

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Munir Ahmed a prisoner at HMP Whatton on 18 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 Munir Ahmed died of a heart attack on 18 August 2018 at HMP Whatton. He was 78 years old. I offer my condolences to his family and friends.

Mr Ahmed had a number of chronic health conditions. The care that he received at HMP Whatton was of a good standard, equivalent to that he could have expected in the community. I am satisfied that prison staff could not have prevented his death. They responded promptly to the emergency, and appropriately tried to resuscitate him before the paramedics arrived.

However, I am concerned that Whatton did not contribute to Mr Ahmed's funeral costs in line with national instructions.

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

March 2019

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Summary

1. On 15 December 2017, Mr Munir Ahmed was convicted of sexual offences and sent to HMP Nottingham. On 15 January 2018, he was transferred to HMP Whatton.
2. Mr Ahmed had a number of chronic health concerns, including Type 2 diabetes, depression, Parkinson's disease and high cholesterol.
3. The healthcare team regularly monitored Mr Ahmed, and noted that his blood pressure fluctuated.
4. On 21 April, Mr Ahmed had dizzy spells, and was referred to a prison GP. By the time that he saw a GP on 30 April, he no longer had dizzy spells.
5. On 13 July, Mr Ahmed saw a prison GP because his ankles were swollen. The GP prescribed him furosemide (a diuretic) to reduce the swelling. He prescribed the same drug again on 14 August.
6. On 17 August, a nurse saw Mr Ahmed on the wing after he told a prison officer that he felt unwell. The nurse noted that he did not have any chest pain, and that the observations that she took were normal. She advised him to speak to prison staff if he felt ill at night.
7. In the early hours of the following morning, Mr Ahmed pressed his emergency cell bell. He could not articulate what was wrong to staff, but later indicated that he was 'okay', and was seen eating and drinking in his cell. Prison staff thought that his blood sugar level was low because he had diabetes.
8. Approximately fifteen minutes later, Mr Ahmed pressed his cell bell again, and the prison officer who responded found that he had trouble breathing. A prison officer called a medical emergency code blue and three prison officers went into Mr Ahmed's cell to support him and make him comfortable while they waited for an ambulance.
9. Mr Ahmed then lost consciousness, staff could not find a pulse and tried to resuscitate him. Paramedics took over approximately 25 minutes later but resuscitation efforts were futile, and Mr Ahmed was pronounced dead at 3.55am.

Findings

10. We are satisfied that the clinical care that Mr Ahmed received at HMP Whatton was equivalent to that which he could have expected to receive in the community.
11. However, the prison did not contribute towards Mr Ahmed's funeral in line with national policy.

Recommendation

- The Governor should ensure that in line with PSI 64/2011:
 - an appropriate contribution is made to Mr Ahmed's family to cover the reasonable costs of his funeral; and

- staff are reminded to offer to contribute towards funeral costs promptly when there is a death in custody.

The Investigation Process

12. 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. Three prisoners did so.
13. The investigator obtained copies of relevant extracts from prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Ahmed's clinical care at the prison.
15. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. 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

17. 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 from Monday to Friday and from 8.30am to 1.00pm 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 took place 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. 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 2018, the IMB repeated its concerns about the award of care to Mitie in April 2017 and said that healthcare provision had remained a significant concern throughout the reporting year. In January 2018 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. However, the IMB noted that the GPs were well regarded by other staff and prisoners.
20. The IMB 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 staff to monitor prisoners while in hospital, resulted in a significant reduction in 'out of cell' time. The IMB considered that the current pressure on staff was unsustainable.

Previous deaths at HMP Whatton

21. Mr Ahmed was the seventeenth prisoner to die from natural causes at HMP Whatton in the past three years. There has been one death at the prison since Mr Ahmed died, which was also from natural causes. There are no similarities between these cases and the circumstances of Mr Ahmed's death.

