Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Thomson a prisoner at HMP Isle of Wight on 14 November 2016

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 Michael Thomson died at HMP Isle of Wight on 14 November 2016 of sepsis, a complication of a subphrenic abscess. Mr Thomson was 70 years old. I offer my condolences to Mr Thomson's family and friends.

Mr Thomson was a frail man, with poor health and reduced mobility. Healthcare staff managed Mr Thomson's many chronic conditions and he received prompt care and was seen, examined and treated without delay. When Mr Thomson became too ill for treatment, he was transferred from hospital back to the inpatient unit at HMP Isle of Wight for end of life care, where he was managed appropriately. I am satisfied that the care Mr Thomson received was equivalent to what 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 2017**

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Summary

Events

1. Mr Michael Thomson received an indeterminate sentence for public protection on 11 November 2011, with a minimum sentence to be served of 7 years for indecent assault on a minor. Mr Thomson transferred to HMP Isle of Wight from HMP Hewell on 23 May 2013.

2. Mr Thomson suffered with poor health and mobility and needed a walking frame and a wheelchair. He had heart problems, depression, hypocalcaemia (high calcium level in the blood serum) and chronic arthritis. He also had a history of stroke and TIA's (mini strokes) and had previously had an operation to relieve pressure from his spinal cord. Mr Thomson had a prison 'buddy' to help him collect his medication and meals.

3. On 21 December 2015, Mr Thomson had an ultrasound scan for a persistent bladder infection, it showed probable gallstones. On 3 March 2016, a scan showed Mr Thomson had a cyst between his liver and aorta, but he had no symptoms. On 29 March, the results of an abdominal scan, confirmed an extended gall bladder and gall stones, with signs of liver cirrhosis. His condition remained symptom free.

4. On 26 July, Mr Thomson told the prison nurse he had fainted several times. He was monitored on the wing but did not complain of fainting again until 12 October, when he saw the prison doctor. The following day, Mr Thomson was admitted to the prison inpatient unit with acute stomach pain. He was sent to St Mary's hospital where he was treated for cholecystitis (inflammation of the gallbladder). He was discharged back to prison on 20 October, after an unsuccessful ERCP (endoscopic retrograde cholangio-pancreatography) operation to remove the gallstones and received antibiotic treatment.

5. On 22 October Mr Thomson's health began to deteriorate and he was transferred to St Mary's hospital and treated for sepsis. On 28 October, Mr Thomson was discharged back to the prison, pending a transfer to Southampton hospital for consideration of a second ERCP operation.

6. Mr Thomson's condition continued to deteriorate and on, 2 November, prison doctors put end of life provisions in place. On 3 November, Mr Thomson was assessed as too poorly to have the ERCP operation, and the referral was cancelled. Prison medical staff continued to manage Mr Thomson's health needs, including his personal hygiene and pain relief effectively, but his health continued to deteriorate and he died on 14 November at 2.56am.

Findings

7. We are satisfied that Mr Thomson received a good standard of healthcare at HMP Isle of Wight, equivalent to what he could have expected to receive in the community. Mr Thomson was promptly admitted to the prison inpatient unit and then to hospital, when he presented with pain and deteriorating health. Medical staff managed Mr Thomson's personal hygiene, pressure areas and pain appropriately. When Mr Thomson became too ill to have the gallbladder

operation he needed, his health deteriorated quickly and healthcare staff at Isle of Wight managed him appropriately. We make no recommendations.

The Investigation Process

8. 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.

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

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

11. 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.

12. The investigator wrote to Mr Thomson's next of kin, his friend, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

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

Background Information

HMP Isle of Wight

14. 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. The inpatient unit includes special facilities for end of life care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good, the inpatient unit provided compassionate care to men with complex needs and prisoners with palliative and end of life needs received excellent care. Handcuffing arrangements for men leaving the prison on escort were proportionate and inspectors found many examples of appropriately reduced levels of restraint for prisoners who were physically incapacitated.

