

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Freddy Walter a prisoner at HMP Isle of Wight on 30 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.

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 Freddy Walter died in hospital on 30 July 2017, of heart failure and a heart attack, while a prisoner at HMP Isle of Wight. He was 73 years old. I offer my condolences to Mr Walter's family and friends.

Although the management of Mr Walter's long term medical conditions was satisfactory, his care when he became acutely unwell was below the standard he could have expected to receive in the community. Prison healthcare staff did not use the expected tools to assess the severity of his illness when he reported prolonged breathlessness and coughing. This led to a delay of up to 48 hours before he was referred for specialist care.

We consider that prison staff should have contacted Mr Walter's next of kin sooner and offered her a greater level of support when he was admitted to hospital.

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**

**July 2018**

## **Contents**

Summary .....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings.....	7

# Summary

## Events

1. On 24 February 2017, Mr Freddy Walter was sentenced to eight years and six months in prison and sent to HMP Elmley. Mr Walter had a history of heart disease, diabetes and a benign tumour in his pituitary gland. Healthcare staff created care plans, prescribed medication and monitored his health conditions. Mr Walter was moved to HMP Isle of Wight on 5 May, where healthcare staff continued to manage and review his health conditions.
2. In the early hours of 22 July, Mr Walter reported breathlessness and a cough which produced brown phlegm. Later that morning, a nurse examined him and telephoned a prison GP to discuss his symptoms. The doctor suspected that Mr Walter had a chest infection and prescribed antibiotics. He instructed healthcare staff to monitor him and arranged a GP review.
3. On 24 July, another prison GP examined Mr Walter. He told the doctor he felt worse. His cough and breathlessness had persisted, he had excess fluid in his ankles and he was too weak to walk. The doctor diagnosed a chest infection, with the possibility of pneumonia and secondary heart failure and sent him to hospital as an emergency. On 28 July, Mr Walter had a heart attack and hospital staff successfully resuscitated him. However, he died at 6.34am on 30 July.

## Findings

4. Prison healthcare staff managed Mr Walter's chronic health conditions appropriately. However, when he became acutely unwell on 22 July, his care did not meet the standard he could have expected to receive in the community. The clinical reviewer considered that healthcare staff should have applied the sepsis protocol and the National Early Warning Score (NEWS) system to assess the severity of Mr Walter's symptoms. Had they used these tools, he might have been referred to secondary care for appropriate treatment 48 hours sooner and there might have been a better outcome.
5. There is no evidence that prison staff informed Mr Walter's next of kin promptly of his admission to hospital, or provided the level of communication and support expected when a prisoner is seriously ill. However, family contact after his death was appropriate and supportive.

## Recommendations

- The Head of Healthcare should ensure that staff consistently use assessment tools, such as the sepsis protocol and the National Early Warning Score (NEWS) system, to assess patients with acute symptoms and escalate care, when indicated.
- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital and that they comply with Prison Service guidance about engaging with prisoners' families.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Isle of Wight, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Walter's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Walter's clinical care at the prison.
9. The investigator and clinical reviewer interviewed four members of staff (two in person and two by telephone conference) at HMP Isle of Wight on 18 September. The investigator interviewed an additional member of staff by telephone on 4 October.
10. We informed HM Coroner for Isle of Wight 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 Walter's wife, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not respond to our letter.
12. We shared the initial report with HM Prison and Probation Service (HMPPS) and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

# Background Information

## HMP Isle of Wight

13. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. It holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is an inpatient unit at the Albany site

## HM Inspectorate of Prisons

14. The most recent inspection of HMP Isle of Wight was in May and June 2015. Inspectors reported that health services were good and prisoners were positive about their care. However, they found that older prisoners and those with lifelong conditions did not always have regular reviews or an appropriate care plan.

## Independent Monitoring Board

15. 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 31 December 2016, the IMB reported that the healthcare team were dedicated and professional, with good leadership. Outpatient services were satisfactory and the inpatient unit in the Albany site provided a high standard of care.

## Previous deaths at HMP Isle of Wight

16. Mr Walter was the seventh prisoner to die of natural causes at HMP Isle of Wight since January 2016. There have been three subsequent deaths from natural causes. There were no significant similarities between the circumstances of Mr Walter's death and those previously investigated.

