Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Bone, a prisoner at HMP Whatton, on 2 November 2022

A report by the Prisons and Probation Ombudsman

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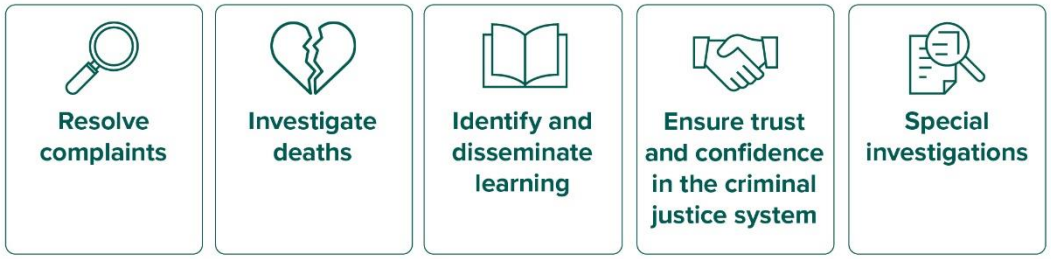
OUR VISION

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

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 service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Frank Bone died of ischaemic heart disease on 2 November 2022 at HMP Whatton. He was 82 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare Mr Bone received at Whatton was partially equivalent to that which he could have expected to receive in the community. There was no evidence that Mr Bone had a coronary heart disease care plan in place, despite having a long history of coronary heart disease and no evidence of a falls risk assessment despite Mr Bone having a history of falls and mobility issues.

The day before Mr Bone died, a healthcare assistant thought he seemed less well than normal but did not escalate her concerns to more senior nursing colleagues. As a result, healthcare staff did not complete follow up clinical observations, which could have identified a clinical cause for his symptoms.

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 **July 2023**

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Summary

Events

1. On 2 August 2022, Mr Frank Bone was sentenced to six years and three months imprisonment for sexual offences and was sent to HMP Leicester. He was 82 years old.

2. Mr Bone had pre-existing medical conditions, including type 2 diabetes, lymphocytic leukaemia (a rare type of cancer that affects the blood and bone marrow) and vertigo. He previously had had a heart attack and stroke. He had a stent inserted into his heart to improve the blood flow and a pacemaker to regulate his heartbeat. Mr Bone used walking sticks and a wheelchair to move around.

3. At 8.00pm on 1 November, Mr Bone rang his personal alarm. An OSG (Operational Support Grade) responded immediately. He told her that he was fine, but wanted his in-cell light left on.

4. At 3.58am the following morning, while carrying out a routine welfare check, the OSG was unable to see Mr Bone in his cell. She called to him, but he did not answer. She radioed the Night Orderly Officer (NOO – the most senior officer on duty) to attend the cell.

5. At 4.02am, the NOO, accompanied by an Assist Night Orderly Officer (ANOO), entered the cell. They saw Mr Bone slumped on the floor. They checked for signs of life, but there were none and there were clear signs that he had been dead for some time. They correctly decided not to attempt cardiopulmonary resuscitation (CPR).

6. Paramedics arrived at the prison at 6.05am and confirmed Mr Bone's death.

7. The post-mortem report gave Mr Bone's cause of death as ischaemic heart disease.

Findings

8. The clinical reviewer concluded the healthcare Mr Bone received at Whatton was only partially equivalent to that which he could have expected to receive in the community.

9. There was no evidence that healthcare staff had devised a had a coronary heart disease care plan or a falls risk assessment for Mr Bone, despite him having a long history of both issues.

10. On the afternoon of 1 November, the day before Mr Bone's death, he displayed clinical symptoms that were not reported by a healthcare assistant. Therefore, clinical observations were not completed, which could have identified a cause for his symptoms.

Recommendations

- The Head of Healthcare should ensure care plans are created for all prisoners with a diagnosis of coronary heart disease in line with NICE guidance 185.

- The Head of Healthcare should ensure that

  - falls risk assessments are completed in line with NICE guidance 161;

  - all physical injuries sustained when a prisoner suffers a fall are clearly documented within the prisoner's medical records in line with NICE guidance 161; and

  - all pre-existing physical injuries are clearly documented at the first-reception health screen and body maps are completed in line with NICE guidance 161.

- The Head of Healthcare should ensure that:

  - all unregistered staff are aware of their responsibility to inform the registered nursing staff of all clinical symptoms that may indicate a deterioration in a prisoner's condition; and

  - clinical observations are completed and recorded for all prisoners displaying symptoms that may suggest a clinical cause for a deterioration in their presentation.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Bone's prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Bone's clinical care at the prison.

14. We informed HM Coroner for Nottingham City and Nottinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

16. Mr Bone's family received a copy of the initial report. They pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Whatton

17. HMP Whatton is a medium security prison in Nottinghamshire which holds up to 841 adult male prisoners convicted of sex offences. Practice Plus Group (PPG) provides primary healthcare and mental healthcare services at the prison.

