Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Onyemaechi, a prisoner at HMP Whitemoor, on 15 September 2021

A report by the Prisons and Probation Ombudsman

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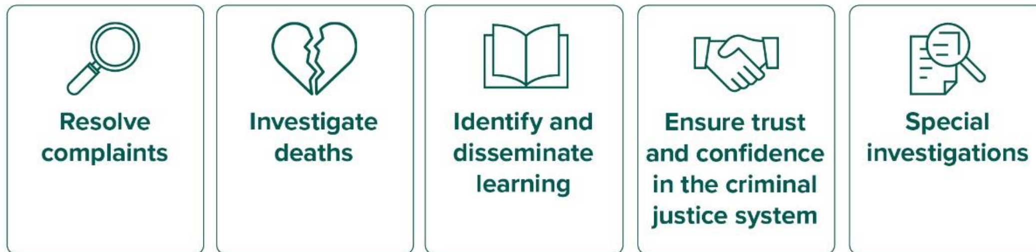
OUR VISION

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.

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 Onyemaechi died on 15 September 2021 of multiorgan failure while a prisoner at HMP Whitemoor. He was 40 years old. I offer my condolences to Mr Onyemaechi's family and friends.

The clinical reviewer concluded that the clinical care Mr Onyemaechi received at HMP Whitemoor was equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned, however, that Mr Onyemaechi was not offered a full health screen until he had been at Whitemoor for almost four months. She considers that this was potentially a missed opportunity to assess his refusal to receive treatment for his autoimmune hepatitis, which contributed to his death.

Mr Onyemaechi was a Category A prisoner and held under Close Supervision Centre (CSC) conditions. He needed to be escorted by six officers and a senior manager to move around the prison and to attend hospital. I am concerned that when Mr Onyemaechi initially needed to go to hospital for medical treatment on the afternoon of 2 September, there were not enough officers on duty to facilitate his transfer.

I am also concerned that the prison restrained Mr Onyemaechi while he was in a medically induced coma. I consider that this was unnecessary and inappropriate, given that the use of restraints should be based on the risk that a person presents at the time.

I have made a recommendation to the Governor about the inappropriate use of restraints before and it is disappointing that I am having to highlight the same concerns in this report.

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 **May 2022**

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Summary

Events

1. On 25 October 2011, Mr Onyemaechi was sentenced to life imprisonment for attempted murder. He received a minimum tariff of 25 years. On 3 June 2019, he was sentenced to 6 years, 7 and a half months for violent offences committed while a prisoner at HMP Full Sutton. On 23 April 2021, Mr Onyemaechi transferred to HMP Whitemoor.

2. In 2018, Mr Onyemaechi was diagnosed with autoimmune hepatitis. In July 2021, he had a consultation with a prison GP and accepted further investigations into this condition. The GP referred him to hospital for review.

3. In August, Mr Onyemaechi was diagnosed with advanced liver dysfunction. On 2 September, a prison GP contacted the hospital, due to concerns that Mr Onyemaechi's liver dysfunction was worsening. He was advised that Mr Onyemaechi needed to go to hospital, but the prison was unable to facilitate his transfer to hospital because there were not enough staff on duty. The hospital agreed to hold a bed for Mr Onyemaechi until the next day.

4. At 9.22pm the same day, Mr Onyemaechi became unwell, and he had difficulty breathing. Healthcare staff asked the officer in charge to call an ambulance. The ambulance was called an hour later at 10.20pm.

5. At 1.50am on 3 September, paramedics arrived, and Mr Onyemaechi was taken to hospital. At around 1.40pm, the next day, he was placed in an induced coma.

6. On 5 September, Mr Onyemaechi had a liver biopsy and during the procedure he had an acute bleed. He remained in an induced coma and was placed on a ventilator.

7. On 15 September at 4.26pm, Mr Onyemaechi died in hospital.

Findings

8. The clinical reviewer concluded that the clinical care Mr Onyemaechi received at HMP Whitemoor was equivalent to that which he could have expected to receive in the community. Healthcare staff promptly recognised and acted on the clinical signs that Mr Onyemaechi's liver was failing and that he needed to be seen urgently at a liver specialist unit.

