

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Todd, a prisoner at HMP Whatton, on 25 October 2020

A report by the Prisons and Probation Ombudsman

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 Martin Todd died on 25 October 2020 of heart failure at HMP Whatton. He was 52 years old. I offer my condolences to Mr Todd's friends.

The clinical reviewer was satisfied that the healthcare Mr Todd received at Whatton was equivalent to that which he could have expected to receive in the community.

I am concerned that when staff found Mr Todd unresponsive in his cell at around 11.50am, there was evidence of rigor mortis, meaning that he had been dead for some time. Wing staff had checked him at around 7.00am and again at 9.00am but had failed to check for signs of life. It is probable that Mr Todd had died in the night but lay undiscovered for several hours.

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

June 2021

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	8

Summary

Events

1. On 21 April 2011, Mr Martin Todd was sentenced to an Indeterminate Sentence for Public Protection (IPP) for sexual offences with a tariff (minimum term) of four years in prison. He was sent to HMP Nottingham.
2. In May 2018, Mr Todd arrived at HMP Whatton on a progressive transfer. He remained at Whatton until his death, apart from short periods in other prisons when he attended court hearings.
3. On 21 November 2019, Mr Todd was sentenced to 12 years imprisonment for historic sexual offences.
4. In October 2020, several prisoners on the same residential unit at Whatton as Mr Todd displayed COVID-19 symptoms and were placed into isolation. On 21 October, one of those prisoners tested positive.
5. On 22 October, Mr Todd appeared to be displaying COVID-19 symptoms and was put into an isolation regime. He later tested negative.
6. On 25 October, at around 11.50am, staff unlocked Mr Todd to serve his lunch. Mr Todd was found unresponsive and a medical emergency code was used to get immediate help. A 999 call was immediately made to East Midlands Ambulance Service. Healthcare staff attended and noted signs of rigor mortis so CPR was not attempted.
7. An ambulance arrived at Whatton at 12.08pm. At 12.21pm, a paramedic confirmed that Mr Todd had died. He estimated he had been dead for between six and 12 hours.

Cause of death

8. The post-mortem found that Mr Todd died from heart failure caused by ischemic heart disease and thickening of the heart muscle.

Findings

9. The clinical reviewer concluded that the care that Mr Todd received at HMP Whatton was of a good standard and equivalent to that which he could have expected to receive in the community.
10. The clinical reviewer did, however, identify some concerns.
11. The clinical reviewer found that while both first and secondary health screening were comprehensive, the merging of reception screenings fell outside recommended practice.
12. The clinical reviewer also identified two concerns about dispensing Mr Todd's prescribed medication (a controlled drug): there were no drug audit sheets for the six weeks preceding Mr Todd's death, and the individual risk assessment for Mr Todd to have his medication in-possession could not be found.

13. When Mr Todd was found unresponsive in his cell at around 11.50am, there was evidence of rigor mortis, meaning he had been dead for some while. Wing staff had checked him at around 7.00am and again at 9.00am, but had failed to check for signs of life. It is probable that Mr Todd had died in the night but lay undiscovered for several hours.

Recommendations

- The Head of Healthcare should review the current practice of merging the first and secondary reception screenings and discuss ways to deliver optimum screening standards and quality care planning with clinical commissioners.
- The Head of Healthcare should ensure that:
 - audits of in-cell possession of medication are completed; and
 - individual risk assessments are completed before prisoners are allowed to hold their medication in their possession.
- The Governor and Head of Healthcare should ensure that the local policy on allowing prisoners to have controlled drugs in their possession during the pandemic is in line with national policy.
- The Governor and Head of Healthcare should ensure that relevant current and historic risk information relating to medication misuse is provided to healthcare staff in order to help support safer and informed decision-making.
- The Governor should ensure that staff understand that they need to satisfy themselves of the wellbeing of all prisoners during the morning unlock.
- The Governor should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman's findings with her.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Whatton informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator wrote to HMP Whatton on 27 October 2020. He obtained a range of documents including copies of relevant extracts from Mr Todd's prison and medical records.
16. NHS England commissioned a clinical reviewer to review Mr Todd's clinical care at the prison.
17. The investigator and clinical reviewer interviewed four members of staff on 3 December 2020. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic.
18. We informed HM Coroner for Nottingham of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. HMP Whatton made repeated efforts to identify Mr Todd's next of kin, but were unable to do so.
20. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Whatton

