Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Louis Whittington, a prisoner at HMP Wandsworth, on 10 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 Louis Whittington died of sudden death in epilepsy on 10 January 2020 at HMP Wandsworth. He was 36 years old. I offer my condolences to his family and friends.

Mr Whittington was unable to talk as a result of a serious brain injury when he was a teenager and I am concerned that prison and healthcare staff did not develop an effective means of communicating with him.

I am also concerned that an Operational Support Grade did not answer an emergency cell bell the night before Mr Whittington was found dead in his cell. He also falsely signed to say that he had carried out two roll checks during the night. We cannot say if these failings affected the outcome for Mr Whittington, but he would at least have been found earlier.

Although Mr Whittington was clearly dead when he was found, prison and healthcare staff attempted to resuscitate him. Although we understand the wish to attempt and continue resuscitation efforts until death has been formally confirmed, we are concerned that this is contrary to European guidance on resuscitation. It is not dignified for the deceased prisoner and is distressing for staff.

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 **February 2021**

Contents

Summary

Events

1. On 30 May 2019, Mr Louis Whittington was remanded to HMP Wandsworth.

2. Mr Whittington had suffered a significant head injury as a teenager which had caused brain damage. As a result, he had serious communication problems and was unable to talk. He had also developed epilepsy and problems with his balance and used a wheelchair. He was able to dress himself and transfer in and out of his wheelchair but needed help with personal care and had problems with continence. He had a history of drug and alcohol misuse.

3. On 11 June, Mr Whittington started receiving daily care and support from local authority social services, including daily personal care.

4. On 9 January 2020, Mr Whittington pressed his cell bell 21 times during the day. He frequently used his cell bell inappropriately. At 8.06pm, Mr Whittington pressed his cell bell again. At 8.44pm, an Operational Support Grade (OSG) went to Mr Whittington's cell and cancelled the cell bell without looking into the cell. At 10.00pm, the OSG signed the night patrol officer's report to confirm that he had completed a roll check.

5. At 6.00am on 10 January, the OSG signed the night patrol officer's report that he had completed a roll check.

6. At about 8.30am on 10 January, an officer found Mr Whittington lying face down on the floor behind the door, obstructing it. The officer reached his hand around the door and felt that Mr Whittington was cold.

7. At 8.40am, a senior officer radioed a medical emergency code blue and a control room officer telephoned the ambulance service. Officers pushed the door open, felt that Mr Whittington was cold and saw that his body was stiff.

8. A nurse went into Mr Whittington's cell and saw that he was not breathing and started chest compressions. Another nurse used a defibrillator.

9. At 8.46am, the nurses agreed that Mr Whittington had died and stopped resuscitation attempts. At 8.50am, ambulance paramedics were at his side and confirmed his death.

Findings

Clinical care

10. The clinical reviewer concluded that the care that Mr Whittington received at Wandsworth was equivalent to that which he could have expected to receive in the community.

11. The social care package that Mr Whittington received was well structured and met his needs in a compassionate manner.

Communicating with Mr Whittington

12. Mr Whittington had severe communication difficulties. We are concerned that there was no structured plan for prison and healthcare staff to communicate effectively with him.

Roll check and cell bells

13. Mr Whittington frequently used his cell bell inappropriately. There is no record that prison managers or officers tried to prevent him doing so or to explain when to use it.

14. The OSG admitted that he did not check Mr Whittington when he pressed his cell bell at 8.06pm on 9 January, and that he did not carry out two roll checks that night. The Governor dismissed the OSG from the Prison Service following a disciplinary hearing.

Emergency response

15. When officers found Mr Whittington on the floor of his cell, they promptly opened the door, radioed a medical emergency code blue and called for an ambulance. However, we are concerned that healthcare and prison staff completed cardiopulmonary resuscitation (CPR) and used a defibrillator despite the presence of rigor mortis. Although we understand the wish to attempt and continue resuscitation until death has been formally recognised, we are concerned that this is not in line with European guidance and that it was not appropriate for staff to perform CPR in these circumstances.

