Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Pitts, a prisoner at HMP Whatton, on 30 March 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*

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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 Ian Pitts died of heart failure caused by ischaemic heart disease on 30 March 2020 at HMP Whatton. He was 85 years old. I offer my condolences to Mr Pitts' family and friends.

The clinical reviewer was satisfied that the care Mr Pitts received was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that healthcare staff did not create care plans to manage Mr Pitts' conditions, review his falls risk assessment or discuss and review an existing DNACPR order with him.

I am concerned that when Mr Pitts was found unresponsive in his cell on 30 March, prison staff did not immediately use an emergency medical code, therefore an emergency ambulance was called not immediately. However, I am satisfied that this did not affect the outcome for Mr Pitts.

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 2021**

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Summary

Events

1. On 12 May 2015, Mr Ian Pitts was sentenced to 12 years in prison for sexual offences. He was initially sent to HMP Hewell and transferred to HMP Whatton in October 2017.

2. Mr Pitts had a number of medical conditions, including high blood pressure, angina and diabetes. He also had previously had a stroke. His prescribed medications were reviewed, and he was regularly reviewed by prison healthcare staff and secondary care staff.

3. At 6.55am on 30 March 2020, an officer conducting a morning roll check found Mr Pitts in his cell lying on the floor and unresponsive. She used her radio to contact the Night Orderly Officer and asked permission to enter the cell with an Operational Support Grade (OSG) to check on his well-being.

4. The officer entered the cell and tried to wake Mr Pitts, but he did not respond. She used her radio to call an emergency medical code. Other staff arrived promptly but, as it was apparent that Mr Pitts had been dead for some time, they decided not to attempt cardiopulmonary resuscitation. Paramedics arrived at Mr Pitts' cell at 7.23am and at 9.07am, a prison GP confirmed that Mr Pitts had died.

5. A post-mortem examination gave Mr Pitts' cause of death as acute left ventricular failure caused by ischaemic heart disease.

Findings

Clinical care

6. The clinical reviewer concluded that, overall, the healthcare Mr Pitts received at Whatton was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community. Mr Pitts had significant health problems and healthcare staff monitored his conditions appropriately.

7. However, the clinical reviewer was concerned that there were no documented individualised care plans for Mr Pitts' care, that falls risk assessments were not updated or reviewed regularly, and that his DNACPR order was not reviewed.

Emergency response

8. The officer who found Mr Pitts lying unresponsive on his cell floor did not immediately use an emergency medical code as she should have done and did not immediately enter his cell. This meant that there was a delay in calling an ambulance. This did not affect the outcome for Mr Pitts as he had been dead some time before he was found but could make a crucial difference in other medical emergencies.

Recommendations

- The Head of Healthcare should ensure that staff create and document individualised care plans for all prisoners with chronic and/or life limiting conditions.
- The Head of Healthcare should ensure that prisoners at risk of falling have a falls risk assessment in place which is reviewed regularly, in line with NICE guidelines.
- The Head of Healthcare at HMP Hewell should ensure that all previous completed DNACPR forms accompany a patient when they are transferred to another prison.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. In particular, staff should:
    - enter a cell where there appears to be immediate danger to life, subject to a dynamic risk assessment; and
    - use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically.
- The Governor should share this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with her.

The Investigation Process

9. 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.

10. The investigator was unable to visit Whatton because of the COVID-19 restrictions. He obtained copies of relevant extracts from Mr Pitts' prison and medical records by email.

11. NHS England commissioned an independent clinical reviewer to review Mr Pitts' clinical care at the prison.

12. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The coroner gave us Mr Pitts' cause of death. We have sent the coroner a copy of this report.

13. We wrote to Mr Pitts' next of kin, his daughter, to explain the investigation and to ask if she had any matters she wished the investigation to consider. She did not respond to our letter.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Whatton

19. HMP Whatton is a medium security prison in Nottinghamshire which holds up to 841 prisoners convicted of sex offences. At the time of Mr Pitts' death MITIE Care and Custody Health 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

20. The most recent full 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 prisoners. 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.

21. HMIP conducted a scrutiny visit to Whatton in August 2020 (in line with its COVID-19 methodology) and reported that managers and staff at Whatton were keeping prisoners relatively safe and motivated during challenging times.

Independent Monitoring Board

22. 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 2019, the IMB considered that there had been an improvement in healthcare provision and an improvement in staffing levels at Whatton.