18. 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. There are no inpatient beds, but there is a palliative care suite in the healthcare centre for end-of-life care.

HM Inspectorate of Prisons

19. 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.

20. HMIP conducted a scrutiny visit at Whatton in August 2020 (in line with its COVID-19 methodology) and reported that managers and staff at Whatton were keeping prisoners relatively safe and motivated during challenging times.

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 for the year to 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.

22. The IMB were 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

23. Mr Bone was the seventeenth prisoner to die at Whatton since November 2020. Of the previous deaths, fifteen were from natural causes and one was self-inflicted. There are no similarities between Mr Bone's death and the previous deaths at the prison.

Key Events

24. On 2 August 2022, Mr Frank Bone was sentenced to six years and three months imprisonment for sex offences and was sent to HMP Leicester. He was 82 years old.

25. Mr Bone had pre-existing medical conditions, including type 2 diabetes, lymphocytic leukaemia (a rare type of cancer that affects the blood and bone marrow) and vertigo. He had had a heart attack and stroke four years previous. He had a stent inserted into his heart to improve the blood flow and a pacemaker to regulate his heartbeat. Mr Bone used walking sticks and a wheelchair to move around. Healthcare staff noted his medical conditions at an initial health screen and created care plans to manage his conditions.

26. Mr Bone told healthcare staff that he had been experiencing dizziness for the previous two weeks, which he thought was due to his vertigo. Healthcare staff reviewed him regularly. On 5 August, a nurse carried out a diabetes review and updated his diabetes care plan.

27. The following day, Mr Bone was still experiencing dizziness and felt generally unwell. Healthcare staff took his clinical observations over the next couple of days and they were all within a normal range, but as a precaution, they referred him to a GP for review. A GP at Leicester saw him on 16 August. Mr Bone told him that the dizziness was getting worse, and that he had also developed a feeling of weakness in his legs. The GP arranged for a full set of blood tests to be carried out. He considered that Mr Bone was dehydrated and encouraged him to drink more fluids.

28. On 12 September, another GP at Leicester saw Mr Bone. She noted that he had a raised heart rate and arranged for him to have an ECG (electrocardiogram used to measure the electrical output of the heart), which was completed on 27 September. The result was abnormal and she sent him to hospital by emergency ambulance. Hospital staff diagnosed him with a chest infection and an inflamed colon. He was admitted to hospital as an inpatient and was given a course of intravenous antibiotics.

29. Hospital staff told healthcare staff that Mr Bone needed a higher level of care than the prison was equipped to provide so prison staff made arrangements to transfer Mr Bone to another prison that was able to care for his needs.

HMP Whatton

30. On 18 October, Mr Bone was discharged from hospital and was transferred to HMP Whatton. Due to his late arrival at the prison, healthcare staff did not complete his initial health screen. He was moved to a large cell equipped with a hospital bed.

31. The following day, a GP at Whatton saw Mr Bone and updated his prescribed medications. He also noted Mr Bone's previous diagnosis of leukaemia. He referred Mr Bone to the haematology unit of Nottingham City Hospital to ensure continuity of his care.

32. Later that day, a nurse carried out an initial health screen. She noted Mr Bone's pre-existing conditions and reviewed and updated his diabetic care plan. During the health screen, she noted that he appeared confused when asked simple questions or given simple instructions. She referred him to the prison's Mental Health Inreach Team (MHIRT) for further review. Due to his history of falls and issues with mobility, he was issued with a personal alarm to alert staff if he needed assistance and received help with daily tasks from social care staff. However, despite his well-documented medical history, there is no evidence in his medical records to indicate that a coronary care plan or a falls risk assessment was created.

33. On 23 October, Mr Bone told staff he was experiencing shortness of breath and control room staff called an ambulance. A nurse attended Mr Bone's cell and took his observations, which were all within a normal range. As his condition improved quickly, she decided to cancel the emergency ambulance.

34. Later that day, Mr Bone fell in his cell. A healthcare assistant (HCA) immediately responded and found him sat on the floor. He said that he had used the toilet and fell on the way back to his bed. She asked him if he had injured himself, and he said that he had pain in his knees and back. She noted that there were large bruises on his knees, which she thought he had sustained prior to arriving at Whatton. He told her that he had he attempted to alert staff, but that his personal alarm had failed to activate. There is no evidence in Mr Bone's medical records to indicate that the HCA escalated any concerns about the bruises on Mr Bone's knees. An officer replaced Mr Bone's personal alarm and ensured it was working correctly.

35. On 24 October, a nurse from the MHIRT attempted to review Mr Bone. However, she noted that he was too unwell to complete a full assessment. She planned to review him at a later date.

36. The following day, a nurse completed Mr Bone's secondary health screen. There was no reference to the fall Mr Bone had sustained on 23 October. Mr Bone continued to be regularly reviewed by healthcare staff and assisted with daily tasks by social care staff.

