Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Hilland Matthews, a prisoner at HMP Whatton, on 6 January 2020

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 Hilland Matthews died from a pulmonary embolism caused by deep vein thrombosis (DVT) on 6 January 2020 at HMP Whatton. He was 73 years old. I offer my condolences to Mr Matthews' family and friends.

The clinical reviewer was satisfied that the standard of care Mr Matthews received at Whatton was broadly equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer considered that when Mr Matthews presented with a swollen leg on 27 December 2019, the nurse should have considered the possibility of DVT.

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 **July 2020**

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Summary

Events

1. On 14 February 2013, Mr Hilland Matthews was sentenced to nine years in prison for sexual offences. He was sent to HMP Norwich. On 21 December 2017, he was moved to HMP Whatton.

2. On 27 December 2019, a nurse saw Mr Matthews because his leg was hot and swollen, and red from foot to knee. She thought it was cellulitis (a skin infection). A prison GP prescribed antibiotics and booked a further appointment for the following week.

3. At the follow-up appointment, the nurse noted that Mr Matthews' leg had improved and she had no concerns.

4. On 5 January 2020, Mr Matthews told staff that he had diarrhoea and vomiting. They advised him to rest in his cell and increase his fluid intake.

5. On 6 January, at 2.50pm, an officer responded to Mr Matthews' cell bell. Mr Matthews' told her he was struggling to breathe. The officer called a medical emergency code. A nurse attended and, when Mr Matthews' became unresponsive, she started cardiopulmonary resuscitation (CPR). Staff continued CPR until the paramedics arrived. The paramedics continued CPR but could not establish a pulse and pronounced Mr Matthews dead at 3.50pm.

6. The post-mortem report concluded that Mr Matthews' cause of death was pulmonary embolism caused by deep vein thrombosis (DVT).

Findings

7. The clinical reviewer considered that the standard of care Mr Matthews received at Whatton was broadly equivalent to that he could have expected to receive in the community.

8. However, the clinical reviewer found that when Mr Matthews presented with a swollen leg, the nurse should have considered the possibility of DVT.

Recommendations

- The Head of Healthcare should ensure that when prisoners present with possible signs of deep vein thrombosis (DVT), staff use the DVT Wells score to assess their condition, in accordance with NICE guidelines.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Matthews' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Matthews' clinical care at the prison.

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

13. One of the Ombudsman's family liaison officers contacted Mr Matthews' nephew to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. He did not respond.

14. The initial report was shared with the Prison Service. The Prison Service found two factual inaccuracy's which have now been amended.

Background Information

HMP Whatton

15. 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

16. The most recent inspection of HMP Whatton was 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

17. 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 31 May 2019, the IMB reported that during the last year, there had been a significant improvement in the healthcare services at Whatton. Referrals were submitted in a timely manner and specialist appointments, including dental, podiatrist, optician and physiotherapy appointments were arranged more quickly than in the community. Healthcare staff had worked hard to deliver a high-quality service.

Previous deaths at HMP Whatton

18. Mr Matthews was the 12th prisoner to die at Whatton since January 2018. All the previous deaths were from natural causes. There were no similarities between the circumstances of Mr Matthews' death and the previous deaths at the prison.

Key Events

19. On 14 February 2013, Mr Hilland Matthews was sentenced to nine years in prison for sexual offences. He was sent to HMP Norwich.

20. On 21 December 2017, Mr Matthews was moved to HMP Whatton. A nurse completed Mr Matthews' initial reception screening. She noted that Mr Matthews was frail and referred him to an occupational therapist.

21. On 11 January 2018, an occupational therapist saw Mr Matthews and completed a falls risk assessment. Equipment was provided to help Mr Matthews with his daily living and a buddy (another prisoner to provide support) was allocated to help him. He was also placed in a cell near to a disabled shower.

22. On 26 November 2019, Mr Matthews was found passed out on his cell floor. He said that he felt dizzy after using his electronic cigarette. He was told to contact healthcare if any further issues occurred.

23. Over the next two weeks, Mr Matthews did not attend to collect his medication. It was agreed that, because of his frailty, his medication would be delivered to his cell.

24. On 27 December, a nurse saw Mr Matthews because his leg was hot, swollen and red from foot to knee. He was also short of breath. The nurse considered he had cellulitis (a skin infection), which he had had before. A prison GP prescribed antibiotic and booked a further appointment for the following week.

25. On 3 January 2020, the nurse saw Mr Matthews for his follow-up appointment. She noted that the redness of his leg had improved and she had no concerns.

26. On 5 January, Mr Matthews told staff that he had diarrhoea and vomiting. They advised him to rest in his cell, increase fluid intake and hand hygiene. They told him that he needed to stay in his cell for 48 hours after his last symptom.

27. At 2.50pm on 6 January, an officer responded to Mr Matthews' cell bell. Mr Matthews told her he was struggling to breathe. The officer gave him his inhaler and called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).

28. A nurse responded to the code blue. She said that when she arrived at Mr Matthews' cell he appeared very pale and felt cold to touch. She called for further assistance and for an automated external defibrillator (AED). The nurse said that moments later Mr Matthews became unresponsive so she started cardiopulmonary resuscitation (CPR) and upgraded the ambulance to urgent.

29. At 3.24pm, the paramedics arrived and continued with CPR. Paramedics gave Mr Matthews a defibrillator shock but could not establish a pulse. They pronounced Mr Matthews dead at 3.50pm.

Contact with Mr Matthews' family

30. On 6 January, shortly after Mr Matthews died, the prison appointed Operational Support Grade as the family liaison officer (FLO). Mr Matthews' brother was listed as his next of kin. The address that the prison held was an old one so a prison manager contacted the police to see if they had any up to date information. The police said that Mr Matthews' brother was listed as deceased. The police gave the prison details of Mr Matthews' nephew. As the address of Mr Matthews' nephew was near HMP Cardiff, the prison chaplain at Cardiff went to the address to break the news of Mr Matthews' death

31. The prison paid for Mr Matthews' funeral in line with national guidelines.

Support for prisoners and staff

32. After Mr Matthews' death, a prison manager debriefed the staff involved in Mr Matthews' care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

33. The prison posted notices informing other prisoners of Mr Matthews' death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Matthews' death.

Post-mortem report

34. The post-mortem report concluded that Mr Matthews died of a pulmonary embolism caused by deep vein thrombosis.

Findings

Clinical Care

35. The clinical reviewer concluded that the clinical care Mr Matthews received at Whatton was broadly equivalent to that which he could have expected to receive in the community.

36. Mr Matthews was frail and sometimes struggled to get around. He was appropriately referred to an occupational therapist who put care plans in place to support him. Healthcare staff made sure that Mr Matthews' medication was taken to his cell when he was unable to attend to collect it.

37. However, the clinical reviewer found that when Mr Matthews presented with a swollen leg, the possibility of deep vein thrombosis (DVT) should have been considered. She noted that there were opportunities to standardise the approach to assessing signs of DVT using the DVT Wells score as recommended by National Institute for Health and Care Excellence (NICE). We make the following recommendation:

    The Head of Healthcare should ensure that when prisoners present with possible signs of deep vein thrombosis (DVT), staff use the DVT Wells score to assess their condition, in accordance with NICE guidelines.

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