Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Alfred Walters a prisoner at HMP Pentonville on 7 February 2018

**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*

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 Alfred Walters died in hospital on 7 February 2018 from heart failure while a prisoner at HMP Pentonville. Mr Walters was 81 years old. I offer my condolences to Mr Walters' family and friends.

Mr Walters was an elderly man who arrived at Pentonville with several long-term health conditions. The investigation found that prison healthcare staff failed to obtain his community medical record and that his high blood pressure was not managed in line with national guidance. The care Mr Walters received at Pentonville was not equivalent to that which he could have expected to receive in the community.

The decision to take Mr Walters to hospital in restraints was wrong. It was not justified by an appropriate risk assessment that took into account Mr Walters' advanced age and poor health. It is not the first time that we have found that Pentonville has failed properly to consider their legal obligations when deciding to deploy mechanical restraints. The Prison Group Director will wish to assure herself that action is now taken to deal with this.

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

## Events

1. On 13 November 2017, Mr Alfred Walters was convicted of indecent assault and sent to HMP Pentonville. He was aged 81 and had several long-term health conditions, including heart disease and high blood pressure.

2. At an initial reception screen, a nurse listed the medication Mr Walters had in a dosette box, recorded a high blood pressure reading and obtained consent to request his community GP record. Shortly afterwards, a prison GP prescribed Mr Walters with all the medication indicated on his dosette box, apart from one (furosemide – a drug that increases the output of urine and is used to treat a number of conditions including heart disease and high blood pressure). On 16 November, a prison GP noted that Mr Walters had high blood pressure and prescribed more high blood pressure medication. Over the next two weeks, healthcare staff noted that Mr Walters had high blood pressure on eight separate occasions, but did not take any further action.

3. On 5 December, a nurse saw Mr Walters for a secondary health screen. She did not record whether staff had requested his community medical record. On 20 December, a prison GP saw Mr Walters for a review and noted that he had a productive cough and bilateral oedema (an accumulation of fluid under the skin caused by high blood pressure and heart failure). The GP prescribed an antibiotic and restarted furosemide. Mr Walters' high blood pressure stabilised over the next four weeks, but started to rise again on 20 January 2018.

4. On 29 January, at about 10.50am, Mr Walters reported bleeding from his anus to a nurse, who took his observations and recorded a low blood pressure reading. A nurse manager saw him for a second opinion, discussed his presentation with a prison GP and requested an ambulance. The GP reviewed Mr Walters with paramedics and noted that staff had not obtained his community medical record. Paramedics took Mr Walters to University College London Hospital, escorted by two officers and restrained by an escort chain. On 30 January, Mr Walters had an emergency operation to treat a large gastrointestinal bleed but did not recover and died in hospital on 7 February. The post-mortem report concluded that he died from heart failure, caused by the gastrointestinal bleed and the stress on the heart caused by the operation.

## Findings

5. Healthcare staff did not obtain information from Mr Walters' community GP which meant they could not be sure of the conditions for which he was prescribed medication. It took too long to for Mr Walters' secondary health screen to take place and the clinical reviewer considered that healthcare staff did not manage Mr Walter's high blood pressure in line with National Institute of Care Excellence (NICE) guidance. We agree with the clinical reviewer that the care Mr Walters received at Pentonville was not equivalent to that which he could have expected to receive in the community.

6. We are concerned that the decision to use restraints when Mr Walters was taken to hospital did not take full account of his poor health and how this affected his level of risk.

7. We are also concerned that the prison family liaison officer did not keep a proper record of contact with Mr Walters' next of kin.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.
- The Head of Healthcare should ensure that all patients with long-term conditions have clear, personalised care plans, with stated aims, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Prison Group Director, London, should assure herself that effective action is taken to ensure that decisions on the use of restraints are evidence based, proportionate and take account of case law.
- The Governor should ensure that the appointed family liaison officer keeps comprehensive records, which accurately record all interactions with the next of kin, from the date he or she is appointed.

# The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Walters' prison and medical records.

10. The investigator interviewed two members of staff at Pentonville on 22 and 26 March 2018. He interviewed three members of staff on 11 April.

