Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerry Mason a prisoner at HMP Isle of Wight on 29 October 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Gerry Mason died of coronary artery disease on 29 October 2015, at HMP Isle of Wight. He was 53 years old. I offer my condolences to Mr Mason's family and friends.

Mr Mason's death, three days after he arrived at HMP Isle of Wight from HMP Winchester, was sudden and unexpected. However, the clinical reviewer was concerned that, despite Mr Mason's evident risk factors, Winchester did not offer him a formal assessment of his risk of dying from heart disease and the opportunity to reduce some of these risks. In this respect, his care in prison did not reflect that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. On 22 September 2014, Mr Gerry Mason was remanded to HMP High Down and transferred to HMP Winchester a week later. In April 2015, he was sentenced to six years in prison for sexual offences.

2. Mr Mason was a heavy drinker and cigarette smoker. He completed an alcohol detoxification programme when he first arrived in prison but had no other health concerns. However, between 22 and 29 September five out of six blood pressure readings were high. The last one, the day after he arrived at Winchester, was within normal limits. There was no record that anyone checked his blood pressure again at Winchester or that he was offered an assessment for heart disease despite his obvious risk factors.

3. On 26 October 2015, Mr Mason transferred to HMP Isle of Wight. At an initial health screen, a nurse and GP recorded that he did not have any significant health issues. The next day, at a further screen, a nurse noted his blood pressure was high and made an appointment to assess it again a week later.

4. At approximately 11.00pm on 28 October, the prisoner in the cell next to Mr Mason heard a loud bang against the wall. He was able to leave his cell using the electronic unlock system which allows prisoners to use the toilets at night and went to Mr Mason's door to ask about the noise. When he got no response he assumed Mr Mason was asleep. He did not report the noise to anyone.

5. The next morning a prison officer noticed that Mr Mason was lying in an unusual position. He went into the cell and found that Mr Mason was unresponsive and cold. He called a medical emergency and the control room called an ambulance. A nurse arrived quickly and noted signs of rigor mortis, so staff did not attempt resuscitation. Paramedics arrived and recorded Mr Mason's death.

Findings

6. Mr Mason was at increased risk of heart disease due to his age, history of heavy drinking and smoking. It is possible that he also suffered from hypertension, a further risk factor, but this was never diagnosed or discounted because previous high blood pressure readings were not appropriately investigated or monitored at Winchester. The original high readings might have been the result of previous alcohol consumption but this was never established. Despite his risk factors, Mr Mason was never offered a formal assessment of his risk of dying from heart disease and the opportunity to reduce some of his risks. In this respect, Mr Mason's care was not equivalent to that he could have expected to receive in the community.

7. When he arrived at HMP Isle of Wight, three days before he died, a nurse booked a follow up appointment for Mr Mason after identifying that he was hypertensive. We consider that healthcare staff assessed Mr Mason appropriately when he arrived. It is apparent that Mr Mason was dead when an officer found him unresponsive on the morning of 29 October and we are satisfied that it was appropriate not to attempt resuscitation.

Recommendations

- The Head of Healthcare at HMP Winchester should ensure that high blood pressure readings are followed up and investigated in line with NICE guidance.
- The Head of Healthcare at HMP Winchester should ensure that cardiovascular risk assessments are offered to all prisoners aged over 40 with relevant risk factors, in line with NICE guidance and that offered in the community.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Isle of Wight and HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

9. The investigator obtained copies of relevant extracts from Mr Mason's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Mason's clinical care at the prison.

11. The investigator interviewed two members of staff and one prisoner at HMP Isle of Wight on 11 November 2015. He interviewed another member of staff by telephone on 1 February 2016.

12. We informed HM Coroner for the 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.

13. One of the Ombudsman's family liaison officers contacted Mr Mason's ex-partner, who he had named as his next of kin, to explain the investigation. She did not have any specific issues or questions for the investigation to consider.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

15. Mr Mason's ex-partner received a copy of the initial report. She did not make any comments.

Background Information

HMP Isle of Wight

16. 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. 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

17. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good and long-term medical conditions were managed well. After deaths at the prison, the prison held multidisciplinary reviews to help identify any lessons to be learned.

