Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alfred Whitehouse, a prisoner at HMP Leeds on 28 November 2016

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 Whitehouse died on 28 November 2016 of pneumonia caused by chronic obstructive pulmonary disease while a prisoner at HMP Leeds. He was 77 years old. I offer my condolences to Mr Whitehouse's family and friends.

I am satisfied that the care Mr Whitehouse received was at least equivalent to that which he could have expected to receive in the community.

However, I am not satisfied that the prison's decision to restrain Mr Whitehouse when they sent him to hospital was justified. I am particularly concerned that once a decision to remove restraints had been taken, an officer restrained Mr Whitehouse using unapproved methods and in a manner which raised significant concerns in the hospital. This incident and other complaints from the hospital, require full investigation. I am also disappointed that HMP Leeds did not inform us of this incident and instead NHS staff notified the investigator significantly late into the investigation.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

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Summary

Events

1. On 21 October 2016, Mr Alfred Whitehouse was sentenced to 20 years in prison for sexual offences and was sent to HMP Leeds. He had a history of lung cancer and chronic obstructive pulmonary disease (COPD). On arrival, he told healthcare staff that he suffered from asthma but did not mention his COPD.

2. On 24 October, wing staff observed Mr Whitehouse struggling to breathe. Healthcare staff attended and called an ambulance. Mr Whitehouse was taken to hospital.

3. The hospital discharged Mr Whitehouse back to HMP Leeds on 17 November after treating him for respiratory failure. The next day Mr Whitehouse told a nurse that he had fallen from his bed and was suffering from rib pain. The prison sent Mr Whitehouse back to hospital.

4. While at hospital, Mr Whitehouse was accompanied by two escorting officers and restrained initially using a single set of handcuffs, subsequently an escort chain. On 24 November, hospital nurses reported concerns about the escorting officers to the prison. They informed the prison that Mr Whitehouse had fallen out of his bed and that officers had been using mobile phones and crocheting. As it was apparent that Mr Whitehouse was receiving end of life care, the prison decided on 25 November that restraints were no longer appropriate.

5. On 26 November, two different officers were supervising Mr Whitehouse. Mr Whitehouse became increasingly agitated and one of the officers decided to tie Mr Whitehouse via his right wrist to his bed using his pyjama top. Hospital nurses asked the officer to remove the pyjama top and formally reported this as a safeguarding issue to the prison.

6. Mr Whitehouse's condition continued to deteriorate and he died in hospital on 28 November.

Findings

7. The clinical reviewer found that Mr Whitehouse received a good standard of care at HMP Leeds. The prison was unable to obtain Mr Whitehouse's full medical records from the community, as he arrived over the weekend, and so could only treat Mr Whitehouse on the information he provided at his initial health screening. Once admitted to hospital, the prison maintained appropriate contact.

8. Senior managers authorised the use of physical restraints during Mr Whitehouse's transfer to hospital, and then while in hospital. He remained restrained until three days before his death. We are concerned that Mr Whitehouse's poor health and mobility were not appropriately considered in making those decisions.

9. The circumstances surrounding the conduct of escorting staff and the concerns raised by the hospital with HMP Leeds are unclear and insufficient details have been made available by the prison to the investigator for us to reach a view. It

was though entirely inappropriate that an officer restrained Mr Whitehouse using unapproved methods and in a way which attracted the serious concern of the hospital. The scope of the internal investigation, which is ongoing, needs to address the full range of issues raised by the hospital with the prison.

10. When Mr Whitehouse became very unwell the prison did not appoint a family liaison officer. Members of staff contacted the nominated next of kin, who declined involvement. However, when Mr Whitehouse died other members of staff then attempted to contact the next of kin, against their wishes.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments understand the legal position on the use of restraints 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
- Escorting staff using restraints should use only approved equipment when appropriately authorised. Staff should understand the limits of their authority and the implications of using unauthorised restraints and the inappropriate use of force.
- The Governor should ensure staff behave professionally when on external escort and log all significant events in the bed watch log.
- The Governor should investigate fully the reported concerns raised by hospital staff about the conduct of those responsible for escorting Mr Whitehouse during his time in hospital and take such action as may be appropriate.
- The Governor should ensure that staff are aware of their responsibilities, set out in PSI 50/2010, to provide all relevant material to the Ombudsman.
- The Governor should ensure that a family liaison officer or appropriate member of staff is appointed as soon as a prisoner is diagnosed with a serious illness, in line with Prison Service Instructions.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Whitehouse's prison and medical records. She interviewed three members of staff.

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

14. We informed HM Coroner for Wakefield of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report.

15. The investigator wrote to Mr Whitehouse's stepson to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

16. The investigation has assessed the main issues involved in Mr Whitehouse's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Leeds

18. HMP Leeds is a local prison, which holds up to 1,212 men. On 1 April 2016, Care UK took over the primary healthcare services from Leeds Community Health. Leeds has an inpatient facility with 24 hour nursing care.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Leeds was in December 2015. Inspectors noted that health provision had declined since the last inspection but outcomes for prisoners remained reasonable overall. Waiting times for most clinics were acceptable and chronic disease management arrangements were impressive.

