Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Hall a prisoner at HMP Whatton on 13 March 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*

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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 I oversee can improve their work in the future.

Mr Frederick Hall died on 13 March 2018 at HMP Whatton from a cardiac condition which caused a heart attack. He was 80 years old. I offer my condolences to Mr Hall's family and friends.

Mr Hall's heart condition was controlled by medication. It was well-managed and kept under review by prison healthcare staff. His death was sudden and unexpected and when he collapsed on the wing, staff responded quickly. I am satisfied that Mr Hall received a good standard of care 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**

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Summary

Events

1. On 20 October 2016, Mr Frederick Hall was sentenced to four years and six months imprisonment for a sexual offence. He was moved to HMP Whatton on 24 February 2017.

2. On arrival at Whatton, the reception medical screen identified his current medication and health problems, which included skin cancer and high blood pressure. He had also been diagnosed with an irregular heart rhythm in October 2017. Nevertheless, Mr Hall was fully mobile and able to carry out all regular daily tasks during his time in prison, and was considered fit for normal location.

3. Due to an irregular heart-beat, Mr Hall was admitted to hospital on 27 October and had a pacemaker fitted. He returned to Whatton on 1 November and was supported by prison and healthcare staff.

4. On 5 March, Mr Hall was again admitted to hospital and diagnosed with heart failure. The following day he was discharged back to Whatton and he continued taking medication for his ongoing condition. Mr Hall was monitored by healthcare staff and his observations were normal, other than a low heart rate which was not low enough to cause concern.

5. On 13 March, just after the 8.00am unlock, an officer heard a loud thud and went to investigate. He was approached by a prisoner who told him that Mr Hall had collapsed on the landing. The officer called for assistance and an emergency was called. Prison staff arrived within minutes and began cardiopulmonary resuscitation (CPR). Healthcare staff, including a doctor, arrived shortly afterwards and continued CPR. Paramedics arrived and took over resuscitation but further efforts were discontinued and the doctor pronounced Mr Hall dead.

Findings

Clinical care

6. The clinical reviewer concluded that the standard of care Mr Hall received at Whatton was equivalent to that which he could have expected to receive in the community.

Emergency response

7. When the officer realised that Mr Hall was in need of medical assistance he immediately called an emergency. Prison officers arrived promptly and began CPR. Nursing staff, paramedics and the general practitioner also attended and worked together to try and resuscitate Mr Hall.

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 visited HMP Whatton on 22 March 2018. She obtained copies of relevant extracts from Mr Hall's prison and medical records.

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

11. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Hall's wife, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Hall's brother raised concerns about Mr Hall's change in location when he died. This was explained to Mr Hall's wife by the prison and she was satisfied with the response.

13. Mr Hall's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Hall's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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.

Background Information

HMP Whatton

15. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 men convicted of sex offences. Since 1 April 2017, MITIE Care and Custody Health have provided healthcare services. 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 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 they provided polite and professional interactions with their patients. There was high demand for routine hospital appointments but 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 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. The board highlighted the high number of older prisoners with significantly different and more costly healthcare needs, including social care. Staff shortages, together with the increasing demand for hospital escorts and bed watches, 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

18. Mr Hall was the twelfth prisoner to die from natural causes at HMP Whatton, since January 2016. He is the second prisoner to die from a heart-related issue during this time.

Key Events

19. On 20 October 2016, Mr Frederick Hall was sentenced to four years and six months imprisonment for indecent assault on a child. He was sent to HMP Whatton on 24 February 2017.

20. On 22 September 2017, a nurse carried out tests on Mr Hall. He had a slightly high rate of breathing but his blood pressure was normal. The nurse put the raised breathing down to anxiety as Mr Hall was not happy with his location on C wing. He was not happy that he was “surrounded by old people” even though these were people of his own age group.

21. On 5 October, Mr Hall was seen by a prison GP. He complained about his care at Whatton. His main concern was pain in his neck which he had been experiencing since 11 August when he had been diagnosed with osteoarthritis of the neck and prescribed anti-inflammatory gel. Mr Hall was concerned that the pain in his neck could be linked to the return of his trigeminal neuralgia (a nerve pain problem in the face). He was keen to ensure that his symptoms were being taken seriously. The prison GP told him that if the symptoms recurred, then they could be addressed in the future as Mr Hall described his current symptoms as minor.

