Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Jo Whitehouse a prisoner at HMP Hull on 9 February 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*

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.

Ms Jo Whitehouse died on 9 February 2018 in hospital of a stroke, having collapsed in her cell at HMP Hull six days earlier. She was 57 years old. I offer my condolences to Ms Whitehouse's family and friends.

Ms Whitehouse had complex gender issues which she had struggled with throughout her life. She was born male but had lived as a woman for many years and had become legally female. When she was first sentenced she was located in a female prison but in July 2016, she was transferred at her request to a male prison (HMP Hull) because she wished to revert to being male. In late 2017, Ms Whitehouse decided she wanted to remain female and, at the time of her death, she was awaiting a transfer back to the female estate.

Ms Whitehouse's frustration about being located in a male prison made her behaviour extremely challenging at times, but I am satisfied that the Prison Service met Ms Whitehouse's wishes about her gender identity and her location appropriately.

Ms Whitehouse had few serious health concerns while she was in prison, other than referrals and monitoring for her hormone and transgender therapy. I am satisfied that the clinical care she received was equivalent to that which she could have expected in the community.

However, I am very concerned that it is likely that Ms Whitehouse had collapsed in her cell some time before she was discovered, and that this was not realised because an officer had failed to perform a welfare check when he unlocked her cell.

I have been unable to establish whether the same officer had seen Ms Whitehouse on the floor and ignored her three hours earlier. If so, this would obviously be a cause for very significant concern.

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 2018**

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Summary

Events

1. On 10 October 2008, Ms Jo Whitehouse was sentenced to a minimum of three years' imprisonment under an IPP sentence. This meant that she was required to remain in prison until the Parole Board was satisfied that she no longer posed a threat to the public.

2. Ms Whitehouse was born male but became female in 2005 after gender realignment surgery. She was initially located in the female prison estate but, after deciding that she wanted to revert to being male, she was transferred to HMP Hull (a male prison) in July 2016 under the name Darren Whitehouse.

3. At her reception health screen, it was noted that Ms Whitehouse had stopped taking her female hormone pills about nine months earlier. No other significant health concerns were raised.

4. In March 2017, Ms Whitehouse started a course of testosterone injections, under the supervision of a Gender Clinic. In October, she declined further testosterone and said that she no longer wanted to revert to being male and wanted to return to the female estate. Over the next few months, Ms Whitehouse became frustrated that she was not able to return to the female estate immediately and her behaviour became increasingly challenging for staff.

5. In November 2017, the Prison Service formally recognised Ms Whitehouse as a woman again and, at her request, her name was changed to Jo Whitehouse in records. In January 2018, Ms Whitehouse was told that she would be transferred to the female side of HMP Peterborough, but she had to wait for the move to be finalised.

6. On 3 February at 6.30am, an officer did a roll check on Ms Whitehouse's cell. He said he saw nothing untoward. At approximately 9.00am, the same officer unlocked her cell. Approximately 20 minutes later, a prisoner discovered Ms Whitehouse lying on the floor of her cell, conscious but unable to get up. He raised the alarm and officers attended immediately. The officers called an emergency code over the radio and healthcare staff arrived promptly. A nurse suspected she had had a stroke and gave her aspirin. An emergency ambulance was called.

7. Ms Whitehouse told healthcare staff that she had been on the floor of her cell since 6.00am. She said she had told an officer at 6.30am that she could not get up but had been ignored.

8. The ambulance crew took Ms Whitehouse to hospital as an emergency. She was located on a specialist stroke ward. She was initially assessed as stable but likely to remain in hospital for a long time.

9. Early on 9 February, Ms Whitehouse had a seizure and suffered a severe bleed in her brain. At 6.38am, the hospital pronounced Ms Whitehouse dead.

Findings

10. We agree with the clinical reviewer that the care Ms Whitehouse received at Hull was equivalent to that which she could have expected in the community. Staff worked hard to support Ms Whitehouse's physical and psychological needs, she was monitored via a complex case process and staff liaised well with specialist gender services who provided expert advice.

11. Ms Whitehouse had complex gender issues which she struggled with throughout her life. As a result, her management in prison was not straightforward. We are satisfied that the Prison Service met her wishes about her gender identity and her location and were in the process of facilitating a move back to the female estate at the time of her death.

12. We are satisfied that the emergency response was appropriate, once prison staff became aware that Ms Whitehouse had collapsed.