23. The IMB also found that while prisoners received a standard of care equivalent to that they would expect to receive in the community, the standard of accommodation in the healthcare unit remained a concern. The Board noted that when the Care Quality Commission carry out their next inspection, they might consider the healthcare unit to be unfit for purpose.

Previous deaths at HMP Whatton

24. Mr Pitts was the 12th prisoner to die at Whatton since March 2018. All the previous deaths were from natural causes. There have been two further natural causes deaths since Mr Pitts' death.

25. In a previous investigation in October 2018, we found that staff did not immediately call an emergency medical code or enter the cell when they found a prisoner unresponsive in his cell. We recommended that staff are reminded of the national and local policies about entering a cell during medical emergencies. In response to our recommendation, the prison issued a Notice to Staff in June 2019 reiterating the Code Red and Blue policies and also the guidelines regarding entering a cell during patrol state.

Key Events

26. On 12 May 2015, Mr Ian Pitts was sentenced to 12 years in prison for sexual offences. He was sent to HMP Hewell.

27. Mr Pitts arrived into custody with pre-existing diagnoses of hypertension (high blood pressure), angina (for which he was prescribed warfarin) and type 2 diabetes. He had also previously had a stroke which had left him with mobility issues which meant he sometimes needed to use a wheelchair. Mr Pitts arrived into prison custody having already decided that he did not wish to be resuscitated if his heart or breathing stopped and had signed a DNACPR (do not attempt cardiopulmonary resuscitation) order to that effect. His prescribed medications were reviewed, and he was reviewed regularly by healthcare staff.

28. Mr Pitts transferred to HMP Whatton on 13 October 2017. A nurse carried out an initial healthscreen. She noted his pre-existing medical conditions and his prescribed medications were reviewed. He was placed under the care of the prison's long-term condition clinic to manage his diabetes and heart condition. This meant that he would be reviewed on a yearly basis.

29. Aside from routine checks by both healthcare staff and secondary care staff, Mr Pitts had little significant contact with healthcare staff in the years that followed.

30. On 14 January 2020, a nurse reviewed Mr Pitts and noted that his pulse was high, and his blood pressure was low. She carried out an ECG and the results showed that he had an increased heart rate. Mr Pitts was taken to City Hospital, Nottingham by emergency ambulance for review. He was accompanied by two prison officers and was not restrained. Following a review by hospital staff, Mr Pitts was admitted as an inpatient. He had a series of tests and the results indicated that he had angina (chest pain caused by reduced blood flow to the heart muscles that indicates a risk of heart attack or stroke). On 16 January, he was discharged from hospital and went back to Whatton.

31. On his return to Whatton, a prison GP carried out a cardiac review. A nurse also reviewed Mr Pitts and put in place an older person care plan.

32. On the evening of 23 March, Mr Pitts had a fall in his cell and cut his head. He was taken by emergency ambulance to Queens Medical Centre, Nottingham. Hospital staff carried out a CT scan and the results showed no concerns. The cut to his head was glued and he was discharged from hospital and returned to Whatton in the early hours of the following morning (24 March). When Mr Pitts returned to Whatton he was reviewed by healthcare staff and received follow up care for his head injury.

33. At 6.55am on 30 March, Officer A arrived on the wing where Mr Pitts was located for her shift. She spoke with the night patrol officer, an Operational Support Grade (OSG), who said that she had had no issues during the night. Officer A started a morning roll check prior to the OSG going off duty. She looked into Mr Pitts' cell and saw him lying on the floor with his head towards the back wall. She knocked on the door and called his name, but he did not respond. She used her radio to contact the Night Orderly Officer, a Custodial Manager (CM), and asked her permission to enter the cell with the OSG to check on Mr Pitts' well-

being. She told the Night Orderly Officer that she worked with Mr Pitts and did not consider him to be a threat to her safety. The Night Orderly Officer agreed and she immediately made her way to the cell accompanied by another officer.

34. Officer A entered the cell and tried to rouse Mr Pitts, but he was unresponsive. Shortly afterwards, the Night Orderly Officer and two officers arrived at the cell. Officer A radioed an emergency code blue (indicating a prisoner has breathing difficulties or is unconscious). She then left the cell to get the emergency grab bag (a bag containing lifesaving medical equipment) from the wing office. While she was gone, staff moved Mr Pitts to the middle of the cell. As they did so, they noticed that his face had a purple tinge and there was stiffness present in his joints (indicating that rigor mortis had set in). They considered that Mr Pitts had clearly been dead for some time and so they did not attempt cardiopulmonary resuscitation.

