

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Mower, a prisoner at HMP Isle of Wight, on 12 May 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 Andrew Mower died of a heart attack on 12 May 2015, while a prisoner at HMP Isle of Wight. He was 70 years old. I offer my condolences to those who knew Mr Mower.

Mr Mower had a number of chronic health conditions, which contributed to his risk of a sudden cardiac death. Although he was an uncooperative patient, the investigation found that his care would have been better coordinated with a clear care plan to monitor, treat and review his complex needs.

While I commend officers and healthcare staff for their effective emergency response when Mr Mower collapsed, which managed to restart his heart and breathing, I am concerned there was a slight delay in taking Mr Mower to hospital as the prison's control room did not call an ambulance immediately the emergency was called. I have made recommendations about this matter to the prison before, and the Governor needs to make sure that control room staff fully understand their responsibilities in an emergency.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. Mr Andrew Mower had been at HMP Isle Of Wight since February 2013. He was serving an indeterminate sentence imposed in July 2012, with a minimum time to serve of nearly ten years. He had a number of health problems, including diabetes and ischaemic heart disease. Healthcare staff monitored these conditions, but Mr Mower did not always attend appointments or take his prescribed medication.
2. Just before 4.25pm on 12 May 2014, Mr Mower collapsed. Officers and healthcare staff responded promptly and radioed an emergency code but it was six minutes later before the control room called an ambulance. The staff managed to resuscitate Mr Mower before paramedics arrived and took him to hospital. In hospital, Mr Mower's heart stopped twice more. The second time he did not respond and a doctor pronounced him dead at 5.56pm.

Findings

3. Mr Mower frequently refused treatment and often did not attend healthcare appointments, which made it difficult to manage his health conditions effectively. Despite his lack of cooperation, the clinical reviewer considered healthcare staff should have implemented a clear care plan to review and manage his conditions and medication.
4. Officers and healthcare staff responded promptly and effectively to the emergency, but we are concerned that control room staff did not call an ambulance immediately as Prison Service national instructions require. This caused a short delay in taking Mr Mower to hospital. While this is unlikely to have affected the outcome for Mr Mower, who received effective emergency treatment from staff at the prison, in other emergencies such a delay could be critical.

Recommendations

- The Head of Healthcare should ensure that all patients with complex needs have a clear personalised care plan, consistent with NICE guidelines, with stated aims, planned interventions and monitoring and regular reviews of medication.
- The Governor should ensure that control room staff call an ambulance immediately a medical emergency code is called.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator visited the Isle of Wight on 19 May 2015 and obtained copies of relevant extracts from Mr Mower's prison and medical records. She spoke to four members of staff and one prisoner during the visit, about Mr Mower's care.
7. NHS England commissioned a clinical reviewer to review Mr Mower's clinical care at the prison.
8. We informed HM Coroner for Isle of Wight of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted a friend of Mr Mower's, who he had named as his next of kin, to explain the investigation. Mr Mower's friend did not have any specific matters for the investigation to consider.
10. 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.
11. Mr Mower's friend was informed the initial report was available, but did not wish to receive a copy.

Background Information

HMP Isle of Wight

12. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Isle of Wight was in June 2015. The report has not yet been published but inspectors told us that healthcare staff managed and monitored cardiovascular risk factors well. They noted that, after deaths at the prison, the prison held multidisciplinary reviews to quickly identify any lessons to be learned.

Independent Monitoring Board

14. 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 December 2014, the IMB said that the prison provided an effective standard of healthcare. There was good attendance at outpatient appointments. The IMB commented that, because of the large number of older prisoners, the prison had one of the highest rates of deaths from natural causes.

Previous deaths at HMP Isle of Wight

15. Mr Mower was the ninth prisoner to die of natural causes at HMP Isle of Wight since January 2014. We have previously identified the need to call an ambulance as soon as a medical emergency code is called.

