

**Investigation into the death of a man in March 2012,
while in the custody of HMP Isle of Wight - Parkhurst**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

September 2012

This is the report of an investigation into the death of the man, a prisoner at HMP Isle of Wight - Parkhurst, who died at Hospital, Newport, Isle of Wight. A post mortem recorded that his death was due to a stroke. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was commissioned to review the man's clinical care while in custody. Staff at Parkhurst co-operated fully with the investigation.

The man had been a prisoner at Parkhurst since June 2010. He had no known health issues. He kept himself very much to himself and declined to engage with treatment programmes that designed to help reduce his risk to the public. As a result he told staff and prisoners that he expected to die in prison.

During the evening of 7 March 2012, staff found the man very unwell when they unlocked his cell. He was taken to hospital quickly where he was found to have suffered a stroke. He was treated in hospital, but his condition continued to deteriorate and he died. I am concerned that the man was not subject to an appropriately individualised risk assessment and, as a result, he left the prison unnecessarily restrained on an escort chain. These restraints were not removed entirely until he was being resuscitated. I make a recommendation regarding this.

The clinical review concludes that the man's clinical care at HMP Isle of Wight was equivalent to that which he could have expected in the community. His stroke could not have been predicted, the prison's emergency response was swift and appropriate contact was made to inform his family.

The recommendation made in the draft report has been accepted by HMP Isle of Wight. I have included the prison's response to the recommendation at the end of this report.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2012

CONTENTS

Summary

The investigation process

HMP Isle of Wight

Key events

Issues

Conclusion

Recommendation

SUMMARY

1. The man died at Hospital, Newport, Isle of Wight following a stroke.
2. In August 2008, the man was found guilty and was sentenced at Chelmsford Crown Court to an indeterminate sentence for public protection, which required him to serve a minimum period of eight years and six months before he could be considered for release. He arrived at HMP Chelmsford the same day. The man spent time at Manchester, Lincoln and Norwich prisons before moving to HMP Isle of Wight - Parkhurst in June 2010.
3. At his health screening interview at Parkhurst, the man informed staff that he had pain in his shoulders for which he prescribed anti-inflammatory medication. He did not raise any other medical problems.
4. The man did not socialise much with other prisoners and spent most of his time pursuing his own interests in his cell. He would not participate in any offending behaviour programmes. He told staff and fellow prisoners that he expected to die in prison.
5. During the evening of 7 March, when staff unlocked the man's cell, they found him very unwell. An ambulance was called and when paramedics arrived they decided to take the man to hospital. The escorting arrangements for the man were that restraints were to be used and two officers were to be at his beside. During the afternoon of 8 March, staff were informed that his condition was getting worse and his restraints were removed and not re-applied. The man's condition continued to deteriorate and he was pronounced dead by a hospital doctor.
6. The clinical reviewer considers the quality of care given to the man at the prison was equivalent to that he could have expected in the community. He made one recommendation which is outside the PPO's remit and for the Isle of Wight NHS Trust to follow up.

THE INVESTIGATION PROCESS

7. This office was informed on the day the man died. The investigator subsequently issued notices to staff and prisoners at HMP Isle of Wight - Parkhurst informing them of the investigation and asking anyone who had relevant information to contact him. No one came forward. The investigator examined all the man's relevant prison records, including his medical records.
8. A clinical reviewer was commissioned to carry out a review of the man's clinical care during his time in custody. The purpose of the review was to establish whether the care which the man received in prison was comparable with that in the community and to identify any points of learning. The clinical reviewer's report was received on 29 May 2012.
9. The investigator visited HMP Isle of Wight - Parkhurst on 12 March and spoke to the Governor, to prisoners A and B (who lived in cells either side of the man) and to staff involved in the man's care. He returned to Parkhurst on 8 May and interviewed Governor A, SO A and the man's personal officer and Officer A. Initial feedback was given to the Duty Governor on 2 July, and was subsequently confirmed in writing.
10. The investigator contacted Her Majesty's Coroner to inform him of the investigation and to obtain a copy of the post mortem report. This report will be sent to the Coroner to assist his enquiries.
11. One of our family liaison officers contacted the man's family. She explained the investigation process and gave them the opportunity to raise any concerns or questions. The man's family were very positive about the support they had received from the prison's family liaison officer and did not have any issues to raise at the outset of the investigation.

