Investigation into the circumstances surrounding the death of a man in hospital whilst in the custody of HMP Whatton

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

This is the report of an investigation into the death of a male prisoner at HMP Whatton, who died in outside hospital on 4 March 2010. He had been taken to hospital after collapsing at Whatton on 27 February and died after having a heart attack while in the shower.

I would like to add my personal condolences to all of those touched by the man's death.

The investigation was undertaken by an investigator from my office. I would like to thank the Governor of Whatton and her staff for their assistance during the investigation. In particular, I am grateful to two members of staff for making the arrangements during the investigation. A clinical review into the man's medical care at Whatton was commissioned from NHS Nottingham County Primary Care Trust. They appointed a clinical reviewer to conduct the review, and I am grateful to him for his timely report.

The clinical review carried out by the clinical reviewer concludes that the man's clinical care was comparable to that available in the community. I have noted the issues highlighted by the clinical reviewer and endorse the recommendation in the clinical review. This concerns the recording of diagnoses made by prison nursing staff.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

SUMMARY

The man died on 4 March 2010 in outside hospital. The man died of natural causes as a consequence of a myocardial infarction (heart attack).

The man was sentenced in July 2002 at a local Crown Court to nine years imprisonment for indecent assault and false imprisonment. He was released on licence from HMP Dovegate on 26 October 2007. Eighteen months later, on 25 April 2009, the man's licence was revoked and he was returned to custody. He arrived at HMP Nottingham on the same day and later transferred to HMP Whatton on 19 June.

During the man's first reception health screening interviews, it was recorded that he had chronic obstructive pulmonary disease (a narrowing of the airways causing shortness of breath), hypertension (high blood pressure) and arthritis. It was noted that the man's bladder had been removed in 2003 after he was diagnosed with cancer. He also smoked.

On the morning of 27 February 2010 (a Saturday), staff responded to the man's cell bell. He informed them that he had collapsed and was having breathing problems. Healthcare staff were asked to see him and he seemed better after they left. Throughout the morning staff observed the man interacting with other prisoners and had no further concerns about his well being.

Later that afternoon staff responded to a cell bell in another prisoner's cell. They found the man lying on the floor of the cell and were informed by his fellow prisoner that he had collapsed. As the healthcare staff had left the prison (their shift ends at 2.30pm at the weekend), an ambulance was called. The man was taken to the Accident and Emergency (A&E) Department of a local hospital. He was admitted later that day to the Coronary Care Unit at another hospital.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that restraints were to be used and two officers remained at the man's bedside.

During the morning of 4 March, the officers on bedwatch took the man for a shower. The man collapsed whilst in the bathroom. Hospital staff were unsuccessful in their attempts to resuscitate the man and he was pronounced dead by a hospital doctor at 9.35am.

The clinical review carried out by a doctor on behalf of NHS Nottinghamshire County PCT considered the care provided for the man. In the clinical reviewer's view, the quality of care given to the man was equivalent to that he would have received in the community. The clinical reviewer makes one recommendation for service improvement. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them.

THE INVESTIGATION PROCESS

1. The investigation was opened on 8 March 2010 by one of the Ombudsman's investigators. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event no one came forward.

2. The investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

3. A clinical review was commissioned from NHS Nottinghamshire County Primary Care Trust into the care provided for the man during his time in custody. I am grateful for the timely report.

4. The investigator visited HMP Whatton on 12 March and spoke to the Governor, as well as other staff involved in the care of the man. He returned on 7 May and interviewed the nurse the man spoke to in the morning and two officers, one of whom was the man's personal officer.

5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

6. The man was estranged from his family and sadly, therefore, the prison has been unable to locate any family members to inform them of his passing. I too have no contact details for any members of the family. This has meant that my office has been unable to involve them in the investigation or to address specific concerns that the family might have wished to be explored in this report.