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 December 2015, the IMB reported concerns at major changes to staffing levels and management structures. However, staff continued to show high levels of care and respect to prisoners. Overall, healthcare provision had improved over the last 12 months although there were concerns that these standards could deteriorate if staffing levels were affected by Care UK's takeover in April.

Previous deaths at HMP Leeds

21. Mr Whitehouse was the fifth prisoner to die of natural causes at HMP Leeds since January 2015. We have made a recommendation about family liaison before.

Findings

The diagnosis of Mr Whitehouse's terminal illness and informing him of his condition

22. On 21 October 2016, Mr Alfred Whitehouse was sentenced to 20 years in prison for sexual offences and sent to HMP Leeds. He had a number of existing health problems when he arrived, including COPD and a history of lung cancer.

23. Mr Whitehouse had been treated for lung cancer and his community GP had recently diagnosed him with respiratory failure due COPD in August 2016. The GP was treating him as a palliative patient.

Mr Whitehouse's clinical care

24. Mr Whitehouse attended his reception screening with a support worker on 21 October. She noted that he moved slowly and unsteadily. He told her had a history of asthma and was prescribed inhalers in the community, but he did not mention his COPD. Later that evening, a nurse saw Mr Whitehouse in his cell, as he was unable to walk down to the prison reception area. She noted he was short of breath but he told her this was normal for him. She organised for a nurse to complete his health screen the following morning.

25. On 22 October, a nurse saw Mr Whitehouse to complete his health screen. He was struggling to breathe and struggled with mobility. She referred Mr Whitehouse to a prison GP, physiotherapist and for a social care assessment. A prison GP saw Mr Whitehouse on the same day and prescribed amoxicillin (an antibiotic) and prednisolone (a steroid) for a chest infection.

26. A nurse saw Mr Whitehouse on 24 October, after officers informed healthcare staff that he was struggling to breathe. She saw him in his cell and noted that he could not speak due to breathlessness. She was unable to take his pulse and recorded that he was very cold with blue fingertips, and called a code blue on her radio (which indicates that a prisoner is having problems breathing). She gave Mr Whitehouse two litres of oxygen using a nebuliser mask. When paramedics arrived, Mr Whitehouse initially refused to go to hospital. They persuaded him to attend hospital and took him to hospital.

27. On 26 October, a nurse noted that he had spoken to a hospital nurse on the Acute Respiratory Care Unit. He recorded that a consultant had reviewed Mr Whitehouse, who was now taking oral antibiotics. The prison contacted the hospital frequently to enquire about Mr Whitehouse's progress and diagnosis.

28. The records are unclear but it appears Mr Whitehouse's health deteriorated on 4 November and the prison contacted his family, who said they did not wish to be involved. His health then improved sufficiently so that on 17 November, an officer contacted the prison to inform them that the hospital was discharging Mr Whitehouse. Mr Whitehouse would require a nebuliser in his cell and was to be located in the inpatient unit in prison to allow him to be easily observed and cared for.

29. A nurse reviewed Mr Whitehouse after he arrived back at Leeds. She noted his discharge summary stated he was not to be resuscitated. 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. When she asked Mr Whitehouse about this, he told her he had not signed a DNACPR and he did not agree to it. She recorded that staff should actively resuscitate him and arranged for a GP review.

30. On 18 November, two nurses reviewed Mr Whitehouse in his cell and examined him. He had reported to officers that he had fallen out of bed and complained of rib pain. Mr Whitehouse was unable to talk in sentences and had grazed his elbow. One nurse sent Mr Whitehouse to accident and emergency at hospital.

31. Following his admission to hospital, healthcare staff contacted the hospital for updates on Mr Whitehouse's condition. The hospital provided end of life care, and Mr Whitehouse died on 28 November.

32. The clinical care Mr Whitehouse received was equivalent to that which he could have expected to receive in the community. The prison acted appropriately on the information they had, for the short amount of time he was in prison.

Mr Whitehouse's location

33. On arrival at Leeds Mr Whitehouse was located in a single cell. After he returned from hospital on 17 November, he was located in a cell in the healthcare unit. He was admitted to hospital promptly and appropriately. We are satisfied that Mr Whitehouse was appropriately located while at Leeds.

Restraints, security, escorts and staff conduct

34. 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.

35. Mr Whitehouse was elderly, frail, increasingly unwell and, from the point of his admission to prison, his very restricted mobility was clear. He was admitted to hospital on 18 November, after falling out of his bed. On admission he was hypoxic (low amount oxygen in the blood), mildly dehydrated and in pain from rib fractures. For Mr Whitehouse's admission to hospital on 18 November, a nurse indicated (by ticking a yes/no answer) that there were no objections to restraints, no other medical considerations, and the treatment could not take place in the prison. Using this information, a prison manager decided that two officers should escort Mr Whitehouse and restrain him, initially using a single set of handcuffs.

