Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Whitcombe, a prisoner at HMP Gartree, on 17 December 2021

A report by the Prisons and Probation Ombudsman

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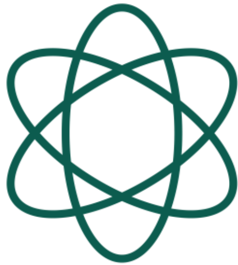
Our vision

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

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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 Michael Whitcombe died in hospital of multi-organ failure caused by COVID-19 pneumonitis on 17 December 2021, while a prisoner at HMP Gartree. He also had tension pneumothorax (a collapsed lung) which contributed to but did not cause his death. He was 72 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the care that Mr Whitcombe received at HMP Gartree was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She made a number of recommendations which the Head of Healthcare will need to address.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that when healthcare staff receive COVID-19 test results, they record the results in the prisoner's SystmOne medical record.

- The Head of Healthcare should ensure that in line with National Institute for Health and Care Excellence (NICE) guidelines, a falls risk assessment is in place for prisoners who are at risk or have a history of falls.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Whitcombe's clinical care at HMP Gartree.

7. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Whitcombe's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.

8. The Ombudsman's family liaison officer wrote to Mr Whitcombe's next of kin, his friend, to explain the investigation and ask if there were any issues she wanted us to consider. She did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Gartree

10. Mr Whitcombe was the seventh prisoner to die at Gartree since December 2019. Of the previous deaths, three were from natural causes (two were due to COVID-19) and three were self-inflicted. There have been two further deaths since Mr Whitcombe's death, both of which were related to COVID-19.

COVID-19 (coronavirus)

11. 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.

12. COVID-19 can make anyone seriously ill, but some people are clinically vulnerable to developing severe illness and complications from the infection.

13. 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. 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).

14. On 17 September 2021, the Government advised that it was no longer necessary for the clinically vulnerable to shield as vaccination had reduced the risk to them.

Key Events

15. On 1 April 2009, Mr Michael Whitcombe was sentenced to life imprisonment for murder and perverting the course of justice. On 4 April 2018, he was transferred to HMP Gartree.

16. At his initial and secondary health screens, it was recorded that Mr Whitcombe had a nasal polyp and unexplained dizziness. Mr Whitcombe's contact with the healthcare department was largely for medication and to arrange hospital referrals to investigate his dizzy spells and frequent falls.

2020

17. At the start of the COVID-19 pandemic in March 2020, Mr Whitcombe had been assessed as being at high risk of developing complications from COVID-19, primarily because of his age. He was advised to shield, but he declined and signed a disclaimer to confirm that he understood the risks of not shielding.

18. In April, Mr Whitcombe attended a hospital appointment, and tests showed that he had an irregular heart rhythm, but this did not explain his dizziness.

19. In June, Mr Whitcombe had intermittent blackouts and falls. Healthcare staff made a routine referral for a neurology appointment. In August, he was still waiting for the neurology appointment, but he had an increased number of falls and complained of morning headaches. Healthcare staff referred him urgently for further tests.

20. Mr Whitcombe had a magnetic resonance imaging (MRI) scan and electrocardiogram test (ECG) in September. The test results did not show anything of concern to explain his falls and dizziness but identified a large nasal polyp.

2021

21. On 10 February 2021, Mr Whitcombe refused to attend a hospital appointment for his nasal polyp.

22. On 26 February, Mr Whitcombe received his first COVID-19 vaccine and his second one on 29 April.

23. In April, Mr Whitcombe complained of ongoing headaches. A prison GP considered that the headaches were possibly due to the nasal polyp and prescribed nasal drops. Mr Whitcombe continued to have falls. In August, a prison GP noted that he had been unsteady on his feet for at least three years. He prescribed more nasal drops.

24. In October, Mr Whitcombe had another GP review. The prison GP concluded that Mr Whitcombe had chronic sinusitis and prescribed antibiotics. The GP also noted that Mr Whitcombe was waiting for a hospital appointment with ear, nose, and throat specialists. Prison healthcare administrators chased the hospital for the appointment.

