

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Adrian Whitehall-Pain a prisoner at HMP Whatton on 30 August 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.

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 Adrian Whitehall-Pain died on 30 August 2017 of pneumonia, caused by emphysema, and heart disease while a prisoner at HMP Whatton. He was 78 years old. We offer our condolences to Mr Whitehall-Pain's family and friends.

Mr Whitehall-Pain had a number of health concerns and his complex care needs were managed well at Whatton.

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 2018

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Annex

Summary

Events

1. On 11 June 2013, Mr Adrian Whitehall-Pain was sentenced to 12 years imprisonment for sexual offences. He was initially sent to HMP Hewell and was later transferred to HMP Rye Hill on 23 June 2014.
2. At his reception health screen, Mr Whitehall-Pain was noted as having mobility issues, as well as a history of heart disease.
3. In April 2015, Mr Whitehall-Pain was treated in hospital for sepsis and a urinary tract infection. On 22 April, he was discharged back to Rye Hill but was readmitted to hospital the following day, where he remained for several weeks while a more suitable prison was found for him.
4. On 9 July 2015, Mr Whitehall-Pain was discharged directly to HMP Whatton. At his health screen on reception it was noted that he was bed-bound and had two carers to provide 24-hour social care. Mr Whitehall-Pain required regular medical attention so he was initially located in the palliative care suite. On 4 August, Mr Whitehall-Pain was transferred to a standard cell but continued to receive 24-hour social care.
5. On 12 June 2017, Mr Whitehall-Pain was taken to hospital with a suspected stroke. He was fitted with a pacemaker and returned to Whatton a week later.
6. On 16 August, Mr Whitehall-Pain developed breathing difficulties and was given antibiotics. Later that day, he experienced breathlessness and an ambulance was called. Paramedics administered medication using a nebuliser but declined to take him to hospital after his symptoms eased. Two days later, paramedics attended Mr Whitehall-Pain after he again experienced breathing difficulties. A prison nurse requested that he be taken to hospital but, after consulting senior staff, the paramedics decided against taking him.
7. On 20 August, a prison GP advised that Mr Whitehall-Pain required an urgent medical assessment and he was taken to hospital. On 28 August, it was noted that he was not responding to treatment.
8. Mr Whitehall-Pain remained in hospital and, on 30 August, at 3.50pm, he was pronounced dead.

Findings

Clinical care

9. The clinical reviewer found that the care which Mr Whitehall-Pain received at Whatton was equivalent to that which he could have expected to receive in the community. Paramedics saw Mr Whitehall-Pain on two separate occasions in August 2017, and declined to take him to hospital until his admission on 20 August. Prison staff, having expressed their concerns on each occasion, acted appropriately in following the advice of the paramedics.

Contact with Mr Whitehall-Pain's family

10. Although there was confusion as to the identity of Mr Whitehall-Pain's next of kin, this was quickly resolved. Contact was then maintained effectively, and the family's wishes were respected throughout.

Restraints and escort

11. Mr Whitehall-Pain was not restrained when he was taken to hospital during his last few months at Whatton.

Recommendations

We make no recommendations.

The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Whitehall-Pain's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Whitehall-Pain's clinical care at the prison.
15. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. The investigator wrote to Mr Whitehall-Pain's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Whatton

18. HMP Whatton in Nottinghamshire is a medium security category prison holding up to 841 men convicted of sex offences.
19. 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

20. The most recent inspection of HMP Whatton was conducted 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

21. 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.
22. The board highlighted the high number of older prisoners with significantly different and more costly healthcare needs, including social care.
23. 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

24. Mr Whitehall-Pain was the eleventh prisoner to die from natural causes since September 2015. There are no significant similarities between this and these previous deaths.