9. She did, however, identify some concerns about Mr Onyemaechi's care.

10. Healthcare staff failed to properly complete the first and second health screens when Mr Onyemaechi arrived at Whitemoor and there was a delay of four months before he was offered a full health screen. The clinical reviewer considered that the failure to undertake the health screenings sooner was a missed opportunity to fully assess Mr Onyemaechi's physical and mental health care, treatment and needs. Healthcare staff also failed to complete the medicines reconciliation exercise, which was also a missed opportunity to reassess Mr Onyemaechi's medical conditions

and his understanding about the medicines he needed in order to manage his autoimmune hepatitis.

11. On 2 September 2021, a prison GP contacted Addenbrookes Hospital because they had concerns about Mr Onyemaechi's liver function. The hospital advised that Mr Onyemaechi should be bought in. Mr Onyemaechi was unable to go to hospital because there were not enough staff on duty to facilitate his transfer to hospital. (Mr Onyemaechi was a category A prisoner and needed six officers and a senior manager to escort him to hospital).

12. We are concerned that the decision to restrain Mr Onyemaechi when he was placed in a medically induced coma was not appropriate and was unsound.

Recommendations

- The Head of Healthcare should ensure that:
    - all first stage health assessments at reception are completed for every prisoner in line with NICE guideline NG57;
    - a second stage health assessment is completed for every prisoner within 7 days of the first stage health assessment, in line with NICE guideline NG57; and,
    - all prisoners entering or transferring to HMP Whitemoor have a medicines reconciliation carried out within 72 days of arrival and before their second stage health assessment in accordance with Quality Standard QS156.
- The Governor should ensure that there are sufficient numbers of staff on duty during the day to facilitate transfers to hospital.
- The Governor should ensure that staff call an emergency ambulance promptly when advised to do so by a doctor or a prison clinician.
- The Governor should share this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.
- The Governor and the Head of Healthcare should ensure that the Healthcare Team contribute to risk assessments regarding the use of restraints when transferring prisoners to an acute hospital setting and that this contribution is clearly documented in the SystmOne records.
- The Governor should write to the Ombudsman and tell her what further steps he will take to ensure ill prisoners are not inappropriately restrained in the future.

The Investigation Process

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

14. The investigator interviewed two members of staff by telephone on 15 September and 10 December 2021.

15. NHS England commissioned a clinical reviewer to review Mr Onyemaechi's clinical care at the prison.

16. We informed HM Coroner for Cambridgeshire and Peterborough 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. One of the Ombudsman's family liaison officers contacted Mr Onyemaechi's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Onyemaechi's brother did not have any questions but asked for a copy of our report.

Background Information

HMP Whitemoor

18. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services and Phoenix Futures provides substance misuse services.

HM Inspectorate of Prisons

19. The most recent inspection at Whitemoor was in March 2017. Inspectors found that healthcare provision was mixed. Primary care was generally appropriate but mental health support did not meet all prisoners' needs.

20. In July and August 2020, HMIP carried out a Scrutiny Visit (a shortened inspection to report on treatment and conditions during the COVID-19 pandemic). Inspectors reported that managers and staff had worked hard to deliver a limited regime during the pandemic, which was better than what was being offered at most other establishments they had visited. Good partnership work meant that key health services, including access to nurses, the GP and mental health support continued.

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 31 May 2021, the IMB reported that the primary healthcare was good overall, with 80% of appointments fulfilled, and that there had been an increase in healthcare staff numbers.

Previous deaths at HMP Whitemoor

22. Mr Onyemaechi was the fifth prisoner to die at HMP Whitemoor since September 2019. Of the previous deaths, two were from natural causes, one was self-inflicted, and one was drug-related.

23. In a previous investigation into a death at Whitemoor in July 2021, we were concerned about the inappropriate use of restraints for a prisoner who had breathing difficulties. He was double handcuffed and continued to be so for 18 hours while his health continued to deteriorate. We recommended that the Governor ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk they present at the time.

24. The Governor accepted our recommendation and said that the Security Governor would conduct a review of the risk assessment process. They said that the outcome of this review would then be shared with those who complete and sign off the risk assessment documentation.

25. It is disappointing that we are having to highlight the same concerns in this report. The Governor must tell us what further steps he will take to ensure ill prisoners are not inappropriately restrained in the future.

Key Events

26. On 25 October 2011, Mr Onyemaechi was sentenced to life imprisonment for attempted murder. He received a minimum tariff of 25 years.

