

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Geoffrey Blay a prisoner at HMP Isle of Wight on 3 January 2017

**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 Geoffrey Blay died on 3 January 2017 of a heart attack at HMP Isle of Wight. He was 64 years old. I offer my condolences to Mr Blay's family and friends.

Mr Blay was a frail man with poor health and reduced mobility. Healthcare staff appropriately managed Mr Blay's many chronic conditions, gave him prompt care and they examined and treated him without delay. I am satisfied that the care Mr Blay received was equivalent to what he could have expected to receive in the community. However, the investigation identified the need for prison staff to check on the welfare of prisoners when they unlock their cell doors.

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**

**July 2017**

## **Contents**

Summary .....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings.....	7

# Summary

## Events

1. On 26 April 2007, Mr Geoffrey Blay was sentenced to 16 years in prison for sexual offences and sent to HMP Wormwood Scrubs. After spending time at other prisons, Mr Blay was moved to HMP Isle of Wight on 2 February 2013.
2. Mr Blay had limited mobility and suffered from a number of chronic health problems, including heart disease, diabetes, high blood pressure and he had recurrent leg ulcers. Healthcare staff created care plans to manage his conditions. They reviewed him frequently and adjusted his medication as necessary. He was allocated a prison carer to help him collect his meals, help keep his cell tidy and wheel him around in his wheelchair.
3. Mr Blay had continuous problems with a chronically infected diabetic foot. He also had problems complying with his diet and controlling his sugar levels. He would over eat against repeated advice.
4. At approximately 8.00am on 3 January 2017, an officer unlocked Mr Blay's cell but did not check that he was well at the time. A short time afterwards, a prisoner found Mr Blay unresponsive on his bed. He went to the wing office and told staff. Two supervising officers entered Mr Blay's cell but they failed to find a pulse. Neither officer attempted cardiopulmonary resuscitation as they said it was clear that Mr Blay was dead.
5. Nurses arrived at the cell at 8.10am and noted that it appeared Mr Blay had been dead for some time. The prison doctor pronounced Mr Blay's death at 8.50am.

## Findings

6. The clinical reviewer was satisfied that the care Mr Blay received at Isle of Wight was equivalent to that he could have expected to receive in the community. Mr Blay suffered from heart problems and issues controlling his diabetes throughout his time in prison. In order to limit these problems, healthcare staff tried to get him to manage his dietary intake without success. We are satisfied that clinicians treated and managed his cardiac and diabetic problems appropriately.
7. We are concerned that, during the morning unlock procedures, officers did not appropriately check Mr Blay's wellbeing.

## Recommendation

- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

## 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 Blay's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Blay's clinical care at the prison.
11. The investigator and clinical reviewer interviewed four members of staff and one prisoner at HMP Isle of Wight on 3 February 2017.
12. 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.
13. The investigator contacted Mr Blay's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had no specific issues he wanted the investigation to consider.
14. Mr Blay's brother received a copy of the initial report. He did not make any comments.
15. The initial report was shared with the Prison Service. The Prison Service pointed out two factual inaccuracies and this report has been amended accordingly.

# 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 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

17. 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.

## 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 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. However, they were concerned that disabled wheelchair access for prisoners may be difficult.

## Previous deaths at HMP Isle of Wight

19. Mr Blay was the fourth prisoner to die of natural causes at Isle of Wight since January 2016. We raised the issue of staff not completing welfare checks in an investigation in 2014.

## Key Events

20. On 26 April 2007, Mr Geoffrey Blay was sentenced to 16 years in prison for sexual offences and sent to HMP Wormwood Scrubs. After spending time at other prisons, on 2 February 2013, he was transferred to HMP Isle of Wight.
21. Mr Blay had a history of type 2 diabetes, his right heel and toes had been amputated (following diabetes complications), depression, high cholesterol, chronic knee joint pain, cellulitis, heart disease (a stent had been fitted in 2012), cataract, a bone infection and swallowing problems. He was morbidly obese and a wheelchair user.
22. Healthcare staff saw Mr Blay frequently to give him his medication and to monitor his diabetes. To help control some of the symptoms of Mr Blay's diabetes, prison doctors prescribed metformin (the initial drug treatment for type 2 diabetics to lower the amount of sugar in the blood). Healthcare staff held annual diabetes reviews and Mr Blay attended diabetes clinics and screening between the annual reviews.
23. Mr Blay frequently developed persistent leg infections. He frequently saw nurses and doctors to monitor and change his leg dressings. Prison GPs prescribed antibiotics and pain relief. He also attended diabetes, chiropody and ophthalmology clinics.
24. Mr Blay's sugar levels fluctuated and prison GPs tried to discover why. On 13 July 2015, a prison GP noted that during the night Mr Blay had low blood sugar levels and complained that he felt dizzy and light headed. He cancelled Mr Blay's prescription for metformin.
25. On 4 August, a prison GP noted that Mr Blay's oramorph (a morphine solution for pain relief) contained sugar so he changed his prescription to standard release morphine tablets. Four days later, when the prison GP rechecked Mr Blay's sugar levels, there was an improvement. Mr Blay told healthcare staff that he had not eaten any calorific food and was planning to decrease his food intake. However, the prison GP found that Mr Blay was not following a diabetic diet - he was eating biscuits.
26. On 18 April 2016, surgeons amputated Mr Blay's lower right leg as he had sepsis and a bone infection in his heel bone.
27. In July, Mr Blay began complaining about unbearable headaches. He told a nurse that the headaches lasted for two weeks and he had a pain over his right eye. Prison GPs recommended Mr Blay take codeine for pain relief.
28. On 24 August, Mr Blay developed an infection in his left foot. Healthcare staff reminded him that he must elevate the affected leg but he did not always comply with this.
29. Between 2015 and 2016, prison GPs referred Mr Blay to consultants at the diabetic medicine and vascular departments at Southampton General Hospital to treat recurrent foot and calf ulcers, sepsis, cellulitis and an underlying chronic heel bone infection.

