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 in January 2014 while in the custody of 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 in January 2014, while in the custody of HMP Isle of Wight. He was 51 years old and died of a blockage in the main artery to his lungs, a complication following surgery. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Isle of Wight was conducted. The prison cooperated fully with the investigation.

In April 2012, the man was sentenced to nineteen years in prison and sent to HMP Woodhill. He moved to HMP Isle of Wight in December 2012. When he arrived, healthcare staff noted that he had undergone extensive surgery to his stomach in 2010. As a result he was incontinent and sometimes had difficulty swallowing Between December 2012 and December 2013, his condition was monitored and managed by healthcare staff but no significant issues arose.

On 28 December, the man was admitted to hospital with abdominal problems. He was diagnosed with a perforated bowel and had an emergency operation. He was discharged from hospital on 17 January 2014 and admitted to the inpatient healthcare unit at HMP Isle of Wight.

On the day he returned to the prison and the next day, a nurse recorded high blood pressure and pulse readings, but these were not followed up. The man collapsed in the inpatient unit on the morning of 22 January. A nurse noted he was clammy and his blood pressure had dropped, but considered this was within normal levels. He moved back to his residential wing that afternoon and on 25 January appeared very unwell and was admitted to hospital. His condition deteriorated rapidly in hospital and he later died.

The clinical reviewer was concerned that there was no post-operative care plan for the man after he was discharged from hospital. He considered that the symptoms he displayed could have been significant indicators of the complications he was experiencing and should have been more effectively monitored and identified as warning signs of his deteriorating condition.

I am also concerned that the man's medical condition was not fully taken into account during the escort risk assessment process and that restraints were therefore used without appropriate justification. This is an issue that has arisen repeatedly in my investigations at HMP Isle of Wight and senior managers need to review practice comprehensively to ensure staff achieve an appropriate and properly evidenced balance between security and humanity.

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 **October 2014**

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SUMMARY

1. In April 2012, the man was sentenced to nineteen years in prison and was sent to HMP Woodhill. He moved to HMP Isle of Wight in December 2012.

2. Healthcare staff noted that the man had undergone extensive surgery to his stomach in 2010 and, as a result, was incontinent. He sometimes had difficulty swallowing and he experienced frequent stomach pains. He ate a soft diet to help with his condition. Between December 2012 and December 2013, healthcare staff managed his condition well and he did not report any significant health problems.

3. On 28 December 2013, a nurse sent the man to hospital as his abdomen was swollen and tight and his blood pressure and pulse rate were high. He remained in hospital and on 29 December was diagnosed with a perforated bowel which needed emergency surgery. He was moved to another hospital for the surgery, after which he was put into an induced coma. He regained consciousness on 4 January 2014.

4. On 17 January, the man was discharged to the inpatient healthcare unit at HMP Isle of Wight. His blood pressure and pulse rate were recorded as high that day and the next day, but there is no evidence that this was followed up. There was no post-operative care plan.

5. On the morning of 22 January, the man collapsed in the inpatient unit. He had no apparent injuries but his blood pressure was low. The nurse who assessed him advised that he should remain as an inpatient, but he apparently insisted on returning to his residential wing that afternoon and he was allowed to go. On 25 January, the clinical team manager saw him, who looked very unwell. She noted that his blood pressure was too low to be recorded, he had a rapid heart beat, was having difficulty breathing and she believed he was going into hypovolemic shock (shock through decreased blood volume). An ambulance was called and he was taken to hospital where he was admitted to the intensive care unit. His condition deteriorated rapidly in hospital and he later died.

6. A post-mortem revealed that the man had died from a blockage of the main artery to the lungs, a complication following surgery.

7. The clinical reviewer noted that the man presented with possible symptoms of complications after his surgery. He considered that a post-operative care plan should have been implemented when the man was discharged from hospital, which would have highlighted the signs and symptoms of possible complications. We are concerned that, despite a number of previous recommendations to HMP Isle of Wight about this issue, his medical condition was not appropriately considered as part of the escort risk assessment when he was in hospital between 28 December and 17 January. We make two recommendations.

