Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Greatorex, a prisoner at HMP Whatton, on 13 July 2019

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 George Greatorex died of hospital-acquired pneumonia on 13 July 2019 while a prisoner at HMP Whatton. He also had chronic obstructive pulmonary disease which contributed to but did not cause his death. He was 78 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the standard of healthcare that Mr Greatorex received was good and equivalent to that which he could have expected to receive in the community.

We have made no recommendations.

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 **December 2019**

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Summary

Events

1. On 30 June 2017, Mr George Greatorex was convicted of sex offences and remanded to HMP Leicester. On 7 July, he was sentenced to 11 years in prison. On 21 July, he was moved to HMP Whatton.

2. At his initial health screen, Mr Greatorex told a nurse that he had rheumatoid arthritis and was mostly immobile. On 4 August, a nurse saw Mr Greatorex and completed a review for asthma and chronic obstructive pulmonary disease (COPD, a lung disease). Mr Greatorex had difficulty using an inhaler because of the arthritis in his hands. The nurse told him that he had COPD.

3. In December 2017, a prison GP saw Mr Greatorex because he had lost a significant amount of weight. She noted that he was frail and asked for an urgent chest x-ray and blood tests. These showed that he had fibrosis (scarring of the lungs) and probably had bronchiectasis (a lung disease) but did not have an infection or tumour.

4. Later that month, a prison GP sent Mr Greatorex to hospital because he had a high temperature and was confused. Hospital staff carried out a CT scan of his chest and abdomen which showed that he had emphysema (a lung condition that causes shortness of breath) and an aortic aneurysm (a bulge in a major blood vessel) in his abdomen.

5. In August and December 2018, Mr Greatorex had COPD reviews.

6. On 5 July 2019, a nurse saw Mr Greatorex because he was feeling unwell. He had a high temperature. Mr Greatorex went to hospital, where he was diagnosed with an infection in the lower part of his left lung. On 10 July, he returned to Whatton with antibiotics and pain relief medication.

7. The following day, Mr Greatorex's condition worsened. A nurse noted that his vital signs were poor and sent him back to hospital, where he was diagnosed with bronchopneumonia and cardiac issues. He signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped.

8. On 12 July, hospital staff said that Mr Greatorex had bilateral pneumonia (an infection in both lungs) and heart failure. On 13 July, Mr Greatorex died of pneumonia.

Findings

9. The care that Mr Greatorex received at Whatton was of a good standard and equivalent to that which he could have expected to receive in the community.

10. When Mr Greatorex went to hospital in 2019, prison staff completed escort risk assessments and senior managers appropriately decided that he should not be restrained.

11. When Mr Greatorex's health deteriorated, a prison manager promptly appointed a family liaison officer who contacted his friend who was his next of kin. His friend was at his side when he died.

12. We make no recommendations.

The Investigation Process

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

14. The investigator obtained copies of relevant extracts from Mr Greatorex's prison and medical records.

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

16. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the cause of death. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer wrote to Mr Greatorex's friend to explain the investigation and to ask if she had any matters that she wanted us to consider. She did not respond.

18. We shared the initial report with the Prison Service. There was one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Whatton

19. HMP Whatton is a medium security prison in Nottinghamshire which holds up to 841 prisoners 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 6.30pm 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

20. 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 interacted politely and professionally with their patients. They noted a high demand for routine hospital appointments but that an increase in the number of available escort officers had significantly reduced the number of cancellations.

Independent Monitoring Board

21. 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 reported that healthcare remained a major concern. They noted that in January 2018, NHS England issued a rectification notice and increased funding to ensure that additional nursing and administrative staff could be recruited. They added that at the end of the reporting year, this notice was still live. The IMB reported that healthcare staff had worked hard to deliver a quality service, and the prison GPs, in particular, received high praise from prisoners and staff. The IMB noted that healthcare staff had told them that the healthcare contract did not adequately take into account the needs of the prison population, including a high proportion of older prisoners and those with complex health conditions. The IMB considered that this had resulted in a substandard provision of care.

Previous deaths at HMP Whatton

22. Mr Greatorex was the fourteenth prisoner to die at Whatton since July 2017. All the previous deaths were from natural causes.

Key Events

23. On 30 June 2017, Mr George Greatorex was convicted of sex offences and remanded to HMP Leicester. On 7 July, he was sentenced to 11 years in prison. On 21 July, he was moved to HMP Whatton.

24. On 21 July, a nurse completed Mr Greatorex's initial health screen. He told her that he had rheumatoid arthritis and was mostly immobile. A prison GP re-prescribed Mr Greatorex's medication.

25. On 27 July, an occupational therapist saw Mr Greatorex to assess his ability to move around his cell. He was not fully cooperative during the assessment and appeared angry and frustrated. She ordered him mobility equipment, including a walking frame and arranged for him to have a physiotherapy assessment.

26. On 4 August, a nurse saw Mr Greatorex and completed an asthma and COPD review. He told her that he had smoked 40 cigarettes a day since he was young and only stopped smoking because prisons were smoke-free. Mr Greatorex had difficulty using an inhaler because of the arthritis in his hands. His peak flow measurements (speed of expiring breath) were low but he was not short of breath. He her that he had not had an acute exacerbation of his lung condition in the previous year. His blood oxygen saturation was slightly low (95%). She told him that he had COPD.

27. On 8 August, a prison GP saw Mr Greatorex and reviewed his medical history and medication. She stopped his furosemide (a diuretic medication used to treat high blood pressure) because his blood pressure was low. She referred Mr Greatorex to a rheumatologist.