13. We are unable to say whether an officer saw Ms Whitehouse on the floor when he did the roll check at 6.30am and ignored her (as Ms Whitehouse told nurses) or whether she was in bed (as the officer says). If an officer did see her on the floor and ignored her, this would be a very significant cause for concern.

14. We are very concerned that the officer who unlocked Ms Whitehouse at 9.00am did not look into the cell and check on Ms Whitehouse's wellbeing as he should have done. Healthcare staff thought that Ms Whitehouse had collapsed some time before she was found at 9.20am because she had been doubly incontinent and the faeces had dried on her. If the officer had carried out a proper welfare check at unlock, an emergency response could have been triggered earlier.

Recommendations

- The Governor should initiate a disciplinary investigation into an officer conduct when he unlocked Ms Whitehouse on 3 February.

- The Governor should ensure that staff are given clear guidance and reminded of their responsibilities when unlocking cells.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him.

16. The investigator visited Hull on 15 February 2018. He obtained copies of relevant extracts from Ms Whitehouse's prison and medical records.

17. The investigator interviewed five members of staff and three prisoners at Hull on 15 February. He also interviewed two further staff members by telephone in May.

18. NHS England commissioned a clinical reviewer to review Ms Whitehouse's clinical care at the prison.

19. We informed HM Coroner for East Riding and Kingston upon Hull of the investigation. He gave us the results of the post-mortem examination, and we have sent him a copy of this report.

20. There was no family involvement in this case. Ms Whitehouse was not in contact with any family members and her nominated next of kin said she did not want to be involved.

21. 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 Hull

22. HMP Hull is a local prison which holds up to 1,056 male prisoners in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a Wellbeing Unit designed to support and progress prisoners with complex healthcare needs which are difficult to meet in a standard prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

23. In August 2018, the Prisons Minister, Rory Stewart, announced that Hull would be one of the prisons participating in the '10 Prisons Project'. This project (with the aid of a £10 million funding injection) seeks to improve safety, security and decency at the prisons by focusing on living conditions, preventing drugs entering the establishments and enhancing the leadership training available to Governors and their staff.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Hull was conducted in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. The healthcare team offered an appropriate range of primary care clinics within an acceptable timeframe. Social care assessments were timely and the provision was reasonably good.

Independent Monitoring Board

25. 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 2015, the IMB reported that Hull benefited from strong leadership with an emphasis on staff motivation and morale. The Board noted that there had been a substantial decrease in the number of applications sent to them from prisoners.

Previous deaths at HMP Hull

26. Ms Whitehouse was the fifteenth prisoner to die at HMP Hull since January 2015, and the tenth to die from natural causes. There were no similarities between Ms Whitehouse's death and these previous deaths.

Ms Whitehouse's background

27. Ms Jo Whitehouse was born male and was originally called David Whitehouse. In 2005, after a long process spanning 20 years, she had gender realignment surgery, was legally recognised as a woman and was given a new birth certificate in the name of Joanne Spencer, which was the name she was sentenced under in 2008.

28. We have used the name 'Jo Whitehouse' throughout this report, although Ms Whitehouse was known by several names in prison, including Darren Whitehouse, which was the name she used when she transferred to HMP Hull.

Key Events

29. On 9 October 2008, Ms Jo Whitehouse (then known as Joanne Spencer) was convicted of arson and other offences. She was sentenced to a minimum of three years' imprisonment under an IPP sentence. This meant that she was required to remain in prison until the Parole Board were satisfied that she no longer posed a threat to the public.

30. She had been diagnosed with an Emotionally Unstable Personality Disorder and chronic depression and in 2012 she had been assessed as having a mild learning disability. She had had a long history of self-harm and contact with community mental health services, including inpatient admissions.

31. After sentencing, Ms Whitehouse returned to HMP New Hall where she had been on remand. In May 2013, she was transferred to HMP Askham Grange, but she could not settle there and was transferred back to New Hall a year later. (Both New Hall and Askham Grange are women's prisons.)

32. Early in 2014, Ms Whitehouse expressed her wish to be regarded as a man, and was referred to a gender reassignment clinic. The clinic said that because she had had gender reassignment treatment before, she would have to live as a man for some time before they could begin the process of reversing her gender. From 2014, Ms Whitehouse was actively seeking a transfer to a male prison to satisfy this requirement, but the process proved to be lengthy and complicated.

Transfer to HMP Hull

33. On 14 July 2016, Ms Whitehouse was transferred to HMP Hull, a men's prison, under the name Darren Whitehouse, and was located on a Vulnerable Prisoners (VP) wing. A nurse reviewed her at the reception health screen. She recorded that Ms Whitehouse had previously had transgender surgery to become female but was now in the process of reverting to being male. She also noted that Ms Whitehouse had stopped taking female hormone pills in November 2015.