Independent Monitoring Board

18. 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 reported that the prison provided an effective standard of healthcare.

Previous deaths at HMP Isle of Wight

19. Mr Mason was the fourteenth prisoner to die of natural causes at HMP Isle of Wight since January 2014. There have been four natural cause deaths since. This figure is relatively high because of the age profile of the population and because the prison provides specialist palliative care. There were no significant similarities between the circumstances of Mr Mason's death and previous deaths.

HMP Winchester

20. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. Central and North West London NHS Foundation Trust provides health services at the prison. The prison's healthcare centre has 24-hour nursing cover and doctors from a local practice run surgeries from Monday to Friday.

HM Inspectorate of Prisons

21. The most recent inspection of Winchester was in February 2014. Inspectors reported that the prison was seriously overcrowded and older prisoners (aged 50 and over) made up approximately 11% of the population. Little was done to meet their specific needs. Inspectors reported that healthcare staff shortages hindered service delivery and development.

Independent Monitoring Board

22. In its latest annual report, for the year to May 2015, the Winchester IMB was concerned about staffing levels at the prison. The IMB noted there had been considerable improvements to induction possesses including first night assessments to identify health needs.

Previous deaths at HMP Winchester

23. There have been six natural cause deaths at HMP Winchester since January 2014. There were no significant similarities between the circumstances of Mr Mason's death and previous deaths.

Key Events

24. On 22 September 2014, Mr Gerry Mason was remanded to HMP High Down. He transferred to HMP Winchester on 29 September. In April 2015, he was sentenced to six years in prison for sexual offences.

25. At an initial health screen at High Down, a nurse noted that Mr Mason appeared physically fit and well and did not have any significant health concerns, but he was a heavy drinker and smoker. He declined help to give up smoking. The nurse recorded that his blood pressure was very high (193/111). A GP referred Mr Mason to the prison's substance misuse team for an alcohol detoxification programme. On 24 September, another nurse recorded that Mr Mason's blood pressure was still high.

26. On 29 September, Mr Mason transferred to Winchester. A nurse noted he had no significant health problems. Three nurses saw Mr Mason on the day he arrived and all recorded high blood pressure readings. A prison GP prescribed medication to continue Mr Mason's alcohol detoxification (thiamine and vitamin B) and referred him to the substance misuse team.

27. On 30 September, a nurse recorded that Mr Mason's blood pressure was within normal limits. There was no record that healthcare staff monitored Mr Mason's blood pressure at Winchester again after that. Mr Mason completed his alcohol detoxification programme on 24 October.

28. In April 2015, Mr Mason accepted help to give up smoking. He was smoking 30 cigarettes a day at the time. In July, he told a healthcare assistant that he had given up smoking and did not want any further support. (However, records show he started again.)

29. On 26 October, Mr Mason was transferred to HMP Isle of Wight. A nurse and a prison GP saw him when he arrived for an initial health screen. The GP noted that he had he had no significant health issues, appeared fit and well and was not been prescribed any regular medication. He said he smoked 20 cigarettes a day. The next day, a nurse saw Mr Mason for a secondary health screen. He took Mr Mason's basic medical observations and recorded that Mr Mason was hypertensive (high blood pressure). He booked an appointment for a nurse to review his blood pressure on 3 November. There was no record that Mr Mason reported any chest pains or any other symptoms.

28 and 29 October

30. Mr Mason was locked in his cell at 7.48pm on 28 October and he did not leave his cell after this time. The cells on the wing where Mr Mason lived do not have toilet facilities. At night, prisoners ask to use the communal facilities using an intercom system and their cells are unlocked electronically. At around 11.00pm, the prisoner in the cell next to Mr Mason heard a loud bang against the wall coming from Mr Mason's cell. He was let out of his cell to use the toilet a few minutes later and went to Mr Mason's cell door. He said he asked Mr Mason why he had banged his wall but Mr Mason did not respond. He thought Mr Mason was asleep so went back to his cell. He did not report this to anyone.