22. On 16 October, a nurse assessed Mr Hall as he complained about pain in his jaw and teeth. His blood pressure was raised which may have been due to the pain, however his pulse was low at 45 beats per minute. (The normal resting heart rate for adults is between 60 and 100 bpm.) Three days later, a nurse confirmed that Mr Hall’s pulse had dropped to 40 beats per minute. On 26 October, Mr Hall’s pulse had dropped further to 36 beats per minute when it was checked by a prison GP, although his blood pressure was still raised. An electrocardiogram (ECG) which records the heart’s rhythm and activity, showed a slow and irregular heartbeat. The following day, Mr Hall was admitted to a hospital Cardiac Unit to have a pacemaker fitted.

23. On 1 November, Mr Hall was discharged from hospital and the next day was given a wedge pillow to prop him up in bed. On 8 November, a nurse re-dressed his pacemaker wound. His heart rate had risen to 54 beats per minute and his blood pressure was almost normal.

24. On 13 February 2018, a nurse carried out a routine cardiovascular (heart and blood vessels) risk assessment. The following day, Mr Hall’s blood and urine samples came back as normal. However, the required checks on his vitamin D and calcium were overlooked by the nurse.

25. On 28 February, Mr Hall was reviewed by a nurse on account of a persistent cough and breathing difficulties. His oxygen saturation was 95% which is slightly low and his respiratory rate was slightly elevated at 16 breaths per minute. The nurse made a GP appointment.

26. On 5 March, Mr Hall was seen by a nurse for persistent wheezing and a cough. Observations confirmed that his pulse, blood pressure, oxygen saturations, body temperature and respiratory rate were normal. A prison GP prescribed

antibiotics and scheduled a review if there was no improvement. An ECG was taken.

27. Later that day, a nurse was notified that the ECG results had returned as abnormal. Although this might have been due to Mr Hall's pacemaker, there were no previous ECG results to compare with, so an ambulance was called. The nurse attended to Mr Hall on the wing and documented some right-sided chest pain. Observations were normal. The paramedic crew which attended decided to take Mr Hall to hospital. Investigations in hospital diagnosed congestive cardiac failure. Advice was given to start Mr Hall on a daily dose of furosemide diuretic, to eliminate water and salt from the body.

28. On 6 March, Mr Hall was discharged back to prison and started taking his medication. He was fully compliant and he said he would let Healthcare staff know if he had any further issues.

29. On 9 March, a prison GP reviewed Mr Hall who was lethargic, coughing up green sputum and breathless on exertion. Physical observations showed signs of a heart murmur (sounds made by turbulent blood in or near the heart), fluid retention in his knees and a rise in Mr Hall's weight. The prison GP diagnosed heart failure and a lower respiratory tract infection. He prescribed antibiotics and medication to relieve the fluid build-up caused by the heart failure. The prison GP arranged to see Mr Hall two weeks later, or sooner if necessary.

30. The next day, Mr Hall was seen by a nurse as he was complaining of pain and 'pins and needles' down his right arm. The symptoms had subsided by the time he saw the nurse but he felt sick from the newly-prescribed medication. Mr Hall also stated that he felt anxious about his wife's visit later that afternoon. Other than a slightly low pulse rate of 50 beats per minute, his observations were normal.

Events of 13 March 2018

31. On 13 March, at 8.00am, Mr Hall's cell was unlocked. It is not clear whether he left his cell immediately, but at some point he made his way up to the second floor of the wing just outside the association room.

32. Officer A heard a loud thud while he was in his office and went out to investigate the source of the noise. He was approached by a prisoner who told him: "Fred has collapsed on the twos landing". Officer A immediately made his way up to the landing where he could see Mr Hall lying in what he described as a "bad way". At 8.18am, he called a code blue emergency on his radio. (This indicates that a prisoner is unconscious or having difficulty breathing.)