34. On 28 July, a nurse reviewed Ms Whitehouse. She noted that Ms Whitehouse had breast pain beneath her breast tissue, and suspected that this might be because she had stopped taking female hormones. Three days later, a prison GP reviewed Ms Whitehouse and prescribed ibuprofen.

35. On 24 August, a healthcare assistant performed an NHS health check with Ms Whitehouse. She noted that Ms Whitehouse was overweight, but that her cholesterol and blood pressure were at acceptable levels. She advised her about her diet and exercise, but otherwise noted that no action was necessary.

36. For the next few months, Ms Whitehouse had few physical health concerns but became increasingly anxious and stressed. At times she was managed under ACCT (the Prison Service procedures for monitoring and supporting prisoners at risk of suicide and self-harm) because of an overdose of prescribed medication, food refusals and low mood. The mental health team regularly reviewed Ms Whitehouse because she experienced mood swings, and because she was struggling to cope in a male prison environment. Ms Whitehouse regularly asked

to be relocated onto a regular wing as she said did not like being on a VP wing, but this was refused due to her vulnerability and for safety reasons.

37. On 27 January 2017, Ms Whitehouse was relocated to J wing, another VP wing. She was allocated a cell equipped for disabled prisoners because it had its own toilet and shower.

38. A consultant psychiatrist at a gender clinic, supervised Ms Whitehouse's gender realignment care. The clinic initially declined her requests for testosterone until they had assessed her. In March 2017, they authorised testosterone injections but monitored their impact on her by regular blood tests. The results were normal apart from a raised alkaline phosphatase (an enzyme in the blood that can indicate a problem with the liver, gall bladder or bones). The clinic referred Ms Whitehouse to an endocrinologist for ongoing monitoring.

39. On 1 October 2017, Ms Whitehouse told an officer that she wanted to stop the testosterone injections and "no longer wanted to progress being male". The next day, she declined further testosterone injections and requested oestrogen (the primary female hormone). She requested a move back to a female prison.

40. In November, Ms Whitehouse's request was considered by the Transgender Case Review Board and the Complex Case Review Board. On 20 November the Prison Service formally recognised Ms Whitehouse as a woman again and, at her request, her name was changed to Jo Whitehouse in records.

41. Over the next few months, Ms Whitehouse became frustrated because she was not given oestrogen and was not able to transfer to a female prison immediately. She was verbally abusive to staff and other prisoners and her behaviour became increasingly challenging for staff.

42. On 18 December, an officer issued her with a formal warning under the Incentives and Earned Privileges (IEP) system (which is used to determine the level of privileges a prisoner has and to provide incentives for good behaviour) after she repeatedly rang her cell bell, and shouted obscenities at officers. In his entry on NOMIS (the Prison Service's electronic record system) the officer referred to Ms Whitehouse as 'Whitehouse' and as 'he'.

43. Later that day, the officer recorded that when he answered Ms Whitehouse's cell bell, 'She was stood in the cell wearing just a pair of boxers. She made no attempt to cover her breasts and openly flaunted herself at me.' (In this entry the officer referred to Ms Whitehouse as 'Jo' and 'she'.)

44. A Supervising Officer (SO) told Ms Whitehouse that she would not be able to leave her cell unless she was wearing clothes. She was also told that staff were trying to get female clothes for her from Askham Grange. On 28 December, Ms Whitehouse's Personal Officer recorded that she had 'started to become very difficult for staff to deal with due to ongoing personal issues' and that she was refusing to speak to those staff who disciplined her for 'pushing the boundaries too far'.

45. Early in January 2018, prison officers issued further IEP warnings to Ms Whitehouse for the misuse of her cell bell. An officer recorded that Ms Whitehouse told her that she thought the only way she could get a transfer out of

Hull was 'to be a bastard and annoy staff'. The officer said she tried to explain to Ms Whitehouse that this was not the right way to secure a transfer and that things would take a little longer because her case was complex.

46. On 17 January, Ms Whitehouse was placed on a disciplinary charge for being abusive to staff and misusing her cell bell. An officer recorded that Ms Whitehouse was demanding a move to another wing and stripped down to her underpants, damaged prison property and screamed and swore at staff who tried to reason with her.