Independent Monitoring Board

16. 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 2015, the IMB said that it was impressed by the standard of healthcare provided by Care UK and the care given by the prison's 24-hour inpatient unit.

Previous deaths at HMP Isle of Wight

17. Mr Thomson was the twelfth prisoner to die of natural causes at Isle of Wight since May 2016. There were no significant similarities between the issues identified in this investigation and those from previous investigations.

Key Events

18. On 11 November 2011, Mr Thomson was sentenced to an indeterminate sentence for public protection, with a minimum sentence to be served of 7 years for sexual offences. He had been at HMP Isle of Wight, Albany site since 23 May 2013.

19. Mr Thomson had poor mobility; resulting from a stroke he had in 2001, and needed walking aids including a walking frame and a wheelchair. He had several chronic health conditions, including peripheral artery disease, cervical spinal stenosis and Gallbladder stones. He suffered with depression and, when his health deteriorated, needed help with personal hygiene. Prison doctors prescribed a number of medications and he often went to hospital for treatment.

20. Healthcare staff implemented care plans to manage Mr Thomson's conditions and reviewed him frequently.

21. On 21 December 2015, Mr Thomson attended an ultrasound appointment for a urinary infection, which confirmed normal kidney and liver function but found probable gallstones. A prison doctor noted the incidental finding as symptom free. His urinary tract was normal and he was referred for a screening scan.

22. On 3 March 2016, the screening scan result for Mr Thomson revealed a cyst between the liver and aorta. A prison doctor discussed this with Mr Thomson, and he had no symptoms. Mr Thomson was referred for a detailed abdominal scan, which he attended on 29 March. The scan showed a distended gallbladder with stones in the biliary ducts and evidence of liver cirrhosis.

23. Between April and July, Mr Thomson's health was monitored. He was referred to urology for his bladder incontinence and had blood tests, which showed mild anaemia, low level ferritin, B12 and folate levels. Prescriptions for iron, B12 and folic acid were given.

24. On 26 July, Mr Thomson reported to a nurse that he had fainted on a number of occasions, following a sudden attack of acid reflux. He also reported rapid weight loss. Mr Thomson was booked in to see the prison doctor the following day, with a note to increase his weight checks. On 27 July, the doctor assessed Mr Thomson and requested an electrocardiogram (ECG – measures the electrical rhythm of the heart) and blood tests. The ECG results were normal.

25. On 17 August, at a multidisciplinary team (MDT) meeting, a decision to gather further information from wing staff regarding Mr Thomson's episodes of fainting, with consideration to admit Mr Thomson to the healthcare unit for observation was made.

26. Mr Thomson was monitored and regularly seen by medical staff but there were no further incidents of fainting until 12 October, when Mr Thomson saw the locum GP. The GP assessed Mr Thomson and noted that he would discuss him at the MDT meeting later that day. A decision to admit him to the inpatient unit for a week for monitoring and a referral for a cardiology appointment was made.

27. On 13 October at 4.10pm, Mr Thomson was admitted to the inpatient unit with acute abdominal pain. A nurse noted Mr Thomson looked pale and gaunt with noticeable weight loss. At 4.30pm that day, Mr Thomson had sudden onset pain to the right side of his stomach. A doctor requested a number of tests including blood and urine tests. However, nursing staff were unable to obtain a urine sample and Mr Thomson was referred to St Mary's hospital at the doctor's request.

28. Mr Thomson was treated for cholecystitis (inflammation of the gallbladder). An ERCP operation to remove the gallstones from the gallbladder was performed but was unsuccessful. He was treated with antibiotics and discharged back to the prison inpatient unit on 20 October, and monitored by medical staff.

29. On 22 October, a nurse saw Mr Thomson, and reported that he appeared weak with breathlessness. The nurse requested for an emergency ambulance to St Mary's accident and emergency department due to the change in his presentation.

30. Mr Thomson was admitted to hospital for treatment for sepsis. He was given antibiotics and IV fluids. On 25 October, the prison matron spoke with the deputy sister at the hospital. She advised that the surgeons had discussed completing another ERCP but, due to this failing the first time, the hospital declined a further ERCP procedure. She referred Mr Thomson to Southampton Hospital for further treatment.