Key Events

16. On 4 August 2011, Mr Andrew Mower was remanded to HMP Pentonville for sexual offences. On 6 July 2012, he was sentenced to an indeterminate sentence with a minimum time to serve of nearly ten years. On 7 February 2013, he transferred to HMP Isle of Wight.
17. At an initial health screen when he arrived at the Isle of Wight, a nurse noted he had a number of long-term health conditions, for which he took medication. He was obese, had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases), ischaemic heart disease, high cholesterol, an irregular heartbeat, high blood pressure, arthritis and pains in his knees. He also had obstructive sleep apnoea and used a continuous positive airway pressure device (CPAP) while he slept. Mr Mower was given a single cell.
18. On 22 February, a prison GP carried out an electrocardiogram (ECG) test. The ECG showed that Mr Mower had atrial fibrillation (an irregular and often fast heart rate). Mr Mower refused further investigation, but agreed to take anti-clotting medication.
19. On 23 April, records show Mr Mower cholesterol levels were higher than previously, but there is no record that anyone reviewed the dose of simvastatin he had been prescribed to treat this.
20. Healthcare staff monitored Mr Mower's condition when he allowed, but he often refused to engage. On 16 July, a prison GP noted his blood sugar level was high and suspected diabetes. In August, he was diagnosed with type two diabetes but refused to take any medication or make lifestyle changes to help control the condition. Healthcare staff continued to review Mr Mower's COPD and general health, including his blood sugar levels whenever possible.
21. On 10 November, records show that Mr Mower cholesterol was further raised, but there was no review or change to his dose of medication. On 27 November, Mr Mower agreed to take metformin for diabetes and his blood sugar level improved after this.
22. On 26 February 2014, Mr Mower complained of shortness of breath and swollen legs. A prison GP considered that this indicated heart failure, but Mr Mower declined any further investigations. At first, he refused medication to prevent fluid build up, but in March he agreed to take furosemide which helped initially. However, on 11 June, a prison GP noted the swelling had become worse and Mr Mower now had ulcers. He advised Mr Mower to keep his legs raised when he could. A nurse dressed his ulcers later that day and he told her he was not taking his furosemide. She advised him to take it.
23. Mr Mower did not attend a number of healthcare appointments to review his diabetes and COPD, and to treat and dress his leg ulcers. Healthcare staff spoke to him about this and stressed the importance of keeping his appointments, but he still often chose not to attend. Healthcare staff were satisfied that Mr Mower had capacity to make decisions.

24. On 28 November, Mr Mower said he had been coughing up blood for a few days, which had cleared and that he had increased swelling of his lower legs. A prison GP diagnosed heart failure and prescribed furosemide again. He arranged for blood tests and a chest X-ray, but Mr Mower refused to have the X-ray.
25. On 8 December, Mr Mower attended a COPD clinic but still refused a chest X-ray. His blood pressure was high (144/62) and a doctor reviewed and adjusted his blood pressure medication.
26. Over the next months, there was nothing significant in Mr Mower's records. He continued to see doctors and nurses when he wanted but did not always attend planned appointments.
27. At around 4.15pm on 12 May 2015, Mr Mower was in the cell of another prisoner. Shortly before 4.25pm, the prisoner said Mr Mower, who was sitting on the bed, stood up, swore, and then collapsed back on to the bed. The prisoner pressed his cell bell and began to try to resuscitate Mr Mower. After about two minutes, no one had arrived so he went to the wing office and alerted two officers. The officers ran to the prisoner's cell. Records show that, at 4.25pm, one of the officers radioed a code blue (a medical emergency code blue indicating circumstances such as when a prisoner is unconscious or has breathing difficulties). Within a minute, a nurse arrived and she and one of the officers, moved Mr Mower to the floor of the landing to allow space to begin cardiopulmonary resuscitation.
28. A further nurse and a healthcare assistant arrived with emergency equipment. The nurse assessed Mr Mower, who was not breathing and had no pulse. He asked the control room to update the ambulance service that Mr Mower had had a heart attack. (Ambulance service records show that the prison did not request an ambulance until 4.31pm.) Two nurses gave chest compressions and maintained Mr Mower's airway. The healthcare assistant attached a defibrillator, which advised four shocks. At 4.38pm, Mr Mower's heart started again and he began to breathe unaided.
29. At 4.44pm, an ambulance arrived and paramedics took Mr Mower to hospital. In hospital Mr Mower's heart stopped twice more. The second time he did not recover and, at 5.56pm, a doctor pronounced Mr Mower dead.

