

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Dennis White,
a prisoner at HMP Moorland,
on 17 December 2020**

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

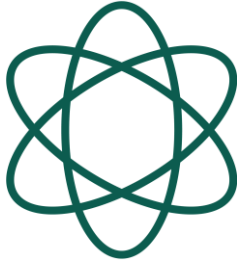
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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

OGL

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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 Dennis White died in hospital from bronchopneumonia on 17 December 2020 while a prisoner at HMP Moorland. He was 88 years old. I offer my condolences to Mr White's family and friends.

Mr White had limited mobility and was in poor health. The clinical reviewer concluded that the clinical care he received before September 2019 was equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer was concerned that there were a number of system failures at HMP Moorland that led to Mr White receiving poor physical and diabetic care. She concluded that the physical and diabetic care Mr White received after September 2019, was not 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

April 2022

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Summary

Events

1. On 23 October 2015, Mr Dennis White was sentenced to life imprisonment for sexual offences. He transferred to HMP Moorland on 2 November 2016.
2. Mr White had several longstanding medical conditions. Prison healthcare staff monitored his conditions and facilitated specialist care.
3. In September 2019, a hospital endocrinologist wrote to healthcare staff at Moorland and recommended that Mr White should commence insulin. Mr White was never prescribed insulin. In May 2020, hospital specialists reminded healthcare staff that Mr White needed to take insulin. Prison GPs were tasked to arrange this. There is no recorded evidence that this was done.
4. On 28 November, a senior pharmacy technician noted that Mr White's health had deteriorated significantly. A nurse saw him and sent him to hospital for review. Mr White was treated for diabetic ketoacidosis.
5. While in hospital on 8 December, Mr White tested positive for COVID-19. His condition deteriorated and on 17 December it was confirmed that Mr White had died.
6. The Coroner concluded in the post-mortem that Mr White died of bronchopneumonia caused by chronic obstructive pulmonary disease (lung disease).

Findings

7. The clinical reviewer concluded that until September 2019, the care Mr White received at Moorland was equivalent to that which he could have expected to receive in the community.
8. The clinical reviewer did, however, find some shortcomings in the management of Mr White's physical care and diabetes care from September 2019 onwards.
9. She was concerned that healthcare staff failed to prescribe insulin to Mr White when recommended by his hospital consultant. Also, there is no recorded evidence that alternatives to insulin were considered and discussed with him.
10. In addition, the clinical reviewer found several examples of poor record keeping as healthcare staff failed to fully update Mr White's medical record to reflect the care and treatment he received.
11. The prison was unable to provide the PPO with a number of documents, including the escort risk assessments, prisoner escort record and bedwatch logs.

Recommendations

- The Head of Healthcare should ensure that there is a robust management plan for actioning care instructions from hospital consultants and an immediate audit of long-term patients is undertaken.
- The Head of Healthcare should ensure that all events relating to contact with a prisoner are fully and accurately recorded in the SystemOne record.
- The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.
- The Head of Healthcare at HMP Moorland should share this report with all healthcare staff named in it, including GPs, so that they are aware of the Ombudsman's and the clinical reviewer's findings.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr White's prison and medical records.
14. The investigator interviewed five members of staff over the telephone on 28 July and 13 August 2021. The interviews were conducted by telephone because of the COVID-19 restrictions in place.
15. NHS England commissioned a clinical reviewer to review Mr White's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff via telephone on 13 August.
16. We informed HM Coroner for South Yorkshire East 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 Ombudsman's family liaison officer contacted Mr White's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Moorland

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

HM Inspectorate of Prisons

20. 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. A strategic approach to health promotion had been developed and bespoke events took place throughout the year. Reception screening identified individuals who needed ongoing help and advice and healthcare referrals were made appropriately. An appropriate range of primary health services and secondary care services was available.

Independent Monitoring Board

21. 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 published in August 2021, the IMB reported that despite COVID-19 and the resulting impact on healthcare provision, they were satisfied that everything possible had been done to maintain essential services and to minimise the risk of infection.

Previous deaths at HMP Moorland

22. Mr White was the ninth prisoner to die at HMP Moorland since December 2018. Of the previous deaths seven were from natural causes and one was drug related. There are no similarities between our findings in the investigation into Mr White's death and our investigation findings for the previous deaths.

