PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 14 May 2014 at HMP Isle of Wight

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who died of a brain haemorrhage on 14 May 2014 at HMP Isle of Wight. He was 78 years old. I offer my condolences to his family and friends.

A clinical review was commissioned to investigate the man's clinical care. The prison cooperated fully with the investigation.

The man was sentenced to 14 years in prison in July 2012. In August, he was transferred to HMP Isle of Wight. He suffered from a range of physical health conditions including asthma, migraines and high blood pressure and also had a depressive illness. He received medication and treatment for these conditions throughout his time in prison.

In November 2013, the man was diagnosed with deep vein thrombosis and spent time in the prison's inpatient unit. He went back to live on a standard residential wing, but his health deteriorated and staff noticed his memory seemed impaired. On 12 May 2014, he was unwell and taken to hospital where he was diagnosed with gastroenteritis. He was discharged back to the prison the same day and went to the inpatient unit for monitoring. He felt worse over the next two days and, on 14 May, he collapsed in his cell and was taken to hospital again. The man had suffered a bleed on the brain and hospital doctors said he would not survive long. He died at 4.18pm that day.

The clinical review has identified the need for improvements in the management of patients with hypertension and deep vein thrombosis, but this would not have affected the outcome for the man. I agree with the clinical reviewer that he received a standard of care equivalent to that he could have expected to receive in the community. In a number of previous reports, I have criticised the inappropriate use of restraints on terminally ill prisoners at HMP Isle of Wight, I am therefore pleased to note that the prison took a proportionate and humane approach and did not use restraints when the man was taken to hospital.

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 **December 2014**

CONTENTS

SUMMARY

1. The man was sentenced to 14 years in prison for sexual offences in July 2012. He was sent to HMP Isle of Wight on 3 August and allocated to a wing for elderly or disabled prisoners. He had asthma, excess stomach acid, migraine, musculoskeletal pain disorder, high blood pressure and was also treated for depression. He was prescribed a number of medications.

2. In June 2013, the man's calf swelled up and his knee became painful. He was diagnosed with an arthritic knee and a bleed in the calf muscle. He continued to have pains in his leg and in November, a doctor diagnosed deep vein thrombosis for which he received daily anti-coagulant injections.

3. During the evening of 3 December, a nurse referred the man to the doctor after he told her that he had fainted that morning and hit his head. The doctor considered the man had fainted because of low blood pressure and stopped his blood pressure medication. He admitted him to the inpatient unit for observation and stayed there until 17 December.

4. Wing staff noted that the man seemed confused and had a poor memory. He was not taking his medication correctly and healthcare staff monitored this. In March 2014, he had two high blood pressure readings, but healthcare staff took no action as they did not consider them high enough. His memory continued to deteriorate and on 6 May 2014, a memory test indicated that his memory problems were a result of his depressive illness, rather than dementia.

5. On the morning of 12 May, the man was unwell with sickness and diarrhoea. A nurse considered he was very unwell and, as there was no doctor available to review him, the nurse called an ambulance. He went to hospital and returned to prison later that day after being diagnosed with gastroenteritis.

6. On 14 May, the man still felt ill. A nurse examined him and asked a doctor to review him. Before this could happen, at about 1.00pm, he collapsed on the floor of his cell. A doctor examined him and he was taken to hospital by ambulance.

7. In hospital, a CT scan revealed that the man had a serious bleed on his brain, which he was unlikely to survive. Hospital staff asked the escorting officers to inform his next of kin. Unfortunately the prison were unable to locate the man's next of kin before he died at 4.18pm that afternoon.

8. We agree with the clinical reviewer that the man's clinical care in prison was equivalent to that he could have expected to receive in the community. Although it is unlikely to have made a difference to the outcome for the man, the clinical reviewer has identified a need for improvements to the management of hypertension and deep vein thrombosis. We make two recommendations about this.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed seven members of staff at HMP Isle of Wight on 17 June and gave the Governor initial written feedback about the preliminary findings of the investigation.

11. NHS England commissioned a doctor to review the man's clinical care at the prison.

12. We informed HM Coroner for Isle of Wight of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers wrote to inform the man's son about the investigation. At the date of this draft report, we had received no response.

14. The man's family received a copy of the draft report. They did not make any comments. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP ISLE OF WIGHT

15. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man lived on the Albany site, on a wing for older or disabled prisoners.

16. Since 1 June 2013, Care UK has provided healthcare at the prison. Before this, provision was by the Isle of Wight Primary Care Trust. There is an inpatient healthcare unit with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

17. The last inspection of Isle of Wight was in May 2012. The Inspectorate found that health services had improved considerably since the previous inspection. However, there were difficulties for prisoners in accessing primary care services promptly, especially at the Albany site. Mental health services had also improved.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to December 2012, the IMB commented that the inpatient healthcare unit provided a very high standard of care.

Previous deaths at HMP Isle of Wight

19. The man was the fourteenth prisoner to die of natural causes at Isle of Wight since January 2013. There are no significant similarities with the circumstances of these deaths.