11. NHS England commissioned a clinical reviewer to review Mr Walters' clinical care at the prison. The clinical reviewer attended joint interviews with the investigator on 22 March and 11 April.

12. We informed HM Coroner for Inner North London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Walters' partner 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.

14. 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. The action plan has been annexed to this report.

# Background Information

## HMP Pentonville

15. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

16. Healthcare services are provided by Care UK in partnership with Barnet, Enfield and Haringey Mental Health Trust. There is a large purpose-built healthcare centre, which has 22 inpatient beds and a daycare facility for patients with mental health problems who are managed on the wings.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Pentonville was in January 2017. Inspectors reported that the prison remained a large, overcrowded local prison with a complex and demanding population.

18. Inspectors found that health screening for new arrivals was prompt, appropriate referrals were made and a GP was available during the reception process. Prisoners had access to a range of nurse-led clinics and pharmacy-led medicines use reviews. Services for prisoners with lifelong health conditions had been transformed and care plans were evident on the electronic medical record.

## Independent Monitoring Board

19. 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 March 2017, the IMB reported that clinical standards generally reflected those a prisoner could expect in the community. However, a shortage of officers and a lack of coordination between prison and medical staff had led to the inadequate identification and assessment of some urgent medical conditions.

## Previous deaths at HMP Pentonville

20. Mr Walters was the twelfth prisoner to die at Pentonville since February 2015. We have previously made recommendations about the management of long-term health conditions and the use of restraints.

# Key Events

21. On 13 November 2017, Mr Alfred Walters was convicted of indecent assault and sent to HMP Pentonville. (He was subsequently sentenced to six years in prison on 24 November.) Mr Walters was aged 81 and had several long-term health conditions, including asthma, high blood pressure and heart disease.

22. At an initial reception screen, Mr Walters told a nurse that he had recently seen a community GP for stomach problems and that he was due to attend Whittington Hospital, London, for a gastroscopy (a procedure where a thin, flexible tube is used to look inside the gullet, stomach and first part of the small intestine). The nurse listed the medication Mr Walters had in a dosette box (a monitored dosage system used to aid compliance with medication in the community), which included perindopril and furosemide (both used to treat high blood pressure and heart failure). She noted that Mr Walters had high blood pressure (157/113mm/Hg) and obtained his consent to request his community medical record.

23. Shortly afterwards, a prison GP saw Mr Walters and noted that he had a letter from Whittington Hospital indicating he had been discharged by the gastroenterology department. The GP recorded that Mr Walters had a history of acid reflux, heart disease and high blood pressure and requested routine blood tests. She prescribed the medication listed by the nurse, except furosemide, and added lansoprazole (a medication used to reduce the amount of acid produced in the stomach). At interview, the GP told the investigator that she prescribed Mr Walters' medication as documented on his dosette box. Prison staff assessed Mr Walters as a vulnerable prisoner and allocated him a cell on the prison's substance misuse wing, which also contains a vulnerable prisoners' unit.

24. On 16 November, a nurse took Mr Walters' clinical observations and recorded a high blood pressure reading (163/119 mmHg). She informed a prison GP, who prescribed doxazosin (a medication used to treat high blood pressure), in addition to perindopril. Over the next two weeks, healthcare staff noted that Mr Walters had high blood pressure on eight separate occasions, but did not take any further action.

25. On 5 December, a nurse saw Mr Walters for a secondary health screen and noted that he presented as stable in mood and well orientated. She asked Mr Walters a series of health-related questions from a standardised template, but did not record whether healthcare staff had requested or obtained his community GP record. On 16 December, a nurse noted that Mr Walters had high blood pressure (176/115mmHg) and liaised with a senior nurse, who arranged for him to have a blood pressure review. The nurse made a note on Mr Walters' electronic medical record asking staff to check his blood pressure that evening, but there is no evidence this took place.