HMP WHATTON

7. Whatton first opened as a detention centre for juveniles, but its role changed in the early 1990s to that of a prison for vulnerable adult offenders. During this time, the prison developed as a specialist establishment for adult male sex offenders to enable them to participate in Sex Offender Treatment Programmes. Whatton has recently undergone large expansions in 2006 and 2008, increasing the capacity by 500 places. All applicants for a place at Whatton must be adult males and category C sex offenders. They should not require the services of a full-time medical officer. The average age of the prisoners at Whatton is far higher than elsewhere in the Prison Service.

8. The regime at Whatton includes education, vocational training, industrial workshops and manufacturing, farms and gardening. There is a large range of offending behaviour programmes, including both Living Skills and Sex Offender Treatment Programmes.

9. The NHS Nottinghamshire County Primary Care Trust is responsible for healthcare provision within the prison. The healthcare centre is open daily, with healthcare staff on duty between 7.30am and 7.30pm. Outside of these hours, Nottinghamshire emergency medical services are used when required. Despite the average age of the prisoners, the PCT has not provided any inpatient healthcare facilities.

10. The healthcare department at Whatton runs a walk-in centre and a nurse-led GP practice. It runs nurse-led triage clinics, blood clinics, specialist clinics and follow up clinics. After the initial consultation, the nurse refers patients to the doctors or arranges appropriate prescriptions to be made up. Nurses take the lead in different diseases, and they have various internal clinical specialists, including in palliative care. Occasionally, external specialist nurses come in. These include diabetic, COPD (chronic obstructive pulmonary disease) and TB (tuberculosis) nurses.

11. There is a portable automated defibrillator located on each wing. These machines can analyse the heart rhythm, diagnosing shockable rhythms and then charging to treat. Defibrillation consists of delivering a dose of electrical energy to the affected heart. This halts abnormal electrical activity in the heart and can allow a normal heartbeat to be re-established.

12. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. This determines the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch is carried out by a duty governor. Visits from the family may be allowed but they are closely monitored to ensure that they do not impinge on the security of the bedwatch.

13. The risk assessment will consider the following:

    i. The prisoner's medical condition. When there is doubt, the prison's medical officer will be asked to advise on any medical objections to the use of restraints.
    ii. Behaviour in prison.
    iii. Home circumstances.
    iv. The nature of the offence (criminal history), the risk to the public and hospital staff, including the risk of hostage taking.
    v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
    vi. The physical security of the hospital.
    vii. Assessment of visits restrictions.

14. According to the policy for performing hospital bedwatches adopted when the man was in hospital, the following options were available to the Governor:

    i. "Escort and bedwatch with two officers or more, with restraints.
    ii. Escort and bedwatch with two officers or more, without restraints.
    iii. Escort and bedwatch with one officer, without restraints.
    iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
    v. … exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952)."

    The level of security necessary for all prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

15. The Investigator reviewed the reports into earlier deaths from natural causes at Whatton. He found no issues in common with the circumstances of the death of a man.

Her Majesty's Chief Inspector of Prisons' Report

16. The HM Chief Inspector of Prisons, made a full announced inspection of Whatton in January 2007. (There has been another, unannounced, inspection at Whatton since the man's death, but the report of that inspection has not yet been published.)

17. In the report of the 2007 inspection, the Chief Inspector noted that there was good practice in the health services provided. She wrote:

    > "There had been a comprehensive health needs assessment that had sought the views of patients, carers and staff as well as reviewing clinical records, and the results were being used to plan services."

Independent Monitoring Board (IMB) Report

18. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. The Board monitors day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Whatton covers the period from June 2008 to May 2009. The IMB drew attention to Whatton being of one of the few prisons where the average age of a prisoner was in the mid forties. The IMB said:

> "The general adult male prison population has about 80% under the age of 40 whilst Whatton will regularly house some 60% to 70% of its 845 prisoners over the age of 40 years. Naturally, this brings a completely different dimension to the healthcare needs of those in Whatton to almost any other prison establishment. It is therefore inevitable that more prisoners will die of natural causes in Whatton with the resultant effect that the healthcare has been required to respond to major incidents from time to time, on the palliative care of individuals. It has done this and continues to do so with great staff dedication and in an extremely sensitive manner."