35. Paramedics arrived at Mr Pitts' cell at 7.23 am. At 9.07am, a prison GP confirmed that Mr Pitts had died.

Contact with Mr Pitts' Family

36. At 9.45am on 30 March, the prison appointed a family liaison officer (FLO). Due to restrictions in response to the Covid-19 pandemic, the FLO informed Mr Pitts' next of kin, his daughter, of her father's death by telephone at 11.00am. The FLO remained in contact with Mr Pitts' daughter, offering support and advice.

37. Mr Pitts' funeral was held on 16 June. In line with national guidance, the prison paid for the full cost of Mr Pitts' funeral.

Support for prisoners and staff

38. The prison posted notices informing other prisoners of Mr Pitts' 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 Pitts' death.

39. After Mr Pitts' death, the Head of Security and Intelligence debriefed the staff who were involved in the emergency response giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

Post-mortem report

40. The post-mortem report gave Mr Pitts' cause of death as acute left ventricular failure (in which the left side of the heart does not pump blood effectively) caused by ischaemic heart disease (a build-up of fatty deposits in the arteries).

41. The pathologist also concluded that Mr Pitts had hypertension (high blood pressure), atrial fibrillation (an irregular heart rate), diabetes and undiagnosed cerebrovascular disease (a condition in which the blood supply to the brain is restricted), all of which contributed to but did not cause his death.

Findings

Clinical care

42. The clinical reviewer concluded that the clinical care Mr Pitts received at Whatton was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.

43. The clinical reviewer did, however, identify some concerns.

Care plans

44. Mr Pitts did not have any care plans in place at Whatton for the day to day care of his chronic health conditions. The clinical reviewer found that while Mr Pitts had good access to healthcare services, particularly in respect of GP reviews and access to external services such as occupational therapy, his care could have been improved if he had had more holistic and individualised care plans in place to manage his conditions. We make the following recommendation:

    The Head of Healthcare should ensure that staff create and document individualised care plans for all prisoners with chronic and/or life limiting conditions.

45. The clinical reviewer also noted that a falls risk assessment and care plan completed at HMP Hewell in 2016, did not reflect Mr Pitts' presentation at Whatton and was never reviewed or updated during his time there, which is not in line with NICE guidelines. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners at risk of falling have a falls risk assessment in place which is reviewed regularly, in line with NICE guidelines.

DNACPR plans

46. Healthcare staff were not aware that a DNACPR order had been completed at Hewell. There is no evidence that the DNACPR order was ever discussed or reviewed with Mr Pitts at Whatton.

    The Head of Healthcare at HMP Hewell should ensure that all previous completed DNACPR forms accompany a patient when they are transferred to another prison.

47. The clinical reviewer has made number of additional recommendations in her report which we do not repeat here but which the Head of Healthcare will need to address.

Emergency response

48. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol which ensures an ambulance is called automatically in a life-threatening emergency. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.

49. PSO 24/2011, *Management and Security of Nights*, says that under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) and no cell will be opened unless a minimum of two/three members of staff are present, one of whom should be the NOO. However, the PSO goes on to say that the preservation of life must take precedence and that where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

50. When Officer A found Mr Pitts unresponsive in his cell on 30 April, she should have immediately called an emergency medical code blue to indicate Mr Pitts was unconscious. This would have triggered the control room to call an ambulance immediately. She should also have considered whether it was safe for her to enter the cell alone to provide immediate assistance to Mr Pitts. Instead, she radioed the NOO and asked for her permission to enter the cell, although she said she knew Mr Pitts and did not consider him a threat to her safety. Once the NOO gave permission, Officer A entered the cell and tried to rouse Mr Pitts, but he was still unresponsive. She then called an emergency code blue, which meant that there was a delay between her first seeing Mr Pitts lying unresponsive on the floor and the ambulance being called.

51. Although this did not affect the outcome for Mr Pitts, who had clearly been dead for some time when he was found, it could make a significant difference in other medical emergencies. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. In particular, staff should:

- **enter a cell where there appears to be immediate danger to life, subject to a dynamic risk assessment; and**
- **use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically.**

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

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