26. On 18 December, a prison GP noted that Mr Walters' blood pressure had lowered (153/80mmHg) and booked him a GP appointment. Two days later, a prison GP examined Mr Walters and recorded that he had a productive cough and bilateral oedema (an accumulation of fluid under the skin caused by high blood pressure and heart failure). The GP did not record the site of the oedema

or whether he spoke to Mr Walters about his high blood pressure. He prescribed amoxicillin (an antibiotic) and restarted furosemide, but did not record a reason for his decision.

27. Over the next four weeks, healthcare staff monitored Mr Walters' blood pressure frequently and it started to stabilise. However, on 20 January 2018, a clinical support administrator recorded that Mr Walters had high blood pressure (161/99mmHg). Healthcare staff recorded four further high blood pressure readings over the next week, but there is no evidence they took further action.

28. On 29 January, at around 10.50am, a nurse saw Mr Walters for a review and he reported bleeding from his anus. He said that it had started the day before and had got worse overnight. She took his clinical observations, recorded a low blood pressure reading (90/54 mmHg) and requested a second opinion. A nurse manager examined Mr Walters and sought advice from a prison GP, before requesting an ambulance. Prison staff called an ambulance at 11.02am. Paramedics arrived at the gate at 11.12am, and at Mr Walters' cell, at 11.27am. The GP reviewed Mr Walters with paramedics prior to his transfer to University College London Hospital and noted that staff had not obtained his community medical record. Two prison officers escorted Mr Walters and restrained him using an escort chain.

29. Hospital staff admitted Mr Walters and on 30 January, he had an emergency operation to treat a large gastrointestinal bleed. After the operation, hospital staff moved Mr Walters to the Intensive Care Unit where he remained sedated and artificially ventilated. Healthcare staff kept in frequent contact with the hospital for updates on Mr Walters' condition, which continued to deteriorate.

30. On 7 February, Mr Walters suffered a series of cardiac arrests and, at 12.23pm, a hospital consultant told escort officers that Mr Walters was not responding to treatment and that they were going to notify his family. At 2.15pm, a doctor pronounced that Mr Walters had died.

### Contact with Mr Walters' family

31. On 30 January, the prison appointed an administration officer as family liaison officer (FLO). The FLO phoned Mr Walters' partner, his next of kin, to inform her that he was seriously unwell in hospital. He arranged for Mr Walters' family to visit the hospital daily and kept in contact with his partner and his daughters to provide updates. However, there is no evidence that he made a record of his contacts in a formal FLO log.

32. The FLO told the investigator that on 7 February, he obtained an update on Mr Walters' condition from an escort officer and phoned Mr Walters' partner, to tell her that hospital staff planned to stop his treatment. There is, however, no written record that this took place. Later the same day, having received notification that Mr Walters had died, the FLO phoned one of Mr Walters' daughters, who was providing support to his partner, to offer his condolences and support. On 8 February, the FLO and a prison chaplain visited Mr Walters' partner and family at their home.

33. The FLO provided ongoing support to Mr Walters' family and attended his funeral, which took place on 13 March. The prison contributed toward the cost, in line with national policy.

### Support for prisoners and staff

34. After Mr Walters' death, a prison manager debriefed the escort officers present at the hospital to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

35. The prison posted notices informing other prisoners of Mr Walters' 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 Walters' death.

### Post-mortem report

36. A post-mortem examination found that Mr Walters died of acute cardiac failure, caused by colonic haemorrhage and left ventricular hypertrophy (enlargement and thickening of the walls of the heart's main pumping chamber, which can develop in response to high blood pressure or a heart condition). The report concluded that the stress on the heart caused by the colonic bleeding and subsequent surgery caused cardiac failure in Mr Walters, who was already a high-risk patient for surgery.

# Findings

### Healthcare procedures for newly arrived prisoners

37. Prison Service Order (PSO) 3050 – Continuity of Healthcare for Prisoners - requires that, when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with. Given Mr Walters' age and the fact he had medication to treat several serious conditions, it was particularly important that healthcare staff should have obtained his community medical record for up to date information on his health conditions and treatment. However, despite numerous opportunities, no one requested information from Mr Walters' GP.