Performance ratings

19. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being "serious concerns" and four "exceptional performance"). For the last four performance reports, HMP Whatton has been given a rating of three (or "good performance").

KEY EVENTS

20. The man was sentenced at a local Crown Court in July 2002 to nine years imprisonment for indecent assault and false imprisonment. He was released on licence from HMP Dovegate in October 2007.

21. In March 2009, the Probation Service became aware that the man had breached the conditions of his licence. On 25 April, his licence was revoked and he arrived at HMP Nottingham the same day. He transferred to HMP Whatton on 19 June where he was located in a single cell (2-28) on the first floor (2s landing) of Alpha Unit 3.

22. At the man's first reception health screen interviews, it was recorded that he had a history of chronic obstructive pulmonary disease (COPD), hypertension (high blood pressure) and arthritis. It was also recorded that his bladder had been removed (a cystectomy) in 2003 after he was diagnosed with cancer. After his operation he was fitted with a urostomy. (This is an opening onto the surface of the abdomen which is used to drain urine after the bladder has been removed. A bag is worn over the opening to collect the urine.) The man was also a heavy smoker.

23. The following medication was prescribed for the man: simvastatin (to lower cholesterol), salbutamol, ipratropium and seretide inhalers (for breathing), lansoprazole (for acid reflux) co-codamol and ibuprofen (for arthritis), and bendroflumethiazide and doxazosin (for blood pressure). The medication was dispensed to him everyday and he did not keep it in his possession.

24. The man was categorised as a category C prisoner. All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape; Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult; Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt; and Category D: open conditions, prisoners who can be trusted not to try and escape.

25. On 7 May 2009 at a nurse review, smoking cessation was discussed with the man but he chose not to accept help to stop. At a further nurse review just over a month later, on 17 June, it was noted that the man had mild COPD. Smoking cessation was again discussed and assistance was still declined.

26. Following a review with the prison doctor on 8 July, a letter was sent to the man's urological consultant regarding follow up of his bladder cancer. A week later, on 15 July, the man saw the prison doctor for a review. The doctor prescribed simvastatin and varenicline (which works by stimulating the nicotinic receptors in the brain and produces an effect that relieves the craving and

withdrawal symptoms when stopping smoking). It was recorded that the man's blood pressure was normal.

27. At a nurse review on 4 August, it was recorded that the man's blood pressure remained normal. After a respiratory review on the following day, the man was prescribed a new inhaler, ipratropium bromide.

28. On 18 August, blood tests were carried out and the results were received on 1 September. They showed impaired kidney function and that the man's cholesterol level had fallen.

29. The man was taken on 7 September for an outpatient appointment with the Urology Department at his local hospital. He was seen by his Urological Consultant and returned to prison later the same day. In his letter dated 8 September, the man's Urological Consultant informed Whatton that the man no longer needed to have routine follow up of his bladder cancer. The Urological Consultant confirmed that the man's renal function should be checked every three months.

30. At his review with the prison doctor on 8 October, it was recorded that the man was congratulated after he stopped smoking. It was noted that he had reduced the use of his inhaler as his breathing was now easier. Pain relief, for arthritis, and lansoprazole, for acid reflux, were both prescribed.

31. Just over three weeks later, on 27 October, the man experienced mild ankle swelling since he had started taking lansoprazole. He informed healthcare staff that he had now stopped taking the medication.

32. At the man's review with the prison doctor on 17 November, it was recorded that the mild ankle swelling had persisted. In view of his higher blood pressure, he was prescribed bendroflumethiazide (this is a diuretic, also known as "water pills", which is used to lower the amount of water in the body and is given to treat high blood pressure).