THE INVESTIGATION PROCESS

8. 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.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. Another investigator interviewed four members of staff at HMP Isle of Wight on 27 March. The investigator interviewed a further six members of staff and a prisoner by telephone. She gave the Governor initial written feedback about the preliminary findings of the investigation.

10. NHS South of England commissioned a clinical reviewer to review the man's clinical care at the prison.

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

12. One of our family liaison officers spoke to the man's sister about the investigation who wanted to know if his medical care was timely and appropriate.

13. The man's family received a copy of the draft report. They raised two questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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HMP ISLE OF WIGHT

14. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man lived on the Parkhurst site.

15. Since 1 June 2013, Care UK has provided healthcare at the prison. 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

16. The most recent inspection of Isle of Wight was in May 2012. The Inspectorate found that health services had improved considerably from the time of their previous inspection. It was noted that Phoenix wing (the wing where the man lived) had good support systems for prisoners with health and mobility needs. There was also positive engagement from staff with prisoners.

Independent Monitoring Board

17. 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

18. The man was the eleventh prisoner to die of natural causes at Isle of Wight since January 2013. It is a concern that in a number of previous reports, we have raised the issue of the use of restraints on critically ill prisoners without fully considered risk assessments.

KEY EVENTS

19. In July 2010, the man was questioned by police in relation to serious offences and then fled to France. In 2011, he consumed drain cleaner in an act of self-harm and spent many months in a French hospital where he underwent extensive surgery to his oesophagus, stomach and bowel. On 27 September 2011, he left hospital and returned to the UK. He was arrested when he arrived at the airport and was admitted to a secure hospital in Lambeth for assessment. He was discharged into police custody on 5 October and remanded to HMP Woodhill on 6 October.

20. On 16 April 2012, the man was convicted and sentenced to 19 years in prison. On 13 December that year, he transferred to HMP Isle of Wight.

21. When the man arrived at the Isle of Wight, medical staff conducted a full health screen. They noted that he had undergone serious surgery to his stomach, and as a result was faecally incontinent, sometimes had difficulty swallowing and experienced frequent stomach pains. He ate a soft diet to help control his condition. They noted that he had been diagnosed with paranoid schizophrenia in 2003. A doctor prescribed olanzapine (an antipsychotic), mirtazapine (an antidepressant), hyoscine butylbromide (to relieve stomach cramps) and propranolol (to treat high blood pressure and anxiety). He said he did not have any contact with his family and listed a doctor from the psychiatric hospital as his next of kin.

22. The man lived on Phoenix wing on the Parkhurst site, a unit predominately for prisoners with health and mobility needs. Apart from attending work, he spent most of his time in his cell and rarely socialised.

23. On 19 December, a nurse saw the man for a mental health review. He noted that his mental health was stable and he was taking his medication as prescribed. Psychiatrists and mental health nurses frequently reviewed him throughout his time in prison and recorded no significant mental health issues.

24. Records show healthcare staff monitored the man's nutritional needs and swallowing problems. No serious medical complaints were noted for the next twelve months.

25. On 26 December 2013, a nurse saw the man, who complained of abdominal pain. He said that the pain had started after he had taken ibuprofen for toothache and his daily dose of hyoscine butylbromide. The nurse told us that he spoke to a doctor, who advised that the abdominal pain was a side effect of his medication. There is no record that the doctor examined him.

26. At 3.19pm on Saturday 28 December, wing staff took the man to the healthcare unit as he complained of pain across his stomach and back. A nurse noted in his medical record that he was pale, clammy, and his abdomen was swollen and tight. His blood pressure and pulse were high. She called the out of hours GP service for advice, but there was no response. She decided that he needed to go to hospital and requested an ambulance. He was escorted by two prison officers and restrained with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

27. The man was admitted to hospital. In the early hours of 29 December, after a CT scan, a consultant informed him that he had a perforated bowel and needed emergency surgery at another hospital. His condition was serious and the hospital consultant asked for the escort chain to be removed. This duty manager initially agreed then completed a formal risk assessment and decided that the escort chain should be reapplied but removed for his operation. The escort chain was reapplied 45 minutes after first being removed and contrary to the request of the consultant.