25. In November, Mr Whitcombe reported COVID-19 symptoms. He was isolated in his cell, pending a COVID-19 test result. Mr Whitcombe received daily welfare checks

until 19 November when he received a negative test result. Healthcare staff failed to record the result in Mr Whitcombe's electronic medical record, known as SystmOne.

26. On 26 November, Mr Whitcombe fell off his bed. A nurse attended and completed full clinical observations using the National Early Warning Score 2 (NEWS2 – a system to assess the severity of acute illness, identify deterioration and determine the appropriate escalation procedures). His score was six (indicating urgent medical attention was required). The nurse requested an ambulance. There was a two-hour delay in the ambulance arriving due to service delays.

27. Mr Whitcombe was escorted to hospital by two prison officers and restrained using handcuffs. He was admitted as an inpatient. The hospital asked that Mr Whitcombe remained restrained for the safety of other patients on the ward. When his condition deteriorated on 28 November, the restraints were removed and were never reapplied.

28. While in hospital, Mr Whitcombe tested positive for COVID-19. Prison healthcare staff obtained daily updates about his condition.

29. On 17 December, Mr Whitcombe died in hospital.

30. The prison assigned a family liaison officer who contacted Mr Whitcombe's friend to inform her that he had died. One of the prison's care team offered support to the escort officer. A prison manager held a formal debrief. Other prison staff and prisoners were informed of Mr Whitcombe's death and reminded of the support available.

31. In line with national policy, the prison contributed to the cost of Mr Whitcombe's funeral.

Cause of death

32. A hospital doctor established that Mr Whitcombe died from multi-organ failure caused by coronavirus (COVID-19) pneumonitis. He also had tension pneumothorax (a collapsed lung) which contributed to but did not cause his death. The Coroner accepted this cause of death and no post-mortem examination was carried out.

Findings

Clinical Findings

33. The clinical reviewer concluded that overall, the healthcare that Mr Whitcombe received at Gartree was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She was satisfied that Mr Whitcombe received a satisfactory standard of care for COVID–19 at Gartree, and that Public Health England guidance was followed appropriately. She did, however, make a number of recommendations which were not related to his death but which the Head of Healthcare will need to address.

Management of Mr Whitcombe's risk of infection from COVID-19

34. During the pandemic, prisons were expected to identify prisoners at risk of complications from COVID-19 and offer them the opportunity to shield. At the start of the COVID-19 pandemic, Mr Whitcombe was assessed as being at high risk of developing complications from COVID-19, primarily because of his age. He was advised to shield, but he declined and signed a disclaimer to confirm he understood the risks of not shielding.

35. On 14 November, Mr Whitcombe was tested for COVID-19, but healthcare staff failed to record the result in his medical record. We therefore recommend:

    The Head of Healthcare should ensure that when healthcare staff receive COVID-19 test results, they record the results in the prisoner's SystmOne medical record.

36. We are satisfied that when Mr Whitcombe became unwell, healthcare staff monitored him closely and sent him to hospital as soon as his condition deteriorated. After his hospital admission on 26 November, he tested positive for COVID-19. It is difficult to say where and when he contracted the virus.

Falls management

37. Mr Whitcombe had numerous falls and a history of dizziness. Although this was not linked to his cause of death, the clinical reviewer found that the care provided to Mr Whitcombe in relation to his falls risk was not always in line with the National Institute for Health and Care Excellence (NICE) guidance.

38. After his first fall, healthcare staff should have assessed Mr Whitcombe, with a view to keeping him safe. In line with the NICE guidelines for assessing and preventing falls in older people, an assessment after his second fall should have highlighted his risks and interventions needed and triggered a medication review to determine what effect his medication might have had on his stability. No adjustments were made and there was nothing to alert staff to his very high risk of falls. Healthcare staff did not use appropriate clinical tools for assessing his risk of falls. We therefore recommend:

The Head of Healthcare should ensure that in line with NICE guidelines, a falls risk assessment is in place for prisoners who are at risk or have a history of falls.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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