28. On 13 December, a prison GP saw Mr Greatorex because he had lost about 13 kilograms in weight since he had been at Whatton. She noted that Mr Greatorex was frail and asked for an urgent chest x-ray and blood tests. The chest x-ray showed that Mr Greatorex had fibrosis (scarring of the lungs) and probably bronchiectasis (a lung disease) but did not have an infection or a tumour.

29. On 20 December, Mr Greatorex had a high temperature and was very confused. A prison GP sent him to hospital, where a CT scan of his chest and abdomen identified that he had emphysema and a moderately-sized aortic aneurysm in his abdomen. Mr Greatorex returned to Whatton the following day, with intravenous antibiotics for a chest infection.

30. On 6 February 2018, a nurse completed an asthma and COPD review. His blood oxygen saturation level was slightly low (96%) but he was not short of breath. Mr Greatorex's inhaler technique was limited because of the arthritis in his hands.

31. On 18 June, a prison GP saw Mr Greatorex because he had a lump on his wrist. The prison GP advised him to see a rheumatologist to prevent serious damage to the joints in his hands but he refused.

32. On 6 August, a nurse carried out an asthma and COPD review. She found no change in his condition and Mr Greatorex said that he was able to eat without becoming short of breath. He said that he was using his preventer inhaler, with

the help of a carer. On 17 December, a nurse completed another asthma and COPD review.

33. On 20 December, an occupational therapist, and a physiotherapist saw Mr Greatorex and noted that he could not extend his knee joints due to arthritis. They advised Mr Greatorex on exercises to improve his mobility and strengthen his legs.

34. On 7 February 2019, a prison GP told Mr Greatorex that she was concerned that he may have a gastrointestinal malignancy (stomach cancer) because his blood and liver function test results were abnormal. The prison GP him under the NHS suspected cancer pathway, which requires patients with suspected cancer be seen by a specialist within two weeks. On 11 February, Mr Greatorex went to hospital, unrestrained. A consultant gastroenterologist told a nurse that he had reviewed Mr Greatorex but was not concerned about his weight loss. He noted that Mr Greatorex should stop taking atorvastatin (for heart disease) and should see a dietician.

35. On 11 March, a nurse assessed Mr Greatorex's inhaler technique and saw that he struggled because he could not put the capsule into the device and said that his carers did it for him. The nurse suggested that he try an easy-breath ventolin inhaler but he found it difficult to use.

36. On 5 July, a nurse saw Mr Greatorex because he felt unwell. He had a high temperature (39.7ºC), was pale and looked unwell. Mr Greatorex went to hospital, unrestrained. Hospital staff said that he had an infection in the lower part of his left lung. On 10 July, he returned to Whatton with antibiotics and pain relief medication.

37. The following day, Mr Greatorex's condition worsened. A nurse saw that his blood oxygen saturation was low (77%) and gave him oxygen. His pulse rate was high (110 beats per minute) and his blood pressure low (73/44). He was sent back to hospital, unrestrained.

38. On 12 July, a nurse telephoned the hospital. Hospital staff told her that Mr Greatorex had bilateral pneumonia (an infection in both lungs) and heart failure. She said that he did not want anyone to resuscitate him if his heart or breathing stopped and had signed an order to that effect.

39. On 13 July, Mr Greatorex died of pneumonia.

Contact with Mr Greatorex's family

40. On 10 July, the Head of Safer Custody appointed an offender manager, as the family liaison officer (FLO) and Custodial Manager (CM) as the deputy family liaison officer.

41. On 11 July, the FLO telephoned Mr Greatorex's next of kin who was his friend and told her that he was in hospital. Mr Greatorex died on 13 July, with his friend by his side.

42. On 14 July, the Head of Security who was also a family liaison officer, telephoned Mr Greatorex's friend and offered her condolences. On 16 July, the FLO telephoned Mr Greatorex's friend and offered her support.

43. On 18 July, Mr Greatorex's friend saw the FLO at Whatton.

44. Mr Greatorex's funeral took place on 1 August, and Whatton contributed to its cost in line with national instructions.

Support for prisoners and staff

45. After Mr Greatorex's death, a prison manager debriefed the staff who were at the hospital when Mr Greatorex died to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices informing other prisoners of Mr Greatorex'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 Greatorex's death.

Post-mortem report

47. There was no post mortem examination. A hospital doctor said that Mr Greatorex died of hospital-acquired pneumonia. He noted that he also had COPD which contributed to but did not cause his death.

Findings

Clinical care

48. The care that Mr Greatorex received at Whatton was of a good standard and equivalent to that which he could have expected to receive in the community. Mr Greatorex died of pneumonia which was a complication of COPD. He had asthma and COPD reviews at least every six months and his care plan was frequently updated. The clinical reviewer found that his care broadly complied with National Institute for Health and care Excellence (NICE) guidelines on COPD as far as possible.

49. Mr Greatorex was frail and used a wheelchair due to his rheumatoid arthritis. He refused to see a rheumatologist. He lived on a wing which had an increased level of support for prisoners with physical health problems and was well supported by nurses, prison GPs and social carers.

50. He had daily visits from carers who helped him with his personal care, medication and dietary needs. Care plans were created and frequently updated. An occupational therapist arranged for him to have a suitable mattress and he had a number of daily living aids. A physiotherapist encouraged him to take exercise but he did not do so.

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