33. On 7 December, results of blood tests showed a further reduction in the man's kidney function. Just over a week later, on 15 December, the man saw the prison doctor who recorded that his blood pressure was not good. He had mild ankle swelling to his mid calves and a raised JVP (jugular venous pressure, a sign of heart failure). The man denied having any increasing shortness of breath or orthopnoea (getting short of breath when lying flat). The decline in kidney function was noted and ramipril was prescribed (this is used to treat hypertension, heart failure and prevention of heart attack and stroke in people who are at risk). Arrangements were made to check the man's kidney function again the following week. An electro electrocardiogram (ECG is a graphical recording of the electrical activity of the heart) was requested and this was subsequently found to be largely normal.

34. On 23 December, the results of further blood tests confirmed that the man's kidney function had slightly improved. At a review with the prison doctor on 29 December, it was noted that the man's blood pressure had also improved. A

subsequent blood test, on 11 January 2010, showed that the kidney function was a little lower again.

35. The man attended a review with both the prison doctor and nurse on 19 January. The decline in his kidney function was noted and further options for medication changes were discussed. It was recorded that his ankle swelling had subsided and the man was short of breath on exertion. He denied any chest pain and his lungs were clear. There were no signs of heart failure or chest infection. A chest x-ray was ordered and a new inhaler, seretide, was prescribed.

36. At a nurse review on 4 February, it was decided that the man should stop taking ramipril due to concerns about his kidney function and possible side effects of the medication. Four days later, on 8 February 2010, the man was taken to hospital for an x-ray. He returned later the same day. The result of the x-ray was received on 11 February. It showed a normal sized heart and clear lung fields.

37. On 11 February, the man saw the prison doctor for a review. The doctor decided to request an echocardiogram (a test which uses high-frequency sound waves to create an image of the heart and surrounding tissues) because the ankle swelling had returned and the man had slight orthopnoea. The man was also prescribed doxazosin (an alpha blocker, used to treat high blood pressure) to assist with controlling his blood pressure.

38. At his review with the nurse on 25 February, the man complained of increased breathlessness when getting dressed in the morning. He was advised to prop himself up in bed more at night and was told that a referral to the prison doctor would be made.

39. Around 7.51am on 27 February, the man rang his cell bell. He informed an officer that he had collapsed and was having problems breathing. The officer informed healthcare and the Orderly Officer that he needed assistance. He was immediately joined by both the Orderly Officer and the man's personal officer. They then unlocked the man's cell door. Two nurses arrived at the man's cell shortly afterwards.

40. When interviewed as part of this investigation, the officer that was informed by the man that he had collapsed said:

> "I was just going off the landing when I heard the cell bell and I attended the cell bell. Observed through the spy hole, the man [was] laying on his bed and I asked him what was the issue and he said he felt unwell and been actually on the floor, felt faint and had managed to press the cell bell and make his way to the bed. I've had sufficient experience before to realise that he didn't look particularly well at that time. I then informed the orderly officer of the day and healthcare."

41. When interviewed as part of this investigation, one of the two nurses to arrive on the scene confirmed that she saw the man during the morning of 27 February. This nurse said:

> "He was conscious, able to speak full sentences and able to converse with us. On our way over to the man, there were concerns [as] they said he was feeling breathless. So we were concerned about his breathing but when we arrived at his room it was clear that he wasn't struggling to breathe at all. No he wasn't on the floor and he wasn't unconscious. He was lying comfortably in bed, talking and chatting to us and obviously then we began our assessment because he was able to chat to us. We did his blood pressure. Blood pressure was 127 over 82. That's within range of normal. A normal young healthy fit person would be 120 over 70 but obviously the man was an elderly gentleman with problems and that's a very good healthy range for him. His oxygen sats [a measurement calculating the oxygen take-up rate in the blood] considering he had COPD was 99%. He should have a 100 but 99% is very good considering his condition."

42. The nurse that saw the man on the morning of the 27 confirmed that the man told her that he had a tingling feeling in his left arm. The nurse said: "There was no left sided weakness, good colour in his fingers. He just said it felt tingly and weak. Maybe he thought that he could have slept funny and it was only in his arm and it didn't go into chest or his back".

