

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Wilkinson a prisoner at HMP Whatton on 25 December 2017

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.

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 Trevor Wilkinson died on 25 December 2017 of pneumonia at HMP Whatton. He was 73 years old. I offer my condolences to those who knew him.

I am satisfied that the healthcare Mr Wilkinson received in prison was generally equivalent to that which he could have expected to receive in the community. He received good, compassionate care from staff at Whatton.

Mr Wilkinson showed signs of vascular dementia and it was unclear whether he always had the mental capacity to make decisions about his own care. He often refused to take his prescribed medication. I am concerned that healthcare staff did not carry out a formal mental capacity assessment to establish the extent of his mental capacity and what actions were in his best interests.

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

August 2018

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Summary

Events

1. Mr Trevor Wilkinson was sent to prison in May 1996. He was released on licence to a nursing home in October 2012 but was recalled to prison in February 2016. He was moved to HMP Whatton later that month.
2. Mr Wilkinson had type 2 diabetes and heart disease. He had very poor mobility and used a wheelchair. He frequently refused to take his prescribed medication.
3. Healthcare staff provided Mr Wilkinson with daily support in accordance with his clinical and social care plans. On 28 March 2017, a prison GP noted that Mr Wilkinson had symptoms of dementia and referred him to a hospital geriatric specialist. Mr Wilkinson refused to attend the appointment.
4. On 27 November, Mr Wilkinson was taken to hospital after falling over in his cell. Hospital doctors treated him for pneumonia and decided he was no longer suitable for active treatment.
5. On 22 December, Mr Wilkinson was returned to Whatton for end of life care. He died at 7.07pm on 26 December.

Findings

6. We agree with the clinical reviewer that Mr Wilkinson generally received care equivalent to that which he could have expected to receive in the community. Carers attended to his personal care during the day and this was provided on a 24-hour basis when he returned from hospital to receive end of life care. The clinical reviewer considered healthcare staff treated Mr Wilkinson with dignity and respect.
7. However, Mr Wilkinson displayed symptoms of vascular dementia and we cannot be clear if he understood the possible consequences of not taking his prescribed medication. There is no evidence that healthcare staff completed a formal mental capacity assessment or recorded how they were confident they were acting in his best interests.

Recommendations

- The Head of Healthcare, Lead GP and Mental Health provider at HMP Whatton should establish clear guidelines for all healthcare staff in the prison to ensure that the principles and requirements of the Mental Capacity Act are followed. This should be underpinned by training for all healthcare staff.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Whatton 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 Wilkinson's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Wilkinson's clinical care at the prison.
11. 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.
12. The investigator wrote to Mr Wilkinson's solicitor to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Whatton

14. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.
15. MITIE Care and Custody Health took over the provision of healthcare services from Nottinghamshire Healthcare Foundation Trust on 1 April 2017. 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

16. 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. Although there was high demand for routine hospital appointments, 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

17. 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 May 2017, the IMB reported its extreme concern about the provision of healthcare since the appointment of MITIE, particularly in relation to pharmacy and mental health.
18. The Board highlighted the high number of older prisoners with significantly different and more costly healthcare needs, including social care.
19. Staff shortages, together with the increasing demand for hospital escorts and bed watches, had 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

20. Mr Wilkinson was sixth prisoner to die from natural causes at HMP Whatton since January 2015. There have been two deaths from natural causes since. There were no similarities with the other deaths.

Key Events

21. On 16 May 1996, Mr Trevor Wilkinson was sentenced to life in prison for sexual offences and sent to HMP Featherstone. On 5 October 2012, he was released on licence a nursing home. On 4 February 2016, Mr Wilkinson was recalled to prison after breaching the conditions of his licence and sent to HMP Nottingham. He was moved to HMP Whatton on 11 February 2016.
22. At an initial health screen at Whatton, a nurse noted that Mr Wilkinson had type 2 diabetes and ischaemic heart disease. He was obese (103kgs) and incontinent. He had very poor mobility and used a wheelchair. He was a smoker and declined help to stop. The same day a prison GP requested Mr Wilkinson's community GP records. These were received on 18 February and the prison GP prescribed Mr Wilkinson his regular medication. Nurses created care plans to manage Mr Wilkinson's medical conditions and social care needs.
23. Mr Wilkinson lived in a standard cell containing a hospital bed and was allocated two carers who helped him with mobility and social care. On 2 March, a nurse saw Mr Wilkinson because he refused to take his prescribed medication. Healthcare staff told him he was at risk of a stroke or a cardiac event if did not take his medication and Mr Wilkinson said he understood. Despite the encouragement of staff, Mr Wilkinson frequently declined his medication.
24. Healthcare staff saw Mr Wilkinson daily in accordance with his care plans. On 7 July, an occupational therapist completed an occupational therapy assessment. She noted that Mr Wilkinson could move independently from his bed to his wheelchair and no longer needed two carers to help him. She discharged Mr Wilkinson from the occupational therapy service but noted the carers would continue to provide Mr Wilkinson support with his social care.
25. On 8 September, Mr Wilkinson assaulted a nurse in his cell when she administered his prescribed medication. Mr Wilkinson was moved to the segregation unit for good order and discipline. Healthcare staff and his carers saw him daily to attend to his clinical and social care. He returned to the wing on 29 September.
26. Mr Wilkinson continued to refuse his prescribed medication. On 4 January 2017, a mental health nurse assessed Mr Wilkinson's mental health. Mr Wilkinson said he did not feel depressed and wanted to be left alone. He understood the risks of not taking his prescribed medication and said he did not feel different when he took them. She noted that Mr Wilkinson needed daily support with his social care in accordance with his care plan.
27. Healthcare staff attended a multidisciplinary team meeting to discuss Mr Wilkinson's mental health and refusal of prescribed medication. A prison GP noted that healthcare staff would continue to encourage Mr Wilkinson daily to take his prescribed medication.
28. Mr Wilkinson often refused to get out of bed. He had a poor appetite and his carers described him as lethargic. On 25 February, a nurse explained to Mr Wilkinson that his continual refusal to take his prescribed medication could have

