that they are not required to carry out cardiopulmonary resuscitation in these circumstances.
69. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison, IRC or residential short term holding facility, and was taken from the European Resuscitation Council Guidelines 2015, which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”.
70. Appropriately, the first member of healthcare staff who arrived almost immediately directed officers to stop. We do however 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 in accordance with European Resuscitation Council Guidelines.