HMP ISLE OF WIGHT

12. HMP Isle of Wight was established on 1 April 2009, by the organisational amalgamation of the former HMP Albany, HMP Parkhurst and HMP Camp Hill. Each site has its own Head of Regime who reports to the Governor. It holds approximately 1,700 prisoners on the three sites. The man lived at the Parkhurst site. The Camp Hill site is a category C training prison and Albany is a category B training prison holding mainly sex offenders. Parkhurst is a category B prison for long term and life sentence category B prisoners and a small number of remanded prisoners from the Isle of Wight courts.
13. Health services at HMP Isle of Wight are commissioned and provided by the Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust Cluster. The Inpatient Healthcare Unit (IHU), which opened in October 2009, is situated on the Albany site. Prison healthcare General Practitioner (GP) services are provided by Beacon - a partnership between the provider arm of the Primary Care Trust and Lighthouse Medical Ltd. The same group of doctors provide an out of hours' service.

HM Inspectorate of Prisons (HMIP)

14. The first inspection of the new HMP Isle of Wight by HM Inspectorate of Prisons was in October 2010. In his introduction to the report of the inspection, the Chief Inspector said:

“HMP Isle of Wight is, in many ways, the sum of its three disparate parts: Parkhurst, Albany and Camp Hill prisons. However, the single senior management team has worked hard to combat the many frailties and unique – and sometimes negative – cultures of the three sites, and has had some success. Thus Parkhurst, which was the subject of coruscating previous criticism from the Inspectorate, has demonstrated considerable improvements in terms of safety and decency.”

15. With regard to healthcare, inspectors reported that primary health services were in urgent need of improvement. At Parkhurst, primary care was in a poor environment, there were few clinics and long waits for the GP. The report noted that primary care services across all the sites were open between 7.30am and 5.30pm each day. After that time, the nurses from the Inpatient Healthcare Unit were available only for telephone advice, or staff contacted the local GP out-of-hours service.

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day-to-day life in prisons to help ensure prisoners are treated fairly and humanely.
17. The last annual report published by the IMB for HMP Isle of Wight was for January to December 2010. The report focused mainly on the challenges the prison faced with the merger of the three sites. The IMB said that healthcare

services at Parkhurst had been understaffed for a long period of time, although a doctor attended for six sessions per week. The IMB was also concerned that healthcare facilities at Parkhurst for prisoners with disabilities were poor. The IMB said that they had no dealings with the man during his time at Parkhurst.

Escort risk assessments

18. When prisoners are escorted to local hospitals, a risk assessment is completed which considers the risk posed to the public by the prisoner, their potential for escape and the likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the need for and the type of restraint to be used (single cuffs or a 1.8 metre long (closet/escort) chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment should be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary.

Previous deaths at HMP Isle of Wight – Parkhurst

19. There have been five deaths through natural causes at HMP Isle of Wight – Parkhurst since January 2009. There are no issues in common between these earlier deaths and that of the man.

KEY EVENTS

20. The man died in March 2012 at Hospital, Newport, Isle of Wight.
21. The man was convicted and he was sentenced to an indeterminate sentence for public protection at Chelmsford Crown Court. His tariff (the minimum term he should serve) was set at eight years and six months which meant he could not be considered for release until February 2017. He arrived at HMP Chelmsford the same day. This was not his first time in prison.
22. In a pre-sentence report, dated 18 April 2008, the man's Probation Officer assessed that the man was a high risk of harm to children. In his psychiatric report, dated 22 April 2008, the Probation Officer, Specialist Registrar in Forensic Psychiatry and Psychotherapy, stated that although there was no evidence that the man was suffering from a mental illness and he described his diagnosis as "multiple disorders of sexual preference". He concluded that it was important that the man attended a sex offender treatment programme (SOTP) while he was in custody.
23. During his sentence the man spent time in Chelmsford, Manchester (to complete to complete a SOTP programme which he subsequently refused to engage with), Lincoln and Norwich prisons before his move to HMP Isle of Wight - Parkhurst on 7 June 2010.
24. At a health screening interview at Parkhurst, on 7 June, the man informed staff that he had painful shoulders for which he was prescribed anti-inflammatory medication. He raised no other medical problems. During his reception health screen it was noted that he was a non-smoker, his blood pressure was normal and he was a normal weight for his height.
25. At a review of the man's prison categorisation, on 22 October, it was decided he should remain a category B prisoner. It was recorded that the man refused to sign his sentence plan and he said he had no intention of undertaking offender behaviour work to reduce his risks as he believed he had done everything he wanted to do in life and was happy if he never got released from custody.
26. In a report dated 28 January 2011, for the sentence planning and review report, Probation Officer A concluded that as the man had not completed any offence focussed programmes he had not reduced his risk of re-offending. She wrote in the conclusions to the report that she was concerned about the man's established pattern of offending behaviour and other issues related to his victims. She recommended that the man should remain in a category B prison.
27. On 16 December 2011, the man had a well man health check, his blood pressure was recorded as 138/88 which was within normal range (most adults in the UK have blood pressure readings in the range from 120/80 to 140/90). As his weight had increased by 5 kilograms over the past 12 months he was given dietary advice.