Key Events

22. On 15 December 2017, Mr Munir Ahmed was sentenced to two years in prison for sexual offences and was sent to HMP Nottingham. On 15 January 2018, he was transferred to HMP Whatton.
23. On arrival, a nurse completed Mr Ahmed's initial healthcare induction. He informed her that he had a history of diabetes, depression, high cholesterol and Parkinson's disease. She took Mr Ahmed's blood pressure, and recorded that it was raised. She noted that Mr Ahmed was due to have regular diabetic reviews and referred him to the GP, dentist, podiatrist and optician.
24. A prison GP saw Mr Ahmed the next day, and assessed him as suitable for keeping and administering his own medication. She prescribed him medications to manage his conditions.
25. On 31 January, a prison GP reviewed Mr Ahmed, and took his blood pressure, which was within a normal range. On 27 February, a nurse saw Mr Ahmed on the wing to review his medication. He explained his medication, insulin and blood pressure checking routine to the nurse, and she noted that he could care for himself. She advised Mr Ahmed and wing staff to contact the healthcare department if there were any concerns about his health.
26. On 21 April, a prison officer asked the healthcare team to visit Mr Ahmed as he felt dizzy. A nurse reviewed Mr Ahmed, and noted that he still felt dizzy, but was coherent and aware of the time and place. She took his observations: his blood pressure was low but both his oxygen and blood sugar levels were normal.
27. Healthcare staff continued to monitor him, and on 30 April, a nurse took Mr Ahmed's blood pressure during a planned diabetic review. His blood pressure was raised at 187/72mmHg. She noted that he should be monitored and referred him to see a GP.
28. On 11 May, a prison GP saw Mr Ahmed and noted that his dizzy spells had resolved, and that his blood pressure was now 134/78 mmHG, which was within a normal range.
29. There are no significant entries in Mr Ahmed's medical records until 13 July when a prison GP saw him because his ankles were swollen. The prison GP noted mild swelling to both ankles but that his chest was clear. He prescribed him furosemide (a diuretic medication used to treat fluid build-up due to heart failure, liver scarring or kidney disease). He prescribed a further four-week course of furosemide on 14 August.
30. At 3.45pm on 17 August, a nurse was asked to see Mr Ahmed as he felt unwell. She examined him, and noted that he was normal in colour, had no chest pain and had been eating and drinking throughout the day. She advised Mr Ahmed to remove a layer of clothing and turned his fan on. She recorded that Mr Ahmed said that he felt better, and that she had told him to speak to prison staff if he felt unwell during the night.

31. At approximately 2.13am on 18 August, Mr Ahmed pressed his emergency cell bell to get the attention of wing staff. An operational support grade (OSG) officer told us that he responded straight away. He said that when he went to Mr Ahmed's cell, Mr Ahmed was noticeably sweating. He said that Mr Ahmed did not say what was wrong, but asked OSG to enter his cell. The OSG explained that he could not come in unless it was necessary and he had permission from the night orderly. The OSG telephoned the control room and spoke to the assist night orderly officer, and explained Mr Ahmed's situation.
32. The assist night orderly officer went to Mr Ahmed's cell, and when he opened the cell door observation panel, he said that Mr Ahmed was sitting on his bed, eating a sandwich and drinking a cup of tea. He then tapped on the glass observation panel, and recorded in his statement that Mr Ahmed returned a 'thumbs up' sign. As Mr Ahmed displayed no signs of distress, He decided not to go into the cell. Both the OSG and the assist night orderly officer believed that Mr Ahmed had low blood sugar, and suggested that he test his blood sugar levels. As they were low, the assist night orderly officer advised him to keep eating to help increase his sugar level to a normal level.
33. At approximately 2.32am, Mr Ahmed pressed his cell bell again and the OSG attended. He said that Mr Ahmed was standing at the door, and was visibly struggling to breathe. The OSG immediately called a code blue (which indicates breathing difficulties). This was received by the control room at 2.33am.
34. The assist night orderly officer and Custodial Manager (CM) were the first to respond and go into Mr Ahmed's cell. Mr Ahmed was still breathing, but was noticeably distressed. Both officers made sure that he was sitting comfortably, and gave him a sugary drink. Mr Ahmed took his blood sugar levels which he said was within his normal range, at 10.1mmol/l (millimoles per litre).
35. After satisfying themselves that he was comfortable, the CM and OSG left the cell to update the control room. A prison officer checked on Mr Ahmed, and saw that he had used the toilet and had then sat on his bed. He left to collect a defibrillator (a device that gives a high-energy electric shock to the heart through the chest wall to someone in cardiac arrest) which was in the centre office (10-15 metres from Mr Ahmed's cell), in case it was needed.
36. The officer went into Mr Ahmed's cell, and noted that he was still sitting up, but his head was to one side. He checked for a pulse, but could not find one. He and the CM moved Mr Ahmed to the floor, and he and the OSG took turns to try and resuscitate him. They continued to do so for approximately 25 minutes before the first response ambulance arrived on the wing and took over at 3.07am.
37. Paramedics continued to perform cardiopulmonary resuscitation, and managed to find a pulse. A prison officer began to arrange the escort paperwork for Mr Ahmed to be taken to hospital, but at 3.55am, paramedics pronounced Mr Ahmed's death.