27. In 2018, Mr Onyemaechi was diagnosed with autoimmune hepatitis following an abnormal liver function test. He was admitted to hospital for a week to receive treatment and was prescribed steroid medication, which he took until August 2018. Mr Onyemaechi stopped taking the medication because he said it made him manic and depressed.

28. On 3 June 2019, Mr Onyemaechi was sentenced to 6 years and 7 and a half months for violent offences he committed while serving his sentence at HMP Full Sutton.

HMP Whitemoor

29. On 23 April 2021, Mr Onyemaechi transferred to HMP Whitemoor.

30. When he arrived at the prison, Mr Onyemaechi was immediately taken to the segregation unit because he was under investigation for assaulting another prisoner at his previous prison. Healthcare staff did not complete a full reception screen as the prison was in 'patrol state' (this is when all prisoners are locked behind their doors and unlock is only permitted in an emergency). A nurse spoke to Mr Onyemaechi through the observation panel of his cell door. She recorded that Mr Onyemaechi had no immediate medical concerns. Mr Onyemaechi was not taking any regular medication.

31. On 24 April, a nurse spoke to Mr Onyemaechi through the observation panel of his cell door. He told her that he had been on some medication in the past but had stopped taking it due to the side-effects. She recorded that she could not complete a full reception screen because Mr Onyemaechi was in isolation (due to COVID-19 restrictions) and that he should be seen at the clinic after his isolation period had ended.

32. On 18 May, Mr Onyemaechi asked for a reception screen. A nurse told him that it would be done as soon as healthcare staff were able to.

33. On 15 July, Mr Onyemaechi had a consultation with a prison GP and accepted further investigations into his autoimmune hepatitis. The GP referred him to Addenbrookes Hospital.

34. On 17 August, Mr Onyemaechi was offered a reception screen, but he refused. He said that as he had been at the prison for months, the questions in the screening were no longer relevant.

Events leading to Mr Onyemaechi’s admission to hospital on 3 September 2021

35. After investigations at Addenbrookes Hospital, Mr Onyemaechi was diagnosed with advanced liver dysfunction on 29 August. He was told that he would need treatment in hospital if it got worse.

36. At approximately 1.30pm on 2 September, a prison GP contacted Addenbrookes Hospital because he was concerned that Mr Onyemaechi’s liver dysfunction was worsening. He was advised that Mr Onyemaechi needed to go to hospital.

37. The prison could not facilitate Mr Onyemaechi’s transfer to hospital because there were not enough officers on duty at that time. Mr Onyemaechi was a Category A prisoner and was located in the prison’s segregation unit. He presented as a high security risk and needed six officers and a senior manager to unlock his cell and to escort him to hospital. The hospital agreed to hold a bed for Mr Onyemaechi until the next day.

38. At 9.22pm, a nurse saw Mr Onyemaechi. His NEWS2 score had risen to 5 and he was having difficulty breathing. (NEWS2 is a nationally recognised tool to facilitate the early detection of deterioration in health. A score of 5 or higher indicates an urgent assessment by acute care professionals in an environment with appropriate monitoring facilities). The nurse told Custodial Manager (CM) A, who was the Oscar 1 (manager in charge), that Mr Onyemaechi needed to go to hospital urgently. An ambulance was called an hour later, at 10.20pm.

39. CM A asked control room staff to contact staff that were off duty to come back to the prison to facilitate Mr Onyemaechi’s transfer to hospital.

40. At 11.08pm, Mr Onyemaechi’s NEWS2 score had risen to 8, which indicated that emergency assessment by a critical care team was needed. Ambulance records show that prison staff updated the emergency services with this information at 11.13pm.

41. At 11.21pm, a nurse told CM A that they needed to carry out checks on Mr Onyemaechi every 15 minutes due to his deteriorating health. The CM told the nurse that this could not be facilitated as officers were arriving at the prison. When staff are called into prison outside of prison hours, the prison has to break the night state. During the night state, all prisoners are locked in their cells and staff do not enter or exit the prison. When the escort staff enter the prison, two managers (Oscar 1 and Oscar 2) have to be present, as well as a dog and handler, to check the staff entering. The control room log shows that the escort staff arrived at the prison at 11.18pm.