## Key Events

17. On 24 February 2017, Mr Freddy Walter was sentenced to eight years and six months in prison for sexual offences and sent to HMP Elmley. It was his first time in prison.
18. At a reception health screen, a nurse recorded that Mr Walter had ischaemic heart disease, type 2 diabetes and high blood pressure. She created cardiovascular, hypertension and diabetes care plans to monitor these conditions. She also obtained Mr Walter's consent to share his community GP records and referred him to the relevant specialist clinics. Owing to an IT problem at that time, she was unable to access his community records. A prison GP then reviewed Mr Walter. In addition to the other conditions listed, he noted that a specialist was monitoring a benign tumour in Mr Walter's pituitary gland. The GP requested blood tests and re-prescribed his existing medication.
19. The next day, a healthcare assistant conducted a more detailed secondary health assessment. Healthcare staff monitored Mr Walter's health conditions and there were no significant entries in his medical record while he was at Elmley.
20. On 5 May, Mr Walter moved to HMP Isle of Wight. During an overnight stay at HMP Winchester on the way there, staff carried out a health assessment. When he arrived at Isle of Wight, Mr Walter had a further health screen and a new patient review was held on 8 May. Healthcare staff conducted reviews of his chronic health conditions in the following weeks.
21. On 30 May, a prison GP examined Mr Walter as he felt unwell and had swollen ankles. The GP thought his fluid retention might be due to the hot weather. They discussed his blood sugar levels, health conditions and medication and the doctor re-referred Mr Walter to the endocrinologist for management of his diabetes and pituitary adenoma. Over the next few weeks, Mr Walter saw healthcare staff to obtain medication.
22. Just before 6.00am on 22 July, wing staff telephoned the healthcare unit to report that Mr Walter had breathing difficulties. A nurse went to see Mr Walter, who told her that he had been coughing up phlegm for the past three days which had left him breathless at times, but he had no chest pain. He had not reported this before. The nurse found that Mr Walter's blood sugar levels were low, so she advised him to eat. She offered to admit him to the inpatient unit for observation if necessary and noted that clinic staff should see him later in the morning for a suspected chest infection. At 8.35am, a nurse advised wing staff to check on him and contact healthcare if they had any further concerns.
23. At 10.19am, a nurse examined Mr Walter in the healthcare clinic and noted a productive cough of brown sputum, shortness of breath and a slight wheeze. She telephoned a prison GP for advice and explained Mr Walter's symptoms. The GP suspected that he had a chest infection and prescribed clarithromycin (an antibiotic), without examining him. He noted that nurses should review Mr Walter the next day and he requested a GP review during the following week, sooner if there was any deterioration.

24. On 23 July, a nurse noted that Mr Walter had started his antibiotics and his observations were similar to the previous day. The nurse advised him to continue drinking fluids. A GP appointment was due the next day.
25. Shortly before midnight, a custodial manager called a nurse to request a sleeping aid for Mr Walter. He had been unable to sleep for the past few nights and had shown the custodial manager some dark brown sputum. The nurse told the custodial manager that he had started antibiotics over the weekend and had a doctor's appointment booked for the next day. She advised that Mr Walter should continue to drink fluids and staff should contact the inpatient unit if they had continuing concerns about him.
26. At 10.26am on 24 July, a prison GP examined Mr Walter. He recorded a history of diarrhoea, coughing, shortness of breath, dark sputum and excess fluid in his ankles. Mr Walter told him that he had felt worse each day and was now in a wheelchair, as he felt too weak to walk. The GP diagnosed a chest infection, with the possibility of pneumonia and secondary heart failure. He referred him to the Accident and Emergency Department of St Mary's Hospital, Newport.
27. Prison staff requested an emergency ambulance at 10.40am and healthcare staff gave Mr Walter oxygen while he waited for the paramedics to arrive. The ambulance arrived at 11.40am and left the prison at 11.50am. Staff completed a comprehensive security risk assessment, concluding that no restraints should be used due to Mr Walter's age, poor mobility and transport by ambulance.
28. Mr Walter was initially admitted to the coronary care unit. Healthcare staff contacted the hospital daily for updates on his condition. On 28 July, hospital staff successfully resuscitated Mr Walter after a cardiac arrest and he moved to the critical care unit. Shortly afterwards, a hospital doctor informed him that due to his poor heart condition they would not attempt resuscitation if he had a further cardiac arrest. In the early hours of 29 July, nurses told the escort officers that Mr Walter was not expected to live much longer. He died at 6.34am, on 30 July.

### **Contact with Mr Walter's family**

29. Escort records show that Mr Walter's wife telephoned the hospital during the morning of 26 July. It is not clear how she learned that her husband was in hospital. When she telephoned again the following day, escort officers checked with the prison that she was approved to contact him.
30. At 1.15pm on 28 July, Mr Walter asked to telephone his wife. The escort officers recorded that they would check with the prison to verify that her number was approved. At 5.00pm, they noted that the prison was unable to verify the number, so they would have to check her identity if he called, but Mr Walters was unable to talk to her at that time, due to breathing difficulties. At 8.05pm, Mr Walters asked for his wife to be informed that he had been moved to the critical care unit and the escort officers passed this on to the prison. Prison records show that an officer notified her of the move at around 8.30pm and told her about Mr Walter's heart attack. He recorded that she already knew that Mr Walter was in hospital. At 7.20am on 29 July, a hospital doctor informed Mr Walter's wife that he was unlikely to survive and nurses kept her informed of his condition.