Key Events

25. On 11 June 2013, Mr Adrian Whitehall-Pain was sentenced to 12 years imprisonment for sexual offences. He initially spent time at HMP Hewell and was transferred to HMP Rye Hill on 23 June 2014.
26. Healthcare assistant, Mrs A, reviewed Mr Whitehall-Pain at a health screen on his reception at Rye Hill. Mrs A observed that Mr Whitehall-Pain was slightly deaf, wore glasses, and used a walking stick. He also had a history of ischaemic heart disease (a condition where the blood vessels are narrowed or blocked affecting the supply of blood to the heart).
27. On 12 February 2015, Mr Whitehall-Pain attended the cardiology clinic at the local hospital. He was diagnosed with ischaemic heart disease.
28. On 7 April, Mr Whitehall-Pain was taken to hospital, where he was treated for sepsis and a urinary tract infection. On 9 April, Nurse Manager, Ms B recorded that Mr Whitehall-Pain's son had told the hospital that his father did not wish to be resuscitated if his heart or breathing stopped. A few days later, Mr Whitehall-Pain was deemed fit for discharge but was kept in hospital while a decision was made about his ongoing health and care needs.
29. On 22 April, Mr Whitehall-Pain returned to Rye Hill. The following day he was returned as an emergency to hospital where he was treated for sepsis and a bilateral pulmonary embolism (a blockage of an artery in the lungs). Ms B noted that he had to be resuscitated en route, and that he remained poorly. Mr Whitehall-Pain remained in hospital for several weeks, while Rye Hill investigated whether there was a more suitable prison for him.

Transfer to HMP Whatton

30. On 9 July 2015, Mr Whitehall-Pain was discharged from hospital to HMP Whatton. Nurse C reviewed Mr Whitehall-Pain at a health screen on his reception at Whatton. She recorded that he was bed-bound, required turning every two hours, and was incontinent. She noted that he had been allocated two carers to provide 24-hour social care. He also had a history of cerebrovascular disease (a range of conditions affecting the supply of blood to the brain, which can include a stroke).
31. On 10 July, Dr D discussed resuscitation with Mr Whitehall-Pain, who stated that he would like to think about it. A 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order means that in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided. Dr D recorded that Mr Whitehall-Pain had the capacity to make this decision, and five days later, the DNACPR was put into place.
32. On his arrival at Whatton, Mr Whitehall-Pain required regular medical attention, so he was initially located in 'The Retreat', a specialised palliative care suite. On 4 August, he was transferred to a standard cell containing a hospital bed, and a side rail and hoist were installed in the room. Mr Whitehall-Pain continued to receive 24-hour social care, and was granted

open door status, meaning his room did not have to be unlocked during the night.

33. Mr Whitehall-Pain's health continued to be monitored and managed on the wing, and he had no significant health concerns for the next 18 months. On 21 December 2015, a multidisciplinary team meeting concluded that Mr Whitehall-Pain was now safe enough to revert to a normal locked door status. On 23 January 2016, Nurse D recorded that Mr Whitehall-Pain now wished to be resuscitated, and his DNACPR was rescinded.
34. On 20 February 2017, Nurse C saw Mr Whitehall-Pain after staff said he had become confused over the weekend. She observed that he was slumped to the right, struggling to stand and appeared flushed. She arranged for a urine test, and Mr Whitehall-Pain was diagnosed with a urinary tract infection. He was treated at Whatton with nitrofurantoin (an antibiotic specifically prescribed for urinary tract infections).
35. On 12 June, Nurse E examined Mr Whitehall-Pain after his carer reported that he was unwell. She observed that he had "a slight droop to right side of mouth. Right pupil sluggish. Unable to test grip to existing right side weakness." Nurse E feared a stroke, and consulted a prison doctor. Mr Whitehall-Pain was taken to Nottingham City Hospital.
36. On 19 June, Mr Whitehall-Pain had a pacemaker fitted to prevent a heart blockage. Later that day, he returned to Whatton.
37. On 16 August, Nurse E saw Mr Whitehall-Pain after he developed breathing difficulties. She obtained a prescription for amoxicillin (an antibiotic used to treat bacterial infections). Later that day, Mr Whitehall-Pain experienced breathlessness, and an ambulance was called. Paramedics administered medication using a nebuliser which seemed to solve the problem, and they decided not to take him to hospital.
38. On 18 August, Nurse F saw Mr Whitehall-Pain, and observed that that he was short of breath, had laboured breathing and an audible wheeze. He also recorded that Mr Whitehall-Pain was not eating or drinking very well. Nurse F noted that Mr Whitehall-Pain's symptoms improved after he used a nebuliser, but decided that he should go to hospital for investigations. An ambulance attended and Nurse F explained Mr Whitehall-Pain's complex underlying conditions to the paramedics. The paramedics stated that he was on antibiotics which would take a few days to start working. Despite Nurse F maintaining that Mr Whitehall-Pain required special consideration, after consulting senior hospital staff, the paramedics decided not to transfer Mr Whitehall-Pain to hospital.
39. On 20 August, Mr Whitehall-Pain became short of breath and had a spell of apnoea (where throat muscles relax during sleep causing the temporary cessation of breathing). Dr E advised that Mr Whitehall-Pain required an urgent medical assessment and sent him to hospital.
40. On 24 August, Nurse E recorded that Mr Whitehall-Pain had completed a DNACPR form at the hospital.