Recommendations

- The Governor and Head of Healthcare should develop a strategy to address the needs of prisoners who have serious communication problems.
- The Governor should ensure that staff:
  - understand the importance of responding to all cell bells as promptly as possible; and
  - do so in line with local policy.
- The Governor should ensure that staff conduct roll checks in line with local policy, including that they:
  - understand why roll checks are important;
  - complete a visual check of each prisoner to ensure they are safe and well; and
  - ask prisoners to uncover their cell observation panels where necessary so that they can see them.
- The Governor and the Head of Healthcare at Wandsworth should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines for Resuscitation.

The Investigation Process

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

17. He obtained copies of relevant extracts from Mr Whittington's prison and medical records.

18. The investigator interviewed four members of staff between 6 August and 27 August. All the interviews were conducted by telephone because of the restrictions in place during the COVID-19 pandemic.

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

20. We informed HM Coroner for Inner West London District of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The Ombudsman's family liaison officer wrote to Mr Whittington's next of kin, his aunt, to explain our investigation. She had no specific questions.

22. Mr Whittington's next of kin received a copy of the initial report but did not respond or make any comment.

23. We shared the initial report with the Prison Service. There were no factual inaccuracies and their action plan has been appended to this report.

Background Information

HMP Wandsworth

24. HMP Wandsworth is a local prison in London and holds up to 1,628 men in eight residential wings. Oxleas NHS Foundation Trust provides physical healthcare and substance misuse services at the prison. South London and Maudsley NHS Foundation Trust provides mental health services. There is an inpatient unit for up to six prisoners (the Jones Unit) which caters for prisoners with a wide range of health needs, and an inpatient unit for up to 12 prisoners with complex mental health needs (the Addison Unit).

HM Inspectorate of Prisons

25. The most recent full inspection of HMP Wandsworth was conducted in March 2018. Inspectors found that most prisoners were satisfied with the quality of health provision but lengthy waiting times for appointments were a recurring theme. They considered the range of primary care services and visiting specialists was appropriate and external hospital appointments were well managed. They were concerned that systems to address prisoners' social care needs were weak and that prisoner carers were used for inappropriate lifting.

Independent Monitoring Board

26. 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 2020, the IMB reported that the Governor and staff responded speedily and energetically to the COVID-19 lockdown and quickly devised new ways of working. The IMB said that health governance was good and management oversight was effective. Action plans were in place to manage the COVID-19 outbreak and the ongoing function of healthcare services.

Previous deaths at HMP Wandsworth

27. There were six deaths from natural causes, two drug-related deaths and one self-inflicted death at HMP Wandsworth in the two years before Mr Whittington's death. Three prisoners have died at Wandsworth since Mr Whittington's death, two from natural causes and one death was self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

28. On 30 May 2019, Mr Louis Whittington was remanded to HMP Wandsworth charged with sexual assault.

29. At his initial health screen, a nurse struggled to communicate with Mr Whittington and relied on information in his medical records to assess him. Mr Whittington had sustained a significant head injury as a teenager, and this had resulted in brain damage. He had developed epilepsy, cerebellar atrophy (which causes unsteadiness standing and walking, poor muscle control and difficulty speaking and swallowing) and cerebral atrophy (which causes muscular weakness and problems with balance). The nurse noted that Mr Whittington used a wheelchair but could stand with support.

30. A prison GP saw Mr Whittington that day and noted that he had difficulty with verbal communication. He reviewed his medical records and represcribed the medication he had received in the community.

31. Mr Whittington was given a cell in the Addison Unit because a wheelchair accessible cell was not available.

32. On 31 May, a nurse carried out Mr Whittington's second health screen. She recorded that Mr Whittington had a history of substance misuse and noted that he no longer drank alcohol. She also noted his history of depression. The nurse assessed his daily activities and noted that he could dress himself and move in and out of his wheelchair without help, but that he needed assistance with personal care. He had problems with continence but could eat and drink independently.

33. On 1 and 2 June, Mr Whittington fell out of his wheelchair. On 3 June, healthcare staff discussed Mr Whittington at the primary care case management meeting. After the meeting, he was re-referred to social services.