38. PSO 3050 also requires that newly arrived prisoners should be offered a general health assessment in the week after first reception. This assessment is expected to be equivalent to a primary care assessment when registering with a new GP in the community. While Mr Walters had a general health assessment, this did not take place until 22 days after he arrived at Pentonville. At interview, a nurse manager told the investigator that healthcare staff on the substance misuse wing were not always made aware that they had a new vulnerable prisoner on the unit and that the process was under review. The clinical reviewer considered that healthcare staff did not try to find out why Mr Walters was prescribed medication before a secondary health assessment, as they should have done under National Institute of Care Excellence (NICE) guidance. This meant that doctors could not be sure what conditions the medications were prescribed to treat. We make the following recommendation:

    **The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050 and National Institute for Health and Care Excellence (NICE) guidance.**

### Clinical care

39. The clinical reviewer found that the care Mr Walters received was not equivalent to that which he could have expected to receive in the community.

40. The clinical reviewer considered that healthcare staff did not manage Mr Walters' high blood pressure in line with NICE guidance. His blood pressure was noted to be high on multiple occasions and, in January, it was 161/99mmHg. An ideal reading is 120/80mmHg and Mr Walters' blood pressure was only within these parameters on two occasions. There was little evidence that staff acted on his high blood pressure readings and no record they created a care plan to monitor his long-term condition. We make the following recommendation:

    **The Head of Healthcare should ensure that all patients with long-term conditions have clear, personalised care plans, with stated aims, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidance**.

## Restraints, security and escorts

41. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change

42. When Mr Walters went to hospital on 29 January, a prison manager reviewed his risk assessment and authorised two officers to escort him using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The assessment identified Mr Walters' overall risk as low. The medical information section, including whether there were any objections to the use of restraints, was not completed. Double handcuffs (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) were identified as the most appropriate level of restraint. However, the prison manager told us that when she saw Mr Walters sitting on an ambulance trolley speaking to medical staff, she decided to reduce the level of restraint to an escort chain.

43. On 30 January, at 12.10am, a prison manager authorised the removal of Mr Walters' restraints for medical treatment. At around 4am, an escort officer updated her on Mr Walters' continued poor health and she liaised with another prison manager, who gave permission for him to remain unrestrained. Officers did not use restraints again for the remaining eight days of Mr Walters' life.

44. We consider that the use of restraints on 29 January was not justified and did not meet the requirements set out in the High Court judgment. Mr Walters was an elderly and frail man who, at the time, had limited mobility and was clearly ill. The risk assessment used was primarily based on the prison's view of his offence with little evidence of any consideration of how Mr Walters' age, health and mobility affected this risk, as the 2007 High Court judgment requires. Whenever restraints are used, the risk assessment must accurately reflect the risk posed at that time to ensure proportionality and to maintain human dignity. We make the following recommendation:

    **The Governor and Head of Healthcare should ensure that all staff completing and authorising risk assessments justifying the use of restraints on prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

45. It is not the first time that we have raised this concern with the prison and, having been assured that action would be taken to prevent a recurrence, we regard this

now as a matter for the Prison Group Director to address. We make the following recommendation:

**The Prison Group Director, London, should assure herself that effective action is taken to ensure that decisions on the use of restraints are evidence based, proportionate and take account of case law.**

### Recording contact with Mr Walters' next of kin

46. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* states, "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill. It is good practice for a log of the contact with the family to be maintained".

47. Although the prison provided evidence that the FLO maintained contact with Mr Walters' next of kin prior to his death, the contacts were noted on various pieces of paper and in no specific order. This made it difficult to obtain a clear understanding of exactly when the prison contacted Mr Walters' family and to know what was discussed. The FLO told us that his understanding was that a FLO log was started after a prisoner had died, but that he always kept a note just in case. While we are satisfied the family contact was appropriate, the prison should make sure that staff keep a contemporaneous record of contacts with a prisoner's next of kin, in line with national guidelines. We make the following recommendation:

**The Governor should ensure that the appointed family liaison officer keep comprehensive records, which accurately record all interactions with the next of kin, from the date he or she is appointed**.

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