

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dacosta Whyte, a prisoner at HMP Featherstone, on 13 March 2021

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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Dacosta Whyte died from heart disease at HMP Featherstone on 13 March 2021. He was 70 years old. I offer my condolences to his family and friends.

The clinical reviewer found that, overall, the care Mr Whyte received at Featherstone was of a good standard and was equivalent to that he could have expected to receive in the community.

Mr Whyte was found dead on the floor of his cell at around 8.30am on 13 March. He had almost certainly been dead for at least two hours. I am concerned that the roll check carried out less than two hours before Mr Whyte was found, failed to identify that he was dead. I am also concerned that a CCTV camera near to Mr Whyte's cell was not working at the time and the prison could not tell us how long it had been out of action.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman

August 2021

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	6

Summary

Events

1. In November 2007, Mr Dacosta Whyte was sentenced to life imprisonment, for murder and conspiracy to rob. He was moved to HMP Featherstone in January 2018.
2. Mr Whyte had been diagnosed with HIV in 2000. He also had diabetes, kidney disease and hypertension (high blood pressure).
3. On 13 March 2021, at 6.47am, an operational support grade (OSG) looked into Mr Whyte's cell while carrying out a roll check (count of prisoners). He noticed nothing untoward.
4. At around 8.30am, an officer unlocked Mr Whyte's cell and found him dead on the floor. It was clear that he had been dead for some time as was dead as he had rigor mortis (stiffening of the body that occurs two to six hours after death), so staff did not try to resuscitate him.
5. The post-mortem examination found that Mr Whyte died from ischaemic and hypertensive heart disease (damage to the heart from blockages in the arteries and high blood pressure).

Findings

6. The clinical reviewer found that overall, the care Mr Whyte received at Featherstone was of a good standard and was equivalent to that he could have expected to receive in the community.
7. Claims by prisoners that Mr Whyte was refused treatment after complaining of chest pains on the afternoon of 12 March, were not substantiated by the investigation.
8. A CCTV camera on Mr Whyte's spur was not working at the time of Mr Whyte's death and there is no record of this having been reported beforehand.
9. Mr Whyte was almost certainly dead on his cell floor when the roll check was carried out at 6.47am, and yet the OSG noticed nothing untoward. We are very concerned that Mr Whyte was not checked properly.

Recommendations

- The Governor should ensure that all CCTV systems are fully functional and regularly checked.
- The Governor should ensure that roll checks are properly carried out and that staff understand their responsibilities to check there are no immediate issues that need attention.
- The Governor should share this report with an OSG and arrange for a senior manager to discuss the Ombudsman's findings with him.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of the relevant extracts from Mr Whyte's medical and prison records.
12. NHS England commissioned a clinical reviewer to review Mr Whyte's clinical care at the prison.
13. We informed HM Coroner for South Staffordshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted a cousin who had been nominated by Mr Whyte's family as the next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no questions but asked for a copy of our report.
15. The initial report was shared with Mr Whyte's cousin. She expressed shock at the findings of the report and commented on several aspects of it. Her comments do not impact on the factual accuracy of the report and have been addressed through separate correspondence.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. Their action plan is annexed to this final report.

Background Information

HMP Featherstone

17. HMP Featherstone is a medium security, category C prison, holding around 650 convicted men. The Practice Plus Group provides healthcare services.

HM Inspectorate of Prisons (HMIP)

18. The most recent inspection of HMP Featherstone was in October 2018. Inspectors found that primary healthcare services were generally very good, with improved staffing levels. Patients with long-term conditions were generally well managed and monitored by GPs. They found some shortcomings in the monitoring for diabetes but that a lead nurse for this condition had been appointed. A lead nurse had also been appointed to support the needs of the few older prisoners. They also found that foreign national prisoners received reasonable support.

Independent Monitoring Board

19. 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 October 2020, the IMB said that, while the pandemic limited the ability of IMB members to visit the prison, Featherstone had coped well with the consequences of the COVID-19 pandemic. Provisions included a spur on a wing for vulnerable prisoners requiring shielding from the virus, and in-cell telephones to help prisoners keep in contact with their friends and families. The IMB said that the physical healthcare of the prisoners appeared to be generally of a good standard.

Previous deaths at HMP Featherstone

20. Mr Whyte was the third prisoner to die at Featherstone since March 2019. One of the previous deaths was self-inflicted and the other was drug related. There are no similarities between those deaths and that of Mr Whyte.

