Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Collings a prisoner at HMP Isle of Wight on 10 January 2016

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*

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Collings died on 10 January 2016 of chronic respiratory failure at HMP Isle of Wight. He was 30 years old. We offer our condolences to Mr Collings' family and friends.

Mr Collings had suffered with a chronic lung condition for a number of years but hospital specialists had been unable to identify the underlying cause. We are satisfied that healthcare staff at Isle of Wight managed Mr Collings' condition appropriately and that his clinical care was equivalent to that which he could have expected to receive in the community.

Mr Collings took illicit medication in prison which is likely to have worsened the effects of his chronic condition. However, we are satisfied that since Mr Collings' death, steps have been taken to reduce the availability of non-prescribed medication in the prison.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **May 2018**

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Summary

Events

1. Mr David Collings (known as Mr David Westley in prison records) was sentenced to life imprisonment in October 2004. He was moved to HMP Isle of Wight in November 2010.

2. Mr Collings had a history of substance misuse and smoked cigarettes. In April 2011, he complained of a reduced appetite and night sweats. A computerised tomography (CT) scan revealed that Mr Collings had pleural fibrosis (scarring of the lungs). Hospital specialists could not identify an underlying cause.

3. In August 2012, Mr Collings completed an opiate detoxification programme after he told a substance misuse nurse he had taken illicit tramadol (an opiate-based painkiller).

4. In July 2014, Mr Collings started antiviral therapy for tuberculosis (TB). His respiratory condition did not improve and he was unable to undergo investigative surgery because of the severity of his lung condition.

5. Mr Collings' condition deteriorated in November 2015 and he required hospital admission on two occasions.

6. In December 2015, he admitted using illicit medication again and received support from the Substance Misuse Service.

7. At 2.50pm on 9 January 2016, a prison nurse found Mr Collings unresponsive in his cell. The nurse made an emergency radio call and paramedics took Mr Collings to hospital. Mr Collings' condition continued to deteriorate and he died in hospital at 2.26pm on 10 January.

8. The post-mortem report concluded that Mr Collings died from chronic respiratory failure caused by pleural fibrosis, with tramadol intoxication a contributory factor.

Findings

9. The clinical reviewer considered that prison and healthcare staff managed Mr Collings' condition well. We are satisfied that healthcare staff could not have prevented his death and he received a standard of care equivalent to that which he could have expected to receive in the community.

10. We are satisfied that Mr Collings received appropriate support from the Substance Misuse Service. While Mr Collings' death demonstrated a failure in the prison's drug strategy at the time, we are satisfied that since then, Isle of Wight has introduced measures to address the supply of and demand for non-prescribed medication.

11. We make no recommendations.

The Investigation Process

12. 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

13. The investigator obtained copies of relevant extracts from Mr Collings' prison and medical records. She interviewed five members of staff at Isle of Wight on 1 July 2016.

14. NHS England commissioned a clinical reviewer to review Mr Collings' clinical care at the prison. The clinical reviewer conducted joint interviews with Miss Masterton

15. 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.

16. One of the Ombudsman's family liaison officers contacted Mr Collings' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked if prison and healthcare staff were aware of the seriousness of her son's medical condition and whether he had taken non-prescribed medication at Isle of Wight. She was also unhappy that the prison family liaison officer broke the news of Mr Collings' death over the telephone.

17. Our investigation was suspended between 26 January 2016 and 12 October 2017 while we awaited the cause of death. The completion of this report was delayed as a result.

18. Mr Collings' mother received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Isle of Wight

20. HMP Isle of Wight (IoW) is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24 hour care for prisoners.

HM Inspectorate of Prisons

21. 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

22. 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 31 December 2016, the IMB said Care UK had proved to be a well led, dedicated and professional team. The standard of healthcare in the prison's 24-hour inpatient unit was of a high standard.

Previous deaths at HMP Isle of Wight

23. Mr Collings was the second prisoner to die at Isle of Wight since January 2016. There have been seven deaths from natural causes since his death. There were no similarities between Mr Collings' death and the other deaths at the prison.

Key Events

24. On 12 October 2004, Mr David Collings was sentenced to life in prison for sexual offences. He was convicted under the name David Westley and his prison records use this name but, according to his mother, his actual name was David Collings and we refer to him by this name throughout our report. Mr Collings spent time in several prisons before being moved to HMP Isle of Wight on 11 November 2010.