36. Two officers escorted Mr Whitehouse. Following his admission to hospital, he was restrained using an escort chain with one end attached to Officer A. (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.) Over the course of the evening, Mr Whitehouse attempted to sit on the edge of his bed and also climb out of his bed. On numerous occasions bed watch staff said they helped Mr Whitehouse back into his bed, after letting him rest on the edge. On one occasion, Mr Whitehouse attempted to climb out of his bed, and fell. Hospital staff reported to the prison and to NHS England that escorting staff were unable to confirm how this had happened or if Mr Whitehouse had hit his head. Hospital staff also reported that Officer B was crocheting and Officer A was on his phone.

37. On 25 November, the prison's Head of Security revisited the risk assessment and decided that Mr Whitehouse should not be restrained because he was receiving end of life care. The restraints were removed. On 26 November, an officer and a custodial manager (CM) took over responsibility for Mr Whitehouse's supervision. During the day, Mr Whitehouse became more agitated and repeatedly attempted to remove his catheter, which he had done previously. Hospital nurses gave Mr Whitehouse medication in order to calm him but when this wore off Mr Whitehouse became agitated again. The escorting officers requested nurse assistance and waited approximately 25 minutes, during this time they were continually moving Mr Whitehouse's arms away from his catheter.

38. The officer then went to find hospital staff and on her return found the CM in the process of tying Mr Whitehouse's arm to the side of the bed with his pyjama top. Nurses arrived, informed him that this was an inappropriate use of restraints, and asked him to remove it. The escort staff did not log the incident in the bed watch log. At interview, both said they felt under pressure and were concerned by how long it took hospital staff to arrive in order to sedate Mr Whitehouse. They said hospital staff had asked them to prevent Mr Whitehouse removing his catheter, which he had done the day before, as it would cause him pain and blood loss. The CM said that his intentions in applying the pyjama top were to stop Mr Whitehouse from hurting himself.

39. Leeds informed the investigator of an internal investigation into this issue which has not concluded and therefore they are unable to provide the findings. Their internal investigation came after hospital staff made a formal complaint both to the prison and to the external body, Leeds Safeguarding Adults Board. They reported the incidents of prison officers either being on their mobile phone, crocheting, not witnessing the fall of Mr Whitehouse, and of him being restrained with a pyjama top.

40. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that the prison's decision of 18 November to restrain Mr Whitehouse was justified, given his very poor health and mobility, and we note that Mr Whitehouse remained under restraint until 25 November, when a senior manager correctly, if belatedly, authorised their removal.

41. We are concerned at the reported unprofessional actions of escorting staff on the 24 November and particularly concerned at staff reportedly using unapproved methods of restraint, although we understand that the CM did this with the best of intentions. It is troubling that HMP Leeds did not inform the investigator of either incident. NHS England passed on the information after the investigator was six weeks into the investigation. We make the following recommendations.

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments understand the legal position on the use of restraints 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.

Escorting staff using restraints should use only approved equipment when appropriately authorised. Staff should understand the limits of their authority and the implications of using unauthorised restraints and the inappropriate use of force.

The Governor should ensure staff behave professionally when on external escort and log all significant events in the bed watch log.

The Governor should investigate fully the reported concerns raised by hospital staff about the conduct of those responsible for escorting Mr Whitehouse during his time in hospital and take such action as may be appropriate.

The Governor should ensure staff are aware of their responsibilities, set out in PSI 50/2010, to provide all relevant material to the Ombudsman.

Liaison with Mr Whitehouse's family

42. PSI 64/2011 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.

43. Although records are unclear, it appears that on 4 November, Mr Whitehouse's health deteriorated. An Offender Supervisor contacted the nominated next of kin, who declined involvement.

44. On 25 November, two CMs attempted to locate Mr Whitehouse's listed next of kin and, at approximately 4.30pm, they attended the address listed on Mr Whitehouse's prison records but no one was in. They did not realise that the listed next of kin had declined to be involved.

45. We would have expected Leeds to appoint a family liaison officer to coordinate and manage contact. There is no record that a family liaison officer was appointed, and instead several different members of staff attempted to contact the family after they had declined involvement. We make the following recommendation:

The Governor should ensure that a family liaison officer or appropriate member of staff is appointed as soon as a prisoner is diagnosed with a serious illness, in line with Prison Service Instructions.

46. Mr Whitehouse's funeral was held on 3 January. The prison arranged the funeral and contributed to the cost, in line with national instructions.

Compassionate release

47. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. Mr Whitehouse was in the custody of HMP Leeds for 38 days before his death on the 28 November. The majority of these were spent at hospital. Unfortunately, HMP Leeds was unable to begin compassionate release procedures as he had nowhere to live and, as he was a month into a 20 year sentence, the application for release was unlikely to have succeeded.

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