

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Berry a prisoner at HMP Whatton on 5 August 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 we oversee can improve their work in the future.

Mr David Berry died on 5 August of a pulmonary embolism (a blood clot in the lung) while a prisoner at HMP Whatton. Mr Berry was 78 years old. I offer my condolences to Mr Berry's family and friends.

Mr Berry had a number of complex health conditions, including diabetes, bladder cancer and Parkinson's Disease, and the care he received at HMP Whatton was of a good standard. I am satisfied that his death was not predictable or preventable.

I am, however, concerned that there was a delay of a few minutes before an ambulance was called (although this is unlikely to have affected the outcome for Mr Berry) and that the next of kin was not informed of Mr Berry's death until the following day.

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 29 November 2010, Mr David Berry was convicted of sexual offences and taken to HMP Wandsworth. He moved to HMP Whatton on 28 March 2013.
2. Mr Berry had a number of health complaints, including asthma and diabetes. During his time at Whatton he was also diagnosed with bladder cancer, from which he recovered, and Parkinson's Disease. All his conditions were well managed.
3. On 5 August, at approximately 9.15am, Mr Berry collapsed while a healthcare assistant was tending to him in his cell. She pressed the emergency bell and an officer helped her to give first aid to Mr Berry. The officer sent a prisoner to ask another officer to call an emergency code. The second officer went to the cell to check what was happening before he called the emergency code.
4. This caused a delay but an ambulance was called and emergency services attended. They transferred Mr Berry to hospital where he died at approximately 11.33am.

## Findings

5. We are satisfied that the care Mr Berry received at HMP Whatton was equivalent to that he could have expected to receive in the community.
6. There was a short delay before an ambulance was called, and the prison did not break the news of Mr Berry's death to the next of kin face to face. We make three recommendations.

## Recommendations

- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies including entering cells and using emergency codes.
- The Governor should ensure that the protocol currently in place with the air ambulance service reflects the correct permissions and is understood by the necessary parties.
- The Governor should ensure that, wherever possible, family liaison officers, or a representative from the prison, break the news of a death to next of kin in person.

## The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr Berry's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Berry's clinical care at the prison.
10. We informed HM Coroner for Nottinghamshire of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
11. The investigator contacted Mr Berry's named next of kin, to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

# Background Information

## HMP Whatton

13. 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

14. 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 healthcare staff, in well-integrated teams, 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

15. 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 2018, the Board repeated its concerns about the award of care to Mitie in April 2017 and said that healthcare had remained a significant concern throughout the reporting year. In January 2017, NHS England had issued a rectification notice to Mitie and provided increased funding to ensure additional nursing and administrative staff could be recruited. At the end of the IMB's reporting year, this notice was still live. Concerns included a shortage of staff to cover the mental health service, delays in making referrals to secondary care, some specialist nursing clinics not being held and issues with the physical facilities. The GPs received high praise, however, from other staff and prisoners.
16. The Board highlighted the high number of older prisoners at Whatton 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

17. Mr Berry's is the sixteenth death from natural causes to occur at HMP Whatton in the past three years and there have been a further two since. We have made recommendations about emergency response procedures before.

## Key Events

18. In November 2010, Mr Berry was convicted of sexual offences and in January 2011 was sentenced to 8 years 155 days imprisonment. He was transferred to HMP Whatton on 28 March 2013.
19. On 28 March, a nurse conducted Mr Berry's reception health screen. She noted that he had Type 2 diabetes and asthma. He was prescribed salbutamol (an inhaler) and referred for a full diabetes assessment.
20. On 10 April, a prison GP conducted Mr Berry's diabetes assessment. He did blood and urine tests and concluded that Mr Berry's diabetes control was good. A care plan was in place and checks were thorough and consistent. Staff quickly took steps to regulate his condition when any fluctuations occurred.
21. In October 2015, Mr Berry was diagnosed with Parkinson's Disease following several falls. He was prescribed medication and received follow up care from the hospital neurology outpatient clinic. When his mobility deteriorated, the prison arranged for him to have special equipment including a walking aid and a mattress to minimise pressure sores. Scans and memory tests revealed that any confusion he exhibited was consistent with his age. When he forgot to take his medication, nurses prompted and supervised him.
22. In December 2015, Mr Berry was diagnosed with bladder cancer. He had been appropriately fast-tracked by the prison after showing symptoms a month earlier. Mr Berry had surgery and treatment. The cancer returned in December 2016 but, after further treatment, Mr Berry was eventually discharged from the prison's cancer service on 20 February 2018. He was considered to be in remission and the post-mortem did not detect any presence of the disease.
23. On 5 August 2018, just before 9.15am, a health support worker visited Mr Berry in his cell to help him shower. While sitting in a chair, he told her he felt sick. She gave Mr Berry a couple of minutes to prepare himself for the transfer from his chair to his wheelchair, and when he told her he felt well enough to do so, she helped him with the transfer. Mr Berry let out two long sighs and she moved round from the back of the wheelchair to face him and saw that Mr Berry's face was grey and his eyes were rolling back.
24. The health support worker managed to get a response from Mr Berry by tilting his chin, repeating his name and physically trying to rouse him. She pressed the cell bell for assistance and continued to try and get a response from Mr Berry.
25. An officer went to the cell. She told him, "He's gone", and the officer helped her manoeuvre Mr Berry onto the floor and started CPR (cardiopulmonary resuscitation). The officer asked a prisoner to go to the office and tell another officer to call a code blue emergency. The prisoner did so and the officer took a defibrillator to Mr Berry's cell. An officer checked whether or not the other officer had called a code blue and the officer said he had not. An officer took the other officer's radio and called a code blue at 9.18am. Staff in the control room immediately called an ambulance.

