

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Catling, a prisoner at HMP Moorland, on 15 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 Brian Catling died on 15 October 2020 from heart failure, while a prisoner at HMP Moorland. He was 61 years old. I offer my condolences to Mr Catling's family and friends.

The clinical review into Mr Catling's death concluded that his care was of a good standard and was equivalent to that which he could have expected to receive in the community.

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

May 2021

Contents

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

Summary

Events

1. On 26 October 2016, Mr Brian Catling was sentenced to 20 years imprisonment for sex offences. On 25 November, he was sent to HMP Moorland.
2. Mr Catling was treated in prison for pre-existing diabetes and schizophrenia, and from 2019, for Parkinson's disease.
3. Mr Catling did not always take his prescribed medication and was suspected of trading it in exchange for vapes. After December 2018, he was no longer allowed to keep his medication in his cell.
4. Mr Catling's health deteriorated a little in 2020, and he found it difficult to manage his worsening Parkinson's disease symptoms. However, in the weeks before his death he gave no cause for concern and only interacted with healthcare staff to collect his medication.
5. On 15 October 2020 at 8.17am, an officer unlocked Mr Catling's cell and found Mr Catling unresponsive. Staff tried to resuscitate him but their efforts were unsuccessful and he was pronounced dead at 8.40am.
6. A post-mortem examination found that Mr Catling died from heart failure.

Findings

7. The clinical reviewer concluded that the care Mr Catling received at Moorland was equivalent to that which he could have expected to receive in the community.
8. We make no recommendations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Catling's prison and medical records.
11. NHS England commissioned an independent clinical reviewer to review Mr Catling's clinical care at the prison.
12. We informed HM Coroner for South Yorkshire (East District) of the investigation. The Coroner gave us the results of the post-mortem and toxicology examination. We have sent the Coroner a copy of this report.
13. The PPO's family liaison officer contacted Mr Catling's next of kin, his daughter, to explain the investigation and ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Background Information

HMP Moorland

15. HMP Moorland is a category C resettlement prison which holds up to 1,000 men. The Practice Plus Group (formerly Care UK) provides healthcare services at the prison, including primary care, mental health and substance misuse services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Moorland was in February 2019. Inspectors found that there had been many improvements since their previous visit in 2016. They reported that resuscitation equipment was well maintained and readily accessible to healthcare staff. They said that healthcare staff levels were a little stretched, but adequate, although only 16% of prisoners said that it was easy to see a doctor and there was over a three week wait for routine GP appointments. Steps were being taken to reduce waiting times. They found the training available to staff was impressive. They said management of long-term conditions was good and patient care was appropriately reviewed. Care plans were detailed and informed ongoing care provision. A comprehensive in-possession policy for medication existed, but inspectors recommended that in-possession risk assessments should be aligned with the policy as this was not happening in all cases.

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 February 2020, the IMB reported that they were satisfied with the healthcare services which they judged to be of a standard equivalent to those available to the community.

Previous deaths at HMP Moorland

18. Mr Catling was the fourth prisoner to die at HMP Moorland since October 2018. The previous three deaths were from natural causes. There are no significant similarities between our findings in this investigation and the other deaths.

Key Events

Background

19. On 26 October 2016, Mr Brian Catling was sentenced to 20 years imprisonment for historic sexual offences. He was moved to HMP Moorland on 25 November.
20. When he arrived in prison, Mr Catling had diabetes, depression and schizophrenia, as well as some less serious conditions. He was prescribed several medications that are available only on prescription.
21. Mr Catling had difficulty with overcoming a nicotine addiction. He traded his canteen (items bought from the prison shop) and his medication with other prisoners, in exchange for vapes. From December 2018, he was not allowed to keep his medication in his cell and had to collect it from the medication hatch. After that time, he was caught on occasion not swallowing the medicines in order to pass them to another prisoner and was sent a warning letter about this in April and August 2020.
22. In 2018, Mr Catling developed a tremor and in April 2019, he was diagnosed with Parkinson's disease. Staff monitored his condition and adjusted his medication as necessary. In 2020, the effects of the disease significantly worsened. A neurology appointment at hospital at the end of March had to be cancelled because of the COVID-19 pandemic. Because of the continuing difficulties he had with his condition, an urgent hospital referral for further assessment of his symptoms was made on 7 September 2020. There is no record of Mr Catling receiving an appointment before his death.
23. Although Mr Catling was concerned about the development of his Parkinson's disease and said that he was having some problems with his memory, in the weeks leading up to Mr Catling's death, there is no record in his medical notes of him raising any concerns. In this time, he was seen by healthcare staff daily when collecting his medication. He received regular support from the mental health team throughout his time at Moorland and this continued during the COVID-19 pandemic. In his report, the clinical reviewer noted the good supportive therapeutic relationship with his mental health nurse.
24. On 25 June, Mr Catling had a routine electrocardiogram (ECG - a machine that checks the rhythm and electrical activity of the heart), which showed an abnormality in his heart's rhythm compared to the previous year. On 7 July, staff made a hospital referral for further investigation, but noted that Mr Catling was not experiencing any chest pains or exhibiting any cardiac symptoms. There is no record of Mr Catling receiving an appointment before his death.
25. Mr Catling was at high risk of developing serious complications if he caught the COVID-19 virus. His medical records show that he was shielding from early on in the pandemic and was still shielding at the time of his death.

15 October 2020

26. At 8.17am on 15 October, an officer unlocked Mr Catling's cell so that he could collect his medications. He appeared to be asleep but when the officer called to

him, he did not respond. The officer checked him more closely and found that he was not breathing and had no pulse. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or has breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) and healthcare staff who were already in the vicinity attended quickly. Despite attempts to revive him, these were not successful and at 8.40am, ambulance paramedics pronounced that Mr Catling was dead.

Contact with Mr Catling's family

27. An officer was appointed as the family liaison officer (FLO) and he contacted Mr Catling's next of kin, his daughter, on the morning of his death. He contacted her by telephone in line with national COVID-19 protocols.
28. Moorland contributed to the costs of Mr Catling's funeral in line with national guidance.

Support for prisoners and staff

29. The Head of Residence debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising and to offer support. Staff put up notices about Mr Catling's death, which signposted support for staff and prisoners.

Post-mortem report

30. A post-mortem and toxicology examination found that Mr Catling died from congestive heart failure (the inability of the heart to pump sufficient blood around the body), caused by ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries) and coronary artery atheroma (the build-up of fatty deposits in major blood vessels in the heart, leading to a blockage). Essential hypertension (high blood pressure with no definable cause) and diabetes were also given as significant conditions that contributed to the death but did not cause it. No drugs were found apart from therapeutic levels of Mr Catling's prescription medication.

Findings

31. Mr Catling had several serious health issues. The clinical reviewer found that staff put in place satisfactory care plans for his conditions, reviewed him regularly, and made referrals to hospital as appropriate. His treatment required significant medication and this was appropriately withdrawn from in-cell possession when concerns were raised. He was supported in shielding from the coronavirus. The clinical reviewer concluded that overall, the care given to Mr Catling was equivalent to that which he could have expected to receive in the community.
32. We make no recommendations.

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