

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Lees, a prisoner at HMP Whatton, on 5 September 2022

A report by the Prisons and Probation Ombudsman

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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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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within the service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systematic failure.

Mr John Lees died of a stroke on 5 September 2022 at HMP Whatton. He was 65 years old. I offer my condolences to Mr Lees' family and friends.

Healthcare staff identified that Mr Lees had high blood pressure when he arrived at Whatton in January 2022. The clinical reviewer found that while staff took some steps to monitor Mr Lees' blood pressure, the care he received 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.

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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Summary

Events

1. In June 2016, Mr John Lees was sentenced to life imprisonment for sexual offences.
2. Later that year, Mr Lees told healthcare staff that he did not want to be resuscitated if his heart or breathing stopped. He signed a Do Not Attempt CPR (DNACPR) notice, which remained in place throughout his time in prison.
3. Mr Lees was moved to HMP Whatton on 18 January 2022. The reception nurse noted that he had high blood pressure. His blood pressure was still high when a nurse saw him on 4 and 11 February.
4. On 18 February, healthcare staff gave Mr Lees a blood pressure monitor and asked him to take and record two readings each morning and two each afternoon for seven days. A nurse saw him on 28 February to discuss the results, but Mr Lees had only recorded one set of readings, not two as instructed. The nurse did not ask him to repeat the monitoring.
5. On 15 August, Mr Lees told a nurse he had fainted. He thought this was due to ongoing pain in his neck and spine resulting from a road traffic accident years before. The nurse found that Mr Lees' blood pressure was high. She booked him in for a blood pressure check in a week's time. On 22 August, Mr Lees' blood pressure was still high. The nurse suggested that Mr Lees should monitor his own blood pressure for a week but when he said he had already done this, she booked him a GP appointment. Mr Lees did not see a GP over the next two weeks.
6. At around 7.40am on 5 September, Mr Lees' cellmate pressed their emergency cell bell after Mr Lees failed to respond when their alarm clock went off. When he checked on Mr Lees and found no pulse, he started CPR.
7. An officer responded to the cell bell and called a medical emergency code. Staff took over CPR, which was continued by paramedics. However, they were unable to resuscitate Mr Lees and he was pronounced dead at 8.15am.
8. The post-mortem report concluded that Mr Lees died from an intracranial haemorrhage (a type of stroke).

Findings

9. The clinical reviewer found no record that healthcare staff had explored with Mr Lees the reasons why he had failed to complete his blood pressure monitoring correctly. They also did not ask him to repeat it. The clinical reviewer concluded that the care Mr Lees received at Whatton was not equivalent to that which he could have expected to receive in the community.
10. Both Mr Lees' cellmate and staff at Whatton carried out CPR on Mr Lees. This was particularly commendable of Mr Lees' cellmate. However, Mr Lees had clearly expressed his wish not to be resuscitated. The Head of Healthcare told us that

there had been communication failings in Mr Lees' case, but that Whatton now had a clear process for passing on information about DNACPR notices which they followed. We are aware that in some prisons, the DNACPR notice is visible on the cell wall. Had it been in this case, Mr Lees' cellmate would have been aware of his wishes. This is something the Head of Healthcare may wish to consider.

Recommendations

- The Head of Healthcare should ensure that all documented interactions have a clear assessment, plan, and where appropriate outcome, recorded.

The Investigation Process

11. HMPPS notified us of Mr Lees' death on 5 September 2022. Arden's templates
12. The investigator issued notices to staff and prisoners at HMP Whatton 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 Lees' prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Lees' clinical care at the prison.
15. The investigator and clinical reviewer interviewed two members of staff and a prisoner on 11 November 2022.
16. We informed HM Coroner for Nottingham 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 Lees' sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified some factual inaccuracies, which are amended in this report.
19. We provided Mr Lees' next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Whatton

20. HMP Whatton is a Category C prison in Nottinghamshire which holds up to 817 prisoners convicted of sexual offences. Practice Plus Group provides healthcare services.
21. The healthcare centre is open from 7.30am to 6.30pm from Monday to Friday and from 8.30am to 6.30pm on weekends and bank holidays. There is an out-of-hours service at other times.

