Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roger Gozney a prisoner at HMP Whatton on 14 October 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 we oversee can improve their work in the future.

Mr Roger Gozney died of diabetic ketoacidosis on 14 October 2018 at HMP Whatton. He was 50 years old. I offer my condolences to Mr Gozney's family and friends.

I am satisfied that the clinical management of Mr Gozney's diabetes at Whatton was equivalent to that which he could have expected in the community. However, I am concerned that the healthcare response when Mr Gozney was unwell on 13 October fell below the standard he could have expected to receive in the community.

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 **August 2019**

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Summary

Events

1. Mr Roger Gozney was serving an indeterminate sentence for public protection and had been at HMP Whatton since 25 July 2013. Healthcare staff regularly monitored Mr Gozney because he had Type 1 diabetes. Contrary to advice from healthcare professionals, Mr Gozney preferred to keep his blood sugar levels high. He was fully aware of the serious risks of doing this.

2. On 13 October, Mr Gozney reported to a wing officer that he had one episode of vomiting. The officer contacted a prison nurse who said that Mr Gozney should be advised to drink plenty of fluids and remain in his cell.

3. At about 4.30pm, a wing officer took Mr Gozney his evening meal. Mr Gozney said that he was fine. He did not give the officer any cause for concern.

4. During a roll count at 8.00pm, Mr Gozney told the night operational support grade he had been vomiting 'for hours'. He did not report any other symptoms or present with a deterioration in his condition.

5. An officer conducting a roll check at about 6.20am on 14 October, saw Mr Gozney lying on his bed, unclothed. The officer could not get a response from him. The officer sought advice from the night operational support grade who confirmed Mr Gozney was not breathing. The officer radioed a medical emergency code blue.

6. The night manager and assisting officer responded immediately and entered the cell. They concluded that Mr Gozney had clearly been dead for some time and no cardiopulmonary resuscitation was attempted.

Findings

7. We are satisfied Mr Gozney received an appropriate level of clinical management for his diabetes while at Whatton. His healthcare needs were adequately identified and met in line with NICE guidelines.

8. However, the healthcare response when Mr Gozney was sick the day before he was found dead, fell below the standard expected in the community. Vomiting is a symptom associated with diabetic ketoacidosis and is a potentially life-threatening problem that can arise with diabetes. The nurse did not give adequate advice to wing staff about how to monitor Mr Gozney and what signs to look out for. As a result, staff did not seek further medical advice when Mr Gozney continued to be sick and Mr Gozney was not observed for ten hours before he was found dead.

9. The officer who found Mr Gozney did not immediately call an emergency code or enter the cell. Although a senior manager highlighted the importance of entering the cell immediately where there are concerns for a prisoner's life during a staff debrief, we consider that more needs to be done to remind all prison staff of their responsibilities.

Recommendations

- The Head of Healthcare should implement a triage template to support healthcare staff when considering a prisoner’s condition and ensuring continuity of care.
- The Head of Healthcare should ensure all healthcare staff are aware of and understand their duties for managing those with chronic diseases, particularly those who are presenting as unwell.
- The Governor should ensure that all staff are reminded of the national and local policies about entering a cell during medical emergencies.

The Investigation Process

10. 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. One prisoner made contact.

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

12. The investigator interviewed six members of staff at Whatton on 9 and 14 January 2019.

13. NHS England commissioned a clinical reviewer to review Mr Gozney's clinical care at the prison. The clinical reviewer attended the interviews on 14 January.

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

15. We wrote to Mr Gozney's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Gozney's mother said she would like to receive a copy of the report and this has been provided.

16. Mr Gozney's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. 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.

Background Information

HMP Whatton

18. HMP Whatton in Nottinghamshire is a medium security prison holding up to 841 men convicted of sex offences. MITIE Care and Custody Health provides healthcare services. The healthcare centre is open on weekdays from 7.30am to 6.30pm and at weekends and Bank Holidays from 8.00am to 1.30pm. There is an out-of-hours service at other times. There is also a palliative care suite in the healthcare centre for end of life care.

HM Inspectorate of Prisons

19. 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 healthcare services were provided by a mix of appropriately skilled staff, in well-integrated teams, and that 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.

