Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Wotton, a prisoner at HMP Durham, on 25 May 2021

A report by the Prisons and Probation Ombudsman

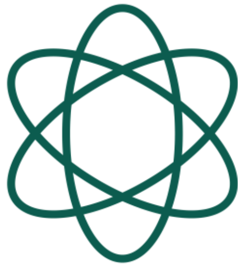
Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 Ronald Wotton died on 25 May 2021 of colon cancer at HMP Durham. He was 80 years old. I offer my condolences to Mr Wotton's family and friends.

The clinical reviewer concluded that the clinical care Mr Wotton received at HMP Durham was of a good standard and equivalent to that which he could have expected to receive in the community.

I am concerned that there was a failure to inform the Coroner of Mr Wotton's death. The Coroner was not aware until 1 June. The next of kin was called to identify Mr Wotton's body two weeks after he had died. This caused Mr Wotton's family unnecessary and preventable distress. I am also concerned that the information the next of kin received from the family did not have a point of contact when the prison's family liaison officer went on leave, and that the family was not offered a contribution to the funeral costs.

I am particularly frustrated and disappointed that I am making another recommendation about the inappropriate use of restraints. The Governor must tell us what further steps he will take to ensure that frail and very unwell prisoners are not inappropriately restrained in the future.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **July 2022**

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Summary

Events

1. On 14 December 2020, Mr Ronald Wotton was sentenced to 16 months in prison for sexual offences. He was sent to HMP Durham. It was not his first time in prison.

2. Mr Wotton had multiple health conditions, including colitis (an inflammation of the bowel).

3. On 18 March 2021, at around 2.15pm, Mr Wotton became unwell with suspected sepsis and he needed to go to hospital for treatment. The prison was unable to facilitate Mr Wotton's transfer to hospital because there were no escort staff available.

4. At around 8.00pm, Mr Wotton's condition worsened, and Mr Wotton was taken to hospital by emergency ambulance. He was diagnosed with urinary sepsis and pneumonia. He was treated and returned to Durham on 29 March.

5. On 28 April, Mr Wotton was admitted to hospital due to a 'flare up' of his ulcerative colitis. His health continued to deteriorate in hospital and he received palliative care only.

6. On 19 May, Mr Wotton was discharged back to Durham. He had an advance palliative care plan in place along with medication for end of life care.

7. At 11.00pm on 25 May, it was confirmed that Mr Wotton had died.

Findings

8. The clinical reviewer concluded that the clinical care Mr Wotton received at HMP Durham was of a good standard and equivalent to that which he could have expected to receive in the community. However, she made some recommendations about secondary health screenings and isolation and shielding due to COVID-19, to improve overall care.

9. We are concerned that when a prison GP considered Mr Wotton needed to go to hospital to receive treatment for suspected sepsis (a life threatening condition) on 18 March, the GP was told this was not possible because there were no prison staff available to accompany him. This meant that Mr Wotton did not receive treatment as quickly as he should have done.

10. We are also concerned that the decision to restrain Mr Wotton when he was taken to hospital on 13 May, and to keep him in restraints for six days, was unsound given his advanced age and poor mobility.

11. We are concerned that neither the police nor the prison notified the Coroner of Mr Wotton's death. This meant that Mr Wotton's funeral was delayed and that his next of kin had to identify Mr Wotton's body 15 days after he died.

12. The prison’s family liaison officer went on leave five days after Mr Wotton’s death. This meant that there was a period of around two weeks when the next of kin had difficulty contacting anyone at the prison for support and advice. There was also poor communication over the prison’s contribution to the cost of Mr Wotton’s funeral.

Recommendations

- The Governor should ensure that there are sufficient staff available to escort prisoners who need to go to hospital urgently.
- The Governor and Head of Healthcare should ensure that:
    - healthcare staff fully and accurately reflect the current health and mobility of a prisoner when they complete the medical section of an escort risk assessment; and
    - all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that the Death in Custody Contingency plans include instructions on how the inform the Coroner of a death in the absence of the police.
- The Governor should ensure that when a prisoner dies in custody, a deputy family liaison officer is appointed and all contact with a next of kin is recorded to provide continuity of support in the absence of the designated family liaison officer.
- The Governor should ensure that in line with PSI 64/2011:
    - an appropriate contribution is now made to Mr Wotton’s family to cover the reasonable costs of his funeral; and
    - FLOs are reminded to offer to contribute towards funeral costs promptly when there is a death in custody.
- The Governor should share this report with the Head of Security and with the Family Liaison Officer to ensure they are aware of the Ombudsman’s findings.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator interviewed two members of staff on 25 May and 18 August. The interviews were conducted by telephone because of the COVID-19 restrictions.