21. HMP Whatton is a medium security prison holding up to 840 men convicted of sexual offences. Healthcare services are provided by Practice Plus Group. Staff are on duty from 7.30am to 6.30pm on weekdays and 8.00am to 1.30pm on weekends and Bank Holidays. Outside those hours prison staff call either the emergency services for an ambulance, or the NHS 111 telephone line for health advice, depending on the prisoner's need. There is no inpatient facility.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Whatton was a Scrutiny Visit in August 2020. Inspectors reported issues with the dispensing of prescription medication, noting:

"The controlled drugs gabapentin (an antiepileptic) and pregabalin (an anticonvulsant) were also given weekly in-possession, which was against national guidance and increased the risk of diversion and misuse. A risk-assessed protocol to return to prisoners collecting controlled drugs from the medication's distribution hatch was still not in place, despite the prison's positive record on COVID-19. These practices needed to be revised to ensure that patients received their medication in the safest way adhering to professional and good practice standards."

Independent Monitoring Board

23. 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 1 June 2019 to 31 May 2020 the IMB reported that they had significant concerns about the physical state of the healthcare facilities, including damp, asbestos and rat infestations.

Previous deaths at HMP Whatton

24. Mr Todd was the tenth prisoner to die at HMP Whatton since October 2018. All the previous nine deaths were from natural causes. There are no similarities between the death of Mr Todd and the preceding deaths.
25. There have been seven deaths since Mr Todd's, all from natural causes, including five from COVID-19.

Key Events

26. On 21 April 2011, Martin Todd was sentenced to an Indeterminate Sentence for Public Protection (IPP) for sexual offences with a tariff of four years. He was sent to HMP Nottingham.
27. Mr Todd had some pre-existing medical conditions, including hypertension (high blood pressure), angina, and chronic back pain and intermittent urinary incontinence due to an old back injury. He had surgery on his back in 2016. He also had a history of drug misuse in the community.
28. In October 2012, Mr Todd was sent to HMP Frankland. During his time there, there were reports through 2015 to 2017 that Mr Todd was involved in the trading of prescription medication, including gabapentin (used for epilepsy and nerve pain) and ketamine (used as an anaesthetic). Both are controlled drugs and are misused and traded in prison because of their euphoric effects.
29. In May 2018, Mr Todd arrived at HMP Whatton on a progressive transfer. He remained at Whatton until his death apart from short periods at other prisons to attend court hearings.
30. In April 2019, during a routine cell search staff found prescription medication in Mr Todd's cell that had not been taken. Mr Todd said it was his. He was placed on a disciplinary charge. There is no evidence that the charge was proceeded with.
31. In September, Mr Todd saw a prison GP, to discuss his back pain. His existing pain relief medication (gabapentin) was increased from two 300 milligram tablets daily to four 300 milligram tablets daily.
32. In October, Mr Todd's yearly Coronary Heart Disease review was completed. Mr Todd had not experienced any cardiac related symptoms since his last review. All bloods and observations were within normal range, so his next review was booked for 1 October 2020 in line with NICE guidelines.
33. Later that month, Mr Todd was seen at the Centre for Spinal Studies and Surgery at Nottingham University Hospitals for review of his long-standing back pain. A management plan was agreed which included increased gym activity and physiotherapy, a review of oral pain relief and an injection into the spine for additional pain relief.
34. On 21 November, Mr Todd was sentenced to twelve years imprisonment for historic sexual offences.
35. On 14 January 2020, Mr Todd saw a prison GP, and requested an increase in gabapentin due to pain at night. The GP added an additional 300 milligrams of gabapentin at night for pain and ordered a bladder scan as Mr Todd was still experiencing occasional urinary incontinence.
36. At the beginning of the COVID-19 pandemic, a national policy change was introduced to assist continuity of care for prisoners during the restricted COVID-19 regime. This allowed prisoners to receive seven days issue of their medication, rather than having to collect it daily at the medication hatch, subject

to an individual risk assessment in each case. In April, Mr Todd received his first issue of seven days of gabapentin under this new policy. There was no individual risk assessment for Mr Todd in his records and the prison could not find one when we asked for it.