43. The man also told the nurse that saw him in the morning that he was anxious about coming back into custody. The nurse suggested that he came to healthcare on the following Monday, 2 March, to speak with one of the nurses. The nurse said that she advised this with a view to referring the man to the mental health team if he was anxious or depressed as they could help him with coping strategies. After the nurses had assessed the man, they left the wing. The nurses advised the officers that, if they had any further concerns about the man, they should contact healthcare. Throughout the morning the officer that he spoke to when he collapsed and his personal officer observed the man moving around the wing and interacting with other prisoners. Around 12.15pm, after the prisoners had collected their lunch, they were locked in their cells as usual.

44. At 2.40pm, the officer to first respond to the bell and the man's personal officer responded to a prisoner's cell bell. When they arrived at cell A3-26 a fellow prisoner, informed them that the man had collapsed in his cell. When interviewed as part of this investigation, the personal officer (each prisoner is allocated a personal officer, who is the first point of contact for any problems), said:

> "I recall a cell bell being pressed and it was a fellow prisoner Cell 26 … he's a prisoner who's polite, respectful he doesn't cause any issue so we thought something was wrong straightaway. We went straight up there and the man was laid out on the floor. He was conscious and

> partly passed out … the fellow prisoner … cushioned his fall and then pressed the cell bell to get the staff up."

45. An ambulance was called and the paramedics arrived around 3.05pm. The paramedics decided that the man should be taken to hospital and the ambulance left the prison 20 minutes later. He was escorted by two Senior Officer's in the ambulance and taken to the Accident and Emergency (A&E) at a local hospital. It was decided that he should be admitted and he moved to the Coronary Care Unit at another hospital at 5.55pm. An ECG was taken at 6.20pm. Hospital staff later confirmed that the man was considered stable and had suffered a myocardial infarction (heart attack).

46. Whilst the man was in the hospital the initial risk assessment, was completed by the Head of Operations at Whatton. He judged that restraints were to be used and two officers should remain on duty at his bedside ('bedwatch'). A log of activities was maintained by the officers on bedwatch duty which was checked on a regular basis by a visiting duty governor.

47. When healthcare staff contacted the hospital on 2 March, they were advised that the man was stable and that there were no plans for his discharge.

48. At 9.05am on 4 March, the man was taken by a Senior Officer and an officer to have a shower. The officer stayed with the man and the Senior Officer remained outside the bathroom. In her statement to the Governor, the Senior Officer wrote:

> On Thursday 4th March 2010 I was on a bedwatch … I did not know the man prior to this. I was given a full handover by the night staff and I also read his security brief. The man was chatty, he spoke about football, who he watched and how he used to play when he was younger. He had breakfast and used the toilet. Just before nine in the morning he asked if he could have a shower, the nursing staff gave him fresh pyjamas and the officer was on the closeting chain [two handcuffs connected by a chain]. They both went into the bathroom and I stood outside. Only a short time after I heard a noise and the officer say "are you alright", the door opened and the officer asked for help. I called the nursing staff who came running. I could see the man was not very well I immediately undid the cuff off him and the officer and myself left the bathroom (but stayed in sight, I then took the cuff off the officer) while the staff did what was needed. The man was sitting in the shower, he was just in his underpants and the water was not running. When I went in he was slumped in the shower when nursing staff came in he was laid on the floor to be resuscitated. At about 9:30am activity stopped and we were told that he was dead."

49. The officer that stayed with the man in the bathroom made the following entry in the bedwatch record at 9.08am:

> "I turned around and the man was slumped in bath. I called for assistance. Nursing staff dragged him out of the bath and I immediately removed cuffs. Left staff to work with the man."

50. At 9.23am the officer contacted a Principal Officer to inform him that the man had collapsed and that nursing staff were carrying out Cardio Pulmonary Resuscitation (CPR). Just over ten minutes later, at 9.35am, a hospital doctor pronounced that the man was dead.

