Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Whiteley, a prisoner at HMP Stocken, on 1 March 2021

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Lee Whiteley died from a pulmonary thromboembolism (a blood clot in the main arteries of the lungs) in hospital on 1 March 2021 while a prisoner at HMP Stocken. He was 41 years old. We offer our condolences to his family and friends.

4. On 29 January 2021, Mr Whiteley tested positive for COVID-19 and was transferred to Stocken's COVID-19 isolation wing. A nurse saw him on 17 February as he had a pain in his back and around his lungs but did not have any obvious COVID-19 symptoms and his clinical observations were all normal.

5. On 1 March, Mr Whiteley reported that he was having difficulty breathing. An officer called a medical emergency code, a nurse attended, and he was taken to hospital by ambulance. He died later that day.

6. The forensic pathologist who carried out Mr Whiteley's post-mortem examination said that while a pulmonary thromboembolism was a recognised complication of COVID-19, in this case the clots were typical of those forming in the leg and travelling to the lung.

7. Post-mortem toxicology results detected methadone and pregabalin in Mr Whiteley's system, but the pathologist considered that these were incidental to his death.

8. The clinical reviewer concluded that the clinical care that Mr Whiteley received at Stocken was equivalent to that which he could have expected to receive in the community. We found no non-clinical concerns and we have not made any recommendations.

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

The Investigation Process

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

11. The PPO investigator has investigated the non-clinical issues in Mr Whiteley's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

12. The Ombudsman's family liaison officer wrote to Mr Whiteley's mother to explain our investigation. She did not respond.

13. We shared the initial report with the prison service. There were two factual inaccuracies in the initial report and five factual inaccuracies in the clinical review which have been amended accordingly.

Previous deaths at HMP Stocken

14. Four prisoners died at HMP Stocken in the two years before Mr Whiteley's death: two of these deaths were from natural causes (one from COVID-19), one was self-inflicted and the cause of the other was unascertained. There has been one self-inflicted death at Stocken since Mr Whiteley's death. There are no significant similarities between our investigation findings in relation to Mr Whiteley's death and the findings in the previous investigations.

Coronavirus (COVID-19)

15. COVID-19 is an infectious disease that affects the lungs and airways. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection.

16. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak which were implemented at local level, depending on the needs of individual prisons.

17. The Ministry of Justice and Public Health England later issued joint guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*. It provides operational recommendations for custodial and healthcare staff on preventing and managing outbreaks of COVID-19, including specific advice on population management, social distancing, actions to take if a prisoner, or staff member develops symptoms, and the use of personal protective equipment (PPE). (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected or have tested positive for COVID-19 within 14 days.)

18. After a period of lockdown, the Ministry of Justice and HM Prison and Probation Service produced *COVID-19: National Framework for Prison Regimes and Services.* This outlines strategies for easing restrictions and modifying regimes, where severe constraints are disproportionate or unsustainable. Prisons are expected to devise local policies within the parameters of the framework.

Key Events

19. In November 2002, Mr Lee Whiteley was sentenced to life in prison for murder. On 19 March 2020, he was transferred to HMP Stocken. He had no significant health issues.

20. On 28 January 2021, a nurse saw Mr Whiteley because he felt unwell. Mr Whiteley said that he felt hot, his body ached, and he was short of breath. She noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) indicated that he was at low clinical risk.

21. On 29 January, Mr Whiteley tested positive for COVID-19, but his temperature was normal. That day, a prison governor issued a Community Notice to inform prisoners that there was a COVID-19 outbreak on the wing where Mr Whiteley lived. Eight other prisoners also tested positive for COVID-19.

22. On 30 January, a nurse assessed Mr Whiteley's COVID-19 risk as low, given his age, and that he had no known underlying health conditions. He was transferred to the COVID-19 isolation wing.

23. On 17 February, a nurse saw Mr Whiteley because he had a pain in his back and around his lungs. He did not, however, have any obvious COVID-19 symptoms. The nurse noted that his chest was clear. Mr Whiteley's physical observations were within the normal range. His NEWS score was a 0 which indicates a very low risk of clinical deterioration. The nurse thought that Mr Whiteley's pain was musculo-skeletal, possibly caused by previous coughing from the COVID-19 infection. He told Mr Whiteley to contact healthcare staff if his symptoms worsened.

24. There is no evidence that Mr Whiteley contacted healthcare again after this. Healthcare staff saw him daily when he went to collect his medication and no concerns were raised.

25. At 11.57am on 1 March, Mr Whiteley pressed his cell bell. An officer responded and opened the door. Mr Whiteley was sitting on his bed and told the officer that he was struggling to breathe. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing and triggers the control room to call an ambulance immediately).

26. A nurse went to Mr Whiteley's cell and saw that he was having difficulty breathing. He noted that Mr Whiteley's temperature was normal, but his blood pressure, pulse and respiratory rates were high, and his blood oxygen saturation level was low. The nurse noted that Mr Whiteley's NEWS score indicated that he should be referred urgently to hospital. Mr Whiteley was sent by ambulance to hospital, where he died at 11.29pm.

27. A post-mortem examination established that he died from a pulmonary thromboembolism (a blood clot in the main arteries in the lungs).

Sue McAllister CB
Prisons and Probation Ombudsman **November 2021**

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