Contact with Mr Mower's next of kin

30. Mr Mower had no living relatives and had named a friend as his next of kin. His friend lived some distance away and the prison arranged for a family liaison officer from HMP Pentonville to inform his friend of his death. The prison arranged and paid for Mr Mower's funeral.

Support for prisoners and staff

31. On the evening that Mr Mower died, a prison manager debriefed the staff involved in the emergency response, to allow them the opportunity to discuss any issues arising and to offer support. Some staff had gone off duty and she contacted them by phone or email. The staff care team also offered support.

32. The next morning, officers told the prisoner who occupied the cell the man had collapsed in, individually before any other prisoners that Mr Mower had died and offered support. The prisoner told us he appreciated this. The prison posted notices informing staff and prisoners of Mr Mower's death, offering support if needed. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Mower's death. The prison held a memorial service for Mr Mower on 8 June.

Post-mortem report

33. A post-mortem examination found that Mr Mower had died of hypertensive and ischaemic heart disease (heart disease caused by high blood pressure and reduced blood supply to the heart) and calcific aortic stenosis (obstruction of the aortic valve). His heart was damaged and a sudden collapse, causing death could have occurred at any time.

Findings

Clinical Care

34. The clinical reviewer noted that Mr Mower had several risk factors for ischaemic heart disease, which would have contributed to his risk of sudden cardiac death. These included atrial fibrillation, hypertension, late onset diabetes, obesity and raised cholesterol. His blood pressure was generally well controlled with medication and once he agreed to take medication, his diabetes was also under control. Doctors appropriately prescribed anti-coagulant treatment for atrial fibrillation. There were indicators of heart failure in February 2014, but Mr Mower refused any further investigation.
35. Doctors prescribed simvastatin to lower Mr Mower's cholesterol from August 2011. However, the clinical reviewer considered that the dose was insufficient to significantly reduce his risk. Mr Mower was taking a lot of medications on repeat prescription and it is not clear from the records whether clinicians reviewed them sufficiently. Changes in doses or the choice of drug was not always explained in the records. Mr Mower had at least two recorded increases in his cholesterol levels, but his dose of simvastatin was not reviewed.
36. The clinical reviewer noted that healthcare staff found it difficult to monitor and treat Mr Mower effectively as he frequently refused treatment and often did not attend healthcare appointments. However, he considered that even when a patient is uncooperative, healthcare staff should adhere to National Institute for Health and Care Excellence (NICE) guidelines on care planning. We recognise that Mr Mower's lack of engagement with healthcare staff, means it is unlikely that there would have been any change in outcome, but there were insufficient care plans to monitor his chronic conditions and to ensure active prescribing when necessary. We make the following recommendation:

The Head of Healthcare should ensure that all patients with complex needs have a clear personalised care plan, consistent with NICE guidelines, with stated aims, planned interventions and monitoring and regular reviews of medication.

Emergency Response

37. Although the officers did not respond immediately to the cell bell when the prisoner pressed it, they explained that they were dealing with an issue with another prisoner in the office at the time. One of the officers said he planned to go as soon as they had finished. Once the prisoner came to the office, the two officers ran to the cell and called an emergency code. While officers should respond to cell bells quickly, we recognise it is not always possible to respond immediately and we are satisfied that the officers responded appropriately with little delay.
38. Healthcare staff arrived promptly and the staff were able to revive Mr Mower before paramedics arrived. The emergency response was appropriate, timely and effective and the clinical reviewer considered the prison and healthcare staff response was commendable.

39. However, we are concerned that control room staff did not call an ambulance immediately when staff radioed an emergency medical code blue, as required by Prison Service Instruction (PSI) 03/2013. The Isle of Wight has an appropriate local medical response protocol, which reflects the national instruction and clearly states that control room staff should call an ambulance immediately. However, records show that control room staff did not call an ambulance until six minutes after the code blue. The delay is unlikely to have changed the outcome for Mr Mower as he received quick and effective emergency treatment, but in other circumstances this could be critical. We have raised this concern with the prison before. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately an emergency code is called.

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