47. Later that day, a SO conducted an IEP review and reduced Ms Whitehouse's privilege level from enhanced to standard. He recorded that, given her behaviour, she should have been reduced to the basic level, but it had been decided only to demote her to standard for the time being because of her complex situation. He wondered if Ms Whitehouse feared moving to Peterborough and was behaving badly in an attempt to stop the move.

48. On 23 January, an officer from the Offender Management Unit recorded that, although Ms Whitehouse's behaviour was problematic, it had improved.

The events of 3 February

49. At 6.30am on 3 February, an officer roll checked Ms Whitehouse's cell. He told the investigator that this involved looking through the cell observation panel to see that the occupant was present and well, and that this took a matter of a few seconds. He said that Ms Whitehouse was "laid under the covers in bed" at the time. He did not record anything out of the ordinary.

50. At 6.32am, CCTV footage shows an officer in the vicinity of Ms Whitehouse's cell for about 20 seconds. It is not possible to see who this was or whether or not the officer looked into Ms Whitehouse's cell.

51. At approximately 9.00am, an officer unlocked Ms Whitehouse's cell door. He later told a prison manager that he had seen nothing untoward in her cell, and that she had acknowledged him when he said hello to her.

52. Shortly before 9.20am, a prisoner checked on Ms Whitehouse. In interview, he said that it was unusual for her not to leave her cell as soon as it was unlocked. He said that he found Ms Whitehouse lying on the floor of her cell near the end of her bed. He said she would have been visible to anyone opening the door. He said that Ms Whitehouse tried to speak but was unable to do so, so he went to get help. He said that officers then arrived within seconds.

53. At 9.34am, an officer called a code blue emergency. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.)

54. A nurse was working nearby and responded to the code blue call immediately. She arrived before other healthcare staff and observed that Ms Whitehouse was propped up against the bed and had been doubly incontinent. She observed that Ms Whitehouse's speech appeared slurred, her extremities were cold and that her mobility was severely impaired to the left side of her body, which had

dropped. She suspected that Ms Whitehouse had had a stroke, and gave her aspirin.

55. The nurse subsequently recorded that Ms Whitehouse told her that she had got out of bed at 6am, felt dizzy and slipped on her shoe, and had not been able to get up since. She also recorded that Ms Whitehouse said 'she was checked on by prison staff at 6.30am who asked her what she was doing on the floor. Jo reports that she had informed them she was unable to get up.

56. Another nurse was designated as the emergency first responder, and arrived shortly after. In interview, she said that she heard the code blue at 9.28am and arrived within three or four minutes. A nurse said that Ms Whitehouse reported that she 'slipped and fell at either 6.00am or 6.30am, when an officer checked on her'. She said that they cleaned Ms Whitehouse but had to use water because faeces had dried onto her.

57. A nurse said that the ambulance crew arrived 20-40 minutes later and confirmed that Ms Whitehouse had had a stroke. She said that the paramedic told her, 'We have to be quick – if the times are correct – because she has to be seen within four hours.' The nurse explained in interview that the four-hour time frame was critical in cases of stroke, because within that time it is still possible to give medication to dissolve blood clots and restore the blood supply to the brain. The nurse said that the timing was already tight if Ms Whitehouse had indeed collapsed before 6.30am.

58. At 10.25am, Ms Whitehouse was sent to the hospital. She was not restrained but was escorted by two officers, of whom one was female. Her prison escort form recorded that she was a transgender female prisoner and should be located on a female ward.

Ms Whitehouse's time in hospital

59. At 10.42am, Ms Whitehouse arrived at hospital. She had a series of tests and was located on the hyper acute stroke ward.

60. On 4 February, a nurse noted that the hospital had confirmed that Ms Whitehouse had had a stroke. The following day, a nurse recorded that Ms Whitehouse was stable but would remain in hospital for quite some time.

61. On 9 February at 5.54am, a nurse noted that Ms Whitehouse had a seizure during the night and that a scan had discovered a severe bleed in her brain. She added that the neuro-surgeon had stated that nothing more could be done for her and she would receive no further treatment. At 6.38am, the hospital pronounced Ms Whitehouse dead.

The circumstances of Ms Whitehouse's discovery

62. A nurse submitted a report based on what Ms Whitehouse had said when she had first attended to her in her cell. She noted, 'The patient informed me that she had slipped at 06:00hrs and was unable to get up, she was unable to press her buzzer and alert staff to her situation. She also reports that at 06:30hrs staff had checked on her and asked what she was doing on the floor, she informed them she had fallen and could not get up, there were no calls to nursing staff and staff

did not investigate this further.' The nurse also noted that Ms Whitehouse had 'been doubly incontinent and the urine and faeces had dried indicating that she had been there a considerable time'.