serious consequences. Mr Wilkinson said he understood and wanted to be left in peace.

29. On 28 March, a prison GP saw Mr Wilkinson in his cell. Mr Wilkinson's chest was clear and he made a referral for a chest X-ray. She noted that Mr Wilkinson was displaying symptoms of dementia, such as confusion and an inability to complete routine tasks, and made a referral to a geriatric specialist at a hospital. She considered that Mr Wilkinson no longer had the mental capacity to understand the risks of refusing his prescribed medication. She noted that healthcare staff should act in Mr Wilkinson's best interests when they gave him his prescribed medication.
30. On 10 April, Mr Wilkinson had a chest X-ray. The results revealed that Mr Wilkinson had chronic obstructive pulmonary disease (COPD - the name for a collection of lung diseases such as chronic bronchitis and emphysema). A prison GP offered Mr Wilkinson help to stop smoking but he declined.
31. On 25 July, Mr Wilkinson was aggressive and verbally abusive towards his carers. He was moved to the segregation unit for good order and discipline and returned to the wing on 1 August.
32. On 7 August, Mr Wilkinson refused to attend an appointment with a geriatric specialist at a hospital and signed a disclaimer to that effect.
33. Mr Wilkinson continued to refuse to take his prescribed medication. On 27 November, he fell over in his cell and a nurse noted that he was conscious and had no obvious areas of pain. Mr Wilkinson's pulse was normal (96bpm), his blood pressure was normal (128/69mmHg) and his oxygen saturation level was normal (97%). The nurse arranged for an ambulance to take Mr Wilkinson to a hospital. Two officers accompanied Mr Wilkinson and did not use restraints.
34. Hospital doctors gave Mr Wilkinson intravenous fluids and antibiotics for pneumonia. Investigations showed that Mr Wilkinson had not fractured any bones when he fell over in his cell. Mr Wilkinson said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
35. On 16 December, hospital doctors decided that Mr Wilkinson was no longer suitable for active treatment and would receive end of life care.
36. Mr Wilkinson was returned to Whatton on 22 December and moved to the palliative care suite. Nurses created an end of life care plan. A nurse arranged 24-hour social care and Mr Wilkinson was granted open door status which meant his cell did not have to be unlocked during the night. Mr Wilkinson died at 7.07pm on 25 December.

Contact with Mr Wilkinson's family

37. An officer acted as the prison's family liaison officer (FLO). Mr Wilkinson did not have any contact with his family and his solicitor acted as his nominated next of kin. At 9.30am on 27 December 2017, the FLO telephoned Mr Wilkinson's solicitor and informed her of Mr Wilkinson's death.

38. The FLO remained in contact with Mr Wilkinson's solicitor until Mr Wilkinson's funeral on 11 January 2018. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

39. After Mr Wilkinson's death, a duty governor debriefed the staff involved with him to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Wilkinson'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 Wilkinson's death.

Post-mortem report

41. A post-mortem examination found that Mr Wilkinson died from pneumonia caused by dementia, ischaemic heart disease and type 2 diabetes.

Findings

Clinical care

42. The clinical reviewer considered that the care Mr Wilkinson received at Whatton was generally equivalent to that which he could have expected to receive in the community. He had poor health and limited mobility, and was appropriately located at Whatton, where he received social care. Staff at Whatton supported Mr Wilkinson throughout, to enable him to maintain his independence and dignity. We agree with the clinical reviewer that Mr Wilkinson received care equivalent to that which he could have expected to receive in the community.
43. Mr Wilkinson frequently refused to take his prescribed medication. On 28 March 2017, a prison GP noted that Mr Wilkinson displayed signs of vascular dementia and did not have the mental capacity to understand the implications of refusing his medication. The prison GP said that healthcare staff should act in Mr Wilkinson's best interests but did not indicate what action healthcare staff should take.
44. The Mental Capacity Act 2005 sets out a list of common factors that must be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. The clinical reviewer said that this would apply each time healthcare staff gave Mr Wilkinson his prescribed medication.
45. The clinical reviewer commented that there was no evidence that healthcare staff completed a formal assessment of Mr Wilkinson's mental capacity to test his ability to understand the risks to his health if he did not take his prescribed medication. We make the following recommendation:

The Head of Healthcare, Lead GP and Mental Health provider at HMP Whatton should establish clear guidelines for all healthcare staff in the prison to ensure that the principles and requirements of the Mental Capacity Act are followed. This should be underpinned by training for all healthcare staff.

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