33. Officer B was one of the first members of staff to arrive and assist Officer A. He fetched the defibrillator from the wing office. Mr Hall gave no sign of breathing and had a very weak pulse so Officer B applied the defibrillator pads and began CPR as directed by the defibrillator. Officer B continued CPR until healthcare staff arrived.

34. Shortly afterwards, Officer C and staff from healthcare arrived and continued to provide CPR to Mr Hall. They all worked together to provide CPR, rescue breaths and apply the defibrillator. Between 8.18am and 8.47am, when the

paramedics arrived, seven shocks from the defibrillator were given to Mr Hall. Other prison officers, who had arrived after hearing the code blue call, assisted by locking the other prisoners back in their cells.

35. At 8.47am, a paramedic arrived and took over from Officer C. He continued to give CPR with support from healthcare staff. The ambulance crew then arrived and assisted the paramedic. They all worked on Mr Hall for approximately 15 to 20 minutes. They decided that as Mr Hall had no vital signs, a doctor should be called. A prison GP arrived shortly afterwards and continued CPR.

36. Mr Hall was moved approximately four feet into the association room. At 9.14am, the prison GP pronounced Mr Hall dead.

Contact with Mr Hall's family

37. Later that morning, the prison appointed an interventions facilitator as the prison's family liaison officer. At 10:50am, the family liaison officer and the Head of Security left the prison to break the news to Mr Hall's next of kin in person. They visited Mr Hall's wife and step-daughter at home, and the family liaison officer and the Head of Security offered their advice and support.

38. The following day, the family liaison officer was informed by the Head of Security that Mr Hall had not died in his cell as originally thought but had collapsed on the landing above. Mr Hall's wife was contacted, the prison apologised and provided the correct information. Mr Hall's wife said she understood. However, the prison later received a call from Mr Hall's brother who was extremely unhappy about the new information. It was explained that the information given originally was what the family liaison officer had been told at the time.

39. The Governor contacted Mr Hall's brother to offer reassurance that there was nothing untoward about Mr Hall's death but he was still very upset. The family liaison officer remained in contact with the family until the funeral, which was attended by the Head of Safer Custody and the family liaison officer. The prison contributed to the costs, in line with national policy.

40. During the opening visit, the investigator spoke to the Head of Safer Custody and discussed the incorrect information initially given to Mr Hall's family. The Head of Safer Custody was very apologetic, explaining that there had been a breakdown in communication and that the prison would ensure that the error did not happen again. We do not feel that it is necessary to make a recommendation.

Support for prisoners and staff

41. After Mr Hall's death, the Head of Residence debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

42. The prison posted notices informing other prisoners of Mr Hall'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 Hall's death.

43. The investigator visited the wing and spoke briefly to the prisoners who were there on the day of Mr Hall's death. They spoke very highly of the efforts made

by staff. They said that all the staff worked very hard together to try to save Mr Hall. In particular, they praised the quick response of Officer A to ensure that Mr Hall received the help he needed as soon as possible.

Post-mortem report

44. A post-mortem examination concluded that the immediate cause of Mr Hall's death was haemopericardium (blood in the sac of the heart). This caused Mr Hall to undergo a myocardial infarction (a heart attack).

Findings

Clinical care

45. The clinical reviewer was satisfied that the care Mr Hall received at Whatton was equivalent to that which he could have expected to receive in the community. Although Mr Hall developed heart failure over the last few weeks of his life, he did not suffer a prolonged period of decline and his sudden death was not foreseeable.

Mr Hall's location

46. It is very unfortunate that Mr Hall's family were originally told that he had died in his cell, when in fact he died on the floor above. However, we are satisfied that this was simply an unfortunate mistake as neither the family liaison officer or the Head of Security were present when Mr Hall died, and that there was no attempt to mislead the family or cover anything up.

Emergency response

47. After the code blue emergency call had been made, the clinical reviewer is satisfied that prison officers began CPR correctly. Nursing staff, the paramedics and the prison GP arrived later and correctly discontinued resuscitation when there were no signs of life.

48. The Head of Healthcare at Whatton has confirmed that all staff were in date for mandatory CPR training, including all staff who responded to the code blue call. All staff did what was necessary to assist Mr Hall without any delay.

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