

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Coates a prisoner at HMP Whatton on 16 July 2018

A report by the Prisons and Probation Ombudsman

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 Peter Coates died on 16 July 2018 while a prisoner at HMP Whatton. He died of a heart attack which was caused by diabetes, high blood pressure and a blockage of the bile duct. He was 51 years old. I offer my condolences to Mr Coates' family and friends.

I am satisfied that the healthcare Mr Coates received at HMP Whatton was good and equivalent to that he could have expected to receive in the community. When he became ill in May 2018, he was promptly sent to hospital, where he remained until his death.

However, I am concerned that Mr Coates' risk was not reviewed to reflect the deterioration in his health and that he, therefore, remained in restraints for longer than he should have done. I am also concerned that Mr Coates' brother was not told that he was in hospital until 12 July, by which time Mr Coates was very ill and finding it difficult to hold a conversation.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. On 3 March 2016, Mr Peter Coates received an eight-year sentence for sexual offences and was sent to HMP Leeds. He was transferred to HMP Whatton on 5 August 2017.
2. Mr Coates had several health complaints, including diabetes and hypertension (high blood pressure), when he arrived at Whatton. Mr Coates was prescribed medication and was advised to increase exercise and lose weight. His blood sugar levels were kept under review and by May 2018 his glucose levels had improved.
3. On 24 May 2018, Mr Coates reported feeling unwell and plans were made to investigate his symptoms further. However, on 26 May, his health deteriorated and he was taken to hospital. While in hospital, although investigations continued, his health deteriorated and he was admitted to the Intensive Care Unit. He died in hospital on 16 July of a heart attack which was caused by diabetes, hypertension and a blockage of the bile duct (presumed to be caused by cancer of the bile duct).

Findings

4. The clinical reviewer considered that the clinical care Mr Coates received at HMP Whatton was of a good standard and equivalent to that which he could expect to receive in the community.
5. The healthcare team of nurses and GPs, worked together to support Mr Coates and to respect his wishes about how he wanted his illnesses to be managed.
6. When he became ill in May 2018, he was taken to hospital promptly.
7. During Mr Coates' stay in hospital his health deteriorated and therefore his risk to the public and of escape was reduced. This was not reflected in his daily risk review, however, and although restraints were eventually removed, they could have been removed earlier.
8. The prison did not appoint a family liaison officer and inform Mr Coates' brother that he was in hospital until a few days before he died. By this time, Mr Coates' health had been deteriorating for over a month and he was very unwell. We consider that a family liaison officer should have been appointed sooner.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners in hospital 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.
- The Governor should ensure that a family liaison officer is appointed and next of kin are informed when a prisoner is in hospital for more than a short period, particularly if the prisoner's health is deteriorating.

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. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Coates' prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Coates' clinical care at the prison.
12. We informed HM Coroner for Nottingham and Nottinghamshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
13. The investigator wrote to Mr Coates' brother to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.
14. Mr Coates' family were informed the initial report was available, but did not wish to receive a copy or make any comment.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
16. The investigation has assessed the main issues involved in Mr Coates' 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.

Background Information

HMP Whatton

17. HMP Whatton in Nottinghamshire is a category C 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

18. 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

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 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

20. Mr Coates is the ninth prisoner to die of natural causes at Whatton since January 2017.

Findings

The diagnosis of Mr Coates' illness

21. Mr Coates was serving an eight-year sentence and had been at HMP Whatton since 5 August 2017. At the initial health screening it was noted that Mr Coates had been diagnosed with testicular cancer and erectile dysfunction in 2004, drug-induced psychosis in 2006 and diabetes in 2017.
22. On 24 May 2018, Mr Coates was seen by a nurse on the wing after he had been alerted by wing staff. Mr Coates said that that he had been feeling ill for over a week and had passed dark brown urine. The nurse noted that Mr Coates' blood pressure and temperature were slightly raised. He reviewed Mr Coates later that afternoon and noted that his skin had a yellow tinge to it. As this could be a sign of potential jaundice, he booked Mr Coates in for a GP clinic the following day.
23. On 25 May, Mr Coates saw a prison GP and blood tests were taken. He advised that if Mr Coates showed any sign of deterioration, he should be admitted to hospital.
24. On 26 May, Mr Coates' blood test results were reviewed by the out of hours GP. These showed that Mr Coates' liver function tests were abnormally high, which may have been caused by the medication Mr Coates had taken to lower his cholesterol. He was therefore advised to stop taking the medication and to have a further review by the GP after the weekend. A nurse told prison staff that that Mr Coates should be sent out to hospital if he deteriorated and no healthcare staff were available. At 8.00pm, prison staff arranged for Mr Coates to be taken to the hospital by taxi as it appeared that he had deteriorated further.
25. Mr Coates remained in hospital and there is evidence to show that healthcare staff maintained good levels of contact with the hospital. Investigations continued while Mr Coates was in hospital and these investigated the possibility that he had cancer of the bile duct.
26. On 16 July, Mr Coates had three cardiac arrests and died in hospital, in the high dependency unit.