28. When interviewed as part of this investigation, the man's personal officer (each prisoner is allocated a personal officer, who is the first point of contact for them) described the man as someone who preferred his own company, staying in his cell watching television, reading and doing mathematical puzzles. Another officer, Officer B, described how the man spent most of his time studying and reading in his cell trying to devise mathematical formulae to predict winning combination of lottery numbers and/or roulette numbers. He said the man was always keen to demonstrate and explain his findings when there was the time.
29. On 24 January 2012, a programme tutor visited the man to assess his motivation to engage with SOTP. The man continued to decline to engage with the programme and signed a form to that effect. He said that he did not believe that it would benefit him as he anticipated that he would die in custody.
30. On 29 January Officer C recorded in the man's record that he was a "quiet, withdrawn man, who does not work but instead spends his time in his cell on mathematical puzzles". Officer C also recorded that the man did not mix with other prisoners on the wing and only came out of his cell for meals and to attend the library. The officer also wrote: "I note that he did not wish to engage with his programmes tutor, this will obviously impact on his sentence but as he's stated 'I'm going to die in prison' this will not affect him". A further entry by the officer on 11 February says: "A very quiet mature man who spends all his time in his cell on mathematical problems or reading. No issues or concerns raised or implied".
31. On the 21 February, the man was seen by prison doctor A, who prescribed eye ointment for conjunctivitis (an eye infection) and another ointment for dry eyes.
32. Nine days later, on 2 March, the man gave a blood sample for routine cholesterol/cardiovascular risk screening. His cardiovascular risk score was recorded as 16.4% (this was entered onto the man's record after his admission to hospital). This calculation is routinely done where a cholesterol result is reviewed, to decide whether a raised level warrants treatment with a statin (a drug for lowering cholesterol levels and preventing cardiovascular disease). The usual threshold for treatment with a statin is a risk calculation over 20%. The result of the man's blood test suggested that routine treatment was not required.
33. At around 4.30pm on 7 March, there was a generator test which caused some cells to lose power including the man's. Officer D said that he had spoken to the man about the loss of power and the man had helped him look at the power boxes to see which lights were out. The officer also saw the man collecting his meal around 4.55pm before he was locked in his cell. Just over an hour later, at around 6.00pm, Officers E and A were assisting staff who were handing out prison shop orders to prisoners. At around 6.10pm, when they unlocked the man's cell they found him in some distress lying on his bed. He was raising and lowering his left arm.
34. In a note to the Governor, Officer A stated that he thought the man "was having a stroke as the left side of his face was dropping/sagging". As the man did not

respond to anything that was said to him Officer E contacted the control room via his radio and asked for medical assistance. There are no healthcare staff on duty at Parkhurst after 5.30pm so the control room immediately called an ambulance. Officer E then called down to Senior Officer A who also came to the cell.