COVID-19 (coronavirus)

23. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
24. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (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.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the

main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

25. On 23 October 2015, Mr Dennis White was sentenced to life imprisonment for sexual offences. On 2 November 2016, he transferred to HMP Moorland.
26. Mr White had a number of pre-existing long-term conditions including type 2 diabetes, osteoarthritis, history of bowel cancer, bladder dysfunction, high blood pressure, tubular adenoma (clumps of cells in the colon), perforated ear drum, anaemia, foot ulcer and weight loss. He also had limited mobility from arthritis. Healthcare staff created care plans and had contact with him frequently to receive his prescribed medications to manage his conditions.
27. Mr White attended appointments at the Endocrinology Department at Doncaster Royal Infirmary to manage his type 2 diabetes. He took tablets to help control his type 2 diabetes. In September 2019, a hospital endocrinologist reviewed Mr White and in a letter to prison healthcare staff recommended that Mr White should start taking insulin because his blood test results showed elevated sugar levels.
28. On 10 December a prison GP acknowledged sight of the hospital letter. She planned to refer Mr White to the Multi Professional Complex Case Conference (MPCC) and for a pharmacy representative or diabetes nurse to train him and monitor his condition.

2020

29. On 12 January 2020, a nurse saw Mr White for a diabetic review. Mr White told her that in September 2019, a hospital consultant told him that he would be on tablets to control his diabetes rather than insulin, but he had never received them. She sent a task for a prison GP to note and arrange to see Mr White for a diabetic review.
30. On 16 January, a nurse noted that Mr White had still not had a review about commencing insulin. She checked again on 30 January and noted that the prison GP still had not seen Mr White. Mr White was reluctant to take insulin due to his age and was doubtful if he would be able to maintain frequent blood sugar level checks.
31. On 6 February, a prison GP saw Mr White to discuss his decision not to use insulin but take tablets instead. She prescribed blood pressure medication (ramipril) and noted that his last sugar level check was in October 2020. She arranged for another sugar level check. The results showed that Mr White had poor diabetic control.
32. A nurse completed another diabetic review on 27 February. She noted that Mr White's sugar levels needed to be checked in 12 weeks because they were still raised. Mr White continued with oral diabetic medication.
33. On 10 March, a locum prison GP saw Mr White. Mr White told her that he did not want to take insulin as he would manage his diabetes through diet.

34. In April, Mr White complained about a sore toe on his left foot, which developed into an ulcer. Healthcare staff tried to manage the ulcer with cleaning and changing the dressings.
35. On 14 May, the hospital diabetic specialist nurse rang a prison nurse to discuss Mr White's diabetes management. The hospital nurse said that Mr White should start taking insulin as his sugar levels were very high. The prison nurse noted that a prison GP needed to see Mr White and discuss this with him. In June, Mr White had a routine blood test. The result showed that he was anaemic.
36. On 23 September, Mr White missed a telephone appointment with an endocrinologist at Doncaster Royal Infirmary because healthcare staff failed to book the appointment in the healthcare appointments system.
37. On 30 October Mr White had a COVID-19 test because other prisoners on his wing had tested positive. Mr White's result was negative, but he isolated for 14 days.
38. By November, Mr White was still experiencing problems with the sore on his toe. His foot was red up to his ankle. A prison GP prescribed antibiotics and made a referral to the diabetic foot clinic. A nurse sought advice from hospital specialists about Mr White's sores. The hospital tissue viability nurse told the prison nurse that staff should follow the prison's local protocol for managing a diabetic ulcer. However, Mr White developed a new ulcer on the ball of his right foot. At this time there was an outbreak of COVID-19 on Mr White's wing. This would have meant there was limited access to the wing. Healthcare staff did not record how Mr White's wounds were cleaned and dressed in these circumstances.
39. On 24 November, Mr White slipped in his cell while trying to get to the toilet. Officers radioed an emergency code blue. Control room staff called an ambulance immediately. A nurse went to Mr White's cell and noted that he did not have any injuries. She checked his observations and his blood pressure, blood sugar, heart rate and ketone levels were all raised. His respiratory rate, temperature and oxygen saturations were normal. Staff arranged for his transfer to hospital. Hospital staff diagnosed diabetic ketoacidosis and Mr White returned to Moorland the next day.
40. On 27 November, the hospital endocrinologist told a prison nurse that Mr White should commence insulin. The nurse tasked a prison GP to prescribe this. The next day, a senior pharmacy technician saw Mr White in his cell to give him his medication. The technician noted that Mr White was unable to take his medication, struggled to take any fluids and had not eaten for several days. The technician asked a senior nurse to see Mr White. A nurse saw Mr White and noted that his heart rate was elevated, his temperature was very low, and his blood pressure and respiratory rate were within the normal range. She sent Mr White to hospital by emergency ambulance. In hospital, Mr White was treated for diabetic ketoacidosis.
41. While in hospital on 8 December, Mr White tested positive for COVID-19. He signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which meant that if his heart or breathing stopped no attempt at resuscitation would be made.
42. Mr White's condition continued to deteriorate in hospital and on 17 December, it was confirmed that Mr White had died.