34. On 6 June, a nurse completed care plans for hygiene, falls, mobility, isolation and observation.

35. On 11 June, Mr Whittington started receiving daily personal care from Keep Independent Through Enablement, a short-term, local authority service for people who have been taken ill suddenly, had an accident or are too old and struggling with daily activities. The lead carer said that she developed a good rapport with Mr Whittington and an effective way of communicating which involved using hand gestures and head movements.

36. On 8 July, a psychologist, saw Mr Whittington and noted that he repeated himself 15 to 20 times. He noted his concern that he could not develop his conversation with Mr Whittington. He discussed with the nursing team if laminated cards may help communication and said that he would set up a trial. There is no evidence that this happened. Throughout July, Mr Whittington frequently pressed his emergency cell bell, but it was not clear why he was using it.

37. On 11 August, a nurse went to Mr Whittington's cell and saw him lying on the floor. Healthcare staff went into the cell and saw that he was having an epileptic

seizure which lasted about 25 minutes. Ambulance paramedics took Mr Whittington to hospital, where he stayed for two days.

38. On 22 August, Mr Whittington was moved to a wheelchair accessible cell on C wing.

39. On 13 September, Mr Whittington fell over in his cell. A nurse saw him and noted that he did not have any injuries.

40. On 18 October, a nurse noted that Mr Whittington frequently pressed his cell bell in the middle of the night for no apparent reason.

41. On 24 October, Mr Whittington was found on the floor of his cell. A nurse saw that he was having difficulty breathing and a seizure. She radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing and triggers the control room to call an ambulance immediately) and gave him oxygen. Mr Whittington recovered, and staff stood down the ambulance.

42. On 2 December, Mr Whittington fell over in his cell. A nurse saw that Mr Whittington was not injured.

43. On 9 December, at a primary care case management meeting, prison staff said that they were concerned about Mr Whittington's wellbeing. They were concerned about his personal hygiene and communication difficulties. Healthcare staff agreed to review the support he was receiving.

Events of 9 and 10 January 2020

44. On 9 January, Mr Whittington pressed his cell bell 21 times. An officer said that he went to Mr Whittington's cell on multiple occasions that day after he pressed his bell. He said that on each occasion, he opened the cell door because Mr Whittington had difficulty communicating and saw that he was sitting in his wheelchair and making a sign for a vape with his hands. The officer said he used Mr Whittington's word board to try to communicate with him. He tried to explain to him that the cell bell was not to be used to ask for a vape. The officer said that Mr Whittington's behaviour that day was no different to his usual behaviour.

45. At 8.06pm, Mr Whittington pressed his cell bell. At about 8.15pm, the officer handed over to the night duty Operational Support Grade and told him that Mr Whittington was using his cell bell repeatedly. At 8.44pm, the operational support grade went to Mr Whittington's cell and cancelled the cell bell. He did not look into the cell. At 10.00pm, the operational support grade signed the night patrol officer's report to confirm that he had completed a roll check.

46. At 6.00am on 10 January, the operational support grade signed the night patrol officer's report that he had carried out a roll check. Between 7.00am and 7.30am, he finished his shift.

47. At about 8.30am, an officer was helping a pharmacy technician to hand out medication to prisoners. He looked through Mr Whittington's cell door observation panel but could not see him. He called to him but got no response.

The officer tried to open the door, but it was obstructed, and he saw through the gap that Mr Whittington was lying face down on the floor behind it. He called a senior officer. The officer reached his hand around the door and felt that Mr Whittington was cold.

48. At 8.40am, the senior officer radioed a medical emergency code blue and a control room officer telephoned the ambulance service and told the operator that Mr Whittington was unconscious and not breathing.

49. An officer went to Mr Whittington's cell and opened the door enough to get his hand in. He saw that Mr Whittington was lying on the floor, with his body between his wheelchair and the bed. The officer touched Mr Whittington's face and thought that he was dead. He reached under Mr Whittington to lift him a little to push the door open. The officer saw that his wheelchair was on its side.