35. Paramedics arrived at around 6.25pm and took over the man's care. After assessing him the paramedics decided to take the man to Hospital, Newport, Isle of Wight. He was moved from the wing to the ambulance on a stretcher and left the prison and was escorted by two officers in the ambulance. The risk assessment was for restraints to be used and for two officers to remain at his bedside (this is known as a bedwatch). The man was restrained by an escort chain, a 1.8 metre length of chain with one cuff attached to an officer and the other to the prisoner.
36. The man arrived at the hospital. A CT scan (using X-rays and a computer to provide detailed images) was carried out, which showed no definite evidence of a stroke, and was suggestive of small vessel disease, a condition that causes a narrowing of the smaller blood vessels which provide blood flow to the heart. He was admitted to the Coronary Care Unit and it was recorded that the man's condition was stable and his Glasgow Coma Score (GCS) was 13/15 which was a good level of consciousness. (The Glasgow Coma score is a range of simple tests performed to assess the level of consciousness. The lowest possible score is 3, which means a deep coma or death, and the highest is 15, fully awake). The man was noted to have right sided weakness affecting his arm and leg and that his eyes deviated to the left.
37. The man was seen by a consultant who requested that the CT scan be repeated. This was because the man had been vomiting that morning, which can be a symptom of pressure inside the skull. It was recorded in the bedwatch log that the man had intermittent signs of movement but appeared to be still asleep.
38. Duty Governor A visited the escort staff to conduct a management check. The healthcare staff from the prison rang Hospital for an update on the man's condition. Hospital staff confirmed that the man had suffered a stroke and would require a long admission and rehabilitation.
39. A hospital nurse noticed that neurological observations had not been carried out. The observations were immediately carried out and as the GCS had deteriorated a doctor was asked to carry out a review. The review was conducted and recorded the GCS as 8. The man was then taken for his second CT scan. The escort staff contacted the prison and the Deputy Governor A gave permission for the restraints to be removed while the man was being treated by the nursing staff. The restraints were removed for the scan and re-applied.
40. On his return from the scan, the man began to have difficulty breathing and needed to be resuscitated. Nursing staff and the resuscitation team asked for the restraints to be removed again so they could treat the man. The bedwatch

staff removed the restraints and informed the prison of their actions. Governor A, Security Manager, agreed to the removal of restraints at this stage. The man's GCS had dropped to 3. The scan showed a massive stroke affecting most of the left side of his brain and the duty neurosurgeon agreed that surgical intervention would not be appropriate. It was decided no further resuscitation would be attempted and 'do not attempt resuscitation' notices were completed by hospital medical staff. Restraints were not re-applied (a formal revised risk assessment was received by the escort staff at 6.05pm)

41. The resuscitation team informed the escort staff that the man's condition was "very, very poor". The escorting officers informed the prison and Governor A arrived at the hospital accompanied by the reverend, a prison chaplain.
42. Governor A told the investigator that he was informed by a consultant that the man had suffered "a massive stroke and that looking at the CT scan that it was unlikely that he would recover. He told me at that point it would be a matter of hours".
43. One of the prison's family liaison officers contacted the man's family to inform them about his admission to hospital and his prognosis. The man's family did not want to attend the hospital, but asked to be telephoned if his condition changed or if he died during the day and informed by text message if this occurred during the night.
44. At around 7.05pm, Officer C and Officer F took over the escort duty and received a briefing from Officer B. In his statement to the investigator, Officer C confirmed they discussed "the clinical diagnosis for the man and Officer B stated that the nursing staff did not expect him to recover". Officer C also noted that restraints were not being used and that a new risk assessment had been completed.
45. The man did not regain consciousness and died in his sleep. As requested, his family were informed by text message and this was followed up with a telephone call from the family liaison officer in the morning.
46. After the man's death, the prison's family liaison officer continued to liaise with his family, assisted with the funeral arrangements and arranged for the man's belongings to be returned to his family. The man's funeral took place in March 2012, and Parkhurst offered financial assistance with the costs in line with national guidance.
47. Prisoners were informed of the man's death during the morning of the death and asked whether they required any additional support or wanted to speak to a Listener (prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). Prisoners who were subject to self-harm and suicide monitoring were reviewed.
48. Prison managers held a 'hot debrief' for staff immediately involved to share information and provide reassurance and support.

Post mortem

49. The post mortem report records the man's death as being due to natural causes, as a consequence a stroke (spontaneous ischaemic cerebral infarction).

