Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Warriner a prisoner at HMP Whatton on 21 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 Mark Warriner died in hospital on 21 February 2018 of pancreatic cancer while a prisoner at HMP Whatton. He was 50 years old. I offer my condolences to Mr Warriner's family and friends.

Mr Warriner complained of abdominal pain throughout his time at Whatton. Prison healthcare staff sent him to hospital frequently for investigations but his cancer was not diagnosed by hospital doctors until one week before he died. I am satisfied that the care Mr Warriner received at Whatton was equivalent to that which he could have expected to receive in the community.

There were some occasions, however, when Mr Warriner was not booked in for follow up appointments with the prison GP when he should have been. There was also one occasion when he missed a hospital scan because the prison had failed to book transport. Although these oversights did not affect the eventual outcome for Mr Warriner, the prison needs to address them.

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**

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Summary

Events

1. Mr Mark Warriner was recalled to prison custody on 16 August 2016 and transferred to HMP Whatton on 20 December. He complained of abdominal pain throughout his time at Whatton. Initially, healthcare staff diagnosed constipation and prescribed laxatives, but Mr Warriner continued to complain of pain.

2. In July 2017, following abnormal blood test results, Mr Warriner was taken to hospital. Hospital doctors diagnosed him with inflammation of the pancreas and gall bladder and he underwent surgery to have his gall bladder removed.

3. During August, Mr Warriner was readmitted to hospital three times and diagnosed in hospital with pancreatitis (inflammation of the pancreas). He was discharged from hospital on 30 September. On 10 October, a prison nurse noted that Mr Warriner had lost 20kg in weight since his arrival at Whatton.

4. Mr Warriner was admitted to hospital for five days in October and three days in November. On both occasions, despite further tests and scans, he was discharged from hospital without a clear diagnosis. On 14 December, Mr Warriner missed a hospital appointment for a scan because the prison had not booked a taxi.

5. On 29 December, Mr Warriner was readmitted to hospital because of concerns about his yellow complexion. He was treated for obstructive jaundice (where the essential flow of bile to the intestine is blocked and remains in the blood) and biliary sepsis (infection) before being discharged on 9 January 2018.

6. Mr Warriner was taken to hospital on 21 January with chest and abdominal pain. On 15 February, a prison nurse called the hospital and was told that Mr Warriner had incurable pancreatic cancer. He died in hospital on 21 February.

Findings

7. The clinical reviewer was satisfied that the care Mr Warriner received at Whatton was equivalent to that which he could have expected to receive in the community.

8. We are concerned, however, that on several occasions prison healthcare staff recorded that Mr Warriner required a follow up GP appointment which was not actioned. He also missed a hospital appointment for a scan because no transport had been arranged. While these oversights did not affect the eventual outcome, we consider that the prison needs to address these issues.

Recommendations

- The Head of Healthcare should ensure that all requests for follow up GP appointments are actioned promptly.

- The Governor and Head of Healthcare should ensure that staff facilitate prisoners' attendance at hospital appointments, including that they make appropriate transport arrangements.

The Investigation Process

9. 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. One prisoner responded.

10. The investigator obtained copies of relevant extracts from Mr Warriner's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Warriner's clinical care at the prison.

12. The investigator and clinical reviewer jointly interviewed two members of staff and one prisoner at Whatton on 24 April 2018.

13. 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.

14. The investigator wrote to Mr Warriner's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He raised the following:

    - He was concerned that Mr Warriner's cancer remained undiagnosed until 16 February, by which time he was told that he only had a few days to live.
    - He asked whether the prognosis would have been different had his brother's cancer been diagnosed earlier.
    - He asked why he was not contacted by the prison until 16 February.

15. Mr Warriner's brother received a copy of the initial report. He did not make any comments.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Whatton

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

18. 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.

HM Inspectorate of Prisons

19. 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.

Independent Monitoring Board

20. 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 expressed concern about the provision of healthcare since the appointment of MITIE, particularly in relation to pharmacy provision.

21. The Board noted that during the reporting year, Whatton had 108 bed watches and 1670 outside hospital appointments, which put a huge strain on the regime of the prison, particularly since the majority required two staff for security reasons.