26. An officer applied the defibrillator to Mr Berry's chest and this advised they should begin CPR. However, Mr Berry had just regained consciousness and shouted out in pain when they tried to resuscitate him. Two nurses arrived and delivered oxygen therapy but Mr Berry lost consciousness again. Paramedics arrived and, shortly afterwards, an air ambulance crew landed. (We note from the minutes of the hot debrief that the air ambulance had landed in a nearby field as the pilot did not think he had permission to land within the prison.)
27. Mr Berry was transported to hospital by land ambulance at approximately 10.15am. The duty governor authorised that no cuffs should be applied. Mr Berry was accompanied by two escorts. Mr Berry arrived at the hospital at 10.33am and was immediately taken to the resuscitation unit. Hospital staff were unable to revive him and he was pronounced dead at 11.33am.

### **Contact with Mr Berry's family**

28. The duty governor decided that as the two addresses for Mr Berry's next of kin were a three and-a-half hour drive away, she would try to telephone them to let them know Mr Berry was in hospital. She was unable to get any response so left a message on the answer machine of one of Mr Berry's friends.
29. Once Mr Berry's death was confirmed, the duty governor contacted staff at HMP Winchester to see if they had a family liaison officer available who could break the news. The prison had no one available as it was a Sunday. She therefore contacted local police to ask them to break the news and to confirm when they had done so.
30. On 6 August, Hampshire police confirmed that they had broken the news of Mr Berry's death to his named next of kin.

### **Support for prisoners and staff**

31. After Mr Berry's death, the duty governor 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.
32. The prison posted notices informing other prisoners of Mr Berry'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 Berry's death.

### **Post-mortem report**

33. The post-mortem investigation concluded that the cause of Mr Berry's death was a "massive pulmonary embolism" (a blocked blood vessel in the lung) which originated in a deep vein thrombosis (blood clot) in his right leg.

# Findings

## Clinical care

34. The clinical reviewer found that staff at Whatton supported Mr Berry in respect of his multiple health issues generally. They consistently monitored him, made appropriate referrals and tweaked treatment and support where necessary. We are satisfied that the care Mr Berry received at HMP Whatton was equivalent to that he could have expected to receive in the community.
35. Mr Berry died of a massive pulmonary embolism (a blocked blood vessel in the lung) most likely caused by deep vein thrombosis (a blood clot) in his right leg. His diabetes, cancer and poor mobility increased his risk of developing blood clots, but in the days leading up to his death he did not complain of pain or swelling in his legs or of chest pain to the nurses or social carers who saw him daily. The clinical reviewer was satisfied that the pulmonary embolism was not predictable or preventable.

## Emergency Response

36. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in Whatton's local policy.
37. In this instance, there was a delay in calling a code blue emergency. The health support worker who was with Mr Berry when he collapsed, was not carrying a radio. Although an officer, who responded to her call for assistance, did have a radio, he did not call an emergency code immediately but instead asked a prisoner to ask another officer to do so. The officer understandably, did not feel he could do this at the request of a prisoner without going to the cell to investigate first. This delayed the calling of an ambulance by a few minutes.
38. The investigator asked an officer why he had not called an emergency code himself. Although the officer demonstrated that he fully understood the emergency codes and the follow-on action when one was called, he said that he felt it was more important that he help the health support worker with CPR than occupy his hands and concentration with the radio. Although we do not think this was the correct response, it is unlikely that this delay had any bearing on the outcome for Mr Berry. Nevertheless, we make the following recommendation:

**The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies including entering cells and using emergency codes.**

We note that the air ambulance did not land within the prison as the pilot did not believe the protocol with the prison allowed this. Other paramedics had already arrived by this point, and Mr Berry was eventually taken to hospital by road in an ambulance. We do not think that the confusion made any difference to the outcome for Mr Berry, but we make the following recommendation:

**The Governor should ensure that the protocol currently in place with the air ambulance service reflects the correct permissions and is understood by the necessary parties.**

### **Family Liaison**

39. PSI 64/2011, *Safer Custody*, says that, wherever possible, the prison's family liaison officer (FLO) must visit the next of kin in person to break the news of a prisoner's death. The PSI also says time is of the essence, to prevent the family learning about the death from another source. Where the next of kin live a long distance away, a FLO from the nearest prison may be asked to break the news. Where this happens, or where the police have broken the news, the prison must arrange a visit as soon as practicable.
40. We appreciate the significant distance between the prison and the next of kin's address, the reduced availability of staff on a Sunday and the fact that the Duty Governor asked another, closer, prison to send someone to break the news. We are concerned, however, that the next of kin did not learn of Mr Berry's death until the next day and that even then it was not from a prison representative. We make the following recommendation:

**The Governor should ensure that, wherever possible, family liaison officers, or a representative from the prison, break the news of a death to next of kin face to face.**



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