Independent Monitoring Board

20. 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 reported that healthcare remained a major concern. In January 2018, NHS England issued a rectification notice and increased funding to ensure additional nursing and administrative staff could be recruited. At the end of the reporting year this notice was still active. Some specialist nursing clinics had not been held at all, such as the substance misuse, diabetic, tissue viability, and sexual health clinics. However, the last two months of the reporting year had shown slight improvement.

21. The Board said that healthcare staff had worked hard to deliver a quality service, and GPs received high praise from prisoners and staff. The IMB also considered that the healthcare contract did not adequately take into account the needs of HMP Whatton's population, including a high proportion of older prisoners and those with complex health conditions. This resulted in a substandard provision of care.

Previous deaths at HMP Whatton

22. Mr Gozney is the twelfth prisoner to die of natural causes at Whatton since January 2017. There are no similarities with those deaths.

Type 1 diabetes

23. Type 1 diabetes causes the levels of glucose (sugar) in the blood to become too high because the body cannot produce enough of the hormone insulin which controls blood glucose. People with Type 1 diabetes need daily injections of insulin to keep their blood glucose levels under control.

24. Hypoglycaemia (a hypo) happens when the blood glucose level drops too low (for example, as a result of missing a meal or exercising excessively). The most common signs are sweating, being anxious or irritable, blurred sight, confusion, trembling and, if not treated, loss of consciousness.

25. When blood glucose levels are too high, it can cause hyperglycaemia (hyper). This can happen, for example, if the individual is unwell, less active or has not had enough insulin for the food they have eaten. Very high blood sugar levels can lead to diabetic ketoacidosis (DKA), a serious problem in which the body starts to break down fat for energy when there is not enough insulin, which leads to a build-up of acid (ketones) in the blood. It can be life threatening and should be treated in hospital.

26. Constant high blood glucose levels can lead to heart disease, stroke, circulation problems and nerve damage (leading to amputations), blindness and kidney failure.

Key Events

27. Mr Roger Gozney was serving an indeterminate sentence for public protection for sexual offences and had been in prison since 2010. On 25 July 2013, Mr Gozney was transferred to HMP Whatton.

28. Mr Gozney had Type 1 diabetes, and was insulin dependent. He previously had had a stroke and was taking epilepsy medication for seizures related to his diabetes. Healthcare staff monitored him regularly.

29. The National Institute for Health and Care Excellence (NICE) guidelines advise patients with Type 1 diabetes to monitor their blood sugar levels four times a day, via a finger prick test. This is to ensure their blood sugar level remains as close to a 'normal' level as possible to avoid potential health problems. NICE guidelines say that an appropriate blood sugar level is between 5 and 7 before breakfast and between 4 and 7 at any other time of day.

30. Due to previous episodes of hypoglycaemia (low blood sugar), Mr Gozney was worried about having further episodes. Despite the serious health risks, Mr Gozney preferred his blood sugar levels to be high and they ranged between 3-15. He did not test his blood sugar regularly or maintain an appropriate diet. A nurse, a clinical matron, said she reminded Mr Gozney of the implications of not managing his diabetes appropriately but Mr Gozney had the capacity to make this decision.

31. On 17 July 2018, Mr Gozney attended a diabetic clinic appointment at Queens Medical Centre. The consultant discharged Mr Gozney from the clinic because he had no interest in improving his diabetic control. Mr Gozney said he was aware of the risk of developing long-term diabetic complications.

32. In line with NICE guidelines, healthcare staff tested Mr Gozney's blood every three months to monitor his blood sugar. His HbA1c (blood sugar) level results ranged between 85-95mmol/mol. A blood test on 20 July, showed his HbA1c to be 94mmol. The ideal range is 48mmol or below. Mr Gozney refused to attend a blood test on 28 September, and said he would 'have it done next time'. Mr Gozney was aware of the risks of having high blood sugar.

33. On 9 October, a healthcare assistant took Mr Gozney's basic observations, such as blood pressure and pulse, and they were normal.

Events of 13 and 14 October 2018

34. At 12.40pm on 13 October, an officer contacted a nurse to report that Mr Gozney had had an episode of vomiting. The nurse told the officer to ensure Mr Gozney remained in his cell and to increase his fluids. She said that if Mr Gozney had any other concerns after 24 hours, prison staff should contact the healthcare unit.