Key Events

21. In November 2007, Mr Dacosta Whyte was sentenced to life imprisonment with a tariff of 22 years, for murder and conspiracy to rob. He was a Jamaican national and was due to be deported at the end of his sentence. On 23 January 2018, he was sent to HMP Featherstone.
22. Mr Whyte had several serious underlying health issues. The most significant of these was HIV (a virus that compromises the immune system) which was diagnosed in 2000. This put him at a much greater risk of developing three of the other serious illnesses that he had. These were type 2 diabetes (the inability of the body to regulate sugar in the blood), kidney disease and hypertension (high blood pressure). He was also at risk of heart problems though he was not treated for any specific heart diseases. These health issues, along with his age, made him vulnerable to serious complications if he were to catch COVID-19.
23. Mr Whyte was offered shielding within his cell in May 2020, and it appears that his regime had some degree of shielding, for example segregated collection of his medications from healthcare. During the summer with COVID-19 infections falling nationally, the prison returned to a more normal regime, including restarting visits in July. However, in October there was an outbreak of COVID-19 in the prison and Mr Whyte was part of a mass test for the virus on 23 October.
24. Mr Whyte tested positive for COVID-19 and was put into isolation in accordance with pandemic protocols. On 27 October, staff advised him to move to the shielding spur of the prison which they felt would be a safer environment for him. Mr Whyte refused and as this was considered to be against his best interests, an assessment of his capacity to make that decision was requested. However, he refused to engage with the assessment.
25. Mr Whyte was ill for a few days and was confused at times. On 29 October, staff called an ambulance and he was taken to hospital. Although he had COVID-19 at the time, his hospitalisation was due to kidney failure rather than COVID-19.
26. Mr Whyte returned to Featherstone on 1 November. He agreed to move to the shielding unit.
27. At the start of November, a prison GP stopped Mr Whyte's diabetes medication because of concern about his kidney function. In December, Mr Whyte complained to a prison officer that he felt ill without his diabetes medication, and the officer referred the matter to healthcare staff. In January 2021, a prison GP noted that Mr Whyte's blood sugars were normal and told him that he should stay off the medication unless his diabetes deteriorated.
28. In January, Mr Whyte attended an HIV clinic to review his antiretroviral drugs (which stop HIV from increasing and damaging the body). A prison GP changed his drugs and assessed his cardiovascular risk (his risk of having an event such as a heart attack or stroke) as high.
29. By March, Mr Whyte's diabetes had become poorly controlled and following blood tests, he was due to restart his diabetes medication on 12 March.

30. At around 7.02pm on 12 March, an officer checked on Mr Whyte by looking through his observation panel. The officer had no concerns.
31. At around 6.47am on 13 March, CCTV shows an Operational Support Grade (OSG) carrying out a roll check (count) of prisoners and looking quickly into all the cells on Mr Whyte's spur. He shone his torch into two cells, neither of which was Mr Whyte's. He said that he did not notice anything unusual.
32. At around 8.30am, an officer unlocked Mr Whyte's cell so that he could collect his medications. He found Mr Whyte lying face down on the floor. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance) immediately. Other prison and healthcare staff arrived quickly, but they did not attempt resuscitation as Mr Whyte was very cold and had rigor mortis (stiffness of the limbs that normally sets in around two to six hours after death). The paramedics who attended declared Mr Whyte dead at 8.51am.

Contact with Mr Whyte's next of kin

33. The prison appointed an officer as the family liaison officer (FLO). She contacted Mr Whyte's nominated next of kin, his brother. However, as he was unwell, the family asked a family friend to take on the role and the FLO made all subsequent contact with her.
34. The prison made the arrangements for Mr Whyte's funeral and contributed financially in line with national guidance.

Support for prisoners and staff

35. After Mr Whyte's death, the Governor carried out a hot debrief for the staff who had been present. She gave staff the opportunity to describe and reflect on their involvement and she reminded them of the support that was available and that it might be a while before the events sank in.
36. The prison posted notices to staff and prisoners informing them of Mr Whyte's death, and offering support. A Custodial Manager (CM) who was Orderly Officer on the day, also wrote a reminder to staff in the wing log of the support available to staff and prisoners.

Post-mortem report

37. The post-mortem report gave the cause of death as ischaemic and hypertensive heart disease (damage to the heart from blockages in the arteries with high blood pressure), with type 2 diabetes mellitus (the inability of the body to regulate sugar in the blood) listed as a background condition that contributed to, but did not cause the death.