Previous deaths at HMP Whatton

22. Mr Warriner was the 17th prisoner to die at Whatton since February 2015. All the deaths were due to natural causes. There have been two deaths since, both due to natural causes. There were no similarities between Mr Warriner's death and the previous deaths at the prison.

Key Events

23. Mr Mark Warriner was released from prison on licence on 6 June 2016. He was recalled to prison custody and sent to HMP Nottingham on 16 August after being charged with making indecent images of children, breaching a restraining order and damaging property. He was subsequently sentenced to a further three years in prison. He was sent to HMP Whatton on 20 December 2016.

24. At his reception health screening, Mr Warriner told the nurse that he had been suffering with abdominal pain since November when someone assaulted him by jumping on his stomach. He also said he had arthritis in his back after being assaulted in 2005 and 2016 and used crutches to get around. He weighed 105kg (obese).

25. On 31 January 2017, wing staff asked healthcare staff to assess Mr Warriner as he was complaining of abdominal pain. A nurse assessed him over the telephone. She advised him to make an appointment in the morning and to take painkillers.

26. A nurse saw Mr Warriner the next morning, 1 February. He continued to complain of abdominal pain and said he felt sick. He said he had not opened his bowels for two weeks. She noted that Mr Warriner had a history of constipation and gave him Senna (a laxative). She noted his medical record: 'To book with GP'.

27. On 28 April, staff called a medical emergency code blue (used to indicate a prisoner has chest pain or difficulty in breathing) when Mr Warriner complained of pain in his chest and abdomen. A prison GP diagnosed constipation, due to long-term use of codeine for arthritis and not drinking enough water, and prescribed a laxative.

28. On 4 May, a nurse saw Mr Warriner, who was complaining of abdominal pain and feeling bloated. He said the laxative was not working. He considered that constipation might be the cause of the symptoms and told Mr Warriner to drink more fluids. He recorded that Mr Warriner should be booked a GP appointment to check whether there might be another cause of the abdominal pain.

29. On 16 May, a nurse saw Mr Warriner who was complaining of constipation. He told her his father had died from liver disease. She gave him Senna and noted that he should be referred to the GP if it did not work.

30. A prison GP saw Mr Warriner on 24 May, who was still complaining of abdominal pain. The GP noted that Mr Warriner did not have diarrhoea or blood in his stools, and there was no family history of bowel problems. He recorded that Mr Warriner's abdomen was very tender and diagnosed possible irritable bowel syndrome or diverticular disease (where bulges or pockets form in the large intestine). He also recorded that there was, 'considerable functional overlay', which he explained at interview meant that some of Mr Warriner's symptoms were likely to have a psychological rather than physical in origin. He recorded that Mr Warriner should have a blood test. He prescribed metronidazole (an

antibiotic), mebeverine (an antispasmodic medication used to alleviate the symptoms of irritable bowel syndrome) and lactulose (a laxative).

31. A prison GP reviewed Mr Warriner's blood test results on 31 May and recorded that his CRP (C-reactive protein – a blood test marker for inflammation in the body) level was high and should be rechecked next week.

32. On 5 July, a prison GP reviewed the blood test results, which showed the CRP level had increased further, and recorded that he probably needed a review by a doctor.

33. A prison GP reviewed Mr Warriner on 12 July in view of his raised CRP level. His abdomen was still tender but the pain was not as bad. His weight and appetite were fine. He re-prescribed metronidazole and noted that the CRP level should be reviewed in a few weeks.

34. A prison GP reviewed Mr Warriner on 20 July. He was still in a lot of pain. He opened his bowels only once a week. She thought there may be a psychological cause but noted that in view of the duration of symptoms, she would refer to him to a gastroenterology specialist, and check his blood and urine.

35. The blood test results were received on 31 July which suggested acute pancreatitis. Mr Warriner was taken to hospital, where he underwent an ultrasound scan and further blood tests, which showed he had inflammation of the pancreas and gall bladder. He had an operation to remove his gallbladder. He was discharged on 6 August.

36. On 11 August, a nurse saw Mr Warriner as he was complaining of abdominal pain and vomiting. His vomit was bright red. His stools were loose, black and foul smelling. He was taken to hospital where he had a computerised tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body) and a magnetic resonance cholangiopancreatography (MRCP) scan (a special type of magnetic resonance imaging (MRI) scan that produces detailed images of the hepatobiliary and pancreatic systems, including the liver, gallbladder, bile ducts, pancreas and pancreatic duct). He was diagnosed with acute pancreatitis.