37. On 28 April, a healthcare administrator noted that a wing officer had called to say that Mr Todd had run out of his gabapentin a day early. No additional action was noted, and no further issues or concerns were reported in relation to Mr Todd's in-possession gabapentin.
38. On 31 July, a nurse undertook a medication review with Mr Todd. She documented that Mr Todd was not taking his aspirin because it made him feel sick and dizzy, and that Mr Todd did not like taking statins. She also noted that he was compliant with gabapentin. The nurse encouraged Mr Todd to take all his medications and Mr Todd said that he would.
39. On 1 October, Mr Todd should have had his yearly Coronary Heart Disease review. This did not take place because all non-urgent routine reviews had been delayed due to the COVID-19 pandemic.
40. On 19 October, Mr Todd requested a blood pressure check. He did not report any chest pain or other concerns but was following advice from clinical staff. His blood pressure was slightly above his normal range. A task was sent to the nurse responsible for cardiac care for further review. Waiting list information shows that Mr Todd was listed for review with the nurse the following week.
41. In October, several prisoners on the same residential unit as Mr Todd displayed COVID-19 symptoms and were placed into isolation. On 21 October, one of those prisoners tested positive for COVID-19.
42. On the afternoon of 22 October, Mr Todd reported that he had a temperature and diarrhoea. He was put into an isolation regime and had a COVID-19 test which was sent for analysis. That evening Mr Todd submitted a complaint form about the lack of exercise on the isolation regime.
43. On 23 October, Mr Todd's COVID-19 test came back negative. Mr Todd was told of this. He remained on the isolation regime, which was due to be reviewed on 27 October. The same day the prison responded to Mr Todd's complaint about a lack of exercise. The prison told Mr Todd that they were complying with the guidelines issued by the Prison Service and Public Health England (PHE).
44. On the afternoon of 24 October, Mr Todd complained that he was suffering from food poisoning with diarrhoea and vomiting. Wing staff contacted the nurse and she advised them that Mr Todd should remain in his cell and drink plenty of fluids.
45. That evening, at around 8.00pm, an Operational Support Grade (OSG) carried out the evening roll check, checking all cells on the unit. She said she saw Mr Todd awake when she checked his cell and that he greeted her through the observation panel.

Events of 25 October 2020

46. On 25 October, at around 7.00am Officer A carried out the morning roll check, checking all cells on the unit. At interview she said that when she looked into Mr Todd's cell, it was dark and difficult to see in. She thought she saw Mr Todd breathing and asleep. She moved onto the next cell.
47. At around 9.00am, Officer A unlocked prisoners on the unit for exercise. Mr Todd was not able to participate in exercise as he was on the isolation regime. Officer A checked on those who were isolating through the observation panel in their doors. She checked Mr Todd's cell and thought he was asleep.
48. At 11.50am, Officer A unlocked Mr Todd to serve his lunch. She entered the darkened cell and called out to him but received no response. She found Mr Todd unresponsive with his eyes open, lying on his back with his glasses clenched in his hand.
49. Officer A radioed a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). A 999 call was immediately made to East Midlands Ambulance Service at 11.52am. Prison and healthcare staff attended and noted signs of rigor mortis, so CPR was not attempted.
50. An ambulance arrived at Whatton at 12.08pm. At 12.21pm, a paramedic confirmed that Mr Todd had died.

Contact with Mr Todd's family

51. Mr Todd had no named next of kin. Mr Todd's funeral was held on 21 December. In line with policy, the prison paid for the funeral.

Support for prisoners and staff

52. After Mr Todd's death, an Operational 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.
53. The prison posted notices informing other prisoners of Mr Todd'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 Todd's death.

Post-mortem report

54. The post-mortem found that Mr Todd died from a cardiac failure (heart failure) caused by ischemic heart disease (also called coronary heart disease, a condition which restricts the flow of blood and oxygen in the heart) and left ventricular hypertrophy (a thickening of the heart muscle).
55. Toxicology tests found no traces of illicit substances.

Findings

Clinical care

56. The clinical reviewer concluded that the care Mr Todd received at Whatton was equivalent to that which he could have expected to receive in the community.
57. The clinical reviewer did, however, identify some concerns.

Health screenings

58. On 19 August 2019, a nurse undertook the first reception / transfer reception screening and secondary health screening with Mr Todd.
59. The clinical reviewer found that while both first and secondary health screening were comprehensive, the merging of reception screenings fell outside recommended practice as secondary screening is intended as a follow-up to assist with the identification of any emerging issues or problems. In Mr Todd's case, he was seen daily for medication and therefore the delivery of a merged screening was not detrimental to his care. However, this may not always be the case for future patients.