HM Inspectorate of Prisons

22. The most recent full inspection of HMP Whatton was in August 2016. Inspectors reported that the quality of health and social care was good and waiting times for treatment were reasonable. Inspectors found that a mix of appropriately skilled staff in well-integrated teams provided health services and interacted politely and professionally with prisoners. They noted a high demand for routine hospital appointments, but that an increase in the number of available escort officers had significantly reduced the number of cancellations.
23. HMIP conducted a scrutiny visit at Whatton in August 2020 (during the COVID-19 pandemic) and reported that managers and staff at Whatton were keeping prisoners relatively safe and motivated during challenging times.

Independent Monitoring Board

24. 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 May 2022, the IMB considered that healthcare services at the prison had benefited from good leadership and coordination across all health and social care functions.
25. The IMB was concerned that the prison's healthcare services continued to be under great pressure due to staff shortages. However, the Board acknowledged the situation within the healthcare department reflected similar pressures in the community. They were pleased to note that every effort had been made by the healthcare team despite those staffing pressures. The IMB also noted the standard of the accommodation within the healthcare centre continued to be of a significant concern.

Previous deaths at HMP Whatton

26. Mr Lees was the twentieth prisoner to die at Whatton since September 2019. Of the previous deaths, 19 were from natural causes and one was self-inflicted. There are no similarities between the findings from our investigation into Mr Lees' death and our investigation findings from the previous deaths.

Key Events

27. On 22 June 2016, Mr John Lees was sentenced to life imprisonment for sexual offences. He was sent to HMP Wakefield.
28. On 14 September, Mr Lees told healthcare staff that he did not want to be resuscitated if his heart or breathing stopped. Healthcare staff completed a Do Not Attempt CPR (DNACPR) notice for Mr Lees which he signed.
29. Mr Lees was moved to HMP Whatton on 18 January 2022. The reception nurse noted that Mr Lees did not take regular medication and had not seen a doctor for a few months, however, his pulse and blood pressure were raised. The nurse arranged a follow up appointment.
30. Wakefield sent Mr Lees' DNACPR to Whatton by recorded delivery on 19 January. This document was scanned into Mr Lees' medical record.
31. On 4 February, Mr Lees attended an appointment with a nurse to discuss his raised pulse and blood pressure. Mr Lees said he thought this was because of his transfer from Wakefield. Mr Lees' blood pressure was still high when it was checked again on 11 February.
32. A GP at Whatton reviewed Mr Lees' DNACPR decision with him on 9 February. He concluded Mr Lees had the mental capacity to make this decision and completed a Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) form which he entered into Mr Lees' medical record.
33. On 18 February, healthcare staff gave Mr Lees a blood pressure monitor and told him to take two readings each morning and two each afternoon for seven days and record the results. Mr Lees met with a nurse to discuss his results on 28 February. However, Mr Lees had only taken one reading each morning and afternoon and not two as instructed. The nurse did not ask him to repeat the monitoring.
34. On 9 March, Mr Lees attended the healthcare department to complain about swollen ankles and calves. A nurse arranged a GP appointment for 16 March. At this appointment, the GP noted Mr Lees had pitting oedema (excess fluid which causes swelling). Mr Lees' chest sounded clear, and he reported no shortness of breath. The GP ordered blood tests to check Mr Lees' kidneys, liver and heart. The GP reviewed the results on 2 April. No further action was needed, as all Mr Lees' results were within normal range.
35. On 15 August, Mr Lees attended the healthcare department and told a nurse that he had fainted. He thought this was connected to ongoing pain in his neck and spine following a road traffic accident years before. Mr Lees said he had experienced previous fainting episodes. Mr Lees' pulse and oxygen levels were within normal range, but his blood pressure was high. The nurse booked Mr Lees in for a blood pressure check the following week, and told him how to make a referral to see a physiotherapist.
36. At a blood pressure review with a nurse on 22 August, Mr Lees' blood pressure remained high. The nurse recommended he monitor his own blood pressure. When Mr Lees said he had done so twice before, the nurse booked him a GP

appointment. The records do not give the date of the appointment but, over the next two weeks, Mr Lees did not see a GP.