37. On 16 August, Mr Warriner was discharged from hospital with a plan that the prison would prescribe appropriate pain relief. Mr Warriner had been given morphine (a strong opiate painkiller) in hospital but this could not be provided in a plastic bottle under prison policy. A prison GP prescribed dihydrocodeine, the strongest painkiller that could be prescribed in the prison, but Mr Warriner said this was not strong enough. He was readmitted to hospital. He was discharged back to Whatton on 22 August.

38. On 22 August, Mr Warriner was assessed by a nurse after reporting diarrhoea and vomiting. She noted he had a painful, distended abdomen. She recorded a National Early Warning Score (NEWS) of 6. (NEWS is a tool used to assess how ill a patient is and whether they require medical intervention. A score of 5 or more indicates that they require an urgent clinical review.) She arranged an emergency transfer to hospital.

39. While in hospital, Mr Warriner had a CT scan, MRCP scan, endoscopy (an endoscope, a tiny tube with a camera attached, is used to examine the lining of the gastrointestinal tract), endoscopic ultrasound (high frequency sound waves are emitted from the tip of an endoscope to produce detailed images of internal organs) and other ultrasound scans. He was diagnosed with pancreatitis and ascites (abnormal build-up of fluid in the abdomen). He was discharged back to Whatton on 30 September. He continued to complain of vomiting and abdominal pain.

40. On 10 October, a nurse noted that Mr Warriner had lost 20kg in weight and now weighed 81.7kg. The GP prescribed build up drinks (nutritional drinks that provide extra energy, protein, fibre and vitamins).

41. On 17 October, officers reported that Mr Warriner had taken an overdose of cyclizine (a medication he was prescribed to treat and prevent nausea and vomiting). He was taken to hospital and was admitted due to abnormal blood results. While he was in hospital, Mr Warriner had a CT scan and was booked in for a MRCP scan but declined to attend. He was discharged on 22 October with a plan to follow up as an outpatient. He later received an outpatient appointment for 23 November.

42. Mr Warriner continued to report abdominal pain throughout November. He was admitted to hospital again on 22 November after abnormal blood test results. Hospital doctors initially thought he had gallstone pancreatitis (gallstones are small stones that form in the gallbladder) but further tests ruled this out. He was discharged on 25 November and was told he would be given an outpatient appointment for a liver biopsy.

43. On 14 December, Mr Warriner had a hospital appointment for a magnetic resonance imaging (MRI) scan (a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) but the prison had not booked a taxi so he missed the appointment.

44. Mr Warriner continued to have abdominal pain and told staff he felt tired all the time. On 18 December, a nurse assessed Mr Warriner, who was complaining of bright red urine. A urine sample showed bilirubin was present (an early indicator of liver disease). The nurse sent a task to the GP on the electronic medical record. A prison GP responded by sending a task to a registered nurse stating, 'To come in for review with GP'. This was not actioned.

45. On 22 December, Mr Warriner was discussed at the lunchtime meeting. His basic observations had been taken and he had been weighed earlier that day. It was noted that he had a yellow complexion and had lost a significant amount of weight (down to 71.8kg). It was noted that he had a CT scan booked for 11 January.

46. A prison GP reviewed Mr Warriner on 27 December. Mr Warriner told him that he was vomiting after meals. The GP prescribed medication to reduce feelings of nausea.

47. On 29 December, a nurse assessed Mr Warriner because a mental health nurse had expressed concern at his yellow complexion. She noted he had yellow

sclera (whites of the eyes), increased abdominal pain and he was cold. She discussed his symptoms with a prison GP and they decided he should be taken to hospital. He remained in hospital until 9 January 2018. While there, he was treated for obstructive jaundice (where the essential flow of bile to the intestine is blocked and remains in the blood) and biliary sepsis (infection).

48. Mr Warriner was taken to hospital for his scan on 11 January but he found it too painful and he was returned to Whatton.