Findings

Clinical care

38. The clinical reviewer noted that Mr Whyte's HIV condition put him at risk of developing diabetes, hypertension and kidney disease. In turn, diabetes, hypertension and kidney disease put him at risk of developing a heart condition. However, there is no record of Mr Whyte complaining of any heart disease related symptoms or of him needing to be tested for any heart conditions.
39. The clinical reviewer considered that overall, the care Mr Whyte received at Featherstone was of a good standard and was equivalent to that he could have expected to receive in the community. She found that his health conditions were all closely monitored and she praised staff for their skilled management of Mr Whyte's long-term health conditions, particularly during the difficulties created by the COVID-19 pandemic. She did however make some recommendations about the prescribing of Mr Whyte's diabetic medication which the Head of Healthcare will need to address.

Claims by prisoners about events on 12 March

40. Although no prisoners contacted us about our investigation, the prison told us that two prisoners had made allegations about events surrounding Mr Whyte's death. They said that on the afternoon of 12 March, there had been an altercation between Mr Whyte and an officer about his medication. They said Mr Whyte wanted medication for chest pains but was told by an officer to go back to his cell. The prison shared the findings of their investigation with the investigator, who also looked at other relevant information.
41. The officer involved said that there had been no issue with Mr Whyte around his medication, and when Mr Whyte received his normal medication earlier in the afternoon from a member of healthcare staff, he did not raise any issues with them. There were inconsistencies in the accounts of the two prisoners, and another prisoner who visited Mr Whyte in his cell later in the afternoon to help him with some paperwork, said that he had not raised any issues with him. The investigator listened to Mr Whyte's telephone calls leading up to his death including his last call at around 5.30pm on 12 March. In that call, and in another the day before, he discussed the results of his blood tests and how a doctor was going to start him on some tablets. This ties in with the information in Mr Whyte's clinical records about going back on medication for his diabetes. In neither call did he raise any complaint about the behaviour of an officer or the clinical treatment he was receiving. In his final call on 12 March, Mr Whyte sounded relaxed and not in any difficulty.
42. We would have expected Mr Whyte to have used his cell bell if he had been in pain. The cell bell record shows that Mr Whyte did not use his cell bell on 12 or 13 March.
43. We are unable to say if Mr Whyte had an altercation with an officer on the afternoon before he died, and if he did whether this was misinterpreted by two prisoners in light of subsequent events. However, we are satisfied on the

evidence available to us, that Mr Whyte did not raise any concerns about chest pains.

CCTV cameras

44. There are two CCTV cameras on the wing that Mr Whyte was on. Only the one furthest away from his cell was working at the time he died. This compromised the availability and clarity of images of the movements around Mr Whyte's cell leading up to and following his death, including visual documentation of the alleged altercation with an officer on 12 March.
45. In reply to questions from the investigator, the prison was unable to say how long the camera had been out of action, or whether it had been reported at all. However, the prison told us that it had been fixed at some point after Mr Whyte's death.
46. We recommend:

The Governor should ensure that all CCTV systems are fully functional and regularly checked.

Roll checks

47. Although the CCTV is not very clear, it does show that on the morning of 13 March, an OSG conducted a roll check on Mr Whyte's spur at about 6.47am. He used a torch to check two cells: one occupied by a prisoner who was subject to regular suicide and self-harm monitoring and the other occupied by a prisoner who had known health problems at the time. CCTV shows the OSG looked quickly into Mr Whyte's cell. He did not use a torch. He said that he would only need to shine a torch into a prisoner's cell if there was not enough light to be able to see a prisoner. We note, however, that there was a particular reason why he used a torch for the two cells he did. He said that he did not notice anything untoward.
48. Mr Whyte was found on the floor of his cell at around 8.30am, with rigor mortis.
49. The timescale for the onset of rigor mortis is not exact as it is affected by several factors such as temperature and muscle mass. However, guidelines from the Royal College of Pathologists suggest that rigor mortis is first detectable in the muscles of the eyelids, neck and jaw between 2 to 6 hours after death in adults, and spreads to the arms, legs and trunk within the next 4 to 6 hours. The pathologist who carried out the post-mortem in this case, described the observations at the roll check as out of keeping with the reported condition of Mr Whyte's body when he was discovered on the floor of his cell.
50. The roll check is not a welfare check and its principal purpose is to establish the presence of the prisoner in the cell. However, given the evidence, it seems almost certain that Mr Whyte was lying dead on the floor of his cell at 6.47am when the OSG conducted the roll check. We consider that the OSG could not have failed to notice this if he had conducted an effective roll check.
51. We recommend:

The Governor should ensure that roll checks are properly carried out and that staff understand their responsibilities to check there are no immediate issues that need attention.

The Governor should share this report with the OSG and arrange for a senior manager to discuss the Ombudsman's findings with him.

**Prisons &
Probation**

Ombudsman
Independent Investigations