15. NHS England commissioned an independent clinical reviewer to review Mr Wotton's clinical care at HMP Durham.

16. We informed HM Coroner for Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The PPO family liaison officer wrote to Mr Wotton's next of kin, his nephew, to explain the investigation. He had concerns about Mr Wotton's weight management; difficulty contacting anyone at the prison; having to identify Mr Wotton's body 15 days after he died; and the errors which delayed Mr Wotton's funeral. These concerns are addressed in this report or in the clinical review.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

19. We sent a copy of our initial report to Mr Wotton's next of kin. They did not notify us of any factual inaccuracies.

Background Information

HMP Durham

20. HMP Durham, which holds up to 1,000 prisoners, is a local prison serving the courts of Durham, Tyneside and Cumbria. Spectrum Community Health CIC provides primary nursing, GP, clinical substance misuse, pharmacy and sexual health services. Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Durham was in 2018. Inspectors reported that the prison did not focus sufficiently on identifying prisoners' immediate vulnerabilities, needs or risks during reception screening and first night processes. They also recommended that the prison introduce a systematic, prison-wide strategy to promote prisoner well-being and that prisoners with long-term health conditions should receive personalised care planning.

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 31 October 2020, the IMB asked when secondary health screening would be reintroduced and commented on inconsistencies in the allocation of prison staff to inpatient healthcare.

Previous deaths at HMP Durham

23. Mr Wotton was the 14th prisoner to die at HMP Durham since May 2019. Of the previous deaths, six were from natural causes, five were self-inflicted and two were drug-related.

24. We have previously made recommendations about the lack of secondary health screenings at Durham. This is the fifth time we have made this recommendation in the last two years. We recommended that the prison should ensure that a second stage health screen is completed within seven days of the first health screen in line with NICE Guidance *Physical Healthcare for Prisoners*. In July 2020, the prison accepted our recommendation and said that a baseline audit would be completed to assess the uptake of secondary screenings and establish any root cause for patients not having or being offered second reception screens. Service user feedback would also be sourced.

25. We have also previously made recommendations about the use of restraints. This is the fourth time we have made this recommendation in the last two years. We were particularly concerned that the medical sections on the escort risk assessments had not been completed and that the prison's decision to restrain a prisoner who was elderly, had multiple health problems, and poor mobility, was flawed. The prison accepted our recommendations and said that updated guidance from the Security Risk Unit at HMPPS was issued (in November 2019) about the use of restraints for hospital escorts. This was communicated to all staff and managers via daily

briefing and a Notice to Staff. The prison also said that the Head of Healthcare would formally request that the relevant prison representative develop an information aid which explains the legal position for staff completing and authorising risk assessment on the use of restraints which would be shared with all staff across the North East Prison Cluster.

26. It is disappointing that we are having to highlight the same concerns in this report. The Governor must tell us what further steps he will take to ensure ill prisoners with poor mobility are not inappropriately restrained in the future.

Key Events

27. On 14 December 2020, Mr Ronald Wotton was sentenced to 16 months in prison for sexual offences. He was sent to HMP Durham. It was not his first time in prison.

28. Mr Wotton had a number of existing health issues, including cancerous tumours in his groin (diagnosed 2013) and pelvic bone (diagnosed 2014), colitis (an inflammation of the bowel, diagnosed 2007) and ischemic heart disease (diagnosed in 2004).

29. On 19 January 2021, Mr Wotton received a letter from Public Health England advising him that he was clinically extremely vulnerable and at high risk of becoming seriously ill if he contracted COVID-19. This risk was appropriately managed by the prison and Mr Wotton was fully vaccinated prior to his death.

30. On 18 March, Mr Wotton became unwell with suspected sepsis (a life-threatening reaction to an infection). At around 2.15pm, a prison GP considered Mr Wotton needed to go to hospital for treatment. Prison staff told the GP that Mr Wotton could not go to hospital as there were no escort staff available.

31. The GP recorded in Mr Wotton's medical records that he spoke to the Duty Governor around 3.30pm and outlined his concerns about Mr Wotton's safety if he did not go to hospital. The Duty Governor said that there were no escort staff available, so the GP 'reluctantly agreed' that Mr Wotton could go to hospital the next morning. It was also agreed that Mr Wotton would be escorted to hospital if his condition deteriorated.

32. Mr Wotton's health deteriorated and at around 8.00pm, he became acutely unwell. A nurse called an ambulance via the control room and Mr Wotton was taken to hospital by emergency ambulance. He was admitted to hospital where he was diagnosed with pneumonia and urinary sepsis. He remained in hospital for treatment until 29 March, when he returned to Durham.

