

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

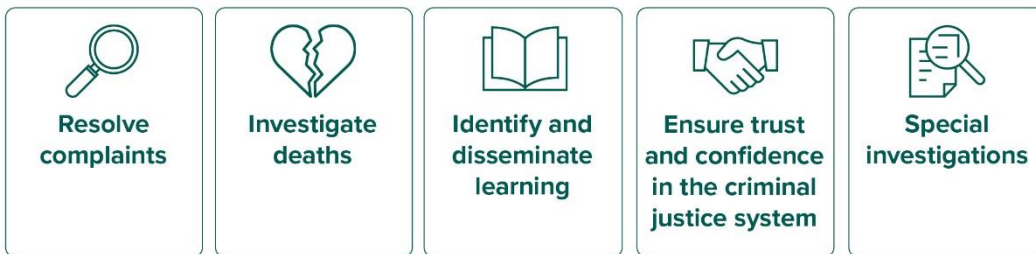
# **Independent investigation into the death of Mr Barry Britton, a prisoner at HMP Whatton, on 3 August 2021**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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 Barry Britton died of lung cancer on 3 August 2021, while a prisoner at Whatton. He was 73 years old. We offer our condolences to Mr Britton's family and friends.
4. The clinical reviewer concluded that the care Mr Britton received at HMP Whatton was of a good standard overall and equivalent to that which he could have expected to receive in the community. She made recommendations to improve clinical staff training in a number of areas, which the Head of Healthcare will need to address.
5. We found no non-clinical issues of concern.

## **The Investigation Process**

6. NHS England commissioned, an independent clinical reviewer, to review Mr Britton's clinical care at Whatton.
7. The PPO investigator investigated the non-clinical issues relating to Mr Britton's care.
8. Mr Britton asked his solicitor to act as his next of kin. The PPO family liaison officer contacted her to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked to receive a copy of our report.
9. The solicitor, NOK, received a copy of the initial report. She did not make any comments on the factual accuracy of the report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. There were no recommendations.

## **Previous deaths at HMP Whatton**

11. Mr Britton was the 21<sup>st</sup> prisoner to die of natural causes at Whatton since August 2018. There are no similarities between our findings in these investigations.

## Key Events

12. On 17 July 2014, Mr Barry Britton was given a life sentence with a five year minimum term for sexual offences and was sent to HMP Chelmsford.
13. On 20 April 2020, staff put systems in place to shield Mr Britton from COVID-19.
14. On 4 September, Mr Britton was convicted of further offences and transferred to HMP Whatton.
15. On 9 October, a GP at Whatton reviewed Mr Britton as part of a new patient assessment. He recorded that Mr Britton had no significant health concerns. Between October and February 2021, no health issues were recorded for Mr Britton.
16. On 9 February 2021, Mr Britton received his first COVID-19 vaccination.
17. On 3 April, Mr Britton told staff he was feeling generally unwell. Healthcare completed basic observations which found that Mr Britton's oxygen levels were low but no concerns were recorded.
18. On 5 April, staff tested Mr Britton for COVID-19. The next day, Mr Britton said he was feeling a little better but would remain in isolation until his COVID-19 test result was available. Mr Britton was coping well and staff had no concerns. Mr Britton's COVID-19 test was negative and his isolation ended.
19. On 13 April, Mr Britton saw a GP at Whatton, to discuss shortness of breath. He also reported he had lost weight and had a cough. The GP requested a chest X-ray and electrocardiogram (ECG - a test for checking the heart's rhythm and electrical activity). She also prescribed an inhaler with salbutamol (a medication for opening up the airways). Mr Britton received a second COVID-19 vaccination.
20. On 20 April, healthcare staff became concerned about Mr Britton's appearance and thought his recent bout of illness might be due to an underlying health issue. Mr Britton said he felt weak at times and was finding it difficult to walk long distances. The GP referred Mr Britton to the local hospital for suspected lung cancer. This was under the NHS England two-week wait referral system for suspected cancers. In the meantime, Mr Britton was monitored daily in the healthcare unit.
21. On 26 April, Mr Britton was escorted to hospital for his planned X-ray appointment. A GP at Whatton, later reviewed Mr Britton's chest X-ray results which showed a lung tumour with metastases (the cancer had spread from the lung, where it originated, to other parts of the body).
22. On 29 April, the prison Multi-Disciplinary Team (MDT) discussed Mr Britton's tumour and next steps. Staff noted that Mr Britton had not yet been informed because other tests were being completed, but that he planned to reduce his work as a wing cleaner due to the decline in his health and strength.
23. On 30 April, Mr Britton attended hospital for a CAT scan (medical imaging used to obtain detailed internal images of the body). The scan confirmed lung cancer.