49. On 12 January, a prison GP tried to get a blood sample from Mr Warriner but was unable to. He had lost weight (66.5kg). Because of his poor health, Mr Warriner was moved to A8 unit, a unit for prisoners with additional care needs.

50. On the evening of 21 January, Mr Warriner was taken to hospital with chest and abdominal pain. He was discharged the following morning, 22 January. Once back at Whatton, he was considered to be very unwell, with a NEWS score of 9. He was sent back to hospital, the same day, as an emergency.

51. On 15 February, a prison nurse called the hospital for an update and was told that Mr Warriner had incurable pancreatic cancer. On 19 February, his prognosis was given as a few days, possibly hours. Mr Warriner died in hospital on 21 February shortly before 12.00pm.

Contact with Mr Warriner's family

52. At 1.30pm on 16 February, an acting custodial manager attempted to call Mr Warriner's next of kin, his brother, but could not get an answer. He arranged for the police to visit Mr Warriner's brother's address, but they found the property was empty and was advertised to let. The police contacted the letting agent, who provided a number for Mr Warriner's sister-in-law. The police called her and passed on the prison contact details. Mr Warriner's brother called the prison later that day and spoke to the Governor who told him that Mr Warriner was seriously ill in hospital.

53. The prison appointed a family liaison officer and a deputy. On 19 February, the family liaison officer visited Mr Warriner in hospital and telephoned his brother to introduce herself. He asked to be notified by telephone of Mr Warriner's death. On 21 February, at around 12.00pm, she telephoned Mr Warriner's brother to tell him that Mr Warriner had died. The family liaison officer kept in contact with him until Mr Warriner's funeral, which took place on 12 March and which she, her deputy and the Head of Safer Custody attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

54. After Mr Warriner's death, a custodial manager debriefed staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

55. The prison posted notices informing other prisoners of Mr Warriner'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 Warriner's death.

Post-mortem report

56. The post-mortem report shows that Mr Warriner died from metastatic pancreatic cancer (the term metastatic means the cancer had spread to other parts of the body). The post-mortem examination found that the cancer in Mr Warriner's pancreas had spread to his lymph nodes and to his lungs.

Findings

Clinical care

57. The clinical reviewer was satisfied that the standard of care Mr Warriner received at Whatton was equivalent to that which he could have expected to receive in the community. Healthcare staff used the NEWS tool to assist their clinical judgement and referred Mr Warriner to hospital when appropriate. They also ensured that he was sent back to hospital quickly when he presented as very unwell following his discharge.

58. The clinical reviewer was unable to say whether there had been a delay in diagnosis by hospital staff or whether an earlier diagnosis would have changed Mr Warriner's prognosis. She said these were issues that would need to be addressed by Nottingham University Hospitals. As such, they are outside the remit of this investigation.

59. We are concerned that on several occasions, healthcare staff recorded that Mr Warriner required a follow up appointment but this was not actioned. For example, on 1 February and on 18 December, a nurse noted that Mr Warriner should be booked to see a GP, but this did not happen. We are satisfied that this did not contribute to the delay in Mr Warriner's cancer diagnosis, but such oversights could have a detrimental impact on prisoners' healthcare in future. We make the following recommendation:

    The Head of Healthcare should ensure that all requests for follow up GP appointments are actioned promptly.

60. On 14 December, Mr Warriner missed his hospital appointment for an MRI scan because the prison had failed to book a taxi. We are satisfied that this did not affect the eventual outcome, but it is important that the prison facilitates prisoners' attendance at hospital appointments and ensures appointments are not missed needlessly. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff facilitate prisoners' attendance at hospital appointments, including that they make appropriate transport arrangements.

61. The clinical reviewer identified some other issues in her report that were not directly related to Mr Warriner's death, but which the Head of Healthcare will need to address.

Restraints

62. Mr Warriner was assessed as a high risk to the public and to hospital staff and was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) on his final transfer to hospital on 22 January. There were no medical objections to the use of restraints.

63. On 5 February, the use of restraints on Mr Warriner was reviewed. In view of his failing health, a decision was taken to remove the restraints and they were not reapplied.

64. We consider that the level of restraints used on Mr Warriner was reasonable. We are satisfied that the use of restraints was reviewed appropriately and that the decision was taken to remove them when his condition deteriorated.

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