51. After the man died, the prison activated its death in custody contingency plan. The police visited the hospital and found no suspicious circumstances. Staff at Whatton tried unsuccessfully to contact any remaining members of the man's family to inform them of his death. As the man had no family or friends to organise a funeral, the prison took responsibility.

52. Prisoners were immediately informed of the death and they were also asked whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) All the prisoners who were thought to be at risk of suicide or self-harm were reviewed.

ISSUES CONSIDERED

Clinical care

53. As noted, a review of the man's medical care was undertaken by the clinical reviewer on behalf of NHS Nottinghamshire County Primary Care Trust

54. The clinical reviewer found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. In his review the clinical reviewer wrote:

> "The man died at what can be considered in current times as relatively early age. However, when his risk factors for cardiovascular disease were taken into account, especially with his significant smoking history, his albeit premature death was not unremarkable. The HMP Whatton healthcare department offered the man all the established primary care preventative strategies to reduce his cardiovascular risk and, with help, he successfully managed stop smoking and lower his cholesterol levels."

55. The clinical reviewer noted that on the day the man collapsed, two experienced nurses attended to him in his cell. The nurses recalled that the man was not breathless, was talking normally in full sentences, and by then his colour had returned to normal. This was confirmed by the observations they recorded. The man did complain of a tingling sensation in his left arm but did not describe central chest pain. In addition, the man considered the arm pain was from when he knocked it when he was on the cell floor.

56. In the clinical reviewer's opinion, both the nurses made a reasonable assumption with the information presented to them. They considered this to be a single episode. The clinical reviewer recorded that the man had experienced previous episodes of dizziness with regard to the side effects of medication. The reviewer suggested that at this point, considering the man's history and risk factors, an ECG could have been taken. When compared with the ECG taken in December 2009, it may well have alerted doctors that a cardiac event such as angina or even a heart attack, was happening. However, the fact that the man had returned to normal was reassuring to all, and no further investigations were requested.

57. The clinical reviewer believes that, as part of ongoing audit and development of the nursing team's clinical skills, when nurses have to make a judgment, they should establish and record a diagnosis. The fact that they may be unable to confirm the diagnosis may then make them reflect on the situation, and request supportive diagnostic tests, or request a second opinion.

The Head of Healthcare at HMP Whatton, as part of ongoing audit of her team's clinical skills, should ensure that her staff establish and record diagnoses. If this is not possible then consideration should be given to diagnostic tests or requesting a second opinion.

Use of restraints

58. As previously mentioned, whilst the man was in hospital the initial risk assessment was for restraints to be used and two officers to remain with him. It was in line with standard procedures that the man was handcuffed in the first instance. At the time the handcuffs were first applied, the man was conscious and could reasonably have been judged to pose a security risk.

59. The risk assessment for the man was regularly reviewed during his time in hospital. Policy and practice in the Prison Service in respect of the use of restraints on prisoner-patients in hospital is extremely risk averse. My own sense is that it has become too risk averse and that an elderly man, in serious ill health and with no known relations, did not constitute a likely escapee. However, I do not criticise the decisions taken by Whatton given the prevailing climate and the expectations of the Service as a whole.

60. The investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Whatton. The Governor may wish to share my assessment with her managers and staff.

CONCLUSION

61. The man arrived at HMP Whatton on 19 June 2009. On 27 February 2010, he suffered a heart attack and was initially taken to a local hospital before being admitted to another hospital later that same day. The man passed away in hospital five days later on 4 March.

62. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were also in line with current policy and expectations.

63. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. In his clinical review the reviewer wrote: "I cannot find any significant shortcomings in how the man was managed whilst serving his sentence at HMP Whatton". The reviewer has made one recommendation, concerning recording diagnoses which I endorse.

RECOMMENDATION

1. The Head of Healthcare at HMP Whatton, as part of ongoing audit of her team's clinical skills, should ensure that her staff establish and record diagnoses. If this is not possible then consideration should be given to diagnostic tests or requesting a second opinion.

   Accepted by HMP Whatton - Further skills audit to be completed with recommendations. Record keeping update to be completed.