33. On 15 April, Mr Wotton was taken to hospital again by emergency ambulance. He was presenting as confused and had a NEWS2 score of 10. (NEWS2 is a nationally recognised tool to facilitate the early detection of deterioration in health. A NEWS2 score of 7 or higher indicates emergency assessment by critical care team is required.) Mr Wotton was discharged from hospital and returned to Durham on 21 April with a course of oral antibiotics.

34. On 28 April, Mr Wotton was taken to hospital by emergency ambulance again, because he had a NEWS2 score of 9. He was diagnosed with a 'flare up' of his ulcerative colitis. He was treated and given medication and discharged back to Durham on 5 May.

35. On 12 May, the GP reviewed Mr Wotton and noted that his health had deteriorated and that he might now be considered for end of life care.

36. On 13 May, Mr Wotton was taken to hospital by emergency ambulance due to an increase in rectal bleeding. He was escorted by two prison officers and restrained using an escort chain. He was admitted to hospital due to another 'flare up' of his

ulcerative colitis. His health continued to deteriorate in hospital. The escort chain was removed at 6.20pm on 18 May.

37. On 19 May, the hospital contacted prison healthcare staff and told them that Mr Wotton was now receiving palliative care only, due to his age and the serious nature of his existing health conditions. Mr Wotton said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

38. On 21 May, he was discharged from hospital and went back to Durham. He had an advance palliative care plan in place, along with medication for end of life care. On the same day, the prison appointed a family liaison officer (FLO). The FLO contacted Mr Wotton's next of kin to inform him of Mr Wotton's deteriorating health.

39. On 24 May, Mr Wotton's next of kin visited him in the prison. They met with the Head of Healthcare. Mr Wotton, supported by his family, said that he felt he was in the right place and did not want to make an application for compassionate release.

40. On 25 May, healthcare staff checked Mr Wotton every two hours. In the afternoon, the Roman Catholic chaplain gave him the last rites. At 11.00pm, a healthcare support worker checked Mr Wotton and found that he was not breathing. A nurse confirmed that Mr Wotton had died.

Informing the police and Coroner of Mr Wotton's death

41. Following Mr Wotton's death on 25 May, an officer called the police to inform them of his death. The police said that they would not be attending the prison because Mr Wotton's death was not considered to be suspicious. The officer challenged this, but the police said that they would not attend and told the prison to contact the funeral directors.

42. At 2.00am on 26 May, the undertakers arrived at the prison to take Mr Wotton to a funeral home. They initially refused to take Mr Wotton as the body had not been formally identified and tagged by the police. A prison officer contacted the police again but the police said that they would not be attending.

43. An officer went to the healthcare unit to assist the funeral directors. He went to the prison reception, got two wrist bands and wrote Mr Wotton's details on them. He gave them to the undertakers to attach to Mr Wotton's body. The undertakers were satisfied and took the body.

44. The Coroner's office was not aware of Mr Wotton's death until 1 June, when Mr Wotton's nephew told them. The Coroner called Mr Wotton's nephew to identify Mr Wotton's body two weeks after he had died.

Liaison with Mr Wotton's family

45. When Mr Wotton died on 25 May, an officer called Mr Wotton's nephew to inform him of Mr Wotton's death and offered her condolences on behalf of the FLO.

46. On 26 May, the FLO telephoned Mr Wotton's family and offered her condolences and support. On 28 May, Mr Wotton's nephew's wife came to the prison to collect his property.

Post-mortem report

47. The Coroner concluded that Mr Wotton died of carcinoma of the caecum (colon cancer) caused by chronic ulcerative colitis (inflammation of the bowel). He also had ischaemic heart disease which did not cause but contributed to his death.

Findings

Insufficient escort staff available

48. We are very concerned that on 18 March, when Mr Wotton became unwell with suspected sepsis, a life threatening condition, he was unable to go to hospital for treatment because there were no prison escort staff available. Healthcare staff outlined their concerns about Mr Wotton's safety if he did not go to hospital but 'reluctantly agreed' that should go to hospital the next morning. However, his condition quickly deteriorated, and he had to be taken to hospital by emergency ambulance that evening and remained in hospital for 11 days. We are concerned that Mr Wotton did not receive the treatment he needed as quickly as he should have done. We make the following recommendation:

    The Governor should ensure that there are sufficient staff available to escort prisoners who need to go to hospital urgently.

Restraints, security and escorts

49. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

50. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. These requirements are reflected in Prison Service Instruction (PSI) 33/2015 on external prisoner movements.