35. The nurse told the investigator that she thought the officer was asking for general advice, rather than highlighting a medical concern, and she did not therefore make a record of this conversation in Mr Gozney's medical notes at the time. (She made a record the following day after she learned of Mr Gozney's death.)

She said that she did not check Mr Gozney's medical records, but that she was aware of his medical history.

36. At about 4.30pm, an officer asked Mr Gozney if he wanted his evening meal. Mr Gozney said he did and the officer took his meal to his cell. Mr Gozney said he was ok. The officer said he had no concerns about Mr Gozney because he walked across his cell to collect his meal and was talking normally.

37. At 8.00pm, an operational support grade (OSG) was conducting the prisoner roll count and saw that Mr Gozney was sitting undressed on his bed with a plastic bowl on his lap. The OSG asked Mr Gozney how long he had been feeling unwell and he said 'hours'. Mr Gozney did not report any other symptoms.

38. After the OSG finished the roll count he spoke to an officer about Mr Gozney being unwell. The officer said that healthcare staff were aware and they would check Mr Gozney in the morning. Mr Gozney did not share any information about his medical conditions with prison staff.

39. At about 6.20am, on 14 October, an officer was conducting the morning roll check and saw Mr Gozney lying naked on his bed. The officer thought Mr Gozney was not breathing so began shouting his name and banging the door, but he did not get a response. The officer said it was his first death in custody so he alerted the OSG and asked his opinion. The OSG looked through the observation panel and agreed that Mr Gozney did not appear to be breathing. At 6.25am, the officer radioed an emergency code blue (indicating a prisoner has breathing difficulties or is unconscious).

40. The night manager and an officer responded immediately, and took the defibrillator with them. They arrived at the house block within a few minutes. An OSG called an emergency ambulance.

41. The night manager opened Mr Gozney's cell door and saw him lying on his bed on his back, with his legs over the side of the bed. His arms were clutching his chest and there was a bowl of unknown fluid on the floor. Mr Gozney's skin was grey, mottled and cold to touch. When the night manager and the officer moved Mr Gozney's legs onto the bed, they noticed his body was stiff. The night manager attached the defibrillator to Mr Gozney and the defibrillator advised no shock. The night manager and the officer decided CPR would not be appropriate as Mr Gozney was clearly dead.

42. Paramedics arrived at 6.43am, and at 6.53am, they confirmed that Mr Gozney had died.

Contact with Mr Gozney's family

43. After Mr Gozney's death, a prison manager was appointed as the prison's family liaison officer. At 11.50am, the prison manager and an officer went to Mr Gozney's mother's house and informed her that Mr Gozney had died. They explained the next steps and procedures and continued to offer support.

44. Mr Gozney's funeral was held on 23 November 2018. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

45. After Mr Gozney's death, a prison manager 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.

46. During the debrief, the prison manager discussed the decision not to enter Mr Gozney's cell and reiterated that preservation of life was paramount in such circumstances.

47. The prison posted notices informing other prisoners of Mr Gozney'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 Gozney's death.

Post-mortem report

48. The post-mortem report gave the cause of death as diabetic ketoacidosis.

Findings

Clinical care

49. Mr Gozney had Type 1 diabetes. Healthcare staff adequately monitored Mr Gozney's condition, in line with NICE guidelines. Mr Gozney chose to maintain his blood sugars higher than recommended, apparently through fear of having a hypoglycaemic shock. Prison healthcare staff and a hospital consultant ensured Mr Gozney was aware of the serious risks of maintaining a high blood sugar level. Mr Gozney had the capacity to make this decision.

50. The clinical reviewer was satisfied that Mr Gozney received an appropriate level of clinical care while at Whatton. Healthcare staff identified and met his healthcare needs and respected his wishes in terms of managing his long-term condition.

51. We are satisfied that the overall management of Mr Gozney's diabetes at Whatton was equivalent to that which he could have expected to receive in the community.

Healthcare response on 13 October 2018

52. On 13 October, Mr Gozney told prison staff he had had one episode of vomiting. An officer told a nurse, who gave advice for Mr Gozney to remain in his cell and to drink plenty of fluids. This is the standard advice given when it is suspected a prisoner has a stomach bug and we note that there had been recent episodes of vomiting on other wings. The nurse did not check Mr Gozney's medical history, but told the investigator she knew of him. From the information given by the officer, the nurse said she was not concerned about Mr Gozney and was confident that wing staff would seek advice if Mr Gozney raised a concern or his symptoms deteriorated.