50. The officers pushed the door open and this caused Mr Whittington's body to roll over. The officer saw that Mr Whittington's face was white and he had signs of rigor mortis.

51. A nurse went into Mr Whittington's cell. She saw that Mr Whittington's tongue was purple and his jaw was fixed, the skin on his face was cold and his face purple and mottled. The officer removed Mr Whittington's jumper and saw evidence that Mr Whittington's blood had pooled. Nurses went to Mr Whittington's cell, started chest compressions and used a defibrillator.

52. At 8.46am the nurses agreed that Mr Whittington had died and stopped resuscitation attempts. At 8.50am, ambulance paramedics were at his side and also confirmed that Mr Whittington had died.

Contact with Mr Whittington's family

53. On 10 January, the Head of Operations, appointed a prison family liaison officer. At 4.15pm on 10 January, the prison family liaison and an officer visited Mr Whittington's aunt, told her that Mr Whittington had died and offered their condolences. The prison family liaison remained in contact with her. Mr Whittington's funeral took place on 25 February and Wandsworth contributed to its cost in line with national instructions.

Support for prisoners and staff

54. After Mr Whittington's death, the Head of Operations 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.

55. The prison posted notices informing other prisoners of Mr Whittington'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 Whittington's death.

Post-mortem report

56. A post-mortem examination established that Mr Whittington died of sudden unexpected death in epilepsy (a recognised complication of epilepsy) caused by epilepsy which in turn was caused by a chronic brain injury. A toxicology report showed that Mr Whittington had therapeutic levels of levetiracetam (a treatment for epilepsy) in his blood.

Findings

Clinical care

57. The clinical reviewer concluded that the care that Mr Whittington received at Wandsworth was equivalent to that which he could have expected to receive in the community.

58. The clinical reviewer said that Mr Whittington did not have any specific risks for sudden unexpected death in epilepsy. His compliance with his epilepsy treatment was erratic but in the six weeks before he died, he appeared to have complied with his treatment.

59. The social care package that Mr Whittington received was well structured and met his needs in a compassionate manner.

Communicating with Mr Whittington

60. An officer said that he was Mr Whittington's key worker (responsible for meeting a prisoner regularly to support their rehabilitation) for part of Mr Whittington's time at Wandsworth. An officer said that when officers answered Mr Whittington's cell bell, they could not communicate with him which frustrated Mr Whittington.

61. An officer said that he was the disabilities officer at Wandsworth. He said that his role was to identify and refer prisoners with specific care needs relating to a disability to the local authority's social services. An officer said that his dealings with Mr Whittington were minimal because he was already under the care of healthcare and social services. He said that he was not involved with Mr Whittington because of his communication difficulties.

62. Mr Whittington's communication difficulties were mostly caused by his inability to speak clearly. The clinical reviewer said that there was no structured plan to set out how prison staff and healthcare staff should most effectively communicate with him. A psychologist suggested the use of laminated cards, but this does not appear to have been implemented.

63. Mr Whittington was at Wandsworth for more than seven months. We are concerned that Mr Whittington's communication needs were not addressed effectively during this time. This was not only frustrating for him, but also unsafe. We are surprised that this was not part of the remit of the disabilities officer. We make the following recommendation:

    The Governor and Head of Healthcare should develop a strategy to address the needs of prisoners who have serious communication problems.

Cell bells and roll checks

Cell bells

64. The purpose of the emergency cell bells is to enable prisoners to contact staff quickly in an emergency (for example, if they are ill). Wandsworth's cell bell policy, which is included in the night patrol policy, states that all emergency cell bells will be answered as quickly as possible and never longer than five minutes

from the time that the emergency bell is activated. During night state, the member of staff should report to the night orderly officer, where a prisoner appears to be unwell, is misbehaving, is covering their cell observation panel or presenting any other concerns.

65. A senior officer said that she had previously answered Mr Whittington's cell bell on the day before he was found dead and that when she opened his door, he looked at her without saying or signing anything. She said that many officers answered his cell bell. She said that if a prisoner frequently misused their cell bell, this should be recorded and dealt with through the Incentives and Earned Privileges (IEP) scheme. There is no record that this happened with Mr Whittington.