ISSUES

Clinical care

50. A review of the man's clinical care was undertaken by the clinical reviewer on behalf of the Southampton, Hampshire, Isle of Wight and Portsmouth Primary Care Trust Cluster. In his review, the clinical reviewer notes that when the man arrived in prison he had no pre-existing conditions and was a non-smoker with normal blood pressure and weight. He had two annual health checks. He gained weight while he was in custody and was offered appropriate dietary advice. The clinical reviewer notes that the man's cholesterol was checked shortly before his death but was below the level requiring any treatment.
51. The clinical reviewer draws attention to hospital staff not conducting neurological observations between 4.00am and 2.00pm on 8 March. He said it was not clear at what interval they were intended to be done, but they are usually every four hours. After this, the man was assessed by a consultant and further tests were conducted which showed a marked deterioration in his condition.
52. The clinical reviewer states that the delay in repeating the "observations should be recorded as a Serious Incident Requiring Investigation (SIRI) requiring investigation by the Isle of Wight NHS Trust". He says that the man had an extensive stroke from which it was clear he would not recover. Earlier observations would have detected this sooner but would not have altered the outcome for the man. In someone for whom the stroke was not so severe, earlier observations might have indicated treatment that would have prevented further damage. The clinical reviewer makes a recommendation about this which is outside our remit but is the responsibility of the Isle of Wight NHS Trust to follow up.

The emergency response

53. The man was discovered by staff during the evening of 7 March. Within a few minutes of his discovery, they had radioed for and received assistance and an ambulance had been called. Paramedics arrived 15 minutes after being requested and they decided to take the man to hospital. He remained in hospital but his condition continued to deteriorate and he was pronounced dead.
54. From both the records and the investigator's interviews with staff we are satisfied that all those involved acted quickly and in a professional and considerate manner.

Restraints, escort and bedwatch

55. In line with its duty to protect the public, the Prison Service will usually require some form of restraint and/or escort staff when prisoners are taken out of the prison. An individual risk assessment should be completed on each occasion covering the risk to the public, the potential for escape and the likelihood of

outside assistance. It should take into account the prisoner's health and mobility. Prison staff suspected the man had suffered a stroke, although this was not confirmed until the following day. However, when he left the prison the man was barely conscious and on a stretcher. The investigator noted that the initial risk assessment carried out appeared to be a generic assessment with a default position to use an escort chain. This is not appropriate and each risk assessment should be based on an individual's risk of escape and risk to the public taking into account their health and mobility at the time.

56. While he was in hospital, the man had his restraints removed on two occasions for treatment, the second time while he was being resuscitated. On the second occasion, following the diagnosis of his condition, the restraints were not re-applied and the risk assessment was subsequently revised. He remained supervised by two officers. We are concerned that the man was clearly very sick and is likely to have presented a very low risk of escape during his time in hospital, yet it was not until he was in need of resuscitation that the restraints were finally removed.
57. The investigator found that the bedwatch log was concise, with legible and appropriate entries. However we are not satisfied that the initial risk assessment fully took into account the man's individual circumstances, and we are not satisfied that the decision to remove restraints was made early enough to ensure the man was given appropriate dignity in his final hours.

The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

58. Both at interview and as part of the debrief following the man's death, Officer C suggested an aide-memoire should be produced for staff on bedwatch duties, on actions to take following a death in custody, and this should form part of the escort documentation. Governor A, who conducted the debrief has taken this forward and the aide-memoire will be issued shortly.

CONCLUSION

59. The man arrived at HMP Isle of Wight - Parkhurst in June 2010. He was serving an indeterminate sentence and had some years to go before he could be considered for release, but he did not engage with any programmes designed to reduce his risk to the public and had said that he expected to die in prison.
60. During the evening of 7 March 2012, the man was found to be very unwell. He was taken to hospital where his condition continued to deteriorate and he died as a result of a stroke during the early hours of March 2012. We are not satisfied that there was an appropriate individual risk assessment for the man or that restraints were removed early enough for him to have appropriate dignity in his final hours.
61. The clinical reviewer concluded that the care of the man received in prison was equivalent to what he would have expected to have received from normal NHS healthcare and we agree.

RECOMMENDATION

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

Accepted: There is often limited information available at the time of an emergency escort. The manager will therefore make an operational assessment of risk. This will be further reviewed as more information becomes available. On planned escorts the risk, as well as the prisoners needs, will be reviewed and periodically updated given any change of circumstance whilst on a bedwatch.