37. On 1 November, a HCA offered to assist Mr Bone into the shower. When she was helping him, she noted that he appeared to be unable to use his left arm and had difficulty standing. She also considered he appeared to be more lethargic than usual and that his breathing appeared laboured. There is no evidence in Mr Bone's medical records to indicate that she took a note of his observations or raised her concerns with senior nursing staff.

38. At 8.00pm on 1 November, Mr Bone activated his personal alarm. An operational support grade (OSG) responded immediately. He told her that he was fine, but that he wanted his in-cell light left on.

39. At 3.58am the following morning, an OSG carried out a routine welfare check. She could not see Mr Bone in his cell. She called his name, but he did not answer. She radioed the Night Orderly Officer (NOO - the most senior officer on duty) to attend the cell.

40. At 4.02am, the NOO, accompanied by the Assistant Night Orderly Officer (ANOO), arrived at Mr Bone's cell. The ANOO called to Mr Bone through the cell door, but he

did not respond. They immediately entered the cell and saw him slumped on the floor, on his left-hand side with his head resting on the toilet. His eyes and mouth were open. The ANOO checked for signs of life, but there were none. He noted some stiffness in Mr Bone's joints, indicating he had been dead for some time. He correctly decided not to attempt cardiopulmonary resuscitation (CPR).

41. At 4.05am, the NOO telephoned the prison communication room to inform them of Mr Bone's death. Control room staff telephoned for an emergency ambulance immediately. However, they were informed that due to an increased volume of calls, and as it was a non-urgent request, there would be a delay to the ambulance.

42. At 6.05am, paramedics arrived at the prison. They immediately confirmed Mr Bone's death.

Contact with Mr Bone's family

43. The prison appointed two officers to act as family liaison officers (FLOs). A FLO, accompanied by the Head of Offender Management Services at the prison, visited Mr Bone's daughter at her home address to inform her of her father's death. However, she was not at home. They returned to the prison and tried to contact her by telephone, but she did not answer. They continued to try to contact her by telephone her without success.

44. At 5.15pm, the FLO and Head of Offender Management Services returned to Mr Bone's daughter's home address. On that occasion she was at home, and they were able to inform her of her father's death. The family liaison officers remained in contact with her, offering support.

45. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

46. After Mr Bone's death, support was offered to the staff involved in the emergency response.

47. The prison posted notices informing other prisoners of Mr Bone'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 his death.

Post-mortem report

48. The post-mortem report gave Mr Bone's cause of death as ischaemic heart disease caused by coronary artery atheroma. He also had hypertension and diabetes mellitus which were contributory factors.

Findings

Clinical care

49. The clinical reviewer concluded that the clinical care Mr Bone received at HMP Whatton was only partially equivalent to that which he could have expected to receive in the community.

50. She noted that despite his long and well documented history of heart disease, he had no coronary care plan in place to manage his care, which is not in line with NICE guidance (National Institute for Health and Care Excellence) NG185 (early and longer-term management of acute coronary syndromes). We recommend:

    The Head of Healthcare should ensure care plans are created for all prisoners with a diagnosis of coronary heart disease in line with NICE guidance NG185.

51. Despite Mr Bone having a recent history of falls and significant issues with his mobility, there was no evidence in his medical records to indicate that a falls risk assessment had been completed for him.

52. On 23 October, Mr Bone sustained a fall in his cell. A HCA immediately responded and found him sat on the floor of his cell. She noted that he had large bruises on his knees, which she assumed he had sustained prior to his arrival to Whatton. There was no evidence in Mr Bone's medical records to indicate that the HCA reported the bruising to senior nursing staff. There is no mention of bruising to Mr Bone's knees on either his initial or secondary health screen.

53. On 25 October, a nurse completed Mr Bone's secondary health screen. However, she did not record in his medical record that he had suffered a fall the previous day as she should have done. We recommend:

    The Head of Healthcare should ensure that

    - **falls risk assessments are completed in line with NICE guidance 161;**
    - **all physical injuries sustained when a prisoner suffers a fall are clearly documented in the prisoner's medical records in line with NICE guidance 161; and**
    - **all pre-existing physical injuries are clearly documented at the first-reception health screening and that body maps are completed in line with NICE guidance 161.**

54. On 1 November, while assisting Mr Bone into the shower, a HCA noted he appeared to be unable to use his left arm and also had difficulty standing. She also considered he appeared to be more lethargic than usual and that his breathing appeared laboured. However, there is no evidence in Mr Bone's medical records to suggest she took a note of his observations or that she raised her concerns with senior nursing staff as she should have done. We recommend:

The Head of Healthcare should ensure that:

- **unregistered staff are aware of their responsibility to inform the registered nursing staff of all clinical symptoms that may indicate a deterioration in a prisoner's condition; and**

- **clinical observations are completed and recorded for all patients displaying symptoms that may suggest a clinical cause for a deterioration in their presentation.**

Inquest

55. The inquest, held on 17 August 2023, concluded that Mr Bone died from natural causes.

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