Events from 3 September

42. At 1.50am, paramedics arrived. Mr Onyemaechi was restrained using doubled handcuffs when he was taken from the prison segregation unit to the escort vehicle. (Double handcuffing is when the prisoner’s hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs.) He was then restrained using single handcuffs when travelling in the vehicle to Addenbrookes hospital. Mr Onyemaechi was accompanied by six officers and a

senior manager, due to the level of risk he presented. He was double handcuffed when he was taken out of the vehicle and into hospital.

43. The hospital treated Mr Onyemaechi with intravenous antibiotics and ran a series of tests to explore his sudden decline in health. Once escort staff were satisfied his hospital room was secure, the level of restraint was reduced to single handcuffs and an escort chain, and to an escort chain only, if hospital staff needed this for any medical intervention. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

44. At around 1.40pm on 4 September, Mr Onyemaechi was placed in a medically induced coma. The level of restraints was reduced to an escort chain.

45. On 5 September, the hospital took a liver biopsy. During this procedure, Mr Onyemaechi had an acute bleed. He remained in an induced coma and was put on a ventilator to help him to breathe. He was still restrained using an escort chain.

46. On 10 September, hospital staff attempted to bring Mr Onyemaechi out of the medically induced coma. Prison staff increased the level of restraints to double handcuffs and an escort chain. Mr Onyemaechi remained unresponsive and on 14 September, the restraints were reduced to an escort chain only.

47. At 11.35am on 15 September, a manager from the Category A Prisoners Section authorised for all restraints to be removed.

48. At 4.26pm, it was confirmed that Mr Onyemaechi had died in hospital.

Post-mortem report

49. The pathologist gave Mr Onyemaechi’s cause of death as multiorgan failure caused by spontaneous bacterial peritonitis (bacterial infection in the abdomen) and cirrhosis (scarring of the liver caused by long-term liver damage) due to autoimmune hepatitis. He also had an intraperitoneal haemorrhage (haemorrhage in the abdomen) following a trans jugular liver biopsy, which did not cause but contributed to his death.

Findings

Clinical findings

50. The clinical reviewer concluded that the clinical care Mr Onyemaechi received at HMP Whitemoor was equivalent to that which he could have expected to receive in the community. Healthcare staff promptly recognised and acted on the clinical signs that Mr Onyemaechi's liver was failing and that he needed to be seen urgently by a liver specialist.

51. She did, however, identify some concerns about Mr Onyemaechi's care.

52. The clinical reviewer found that when Mr Onyemaechi transferred to Whitemoor, healthcare staff were unable to carry out a full reception health screen because the prison was in patrol night state. The reception screen was further delayed by Mr Onyemaechi being in isolation due to COVID-19 restrictions. Mr Onyemaechi was not offered a health screen until the 17 August, almost four months after he arrived at Whitemoor. At this point, Mr Onyemaechi refused the health screen.

53. Although Mr Onyemaechi was not taking any medication when he arrived at Whitemoor, healthcare staff did not undertake a medicines reconciliation exercise as they should have done. This should have taken place within 72 hours of his transfer and despite Mr Onyemaechi telling a nurse on his second day at Whitemoor that he had previously been taking medication, but he had stopped taking it due to the side effects.

54. The clinical reviewer considered that the failure to undertake the health screenings sooner was a missed opportunity to fully assess Mr Onyemaechi's physical and mental health care, treatment and needs. The clinical reviewer also considered that a failure to complete the medicines reconciliation exercise was also a missed opportunity to reassess Mr Onyemaechi's knowledge, beliefs and concerns about the medicines he needed to take in order to manage his autoimmune hepatitis condition.

55. We recommend:

The Head of Healthcare should ensure that:

- **all first stage health assessments at reception are completed for every prisoner;**
- **a second stage health assessment is completed for every prisoner within 7 days of the first stage health assessment, in line with NICE guideline NG57 and;**
- **all prisoners entering or transferring to HMP Whitemoor have a medicines reconciliation carried out within 72 days of arrival and before their second stage health assessment in accordance with Quality Standard QS156.**

Non-Clinical Findings

Emergency response

56. We are concerned that on the afternoon of the 2 September, the prison could not facilitate Mr Onyemaechi's transfer to hospital because there were not enough officers on duty at that time. This meant that there was a delay in him receiving the appropriate treatment for his deteriorating condition.