63. After Ms Whitehouse's death, a prison manager investigated the substance of the nurse's report.

64. On 13 February, he interviewed an officer, who told him that he saw Ms Whitehouse in bed when he did his morning roll check at 6.30am. The officer also told the Governor that he saw nothing untoward when he unlocked Ms Whitehouse's cell at around 9.00am, and that he received an acknowledgement from her when he offered a greeting.

65. On 5 April, the Governor interviewed the officer again at our request in the light of the CCTV footage which showed an officer adjacent to Ms Whitehouse's cell at 6.30am. The officer said that he had simply pinned up a visits list on the notice board that was nearby. The Governor said that the officer was in the vicinity of Ms Whitehouse's cell for four to five seconds at most, and concluded:

> '[There is] no evidence to support any suggestion that he engaged in conversation with Ms Whitehouse at this or any other time. There is no evidence to support Ms. Whitehouse's allegation that she was on the floor and unable to press the cell bell.'

66. In interview a nurse told the investigator that when she first saw Ms Whitehouse, she 'was covered in urine and faeces which had dried up'. She said that she asked Ms Whitehouse whether she had called for help, and that 'Jo said she had fallen and she couldn't get up, so I'd asked her if she'd called for any help or anything and she told me that the officer who did the check - I think it was 6.30 - asked her what she was doing on the floor and she told him that she'd fallen and she couldn't get up'.

67. In interview with the investigator, the officer confirmed that he was the only officer around at 6.30am. He said that he had not had a conversation with Ms Whitehouse when he did the roll check. He said that he would have remembered if he had spoken to Ms Whitehouse because it would have been an unusual event. When asked why Ms Whitehouse might have said that he had seen her on the floor and spoken to her, the officer said, 'Prisoners do lie, don't they?' and 'She may have deliberately laid herself on the floor.' When asked about the dried faeces, the officer said she may have done this in bed and then lain or slipped onto the floor. He also said that Ms Whitehouse may have been 'looking at making some sort of money with her claim of negligence by the Prison Service, just by the fact that the sort of person, sort of prisoner, she was in my dealings with her'.

68. The officer also told the investigator that he had not spoken to Ms Whitehouse when he unlocked her cell at 9.00am, and that he did not look into her cell at this time. He said that he did not look in because of Ms Whitehouse's tendency to expose herself to male officers. He also said that male officers were advised to avoid dealing with her if they could. When the investigator asked the officer why he had told the Governor that he had looked into Ms Whitehouse's cell when he

unlocked her and that she had responded to his greeting, the officer said that he was not aware of saying this.

Contact with Ms Whitehouse's family

69. Shortly after first arriving in prison, Ms Whitehouse nominated a friend as her next of kin. This same friend remained as her nominated next of kin.

70. On 5 February 2018, the prison appointed Ms Whitehouse's family liaison officer (FLO). The following day, the FLO recorded that there was an address for Ms Whitehouse's friend but no phone number. She wrote to her at that address.

71. The FLO recalled Ms Whitehouse had a sister. She asked the police for her contact details, but the police said that they were not permitted to pass on any details without consent. The FLO managed to locate Ms Whitehouse's sister's address and wrote to her. Neither Ms Whitehouse's friend nor her sister replied.

72. At 12.15pm on 9 February, the FLO and the Governor visited Ms Whitehouse's friend at her home and informed her of Ms Whitehouse's death. She said she did not know Ms Whitehouse very well and was not aware that she was her next of kin. Ms Whitehouse's friend was unable to assist in locating any family and said that she did not want any further involvement.

73. Ms Whitehouse's funeral was held on 5 March. The prison paid for the cost of this in line with national guidance.

Support for prisoners and staff

74. After Ms Whitehouse's death, the duty governor debriefed the staff involved in her bedwatch, to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

75. The prison posted notices informing other prisoners of Ms Whitehouse'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 Ms Whitehouse's death.

Post-mortem report

76. The post-mortem concluded that Ms Whitehouse died from extensive right-sided brain infarct (cell death in the brain caused by being deprived of blood supply), caused by secondary pontine haemorrhage (bleeding in the brain). The underlying cause was given as an occlusion of the right cerebral artery (an obstruction of one of the main arteries feeding the brain). This is commonly referred to as a stroke.