Mr Coates' clinical care

27. The clinical reviewer is satisfied that Mr Coates received a good standard of care at Whatton prior to his admission to hospital and that the care was equivalent to that he would have received in the community.
28. The clinical reviewer also comments on the continued good communication between healthcare staff and the hospital after Mr Coates admission to hospital.

Mr Coates' location

29. Mr Coates lived on a general residential wing at Whatton before he was admitted to hospital. We are satisfied Mr Coates' medical needs could be met on a normal wing before he became ill in May 2018 and that he was appropriately located.

Restraints, security and escorts

30. 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.
31. On 26 May when Mr Coates was transferred to hospital in a taxi, he was restrained using single cuffs. Although, his health had deteriorated, he was still mobile and we are satisfied that the decision to restrain him was reasonable.
32. During Mr Coates' time in hospital although his health declined, he was still kept under restraints. On 10 July, six days before he died, after a risk review by prison management it was decided that restraints should not be used when Mr Coates was on the ward. When he went for treatment or during a transfer, however, an escort chain was to be used. (An escort chain is a long chain with a handcuff at each end.)
33. In the days prior to this decision, however, bedwatch records state that Mr Coates spent most of his time sleeping and that his mobility was limited. This shows that his level of strength had generally declined and hence his risk would have also reduced. The decision to remove restraints while he was on the ward might therefore have been made earlier if prison staff had sought medical advice on Mr Coates' health and mobility and how that might affect his risk and ability to escape. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners in hospital 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.

Liaison with Mr Coates' family

34. On 11 July, HMP Whatton appointed a prison family liaison officer (FLO). The FLO visited Mr Coates in hospital on the same day and introduced himself. He asked Mr Coates about his next of kin, family and friends. Mr Coates said that he only wanted contact with his brother. The conversation was difficult as Mr Coates was drifting in and out of sleep/consciousness. The FLO noted that he would contact Mr Coates' brother when he had more information on his condition.
35. The following day, the FLO managed to contact Mr Coates' brother. He visited Mr Coates that day and met the FLO who explained his role. He was also able to discuss Mr Coates' condition with his doctors.

36. On 16 July, after the FLO had been notified that Mr Coates' had died he tried to call Mr Coates' brother to notify him of the death as previously agreed. After several attempts, he managed to get through but found that Mr Coates' brother was already aware that his brother had died as he had been told by hospital staff. The next day, the FLO spoke to Mr Coates' brother again and was able to provide support and discuss details of the funeral service.
37. The funeral took place on 29 August 2018 and was attended by the FLO and the Head of Safer Custody. The prison provided a financial contribution in line with national policy.
38. We recognise that Mr Coates was not considered to be seriously ill when he was first admitted to hospital on 26 May. However, when he remained in hospital with deteriorating health, being investigated for possible cancer, we consider that the prison should have appointed a family liaison officer and informed Mr Coates' brother that he was in hospital before they did. By the time this happened on 11 July, Mr Coates was very unwell and finding it difficult to hold a conversation. We make the following recommendation:

The Governor should ensure that a family liaison officer is appointed and next of kin are informed when a prisoner is in hospital for more than a short period, particularly if the prisoner's health is deteriorating.

Compassionate release

39. 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.
40. Whatton started to complete the paperwork to apply for compassionate release for Mr Coates. However, they did not submit an application before Mr Coates died as he had not been diagnosed with a terminal illness or been given a prognosis. We are satisfied that compassionate release was appropriately considered in the circumstances.

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