53. Wing staff saw Mr Gozney at 4.30pm and 8.00pm. Although Mr Gozney still reported feeling sick, he did not report any other symptoms. He could walk and was communicating with staff appropriately. Mr Gozney did not give wing staff any cause for concern about his health and they thought that he had a stomach bug. Prison staff also said that Mr Gozney did not share any information about his medical conditions with them. As a result, they did not seek further medical advice when he continued to feel unwell and he was not checked overnight.

54. The coroner gave the cause of death as diabetic ketoacidosis. One of the symptoms of diabetic ketoacidosis is vomiting.

55. We are concerned that although the nurse knew that Mr Gozney had diabetes, she relied on wing staff to seek advice if Mr Gozney's condition deteriorated. Wing staff had no knowledge of Mr Gozney's diabetes or the symptoms of diabetic ketoacidosis, so it is difficult to understand why she thought wing staff would have known how to appropriately monitor Mr Gozney. As a result, Mr Gozney was not observed for over ten hours.

56. Telephone triage is provided by nurses in the healthcare centre from 8.00am to 8.45am to allow prison staff to raise concerns or queries on behalf of prisoners.

A formal triage template is not used by healthcare staff at Whatton, but morning triage calls and calls raising queries/concerns are responded to using the Royal College of GP (RCGP) standards for clinical assessment.

57. When wing staff called the healthcare unit for advice about Mr Gozney's vomiting, the call was not triaged using a formal template. The opportunity to safety net prisoners with chronic conditions like diabetes was, therefore, missed. If the nurse had used a triage template and opened Mr Gozney's electronic medical record, his diabetes would have been apparent and she would have been able to give wing staff appropriate advice about how to monitor Mr Gozney. The clinical reviewer considers that a template accessible to all healthcare staff on SystemOne (which is the system used to access a prisoner's electronic medical record), would enhance communication and continuity of care. We agree.

58. The clinical reviewer also considers that the nurse should have told wing staff that Mr Gozney was an insulin dependent diabetic who was unlikely to check his blood sugar levels, and that he needed to drink 100milliletres (ml) of fluid each hour. They should also have been told that if he was unable to do this and/or his vomiting continued for more than four hours (as it did), they should seek advice from the out of hours GP. Instead they were not told that vomiting could be potentially serious for Mr Gozney or what signs of deterioration they should look out for, and were left to make their own judgement without medical advice. The clinical reviewer considers that in this respect the care was not equivalent to that which he could have expected to receive in the community. We agree.

59. If wing staff had been given appropriate advice, it seems likely that they would have sought advice from the out of hours doctor when Mr Gozney reported that he had been feeling unwell for hours and would have monitored him overnight. Although it is not possible to say if the outcome might have been different for Mr Gozney, he could have received medical intervention prior to his death.

60. We make the following recommendations:

The Head of Healthcare should implement a triage template to support healthcare staff when considering a prisoner's condition and ensuring continuity of care.

The Head of Healthcare should ensure all healthcare staff are aware of and understand their duties for managing those with chronic diseases, specifically those who are presenting as unwell.

Emergency response

61. In a medical emergency preservation of life is paramount. The security policy which states staff should not enter a cell unaccompanied only applies where there is no concern for a prisoner's life. Where there is such concern, staff should enter the cell if they consider it safe to do so.

62. The officer who found Mr Gozney said that he had not been in post long and this was his first experience of finding an unresponsive prisoner. He said he asked for the OSG's opinion as he did not want to make a mistake. The OSG and the officer said they did not enter the cell as the night manager and another officer

arrived so promptly. Although entering the cell immediately would not have changed the outcome for Mr Gozney, this could be critical in other cases.

63. After Mr Gozney's death, a prison manager held a debrief with the staff involved and highlighted the importance of entering a cell for preservation of life. This was good practice but we consider that the prison should also have reminded all prison staff of their responsibilities in a medical emergency. We make the following recommendation:

The Governor should ensure that all staff are reminded of the national and local policies about entering a cell during medical emergencies.

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