51. The medical section of the risk assessment for Mr Wotton's last journey to hospital on 13 May 2021, recorded that Mr Wotton was in a wheelchair and that there were no cuffing restrictions. The security assessment noted that Mr Wotton was a category C prisoner who was a medium risk to the public and hospital staff and a low risk of hostage taking and escape. A prison manager decided that Mr Wotton should be restrained and accompanied by two escorting officers for the journey and treatment. The restraints were removed on 18 May.

52. In interview, the authorising manager said that he made the decision to use an escort chain to restrain Mr Wotton due to the risk of harm he posed to staff and others, in particular, females. The authorising manager acknowledged that Mr Wotton was in a wheelchair but said that he did not consider someone being in a wheelchair prevented their ability to cause harm, without knowing why they were in a wheelchair. He said he also took into account that Mr Wotton had been verbally and physically abusive to prison and healthcare staff at Durham on occasions.

53. We are concerned that the medical section of the risk assessment did not clearly set out the details of Mr Wotton's current level of health and mobility so that the authorising manager could make an informed decision about the appropriateness of restraints. It is not sufficient to say that the prisoner is a wheelchair user as this does not give sufficient detail about the prisoner's level of mobility. The medical section should also have said that Mr Wotton was very frail and ill and was reaching the end of his life.

54. We also question whether Mr Wotton should have been assessed as a 'medium' risk to the public, given his ill health and his age. Although he had been very verbally abusive to hospital nurses during previous hospital admissions, we do not consider that verbal abuse in itself justifies the use of restraints. Hospital staff are used to dealing with people who are abusive and aggressive when they are confused and ill and Mr Wotton was accompanied by two escort officers. In the circumstances, we question whether the use of any restraints was proportionate when he was escorted and then admitted to hospital on 13 May and whether it was necessary for him to remain in restraints for six days. We consider that the authorising manager's decision to use restraints was unsound.

55. We are concerned that we are having to repeat our recommendation from our previous investigation at Durham where we found a similar inappropriate use of restraints. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **healthcare staff fully and accurately reflect the current health and mobility of a prisoner when they complete the medical section of an escort risk assessment; and**
- **all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

Informing the police and Coroner of Mr Wotton's death

56. Since Mr Wotton's death, the Coroner's Office and the prison have raised their concerns with the police about their refusal to attend the prison when Mr Wotton died. The police apologised for failing to attend.

57. The Coroner's Office told the investigator that they would usually expect to be informed of a death in prison by the police and, in our experience, this is what usually happens. However, Prison Service Instruction (PSI) 64/2011, Safer Custody, says that 'following a death in custody the prison…must promptly notify…the coroner'. Ultimately, the prison has the responsibility to inform the coroner of any deaths and must have contingency plans in place to ensure that the Coroner is promptly informed if the police are unable to attend a death in custody in future. We recommend:

The Governor should ensure that the Death in Custody Contingency plans include instructions on how the inform the Coroner of a death in the absence of the police.

Liaison with Mr Wotton’s family

58. Mr Wotton’s nephew said that he had difficulty in contacting the prison FLO and, that after they collected Mr Wotton’s property on 28 May, the FLO did not contact the family again until 15 June. The FLO said that she was on annual leave from 30 May for a week, and after that she was attending training outside the prison.

59. Bereaved families are going through a very difficult and emotional process and may rely on family liaison officers for support and information. We consider that a deputy liaison officer should have been appointed to cover the FLO’s absence and support the family, especially as Mr Wotton only died five days before she was due to go on leave. It is important that the prison have contingency plans in place to cover staff absences and that they maintain effective contact with the bereaved family. We make the following recommendation:

    The Governor should ensure that when a prisoner dies in custody, a deputy family liaison officer is appointed and all contact with a next of kin is recorded to provide continuity of support in the absence of the designated family liaison officer.

60. We are also concerned that there was poor communication over the prison’s contribution to the cost of Mr Wotton’s funeral. The FLO said that she understood the Head of Healthcare had discussed the prison’s funeral contributions with the next of kin. However, the Head of Healthcare said she had never discussed this with the family. We consider that it is the responsibility of the FLO to have this discussion and to ensure that the payment is made. The FLO has been unable to locate any records to demonstrate that any funeral payments were made. We make the following recommendation:

    The Governor should ensure that in line with PSI 64/2011:

    - **an appropriate contribution is now made to Mr Wotton’s family to cover the reasonable costs of his funeral; and**
    - **FLOs are reminded to offer to contribute towards funeral costs promptly when there is a death in custody.**

Learning Lessons

61. We consider it important that staff learn lessons from our investigations. We, therefore, recommend:

    The Governor should share this report with the Head of Security and with the Family Liaison Officer to ensure they are aware of the Ombudsman’s findings.

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