24. On 10 May, Mr Britton had a follow up consultation at hospital. When he returned to the prison healthcare unit, he told staff he had been diagnosed with lung cancer. A letter from the hospital registrar was sent to the prison confirming this.
25. On 18 May, Mr Britton met with the GP to discuss his cancer diagnosis. Mr Britton also spoke to the hospital oncologist (cancer specialist) to discuss possible cancer treatments, which he declined. Later the same day, Mr Britton said he did not want to be resuscitated if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect.
26. On 11 June, Mr Britton was transported to hospital for an oncology appointment. He was not restrained due to his poor health. Mr Britton was diagnosed with metastatic adenocarcinoma of lung lesion (where cancer has spread to other parts of the body) and told he had six months to live.
27. Mr Britton returned to Whatton later the same day and met with a nurse to discuss care planning. The nurse and Mr Britton agreed that he would attend weekly MDT meetings to discuss ongoing palliative care requirements.
28. On 15 June, prison staff suggested Mr Britton be transferred to a hospital or care home due to his declining health. Mr Britton said he did not want to transfer and said that he would like to remain at Whatton, where he had support from friends. Mr Britton did not want to apply for early release on compassionate grounds (this process is available to those who are given a terminal prognosis). He stayed on the healthcare unit and continued to receive care and monitoring in prison.
29. On 24 June, the GP reviewed Mr Britton. She recorded that Mr Britton's health was declining but that he remained reasonably cheerful and accepting of his diagnosis. He felt that he was being well supported.
30. On 7 July, healthcare took Mr Britton's clinical observations which showed his oxygen saturation levels and pulse rate had reduced significantly, and his temperature was high. At approximately 11.30am, healthcare staff called a code blue (to indicate that someone had breathing difficulties and to request an ambulance). Mr Britton refused to go to hospital and the ambulance was cancelled. He was given oxygen for 10 minutes, after which his saturation levels improved slightly, but they soon began to worsen again. A nurse asked the GP for advice on how to proceed. Health records do not make clear what advice she received.
31. At 4.16pm, a further code blue was called when Mr Britton's saturation levels fell again. This time, Mr Britton agreed to go to hospital and was transported without restraints. At hospital, Mr Britton was diagnosed with pneumonia and prescribed antibiotics. He tested negative for COVID-19.
32. On 9 July, Mr Britton discharged himself from hospital and returned to Whatton. He told hospital staff he did not want treatment for his pneumonia. Hospital staff assessed that Mr Britton had the mental capacity to make the decision and explained to Mr Britton that the decision may shorten his life. Mr Britton confirmed he understood this. An oxygen concentrator (a medical device that provides oxygen) was delivered to Mr Britton for use in prison.

33. On 12 July, a nurse recorded that Mr Britton's health was continuing to deteriorate and he had weeks to live. Healthcare staff completed regular checks on Mr Britton and ensured he was comfortable.
34. On 14 July, staff agreed that Mr Britton needed one-to-one nursing care because he was struggling to move independently. Mr Britton found it difficult to speak because he was constantly short of breath. Overnight care was arranged and an open-door policy (allowing healthcare staff to provide direct in cell care 24 hours a day) was implemented. Healthcare staff continued to provide daily support to Mr Britton, supported by social care assistants and occupational health colleagues.
35. At approximately 4.00am on 2 August, Mr Britton fell out of bed. Staff helped Mr Britton back into bed and made him comfortable. A nurse attended in the morning and assessed Mr Britton who had a small bruise on his right shoulder.
36. On 3 August at 4.30pm, wing carers could not get a response from Mr Britton and asked an officer to come to Mr Britton's cell. The officer sought a verbal response and checked Mr Britton's breathing, but there was no response. He asked a social care support worker, to attend. The wing carer also checked for signs of life, without success. The officer called a code blue emergency, triggering a request for an ambulance. Two nurses arrived soon after and a nurse confirmed that there were no clinical signs of life. At 5.00pm, an ambulance crew arrived and pronounced that Mr Britton had died.

## **Post-mortem report**

37. The coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor concluded that Mr Britton died of metastatic carcinoma of the lungs (cancer that has started to spread into other parts of the body). Chronic Obstructive Pulmonary Disease (COPD - a group of lung conditions that cause breathing difficulties), and ischaemic heart disease (where the blood vessels supplying the heart are narrowed or blocked) were listed as contributory factors.

## **Inquest**

38. The inquest into Mr Britton's death concluded on the 4 April 2022. The coroner confirmed that Mr Britton died of natural causes.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**July 2023**

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