31. The next morning, at around 7.10am, an officer looked through the window of Mr Mason's cell door while patrolling the wing. He noticed that Mr Mason was not moving and was lying in an unusual position. He knocked on the door but Mr Mason did not respond. He got a manager's permission to go into the cell and a member of staff in the prison's control room unlocked the cell remotely. He checked Mr Mason and found that he was unresponsive, stiff and cold. He radioed a code blue (an emergency code indicating circumstances such as when a prisoner is unconscious and not breathing). A control room operator immediately called an ambulance. A few minutes later, a nurse arrived with emergency equipment. He checked Mr Mason and found signs of rigor mortis, indicating that Mr Mason had been dead for some time and decided that resuscitation would not be possible. Paramedics arrived at 7.24am and, at 7.36am, recorded that Mr Mason had died.

Contact with Mr Mason's family

32. After Mr Mason died, the prison appointed a prison support worker, an officer and a prison manager as family liaison officers. That afternoon, the prison support worker and the officer went to see Mr Mason's ex-partner (who he had named as his next of kin) at the address he had given when he arrived at the prison. When they got there, they found that she had moved, so telephoned and arranged to meet her in person to inform her that Mr Mason had died. Mr Mason's ex-partner said that Mr Mason had other family members who ought to be informed but she did not have contact details for them.

33. The next day, a prison manager contacted the police for help tracing Mr Mason's family. On 9 November, after receiving contact details from the police, she telephoned Mr Mason's mother and brother to inform them of his death.

34. The prison manager remained in contact with Mr Mason's ex-partner and other family members for support. Mr Mason's funeral was held on 4 December. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

35. After Mr Mason's death, a prison manager debriefed the staff involved in the emergency response to offer support and that of the staff care team.

36. The prison posted notices informing staff and prisoners of Mr Mason's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Mason's death.

Post-mortem report

37. The report of a post-mortem examination concluded that Mr Mason had died of a heart attack due to coronary stenosis (a narrowing of the arteries in the heart) caused by heart disease. The report noted that the narrowing of the arteries had taken place silently (undetected) over a long period.

Findings

Clinical care

38. We are satisfied that, when Mr Mason transferred to the Isle of Wight, a nurse appropriately assessed his blood pressure and made an appointment to review it. Although he did not record the reading, he recognized this would have been best practice. We consider that Mr Mason received appropriate clinical care during his short time at the Isle of Wight but the clinical reviewer had some concerns about aspects of his care at Winchester.

39. In the first week Mr Mason spent in prison, nurses at High Down and Winchester recorded that his blood pressure was high five times, including three on the day he arrived at Winchester. A sixth reading the next day was within normal range. Nurses recorded the high readings without any comment or a plan of action and no one investigated the high blood pressure readings further. National Institute for Health and Care Excellence (NICE) Guidance suggests that high blood pressure should always be retested in the same consultation and the lower of the two readings should be used to make a decision on management. Repeat blood pressure testing should be arranged, and a recognised cardiovascular risk assessment tool used. Hypertension is a known contributor to cardiac disease. Blood pressure can be elevated by excessive alcohol consumption and it is possible it returned to normal after Mr Mason's enforced abstinence, but this was never tested further. The clinical reviewer noted that no one did enough to make the diagnosis of hypertension of disprove it and this was not good care.

40. Mr Mason's possible hypertension, age and history of heavy drinking and smoking were obvious risk factors of heart disease. NICE guidance for cardiovascular disease states that there should be a systematic process for risk assessment of the condition for those likely to be at risk from the ages of 40 up to 84 years. There was no record that anyone considered a cardiovascular risk assessment at Winchester. The clinical reviewer considered that a risk assessment and further monitoring of his blood pressure might have led to the possibility of some treatment to reduce Mr Mason's risk of sudden death from cardiac disease. We make the following recommendations:

    The Head of Healthcare at HMP Winchester should ensure that high blood pressure readings are appropriately followed up and investigated in line with NICE guidance.

    The Head of Healthcare at HMP Winchester should ensure that cardiovascular risk assessments are offered to all prisoners aged over 40 with relevant risk factors, in line with NICE guidance and that offered in the community.

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