Events of 5 September 2022

37. At around 7.00am on 5 September, an officer carried out a routine check of all prisoners on Mr Lees' wing (C Wing). He reported no issues. and said in a statement that he got a response or noted movement from every prisoner.
38. At 7.41am, Mr Lees' cellmate pressed the emergency cell bell. He said that he had been having a wash and the alarm clock had gone off, but Mr Lees did not respond. He checked Mr Lees for a pulse but could not find one, so began CPR. An officer arrived at the cell around 30 seconds later and could see through the observation panel in the cell door what was happening. He immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). The control room called for an ambulance immediately.
39. The officer went into the cell. He and the cellmate lowered Mr Lees to the floor, and the cellmate continued CPR while the officer collected a defibrillator. The officer returned and took over CPR.
40. Another officer responded to the code blue and took over CPR, assisted by a colleague. Two nurses arrived at around 7.45am. An officer told the nurses that the defibrillator he was using did not seem to be working. The nurses changed the defibrillator for one they had brought with them. It indicated that no shock was required and to carry on CPR.
41. The nurses administered oxygen and continued with CPR, until paramedics arrived.
42. Paramedics arrived at Whatton at 8.00am. They continued CPR but were unable to resuscitate Mr Lees.
43. An Air Ambulance doctor confirmed Mr Lees' death at 8.15am.

Contact with Mr Lees' family

44. Two prison staff visited Mr Lees' sister to inform her of her brother's death.
45. The prison contributed to Mr Lees' funeral expenses, in line with national instructions.

Support for prisoners and staff

46. After Mr Lees' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
47. The prison posted notices informing other prisoners of Mr Lees' 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 Lees' death.

Post-mortem report

48. Mr Lees' post-mortem examination concluded that he died from an intracranial haemorrhage (a type of stroke that occurs when a blood vessel inside the skull bursts and bleeds into and around the brain).

Findings

Clinical care

49. The clinical reviewer concluded that Mr Lees' care at Whatton was not equivalent to that which he could have expected to receive in the community.
50. Although healthcare staff asked Mr Lees to carry out blood pressure monitoring himself, in line with NICE guidelines, he clearly did not understand what to do as he recorded only one reading each morning and evening rather than two. The clinical reviewer found no record of the reason for this being explored with Mr Lees or him being asked to repeat the monitoring. Mr Lees should have been given further instructions on how to complete his blood pressure monitoring himself and how to record the results. We recommend:

The Head of Healthcare should ensure that all documented interactions have a clear assessment, plan, and where appropriate outcome, recorded.

Governor and Head of Healthcare to note

51. Mr Lees had a DNACPR in place. The Head of Healthcare told us that while Mr Lees' DNACPR was scanned into his electronic medical record, there was no record that it was sent to wing staff. She said that there was now a clear process in place for DNACPRs. As well as scanning the DNACPR into the medical record, healthcare staff inform the senior officer in charge (who adds it to the daily briefing sheet) and send it to the wing for storage in the wing file. She said this process was not in place at the time of Mr Lees' death.
52. Mr Lees' cellmate was unaware of the DNACPR. Delivering CPR can be distressing and unpleasant and it is commendable that he immediately began CPR when he found Mr Lees unresponsive. He could not have known that this was against Mr Lees' wishes. The Governor should ensure that the cellmate's actions are recognised.
53. Our investigations have found that some prisons display DNACPRs on the prisoner's cell wall, so that their wishes are clear to anyone who might be first to respond to a medical emergency. Had that been done in this case, Mr Lees' cellmate would have been aware of his wishes. The Head of Healthcare told us at interview that she was considering whether there needed to be something visible to make it clear that a prisoner had a DNACPR in place, such as a notice or bracelet worn around the wrist. She will wish to consider this further.
54. During the hot debrief, wing staff said that they did not feel confident using the defibrillator and thought it was not working properly when in fact it was. The Governor and Head of Healthcare may wish to consider defibrillator training for staff.

Inquest

55. The inquest, held on 4 September 2023, concluded that Mr Lees died from natural causes.

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