66. An officer said that Mr Whittington 'pretty much constantly' used his cell bell. He said that sometimes there would be no reason for the use of the cell bell but sometimes Mr Whittington had a genuine reason for using it.

67. We cannot say why Mr Whittington pressed his cell bell at 8.06 pm the night before he was found dead, or whether the outcome might have been different if operational support grade had answered it and checked on Mr Whittington's welfare. Instead, the operational support grade cancelled the bell at 8.44pm, without looking into Mr Whittington's cell.

68. We are concerned that there is no evidence that prison staff had tried to explain to Mr Whittington in a structured way that the bell should only be used in an emergency or checked that he understood that. If that had been done and Mr Whittington had continued to use the bell inappropriately, his behaviour could have been dealt with through the IEP scheme. As it was, Mr Whittington continued to use the bell frequently, often for unimportant matters, and there was therefore a real risk that some staff might become complacent or irritated and so answer his bell less promptly than they should have done – or not at all, as happened on the night of 9 January.

69. Mr Whittington's condition made him particularly vulnerable and it was essential that he was able to call for prompt assistance if he needed it. We therefore consider that the prison should have taken steps as a priority to ensure that Mr Whittington understood when to use the cell bell, and to ensure that all staff understood the need to answer it promptly, even if Mr Whittington frequently misused it. This is one of the ways in which the failure to establish a system of communicating with Mr Whittington left him at risk.

70. We recommend:

The Governor should ensure that staff:

- **understand the importance of responding to all cell bells as promptly as possible; and**
- **do so in line with local policy.**

Roll checks

71. Although the primary purpose of a roll check is to establish that all prisoners are in their cells, it also provides an important opportunity to check that prisoners are safe and well. Wandsworth's night patrol policy states that staff who carry out a roll check must see a prisoner's face or obtain a response from him. It states that if the member of staff who has carried out the check is not satisfied with the response or movement of the prisoner, they should notify the night orderly officer (most senior officer on duty in the prison) immediately.

72. On 14 April 2020, the Governor carried out a disciplinary hearing to investigate allegations of gross misconduct against the operational support grade. During the hearing, he said that he did not carry out the roll checks at 10.00pm and 6.00am that he had signed to say that he had completed. He also agreed that he had not answered the cell bell correctly at 8.44pm on 9 January. The Governor dismissed him from the Prison Service.

73. We cannot say if the operational support grade's failure affected the outcome for Mr Whittington but, if the roll checks had been done, he would at least have been discovered on the floor of his cell more quickly.

74. We consider that it is critical that staff understand the importance of roll checks to ensure this does not happen again. We make the following recommendation:

    The Governor should ensure that staff conduct roll checks in line with local policy, including that they:

    - **understand why roll checks are important;**
    - **complete a visual check of each prisoner to ensure they are safe and well; and**
    - **ask prisoners to uncover their cell observation panels where necessary so that they can see them.**

Emergency response

75. When officers found Mr Whittington on the floor of his cell, they promptly pushed open the door, called a medical emergency code blue and telephoned an ambulance. There were clear signs that Mr Whittington was dead: he had rigor mortis, his tongue was purple, his jaw was fixed, the skin on his face was cold, his face purple and mottled and blood had pooled in his body. All of this suggested that he had been dead for at least four hours and that attempts to resuscitate him would be futile.

76. We are concerned that, despite these signs, healthcare staff carried out CPR and used a defibrillator.

77. While we understand the wish to continue resuscitation until death has been formally confirmed, staff should understand, in line with the European Resuscitation Council Guidelines for Resuscitation 2010, that resuscitation is inappropriate when there is clear evidence, such as the presence of rigor mortis, that it will be futile. It is not only undignified for the deceased but distressing for staff. We make the following recommendation:

The Governor and the Head of Healthcare at Wandsworth should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate, in line with European Resuscitation Council Guidelines for Resuscitation.

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