Contact with Mr White's family

43. On 12 December, the prison appointed a family liaison officer (FLO). The FLO attempted to contact Mr White's family by telephone over several days to advise them that he was seriously ill in hospital but there was no response. When Mr White died, the police visited Mr White's son to break the news of his death. The FLO then contacted Mr White's son to offer his condolences and support.
44. Mr White's funeral was held on 6 April 2021. The prison contributed towards the costs of the funeral in line with national guidance.

Support for prisoners and staff

45. After Mr White's death, the Head of Security debriefed the escort staff to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
46. The prison posted notices informing other prisoners of Mr White's 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 White's death.

Post-mortem report

47. The Coroner concluded that Mr White died of bronchopneumonia caused by chronic obstructive pulmonary disease (lung disease). Mr White also had diabetes, high blood pressure and ischaemic heart disease (narrowing of the arteries) which did not cause but contributed to his death.

Findings

Clinical care

48. The clinical reviewer concluded that until September 2019, the management of Mr White's long-term conditions was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that there were many aspects of Mr White's physical healthcare that were comprehensive and referrals to secondary care under the two-week cancer pathway were managed effectively.
49. The clinical reviewer did, however, find some shortcomings in the care Mr White received and concluded that from September 2019 his physical healthcare and diabetes care was not equivalent to that which he could have expected to receive in the community.
50. In addition, the clinical reviewer found that there was poor communication, poor record keeping, unactioned tasks and failure to administer vital medication in a timely manner.

Diabetic management

51. Prison Service Order (PSO) 3050, *Continuity of Healthcare for Prisoners*, gives guidance on the clinical management of prisoners and emphasises the importance of continuity in the success of clinical interventions and treatment. There should have been a plan for Mr White's diabetic care with good, clear, holistic care plans, which should have been communicated within the healthcare team.
52. Mr White's diabetes was unstable for a significant period of time. The clinical reviewer said that problems with his diabetic management began from the end of 2019 and that his physical health started to deteriorate from 2020.
53. When hospital specialists recommended that Mr White should start taking insulin, prison healthcare staff did not follow this through. Healthcare staff saw the hospital letter outlining the request and tasks were created within his medical record. However, these went unactioned. By the time healthcare staff noticed this omission Mr White declined to take insulin. Medical records show that healthcare staff had discussions with Mr White about the risks of not taking insulin, but these discussions were not fully documented, and Mr White did not sign any disclaimers.
54. Mr White developed a diabetic foot ulcer. The clinical reviewer noted that from 30 October to 15 November 2020, there was no record to indicate that his wound was being cleaned and dressed.
55. The clinical reviewer also found that Mr White's blood pressure medication was not prescribed until nearly five months after it had been recommended. She considered that a record of discussions about his blood tests and blood pressure could have prompted healthcare staff to better assess any improvements or deterioration in his condition. The clinical reviewer considered that these were missed opportunities to explore and document Mr White's medical history and signpost him to other specialist services.

56. At interview, the Head of Healthcare acknowledged the shortcomings in relation to Mr White's diabetic care and said that the healthcare team had started to implement the necessary changes to prevent this from happening again. To build upon these changes, we make the following recommendation:

The Head of Healthcare should ensure that there is a robust management plan for actioning care instructions from hospital consultants and that an immediate audit of long-term patients is undertaken.

Record keeping

57. The General Medical Council (GMC) says that clinical records should include relevant clinical findings; decisions made and actions agreed, who is making the decisions and agreeing the actions; information given to patients; any drugs prescribed or other investigation or treatment; and details of who is making the record and when it was made.

58. The clinical reviewer was concerned that healthcare staff failed to keep Mr White's medical records up to date with the contact, care and treatment he received for his physical and diabetic care, which is not in line with GMC advice. We recommend:

The Head of Healthcare should ensure that all events relating to contact with a prisoner are fully and accurately recorded in the SystemOne record.

59. The clinical reviewer has made several other recommendations about record keeping, which we do not repeat in this report but which the Head of Healthcare will need to address.

Missing paperwork

60. The investigator asked for the last escort risk assessment, prisoner escort record (PER) and bed watch logs. The prison said they could not locate all of the documents. They provided a copy of the incomplete initial risk assessment.

61. We are concerned that the prison was unable to provide us with any escort risk assessments, PERS or bedwatch logs. These records can provide crucial evidence for investigations, and we would expect the prison to ensure that evidence is preserved following a death in custody to enable appropriate scrutiny and accountability. We are therefore unable to comment on the use of restraints and the events when Mr White left the prison for hospital. We make the following recommendation:

The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

Learning lessons

62. We consider it essential that staff learn the lessons from our reports. We therefore recommend that:

The Head of Healthcare at HMP Moorland should share this report with all healthcare staff named in it, including GPs, so that they are aware of the Ombudsman's and clinical reviewer's findings.

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