KEY EVENTS

20. On 26 July 2012, the man was sentenced to 14 years in prison for sexual offences. He went to HMP Isle of Wight on 3 August 2012. His initial health screening noted he had a left shoulder injury and a black eye from falling off a bunk bed in the past few days. A nurse noted his medications and that he suffered from depression.

21. At his second health screen on 6 August, a prison GP noted that the man had asthma, high blood pressure, excess stomach acid, migraine, musculoskeletal pain disorder and a depressive illness. The GP noted the man took various medications for his health problems, including anti-depressants.

22. A mental health nurse assessed the man on 10 August, but no further input was planned. He continued to receive his medication regularly and saw the doctor occasionally to review them. In May 2013, he reported pain in his knee and that his calf was swollen. He was admitted to the inpatient unit for observations on 2 June. On 4 June, he went to hospital for tests and was diagnosed with an arthritic knee and a calf haematoma (a bleed in the calf muscle), which the hospital considered would settle in time. The hospital discharged the man on 7 June. Initially, he went to the prison's inpatient unit and, on 10 June, returned to his wing.

23. Records show that the man's physical and mental health began to deteriorate. His anti-depressant medication was increased and he continued to have leg and knee pains. On 15 November, a doctor was concerned that the man might have a deep vein thrombosis after he complained of continued leg pain. On 19 November, he went to hospital for a scan, which confirmed the diagnosis. He was prescribed daily anti-coagulant injections (to prevent blood clotting), which he received for the rest of his life.

24. During the evening of 3 December, a nurse saw the man, who said at he had woken up on the cell floor at around 4.00am that morning after he had blacked out and hit his head. He said he told someone but no action was taken. We found no evidence that he reported it earlier in the day. The nurse arranged for him to see the doctor and, at 5.55pm, a prison GP assessed him. The man said he often fainted and the doctor diagnosed hypotension syncope symptom (fainting when standing from sitting or lying down because of low blood pressure). The records show only this incident of fainting. The doctor admitted the man to the inpatient unit for observations and stopped his blood pressure medication. Staff noted he was unsteady on his feet and his mobility was becoming an issue. He stayed in the inpatient unit until 17 December, when healthcare staff considered he was at less risk of falling and he returned to his wing.

25. On 23 December, an officer told a nurse that there was a lot of medication in the man's cell and he needed monitoring because he was confused. The nurse visited him and removed boxes of medication because some were out of date, some were not currently prescribed and some could not be identified. She noted the man's compliance in taking medications needed monitoring

and that if there were further problems they might need to consider giving him his medication daily or supervised. A system to monitor his weekly medication was used and there is no record that there were any problems about his medication after this.

26. During March 2014, records show that the man had two high blood pressure readings (151/96 and 153/100), but there is no record that any action was taken. Prison and medical staff continued to monitor him and he remained living on his wing. His memory was often noted to be poor. On 6 May, he had a memory test which showed his impairment was because of depression rather than dementia.

27. At lunchtime on 12 May, the man told an officer that he had sickness and diarrhoea and needed help. The officer phoned healthcare staff and a nurse attended within ten minutes. She noted he was drowsy and seeing double, but aware of what was going on around him. She recorded he had high blood pressure (207/102), a normal pulse (69bpm), a low temperature of 35.5, his oxygen saturation was 97% (within normal range), and his blood sugar levels were elevated. The nurse was concerned about the man's health and, as no doctor was available, she called an ambulance at 12.30pm. He was taken to hospital by ambulance at 1.14pm. He was not restrained.

28. At 6.55pm the same day, the man returned to the prison healthcare unit. The discharge note from the hospital said he had gastroenteritis.

29. A nurse noted that the man rang his cell bell in the early part of the night on13 May and complained of a headache. The nurse gave him paracetamol. On 14 May, a nurse saw him after he rang his cell bell at around 11.30am. She noted his blood pressure was high (176/76), his pulse was normal (76bpm), he had a slightly low temperature (36.5) and oxygen saturation of 97%. Two nurses helped the man to wash and change and also changed his bedding because it was soiled. His speech was slurred, but was much clearer once he had got out of bed and dressed. They asked a GP to review him that afternoon.

30. A nurse checked on the man at about 12.00pm and recorded he was fine. At about 1.00pm, two nurses were on the landing outside the man's cell when they heard a bang. They found him collapsed, semi-conscious on the floor of his cell. They called another nurse and a doctor to assist and they attended immediately. The doctor took the man's blood pressure which was high (224/103) and his pulse which was normal (64bpm). The doctor carried out an ECG which showed no evidence of a heart attack. The man's oxygen saturation was 100%, but his responses to pain and voice were slow. The doctor requested an ambulance at 1.08pm. The paramedics arrived at 1.12pm and took him to hospital. He was not restrained.

31. A CT scan at the hospital revealed a large bleed on the man's brain. At 2.58pm, a hospital doctor asked prison escort officers to contact his next of kin as he was not expected to survive for very long. The escort officers

informed the prison, but the prison was not able to trace his next of kin before he died at 4.18pm.