Contact with Mr Ahmed's family

38. On 18 August 2018, after Mr Ahmed's death, a prison officer was appointed as the Family Liaison Officer (FLO). He and the Imam at the prison, visited Mr

Ahmed's wife at 10.30am. The Imam broke the news of Mr Ahmed's death to the family, and offered emotional support.

They met the family the next day so that they could view Mr Ahmed's body at the hospital. While at the hospital, Mr Ahmed's son asked the FLO about financial support for the funeral. The FLO noted in the FLO log that he would find out and noted that he would give the family a 'financial help' booklet. However, there is no evidence that the prison offered to contribute towards Mr Ahmed's funeral costs. Mr Ahmed's funeral took place on 24 August 2018.

Support for prisoners and staff

39. After Mr Ahmed's death, the Head of Operations debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support.
40. The prison posted notices informing other prisoners of Mr Ahmed's death, and offering support.

Post-mortem report

41. The post-mortem investigation concluded that the cause of Mr Ahmed's death was a heart attack which in turn was caused by ischaemic and hypertensive heart disease. Mr Ahmed also had Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

42. The clinical reviewer found that staff at Whatton consistently monitored and supported Mr Ahmed, and provided good clinical care for his multiple health issues. She found that continuity of care was good, and Mr Ahmed was reviewed and supported by the same GP, nursing and healthcare staff. We agree with the clinical reviewer that the care Mr Ahmed received at HMP Whatton was equivalent to that which he could have expected to receive in the community.
43. Mr Ahmed died of heart failure, ultimately caused by ischaemic and hypertensive heart disease. The clinical reviewer noted that Mr Ahmed had a history of high cholesterol, diabetes and high blood pressure, all of which were known to cause atherosclerosis (a build-up of plaque in the arteries).
44. While the nurse who saw Mr Ahmed on the evening before his death did not complete a full set of clinical observations, she was not concerned by his presentation. She did not report any warning symptoms, such as chest pain, which would have warranted an escalation of his care.
45. The clinical reviewer made two recommendations which the Head of Healthcare will need to address.

Family liaison – funeral costs

46. On 19 August 2018, Mr Ahmed's son asked the prison's family liaison officer about financial assistance for his father's funeral. The FLO recorded in the family liaison log that he would give Mr Ahmed's family a leaflet about financial assistance, but the prison did not offer a contribution towards the cost of the funeral.
47. The investigator spoke to Mr Ahmed's son, who confirmed that they were never offered any money towards his father's funeral. Prison Service Instructions (PSI) 64/2011 requires prisons to offer to pay a contribution towards reasonable funeral expenses of up to £3,000.
48. Mr Ahmed's son told the investigator that as he was not working, the family were worried about the financial implications of his father's funeral. The prison's reluctance to follow national guidance and offer financial assistance contributed to what was already a difficult time for Mr Ahmed's family. Whatton has still not contributed towards Mr Ahmed's funeral costs. We make the following recommendation:

The Governor should ensure that in line with PSI 64/2011:

- **an appropriate contribution is made to Mr Ahmed's family to cover the reasonable costs of his funeral; and**
- **staff are reminded to offer to contribute towards funeral costs promptly when there is a death in custody.**

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