The Head of Healthcare should ensure that first and secondary reception screenings are held separately in line with recommended practice.

In-possession medication and information sharing

60. Mr Todd had been prescribed gabapentin (a Schedule 3 Controlled Drug) for several years for back pain before he arrived at Whatton.
61. In April 2020, the Prison Service's delivery of medication policy changed during the COVID-19 pandemic. To assist continuity of care, instead of collecting their medication daily from the medication hatch, prisoners could be given seven days dosage to keep in their cells, subject to an individual risk assessment. Mr Todd was one of those who moved to weekly gabapentin dispensing.
62. The clinical reviewer identified two concerns about dispensing Mr Todd's gabapentin. First, there were no drug audit sheets for the six weeks preceding Mr Todd's death. These sheets provide a level of assurance that medication use is being monitored in order to help identify misuse.
63. Second, the individual risk assessment for Mr Todd to have his gabapentin in-possession could not be found. It is not clear what information was considered in the risk assessment or if one was completed.
64. Mr Todd had a history and pattern of trading of prescription medication, including gabapentin in the recent past at HMP Frankland. In 2019, information at Whatton suggested that Mr Todd might be involved in the trading of medication.
65. We are concerned that there is no evidence that the information about Mr Todd's history of medication misuse and diversion was shared with healthcare staff to inform their prescribing or the risk-assessment when Mr Todd was moved onto weekly gabapentin dispensing.

66. After this death, on 27 October 2020, a security intelligence report suggested that Mr Todd may have taken an accidental overdose of gabapentin to alleviate the boredom of the lockdown regime. It was also suggested that this was medication he had initially intended to trade with other prisoners but could not because he was placed in isolation. However, the post-mortem toxicology report found no evidence that Mr Todd had taken an excessive amount of his prescribed medication.
67. In their scrutiny visit in August 2020, HM Inspectorate of Prisons reported that the weekly dispensing of gabapentin was not best practice and was against national policy. However, at interview the Head of Healthcare disagreed and said the national guidance did permit the weekly dispensing of gabapentin.
68. We make the following recommendations:

The Head of Healthcare should ensure that:

- **audits of in-cell possession of medication are completed; and**
- **individual risk assessments are completed before prisoners are allowed to hold their medication in their possession.**

The Governor and Head of Healthcare should ensure that relevant information about possible medication misuse is provided to healthcare staff in order to help support safer and informed decision-making.

The Governor and Head of Healthcare should ensure that the local policy on allowing prisoners to have controlled drugs in their possession during the pandemic is in line with national policy.

Unlock procedures and wellbeing checks

69. Officer A had checked on Mr Todd when she carried out the roll check at about 7.00am and when she unlocked other prisoners for exercise at about 9.00am. She told us that she thought he was asleep and breathing on both occasions. She said that it was difficult to see into the dark cells at the roll check and that she did not want to disturb Mr Todd at 9.00am as he and other prisoners liked to lie in.
70. We are concerned that when Mr Todd was found in his cell at 11.50am, rigor mortis was present. Part of the Body Worn Camera (BWC) footage of the emergency response records a paramedic confirming Mr Todd's death. In the footage he estimates that Mr Todd had been dead for between six and twelve hours. This means that Mr Todd had almost certainly been dead when Officer A checked on him at 7.00 and 9.00am.
71. 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, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable. The specification requires there to be positive engagement between staff and prisoners and for prisoners to be supported and their daily*

needs met, and this clearly requires some form of interaction or conversation to take place at times during the day”.

And:

“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.”

72. In interview, a Supervising Officer (SO), the unit SO on 25 October, said Whatton’s Local Security Strategy (LSS) did not require staff to get a response from prisoners when roll checks were being carried out. He said he thought this was confusing for staff.
73. We accept that it may not be appropriate for staff to get a response from prisoners during a morning roll check. However, PSI 75/2011 is clear that staff are expected to check prisoners’ wellbeing by getting a response at unlock, including checking on prisoners who are not leaving their cell.
74. It is unlikely that the outcome would have been different for Mr Todd if he had been discovered earlier, but a failure to check on a prisoner’s wellbeing at unlock could make a critical difference in other cases. We make the following recommendations:

The Governor should ensure that staff satisfy themselves of the wellbeing of all prisoners during the morning unlock.

The Governor should ensure that this report is shared with Officer A and that a senior manager discusses the Ombudsman’s findings with her.

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