Findings

Clinical care

77. The clinical reviewer concluded that the care Ms Whitehouse received at Hull was equivalent to that which she could have expected in the community. She was satisfied that Ms Whitehouse had access to clinical health checks and was appropriately reviewed for her health concerns, and that the healthcare team worked hard to support Ms Whitehouse's physical and psychological needs, that she was monitored via a complex case process and that staff liaised well with specialist gender services who provided expert advice. We share the clinical reviewer's conclusion.

78. Ms Whitehouse has complex gender issues which she struggled with throughout her life. We are satisfied that the Prison Service met her wishes about her gender identity and her location and were in the process of facilitating a move back to the female estate at the time of Ms Whitehouse's death.

Emergency response

79. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.

80. We are satisfied that staff responded appropriately when a prisoner alerted officers to Ms Whitehouse's situation. They were on the scene straight away and a code blue was called without delay. Healthcare staff arrived promptly, and an ambulance was requested immediately.

Roll checks and unlocking procedure

81. A roll check is primarily a security check to count prisoners to ensure that they are present in their cells, but it is also an opportunity for any concerns about prisoners' safety to be identified and addressed.

82. At unlock, officers should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) Manual says:

> 'Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.'

83. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

> 'Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight …

but staff unlocking them have not noticed that the prisoner had died. This is not acceptable ...

'[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.'

84. Our investigation has not been able to establish when Ms Whitehouse collapsed in her cell or how long she had been lying there before she was found at about 9.30am.

85. A nurse says that Ms Whitehouse told her that she had been on the floor since about 6.00am and that an officer had seen her at about 6.30am and asked her why she was on the floor and she had said she could not get up, but they ignored her. The nurses account of what Ms Whitehouse said is supported by another nurse who was also present. Both nurses also say that Ms Whitehouse had dried faeces on her where she had been incontinent and that this indicated that she had collapsed some time before she was found.

86. An officer, who was the only officer around at the time, says that he saw Ms Whitehouse in bed (not on the floor) when he did the roll check at 6.30am and that he did not speak to her. He also says that the roll check only took a few seconds and that this would not have been long enough to have the conversation Ms Whitehouse described. The Governor who conducted the internal investigation, concluded that the officer was only around Ms Whitehouse's cell for four to five seconds at most. However, having viewed the CCTV, we are satisfied that someone (presumably that officer) was beside Ms Whitehouse's cell for over 20 seconds, which would have been time to have had a conversation. We cannot, however, tell from the CCTV whether a conversation did take place.

87. We are unable to say which account is correct. Certainly, if Ms Whitehouse had been on the floor when the officer did the roll count at 6.30am, he should have seen her and called for assistance. Not to have done so would have been a serious dereliction of duty.

88. Ms Whitehouse was discovered on the floor at about 9.20am, about 20 minutes after the officer had unlocked her. The officer has given two different accounts of what happened at unlock. He told the Governor that Ms Whitehouse was alive and well and responded when he greeted her. However, he told the investigator that he did not speak to Ms Whitehouse and did not look into her cell when he unlocked her because of her tendency to expose herself.

89. Given the nurses evidence about the dried faeces, it seems more likely than not that Ms Whitehouse had collapsed some time before she was unlocked and that the officer did not notice this because he did not look into her cell to check on her wellbeing, as he should have done.

90. This is a cause for significant concern. We cannot say whether a proper check on Ms Whitehouse's welfare at unlock would have affected the outcome for her, but

it would have triggered an emergency response sooner. Minutes can make the difference between life and death in any medical emergency and, in the case of a stroke, it is critical to get the patient to hospital within four hours of its onset to prevent further and irreparable damage.

91. In the light of the officer's interview with the investigator, we recommend that:

The Governor should initiate a disciplinary investigation into the officer's conduct when he unlocked Ms Whitehouse on 3 February.

We also recommend that:

The Governor should ensure that staff are given clear guidance and reminded of their responsibilities when unlocking cells.

Liaison with Ms Whitehouse's next of kin

92. Prison Rule 22(1) says that when a prisoner becomes seriously ill the Governor shall inform the prisoner's next of kin at once.

93. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* 'prisons must ensure that an appropriate member of staff engage with the next of kin of prisoners who are seriously ill", and that "time will be of the essence in order to try to ensure that the family do not find out about the death from another source.'

94. Ms Whitehouse was not in contact with her family and had listed a friend as her next of kin. This friend indicated that she was not aware that she was her next of kin and declined be involved. The prison also located an address for Ms Whitehouse's sister and wrote to her, but did not receive a reply. We are satisfied that the prison conducted its family liaison duties appropriately.

Prisons & Probation Ombudsman
Independent Investigations

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