28. At 11.25am the same day the man was airlifted to the other hospital. He was unrestrained during the flight but an escort chain was applied on landing and removed again later that day for surgery. After his surgery, he was placed in an induced coma and moved to the intensive care unit of the hospital. He remained unrestrained.

29. The man remained in an induced coma and on 3 January 2014, had another operation to close his wound. He regained consciousness on 4 January. Hospital staff asked that the escort chain should not be applied as the handcuff could impede the blood flow to his arm. Despite this request, at 3.50am on 5 January, the escort chain was reapplied. He remained in hospital until 16 January when he was transferred to the first hospital. A nurse visited him the next day to assess his needs for discharge and was told that he was fit to return to prison.

30. At 5.45pm on 17 January, the man returned to the inpatient health unit at HMP Isle of Wight. A doctor reviewed his medication that day and a student nurse recorded his blood pressure and pulse rate as high. There was no post-operative care plan and no evidence that this was followed up. On 18 January, she recorded his blood pressure and pulse readings as higher than they were the previous day. Again, there is no record that anyone followed this up.

31. At 10.00am on 22 January, a nurse saw the man after he collapsed in the dining room of the inpatient unit. She noted he looked clammy and nervous, but had no apparent injuries. His blood pressure had dropped but the nurse considered it was still within an acceptable range and she was not too concerned about it. She advised him to drink more and that he needed to stay as an inpatient. However, he insisted on returning to his wing and was allowed to go back to Phoenix wing that afternoon. There were no further significant entries in his medical records until 25 January.

Events of leading up to the incident

32. At about 9.15am several days later, an officer saw the man outside the wing office. She said he looked yellow and unwell. He was clammy and breathless and she asked if he needed a nurse to come to see him on the wing. He declined and said that he wanted to go to collect his medication. She gave him the keys to an electric wheelchair Phoenix wing has for prisoners to use. She watched him go from the wing to the healthcare unit, approximately 100-150 yards away. He left the wheelchair outside and walked in.

33. Nurses were concerned at the man's appearance and at 9.30am the clinical team manager examined him. He said he had not eaten or drunk anything that

morning. The manager noted that he looked very unwell. His blood pressure was too low to be recorded, he had a rapid heart beat, and he was having difficulty breathing. She believed that he might be going into hypovolemic shock (caused through decreased blood volume). She gave him oxygen and his condition stabilised.

34. The prison called an ambulance which took the man to hospital. He was not restrained. The hospital diagnosed metabolic acidosis (when there is too much acid in the body). He was considered to be seriously ill and he was moved to the intensive care unit later that afternoon.

35. At 4.00am, the man was placed on dialysis as hospital staff were concerned that he was suffering organ failure. At 4.55am, he requested oxygen but became unresponsive shortly afterwards. Hospital staff began to try to resuscitate him but he did not respond. At 5.18am, a doctor declared his death.

36. A post-mortem gave the cause of death as pulmonary thromboembolism (blockage of the main artery to the lungs) and presumed peripheral phlebothrombosis (blood clots formed in the deep veins of the body). The pathologist stated that the man's recent surgery and subsequent immobilisation were relevant factors.

Family liaison

37. When the man was taken to hospital on 25 January, officers asked him twice if he would like his family informed, but he declined. He had listed a doctor from the psychiatric hospital as his next of kin. After he died the prison contacted the doctor, who said that he did not want any involvement. He had not recorded any contact details for his family.

38. A prison family liaison officer was appointed. She contacted Thames Valley Police to assist in locating the man's father. On 27 January, the police visited his father and sister and told them of his death.

39. On 28 January, the family liaison officer contacted the man's sister. The prison returned his property to his family and offered financial assistance towards funeral costs, in line with national guidelines. The funeral was held on 20 February.