30. In consultation with specialist vascular nurses, prison nurses drew up care plans to manage and dress Mr Blay's chronic leg wounds. Nurses gave him further advice to elevate his legs.
31. Due to his limited mobility, Mr Blay was moved to a disabled cell and had a prisoner carer to help him with day-to-day living activities, such as keeping his cell clean. The prison carer described Mr Blay as elderly, frail and disabled.
32. On 2 January 2017, the prison carer said that, uncharacteristically, Mr Blay was not talkative and told him he just wanted to sleep. He had not eaten his lunch or dinner and had not drunk any fluids. The prison carer said he asked staff to keep an eye on him. The investigation has not been able to identify who the prison carer told and staff did not record any information about this in the wing observation book. Staff locked prisoners into their cells at 6.00pm that day.

### **Events on 3 January 2017**

33. At 6.15am, the first prison officer commenced the morning roll check. He said that he checked all cells. He opened the cell door flap for Mr Blay's cell and completed a visual check. He said he saw Mr Blay lying on his left side on his bed, half covered with his bedding, and he looked like he was asleep.
34. At approximately 8.00am, the second officer said he unlocked Mr Blay's cell door and left it slightly ajar. He said he did not look into the cell, as he believed he was under no obligation to do so. He said he was preoccupied with getting back to the wing office to organise things and to take telephone calls.
35. The prison carer said that he was unlocked from his cell just before 8.00am and went to Mr Blay's cell. He said that the cell door was unlocked and he entered the cell. He saw that the quilt was on the floor, Mr Blay was upright on the bed, and his leg was at an odd angle. He said he could see something was wrong. He went towards the bed, called Mr Blay's name and asked if he was ok. He touched Mr Blay's knee, which was warm, and noticed his eyes were glazed. He left the cell and went to wing office to alert staff.
36. A third officer and a Senior Officer (SO) went to Mr Blay's cell. They could not find a pulse. At 8.00am, the SO rang the control room and asked them to contact healthcare staff. She did not use a radio emergency code blue (to indicate a medical emergency) or attempt resuscitation as she said it was clear Mr Blay had been dead for a period of time.
37. Control room staff immediately contacted healthcare staff and asked them to go to Mr Blay's cell. At 8.10am, the clinical team manager, and a healthcare assistant attended. The clinical team manager said that he did not attempt resuscitation because there were no signs of life and Mr Blay's skin was mottled and cold. He said that it appeared Mr Blay had been dead for some time and an offensive odour was present.
38. At 8.50am, a prison GP attended and confirmed that Mr Blay had died.

### **Contact with Mr Blay's family**

39. The prison appointed a prison manager as the family liaison officer (FLO) with an officer as his assistant. Mr Blay had told staff that he had no contact with his family and he did not want to nominate anyone as his next of kin. After his death, staff found a telephone number for his brother in Mr Blay's record. The assistant officer telephoned Mr Blay's brother to tell him of his death and offered him condolences and support.
40. Mr Blay's funeral was held on 23 February. The prison contributed to the costs, in line with national policy.

#### **Support for prisoners and staff**

41. After Mr Blay's death, a prison manager 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.
42. The prison posted notices informing other prisoners of Mr Blay'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 Blay's death.

#### **Post-mortem report**

43. The Coroner confirmed the cause of death was cardiac failure, hypertension (high blood pressure) and ischaemic heart disease due to diabetes mellitus.

# Findings

## Clinical care

44. The clinical reviewer noted that Mr Blay had a complex medical situation, in which the treatments for one condition adversely affected another condition, and monitoring of his rheumatological conditions was difficult because of his chronically infected diabetic foot.
45. The clinical reviewer concluded that the level of care provided for Mr Blay's diabetic foot complications was greater than that generally available in the community. However, the clinical reviewer considered that the prison GP should not have cancelled Mr Blay's metformin prescription but should have reduced his insulin dose.
46. The clinical reviewer noted that Mr Blay's diabetes, previous history of smoking and his other health problems put him at a very high risk of having a heart attack.
47. The clinical reviewer found that the actions of the healthcare team on 3 January were prompt, professional and appropriate.
48. Overall, the clinical reviewer concluded that the care was equivalent in range and standard to that available in the community.
49. The clinical reviewer made a number of recommendations about Mr Blay's clinical care in the years before he died. These were unlikely to have changed the outcome for Mr Blay so we do not repeat them here. The Head of Healthcare will need to address the points raised in the clinical review.

## Welfare checks

50. Two officers conducted checks at about 6.15am and 8.00am. The first officer told the investigator that he completed a visual check and saw Mr Blay asleep on his bed. The second officer said when he unlocked the cell door, he did not routinely check prisoners' welfare when unlocking cells, as he believed he was not required to do so.
51. For their own safety, officers are supposed to look through the observation hatch before unlocking a cell door. When unlocking cells, they should also take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

“Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”
52. HMP Isle of Wight issued an operational instruction in 2015, stating that when unlocking a prisoner staff should “ensure that they check on the welfare of the prisoner(s)”. After Mr Blay's death, the prison reissued the notice on 20 January

2017 and added that even where prisoners were unlocked electronically, it was still the responsibility of staff to undertake a welfare check.

53. Although there is no evidence to confirm the time Mr Blay stopped breathing or that earlier action could have made a difference to the outcome for him, in other circumstances, failure to adhere to the unlock procedures could lead to a delay in treating a seriously ill prisoner. While we recognise that the prison have reissued the operational instruction, we make the following recommendation:

**The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.**

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