41. On 28 August, Mr Whitehall-Pain was diagnosed with stage 1 acute kidney injury and pulmonary oedema (fluid accumulation in the tissue and air spaces of the lungs). Nurse E noted he was not responding to treatment.
42. Mr Whitehall-Pain remained in hospital and, on 30 August, at 5.50pm, he was pronounced dead.

Contact with Whitehall-Pain's family

43. The identity of Mr Whitehall-Pain's next of kin was unclear but contact details for his son, daughter and cousin were listed in his records. On 24 August, the prison appointed Officer F as his family liaison officer.
44. That evening, Officer F spoke to Mr Whitehall-Pain's son, who advised him not to contact Mr Whitehall-Pain's daughter. Shortly afterwards, Mr Whitehall-Pain's daughter called Officer F and said she could not understand why he had been told not to contact her. She told Officer F that she considered herself to be the next of kin as she was the eldest sibling. Later that evening, Mr Whitehall-Pain's daughter was confirmed as his nominated next of kin.
45. On 29 August, Officer F spoke to Mr Whitehall-Pain's daughter about her father's deteriorating condition. She was unable to visit him, so asked whether it was possible to speak to him by telephone. She later changed her mind when told that her father would not understand very much on the phone, but took the contact details of the hospital so she could obtain updates on his condition. Later that day, Officer F arranged a visit for Mr Whitehall-Pain's son, who visited his father the following morning.
46. Mr Whitehall-Pain's son was at his father's bedside when he died. He asked Officer F not to contact Mr Whitehall-Pain's daughter at this stage, as he had already informed her of their father's death. Officer F emailed Mr Whitehall-Pain's daughter the next day, and resumed regular contact.
47. Mr Whitehall-Pain's funeral was held on 6 October. The prison contributed to the cost of his funeral in line with national guidance.

Support for prisoners and staff

48. After Mr Whitehall-Pain's death, Duty Governor G 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.
49. The prison posted notices informing other prisoners of Mr Whitehall-Pain'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

50. The post-mortem concluded that Mr Whitehall-Pain died from pneumonia, caused by emphysema and ischaemic heart disease.

Findings

Clinical care

51. The clinical reviewer considered that the care that Mr Whitehall-Pain received at Whatton was equivalent to that which he could have expected to receive in the community. He had several serious health concerns and limited mobility, and was appropriately located at Whatton, where he was in receipt of 24-hour social care. Staff at Whatton supported Mr Whitehall-Pain throughout, to enable him to maintain his independence and dignity,
52. Paramedics attended Mr Whitehall-Pain twice during August 2017, but declined to transfer him to hospital. He subsequently became very ill and was admitted to hospital, where he died. However, it is clear from Mr Whitehall-Pain's medical notes that nursing staff at Whatton robustly expressed their concerns about his health, and that the decision not to admit him to hospital was taken by the paramedics alone. We are satisfied that Whatton staff acted appropriately.

Contact with Mr Whitehall-Pain's family

53. When Mr Whitehall-Pain was admitted to hospital in August 2017, there was initially some ambiguity as to the identity of his next of kin. We note that Mr Whitehall-Pain's son advised Officer F not to contact Mr Whitehall-Pain's daughter for reasons which have not been made clear. This confusion was then quickly resolved, and we are satisfied that contact was maintained effectively from then onwards.
54. Mr Whitehall-Pain's son was at his bedside when he died. He requested that Officer F should not contact Mr Whitehall-Pain's daughter at that time, because he had already informed her of their father's death and she was still upset. Officer F fully respected the wishes of Mr Whitehall-Pain's family, and resumed contact a few days later, providing good support throughout.

Restraints and escort

55. Mr Whitehall-Pain was not restrained when he was taken to hospital during his last few months at Whatton.

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