31. A hospital nurse informed Mr Walter's wife of his death. Two hours later, the deputy family liaison officer telephoned Mr Walter's wife to offer condolences and support. He and another prison family liaison officer visited her a few days later and continued to support her. In line with national policy, the prison contributed to the costs of Mr Walter's funeral, which took place on 8 September.

### **Support for prisoners and staff**

32. After Mr Walter's death, a prison manager debriefed the prison escort staff at the hospital and offered support.
33. The prison posted notices informing other prisoners of Mr Walter'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 his death.

### **Post-mortem report**

34. A post-mortem examination concluded that the cause of Mr Walter's death was heart failure and a heart attack caused by hardening of the arteries. He also had lung cancer. The post-mortem report listed in full the following cause of death:

- 1a congestive cardiac failure
- 1b acute myocardial infarction
- 1c severe coronary artery atheromatous disease
- 2 adenocarcinoma of the right lung.

# Findings

## Clinical care

35. When Mr Walter arrived at the prison, healthcare staff assessed him and put in place appropriate care plans to monitor and treat his longstanding medical conditions. The clinical reviewer concluded that the management of Mr Walter's long-term health conditions was equivalent to that which he could have expected to receive in the community. However, he considered that Mr Walter's care during his final illness fell short of the standards expected.
36. There were three missed opportunities to refer Mr Walter to secondary care sooner, when he became acutely unwell on 22 July. The clinical reviewer considered that given Mr Walter's age, history of diabetes and heart disease, symptoms of acute coughing, breathing difficulties and reduced appetite, as well as a raised respiratory rate and reduced oxygen saturation, the prison GP should have physically examined him after the nurse telephoned for advice about his symptoms on the morning of 22 July. The clinical reviewer felt that this might have resulted in a diagnosis of heart failure and, in turn, triggered appropriate treatment, rather than antibiotics for an infection.
37. The clinical reviewer noted that if the healthcare department's sepsis protocol had been applied, this would have led to an assessment of Mr Walter at hospital on the same day. Healthcare staff acknowledged this in a review conducted shortly after his death.
38. The clinical reviewer established that the healthcare department at Isle of Wight had implemented the use of the Royal College of Physicians National Early Warning Score (NEWS), a system to identify the severity of acute illnesses and the risk of deterioration. Healthcare staff used it routinely to assess acutely unwell prisoners in the inpatient and residential units. The clinical reviewer felt that staff should have applied the NEWS system during their contact with Mr Walter between 22-24 July and that this might have indicated that his illness was more severe than his presentation. He believed that application of the system would have led to either a full clinical assessment by a doctor, or an emergency admission to hospital on 22 July.
39. The clinical reviewer considered that the failure to apply either NEWS, or the sepsis protocol denied Mr Walter the opportunity of optimal treatment for 48 hours. He added that it was possible, but not definite, that Mr Walter might have had a better outcome if different clinical decisions had been made on 22 July. We agree with his conclusions and make the following recommendation:  
  
**The Head of Healthcare should ensure that staff consistently use assessment tools, such as the sepsis protocol and the National Early Warning Score (NEWS) system, to assess patients with acute symptoms and escalate care, when indicated.**
40. In the clinical review report, the clinical reviewer made additional recommendations on matters not directly related to Mr Walter's cause of death but which the Head of Healthcare will wish to address.

## Family liaison

41. Prison Rule 22 instructs that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011, about safer custody, sets out the expectation that if a prisoner suffers an unpredicted or rapid deterioration in their physical health an appropriate member of prison staff should engage with their next of kin to provide information and support.
42. The prison was unable to produce any evidence of how and when Mr Walter's wife, his next of kin, found out that Mr Walter was in hospital, so it is unclear whether prison staff had notified her. The first reference to his wife was in escort records which showed that she had telephoned the hospital during the morning of 26 July and again the next day. Escort staff checked with the prison to confirm that contact was permitted, which suggests that the prison had not previously arranged or authorised such contact. On 28 July, Mr Walter asked to telephone his wife, but was considered too unwell to speak to her. That evening, he asked for her to be informed of his move to the critical care unit and the prison contacted her around 25 minutes later. The prison appointed family liaison officers shortly after Mr Walter died.
43. We are satisfied that the prison's family liaison officers provided appropriate and continuing support to Mr Walter's wife after his death. However, we cannot be certain that the prison informed her promptly that he was seriously ill, or provided the level of support expected when a prisoner is in hospital. It seems that most of the contact during that time was initiated by his wife, or at his request, with little or no proactive engagement by prison staff. By the time the prison approved a direct call between them, he was too ill to have a conversation with his wife. We make the following recommendation:

**The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital and that they comply with Prison Service guidance about engaging with prisoners' families.**

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