ISSUES

Clinical care

Care plans

40. The clinical reviewer says that, when the man was discharged from hospital on 17 January, a care plan should have been put in place to monitor his post-operative care. In the week after his discharge from hospital, he displayed symptoms and signs which may have been significant indicators of the complications that led to his collapse. On two occasions his blood pressure and pulse rate were recorded as high, but there is no evidence that this was acted upon.

41. The man collapsed five days after he was discharged from hospital. A nurse noted his blood pressure was low, but was satisfied it was still within an acceptable range. He was allowed to leave the inpatient unit that day and the lack of a post-operative care plan meant that he was not monitored and his clinical observations were not taken again until 25 January, when he was seriously ill. A care plan would have highlighted the signs and symptoms of potential complications and ensured regular monitoring. We make the following recommendation:

    The Head of Healthcare should ensure that post-operative care plans are implemented to monitor all prisoners returning from hospital after surgery.

Escort risk assessments and restraints

42. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

43. When the man was taken to hospital as an emergency escort on 28 December, no formal risk assessment was completed and an escort chain was used. The escort chain was removed at the request of a consultant at hospital, but reapplied 45 minutes later. The duty manager completed a formal risk assessment which indicated that the man was considered to be a low risk of escape and low risk to the public and there were no behavioural concerns. The medical section of the risk assessment was not completed. Despite this he authorised restraints to be used. Subsequent requests by hospital staff at hospital for the restraints to be removed because of the risk of impeding blood

flow to the man's arm were discounted and the escort chain was reapplied on 5 January, after he regained consciousness, although he was bed bound and very poorly. The risk assessment was not revisited.

44. We are concerned that despite the man's serious condition and hospital staff requests for the removal of restraints, his medical condition was not appropriately considered, particularly in relation to the impact his condition had on his risk of escape. This is an issue we have raised a number of times with HMP Isle of Wight. Although our previous recommendations have been accepted, and action plans submitted, it is apparent that seriously ill prisoners, such as the man, are still restrained without a satisfactory and comprehensive risk assessment that complies with the 2007 High Court judgement. We repeat the following recommendation:

The Governor should comprehensively review practice to ensure that all staff undertaking risk assessments for prisoners taken to or in hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that post-operative care plans are implemented to monitor all prisoners returning from hospital after surgery.

2. The Governor should comprehensively review practice to ensure that all staff undertaking risk assessments for prisoners taken to or in hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that post-operative care plans are implemented to monitor all prisoners returning from hospital after surgery.	Accepted	Healthcare staff now develop appropriate care plans for patients returning from hospital. These record potential complications, required observation levels and identify when a GP or the hospital should be contacted.	Completed and on-going Head of Healthcare
2	The Governor should comprehensively review practice to ensure that all staff undertaking risk assessments for prisoners taken to or in hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	Briefings to senior staff have taken place, and an e-mail has been sent to all operational managers, to remind them of the need to consider the use of restraints on an individual basis and to take medical assessments of mobility into consideration when assessing each prisoner's risk of escape and/or risk of causing harm to others. The South Central DDC has discussed this issue with the Governor and is content that appropriate action has been taken to remind staff of their responsibilities in line with the senior leaders' bulletin from the Director of Public Sector Prisons and the Deputy Director of Contracted Prisons issued in January 2014. The DDC and Governor will ensure that where restraints can be safely removed for prisoners with terminal or serious illnesses they will be, and that no prisoner will wear restraints without a full and up to date justification.	Completed and ongoing South Central DDC

			The decision making process with regards to the appropriateness of restraints has now significantly improved with different departments working closer together when decisions are made and questions in risk assessments now accurately record clinical information regarding a patient's mobility. Operational managers inform senior managers when a risk assessment has been completed. They then reassess this within 24 hours of any prisoner being admitted to hospital or immediately following any serious decline in their medical condition. Escorting staff also make dynamic assessments of a prisoner's mobility and behaviour during an escort and record this on Prison-NOMIS upon their return to the prison. The DDC continues to review restraint documentation during her scheduled visits to HMP Isle of Wight.	