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Liaison with the man's family

32. The man had no listed next of kin. A prison family liaison officer traced his cousin on 14 May, who gave a phone number for his sister, but the number was out of use. The family liaison officer eventually located the man's son, through the police, who informed him of his father's death on 14 May.

33. The man's son contacted the family liaison officer, who offered support and guidance. The man's funeral was on 27 June and representatives from the prison attended. The prison organised and paid for the funeral in line with national guidance.

Support for staff and prisoners

34. A hot debrief was held for the officers who escorted the man to hospital on 14 May. All other staff interviewed said they felt appropriately supported. Notices in the prison informed other prisoners of his death and who to contact for support if they had been affected. A memorial service was held at the prison.

Post-mortem

35. A post-mortem showed that the man died of a spontaneous cerebellar haemorrhage (brain haemorrhage). There were no other significant findings.

ISSUES

Clinical care

36. We agree with the clinical reviewer that the care the man received in prison was equivalent to that he could have expected to receive in the community. The clinical reviewer had some concerns about the management of deep vein thrombosis and hypertension at the prison, but pointed out that this was unlikely to have affected the outcome for the man. He also had some concerns about the treatment the man received in hospital on 12 May, but they are outside the remit of this investigation and will be considered separately by NHS England.

Management of deep vein thrombosis

37. The clinical reviewer noted that, after the man was diagnosed with a deep vein thrombosis (DVT), treatment with heparin (an anti-coagulant) was started at an appropriate dose. Such treatment can cause reduced platelets and raised potassium levels and blood tests should be carried out before treatment and regularly afterwards. Although blood tests were carried out before the treatment began (and the results were normal), they were not repeated until May 2014; over five months after treatment began. Fortunately, the results were satisfactory at that time.

38. The clinical reviewer said that a DVT normally requires three to six months of treatment. There is no indication of the proposed length of treatment when the man started heparin by injection, and he remained on the treatment until he died, (a period of six months). It is also not clear why his anti-coagulant treatment was not switched to warfarin (an oral anti-coagulant), which the clinical reviewer says is the normal treatment for DVT. The clinical reviewer noted that while anti-coagulant treatment can increase the risk of spontaneous bleeding, withholding such treatment in someone with DVT increases the risk of a pulmonary embolism (which also can be fatal). The clinical reviewer therefore had no concerns about the man receiving anti-coagulant treatment. However, the management of DVT would be improved through a clear protocol which covers type and length of treatment and what monitoring is required in line with the National Institute for Health and Care Excellence (NICE) guidelines. We make the following recommendation:

    The Head of Healthcare should ensure there is a protocol for the clinical management of prisoners with DVT, which is in line with NICE guidelines and makes clear the type and length of treatment and the monitoring required.

Blood pressure monitoring

39. The man suffered from high blood pressure when he came to prison and received treatment for this. After his fall, the medication for hypertension was stopped because his blood pressure was too low and causing his falls.

Healthcare staff tested and recorded his blood pressure regularly. There are two occasions in March 2014, when his blood pressure was high at 151/96 and 153/100, but no action was taken. Clinical staff told us they considered this was not quite high enough to act on.

40. The clinical reviewer says that although a cerebellar bleed is most often caused by hypertension, the blood pressure levels recorded for the man over time show this is very unlikely to have caused his bleed. However, NICE guidelines state that the target blood pressure for those under 80 is 140/90 and anything over this should be reviewed. The policy used by healthcare staff at the prison was out of date and should incorporate the most recent NICE guidance. We make the following recommendation:

The Head of Healthcare should ensure the policy for monitoring patients with hypertension is updated to reflect current NICE guidelines and that high blood pressure is appropriately reviewed.

RECOMMENDATIONS

1. The Head of Healthcare should ensure there is a protocol for the clinical management of prisoners with DVT, which is in line with NICE guidelines and makes clear the type and length of treatment and the monitoring required.

2. The Head of Healthcare should ensure the policy for monitoring patients with hypertension is updated to reflect current NICE guidelines and that high blood pressure is appropriately reviewed.

ACTION PLAN: The man – HMP Isle of Wight

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure there is a protocol for the clinical management of prisoners with DVT, which is in line with NICE guidelines and makes clear the type and length of treatment and the monitoring required.	Accepted	HMP Isle of Wight Health Services has a guidance document in place to aid clinicians considering suspected thrombo-embolic disease. The guidance has now been updated to reflect the current NICE guidelines, making it clear the type and length of treatment and the monitoring required.	Completed Head of Healthcare
2	The Head of Healthcare should ensure the policy for monitoring patients with hypertension is updated to reflect current NICE guidelines and that high blood pressure is appropriately reviewed.	Accepted	The prison's guidance on cardio vascular disease is currently being reviewed to ensure it reflects the current NICE guidelines and that high blood pressure is appropriately reviewed.	31 October 2014 Head of Healthcare