57. That evening, a nurse told CM A that Mr Onyemaechi needed to go to hospital urgently. An ambulance was called an hour later at 10.20pm. CM A told the investigator that he had difficulty recalling the exact sequence of events that evening, but if healthcare staff had asked him to call an ambulance, he would have asked the control room to call one straight away. He could not explain why an ambulance was called an hour after the nurse had asked for one. The investigation has been unable to establish why an ambulance was not called immediately.

58. We make the following recommendations:

The Governor should ensure that there are sufficient numbers of staff on duty during the day to facilitate transfers to hospital.

The Governor should ensure that staff call an emergency ambulance promptly when advised to do so by a doctor or a prison clinician.

The Governor should share this report with CM A and arrange for a senior manager to discuss the Ombudsman's findings with him.

Restraints, security and escorts

59. Mr Onyemaechi was a Category A prisoner and held under Close Supervision Centre (CSC) conditions. In his prison escort risk assessment, he was assessed as a high risk of harm to the public, a medium risk to hospital and of escape, and a general risk to prison staff. The escort risk assessment summary says, 'As a Category A, CSC prisoner he is deemed to pose a risk to the public. Linked to illicit substance abuse, prone to outbursts of extreme violence, which would present a risk to prison staff as well as hospital staff'. Given his offending history and the level of risk he presented, we are satisfied that Mr Onyemaechi was appropriately restrained when he was taken to hospital.

60. We are concerned that Mr Onyemaechi was, at times, restrained unnecessarily while he was in hospital.

61. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

62. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in

the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

63. This is reinforced in the *National Security Framework – External Escorts*. Sections 5.7 and 5.8 sets out the circumstances when restraints would not be appropriate. They say:

> "Handcuffs will not normally be used … if the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate. Restraints will not normally be necessary for example, when the prisoner's mobility is severely limited, e.g., due to advanced age or disability unless there are grounds for believing that an escape attempt may be made with external assistance."

64. Once Mr Onyemaechi was medically sedated on 4 September, we consider that he was no longer a risk to medical or prison staff. Escort staff were aware that he was placed in a medically induced coma because this is clearly recorded in the bedwatch log, which says, 'Mr O placed in an induced coma' and Mr Onyemaechi's level of restraints were reduced to an escort chain.

65. On 10 September, hospital staff attempted to bring Mr Onyemaechi out of the coma. His level of restraints was increased to double handcuffs. On 12 September, hospital staff had restarted Mr Onyemaechi's sedation, as he had been struggling to breathe when he was not sedated. Bedwatch paperwork records that on 14 September, Mr Onyemaechi's restraints were reduced to an escort chain 'due to being unconscious'. There appears to be no prison healthcare input into the escort risk assessment process during the period when Mr Onyemaechi was placed in a medically induced coma, despite healthcare staff having initiated the arrangements for his hospital transfer.

66. We consider that the prison should have made the decision to remove Mr Onyemaechi's restraints sooner. As soon as he was placed in a coma prison escort staff should have sought the necessary authority to remove the restraints, particularly when Mr Onyemaechi had been escorted by six officers and a senior manager. The bedwatch log recorded that restraints should continue to be used because Mr Onyemaechi could become conscious at any time. Mr Onyemaechi was medically sedated by hospital staff and he could not have come out of the coma without medical intervention. It is difficult, therefore, to justify the use of restraints while Mr Onyemaechi was under medical sedation and given the number of prison escorts.

67. We acknowledge that the prison appropriately removed Mr Onyemaechi's restraints before he died. Mr Onyemaechi died around five hours later, at 4.26pm. We recognise that many factors have to be taken into account in determining the level of restraints, however, we consider that the decision to restrain Mr Onyemaechi while he was in a medically induced coma was unsound.

68. In a previous investigation into a death at Whitemoor in July 2021, we were concerned about the inappropriate use of restraints for a prisoner who had breathing difficulties. It is disappointing that we are having to highlight similar

concerns in this report and are having to repeat our recommendation. The Governor must tell us what further steps he will take to ensure ill prisoners are not inappropriately restrained in the future.

69. We make the following recommendations:

The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, and that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

The Governor and the Head of Healthcare should ensure that the Healthcare Team contribute to risk assessments regarding the use of restraints when transferring prisoners to an acute hospital setting and that this contribution is clearly documented in the SystmOne records.

The Governor should write to the Ombudsman and tell her what further steps he will take to ensure ill prisoners are not inappropriately restrained in the future.

Inquest

70. The inquest concluded that Mr Onyemaechi died of natural causes.

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