31. On 28 October, Mr Thomson was discharged back to the prison inpatient unit, awaiting consideration for the ERCP operation at Southampton Hospital. Mr Thomson was given a pressure relieving mattress the following day and a careplan to manage his pressure sores and personal care was put in place.

32. On 30 October, a doctor discussed DNACPR (do not attempt cardiopulmonary resuscitation in the event his heart or breathing stopped) with Mr Thomson, who told him he wished to receive full treatment and resuscitation. On 2 November, a doctor discussed the DNACPR with Mr Thomson again and explained that intervention at this time due to his frailty and ill health would be futile. Mr Thomson agreed to a DNACPR being put in place and a doctor arranged for a palliative care 'just in case box', to include a syringe driver to manage pain and an open door policy, which was put in place later that day.

33. On 3 November, a doctor confirmed that Mr Thomson was too frail and ill for surgery and cancelled the ERCP referral. On 5 November, a syringe driver was fitted to manage Mr Thomson's pain.

34. Mr Thomson's health continued to deteriorate and prison medical staff cared for Mr Thomson, managing his pain relief, pressure sores and personal hygiene, to make him comfortable.

35. On 14 November at 1.40 am, a nurse noted a slight deterioration in Mr Thomson's health, while seeing to his personal care needs. He appeared agitated and she administered prescribed pain relief to make him comfortable. At 1.49am, the nurse completed a general observation and Mr Thomson had no pulse. She contacted Oscar one (the orderly officer, responsible for running the

prison at night time) for an out of hours doctor but was told there was not one on call and paramedics were asked to attend.

36. Paramedics attended and confirmed Mr Thomson's time of death at 2.56am.

Contact with Mr Thomson's family

37. On 30 October, when Mr Thomson's condition deteriorated, the prison appointed a supervising officer as the family liaison officer (FLO). Mr Thomson had listed his friend as his next of kin and requested that he was told of his condition. The FLO made several attempts to speak with Mr Thomson's next of kin by telephone but was unsuccessful. The FLO eventually spoke with him on 3 November, after asking his probation officer for assistance. He updated him with Mr Thomson's condition regularly.

38. At 7.55 am, on 14 November, the FLO telephoned Mr Thomson's next of kin, his preferred method of contact in the event of Mr Thomson's death, and told him that Mr Thomson had died. He arranged to visit him later that week. The FLO offered advice and support. He remained in contact with him until after Mr Thomson's funeral. Mr Thomson's funeral was held on 19 November and the prison contributed to the costs of the funeral, in line with national policy.

Support for prisoners and staff

39. After Mr Thomson's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

41. A post-mortem examination concluded that Mr Thomson died of sepsis caused by a subphrenic abscess (infected fluid between the diaphragm, liver and spleen).

Findings

Clinical care

42. Mr Thomson had complex medical needs. His mobility and health continued to deteriorate in prison with complications arising from gallstones. Healthcare staff at HMP Isle of Wight liaised effectively with the hospital about his care and implemented care plans, which were well communicated within the healthcare team and discussed with Mr Thomson. Wing staff and prison medical staff responded quickly and appropriately when Mr Thomson became unwell and paramedics were summoned immediately.

43. While at hospital Mr Thomson had an ERCP operation, which was unsuccessful. The clinical reviewer stated that in a younger or fitter male, surgery can be performed with relative ease. However, because of Mr Thomson's poor health, procedures to treat these complications failed and his health never improved to a point where he would be sufficiently fit for anaesthesia. Mr Thomson understood that it was not a successful procedure and was keen to transfer back to the Isle of Wight.

44. Prison healthcare staff managed Mr Thomson's physical condition, his pain control and his wellbeing effectively. The clinical reviewer considered that Mr Thomson's primary care was of a good standard and we are satisfied that Mr Thomson's care and treatment at Isle of Wight was good and at least equivalent to that he could have expected to receive in the community.

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