25. On arrival at Isle of Wight, a prison nurse completed Mr Collings' initial health assessment. Mr Collings had spent the whole of his adult life in prison. He had a history of substance misuse and told the nurse he had lost three stone in the past two years. Mr Collings was a smoker and refused help to stop. The nurse made a referral to a prison GP.

26. On 15 November, a prison GP examined Mr Collings and arranged a full set of blood tests and made a referral for an ultrasound scan. The results of the tests and scan were normal.

27. On 13 April 2011, a prison GP saw Mr Collings who complained of a reduced appetite and night sweats. The GP noted that investigations had not found an underlying cause for Mr Collings' weight loss. He made a referral for a chest X-ray. The results revealed bilateral pleural effusions (fluid between the lungs and the chest wall) and a raised possibility of tuberculosis (TB - a bacterial infection that mainly affects the lungs). Mr Collings was admitted to St Mary's Hospital for further investigations.

28. Hospital doctors arranged a computerised tomography (CT) scan (uses X-rays and a computer to create detailed images of the inside of the body) and a pleural biopsy to exclude cancer and to check for infections, in particular TB. The results of these investigations showed that Mr Collings had pleural fibrosis (benign scarring of the lungs) and did not have TB. Doctors made a referral to the respiratory clinic at St Mary's Hospital.

29. On 16 August, Mr Collings saw a respiratory specialist at St Mary's Hospital who could not find an underlying cause for pleural fibrosis. The results of a HIV test were negative. Mr Collings saw the respiratory specialist again in December and had a CT scan. The results did not reveal any significant change to his condition. In March and April 2012, Mr Collings declined to attend an appointment with the respiratory specialist.

30. On 31 May 2012, the respiratory specialist discussed Mr Collings' condition with a prison GP. The GP agreed to encourage Mr Collings to attend the respiratory clinic to have a CT scan. This took place on 23 October and the results did not reveal any significant change to Mr Collings' condition.

31. On 6 August, a nurse from the prison's Substance Misuse Service saw Mr Collings who told him he had taken illicit tramadol (opiate-based painkiller) and subutex (used to treat opiate addiction and chronic pain). The nurse created an opiate detoxification programme. A prison GP prescribed methadone (used to help withdraw from opiate misuse). The nurse saw Mr Collings daily to ensure he remained compliant with the detoxification programme.

32. On 5 April, a prison nurse saw Mr Collings to discuss his opiate detoxification programme. Mr Collings said he was not using illicit substances and was aware that he could contact the Substance Misuse Service for further support.

33. On 22 May, Mr Collings saw a prison nurse and said he was taking non-prescribed tramadol. A healthcare multidisciplinary team (MDT) meeting decided that Mr Collings should undertake a short detoxification programme using subutex. A prison GP noted the hospital doctor's advice that Mr Collings was not suitable for methadone due to his underlying respiratory condition. Mr Collings refused to move to the prison's inpatient unit and said he would complete the detoxification programme on the wing.

34. On 31 May, Mr Collings was admitted to St Mary's Hospital after he had a seizure. He was returned to Isle of Wight on 1 June. The same day he told a prison GP he had taken non-prescribed gabapentin (used to treat epilepsy and nerve pain but can also be used to produce euphoria and enhance the effects of other drugs, such as opiates).

35. On 24 July, Mr Collings was admitted to Southampton General Hospital for a pleural biopsy and bronchoscopy (examination of the airways). The results revealed pleural fibrosis and chronic inflammation on Mr Collings' lungs with no underlying cause.

36. Mr Collings refused to attend the respiratory clinic in August and October. On 23 December, he agreed to see the respiratory specialist who noted that Mr Collings' condition was stable and he would see him in six months time. The respiratory specialist made a referral to a TB specialist at the Royal South Hants Hospital.

37. On 9 July 2014, Mr Collings saw a TB specialist who decided that the likeliest underlying cause of Mr Collings' condition was TB. Mr Collings started antiviral therapy. Healthcare staff continued to monitor him regularly.

38. Mr Collings' antiviral therapy for TB ended on 16 July 2015. A prison GP noted that the treatment had not improved Mr Collings' night sweats.

39. On 13 August, a prison GP examined Mr Collings who complained of a headache and vomiting. The GP recorded Mr Collings' oxygen saturation level as 86 % (low). He arranged an ambulance to take Mr Collings to St Mary's Hospital for further investigation. Hospital doctors gave Mr Collings oxygen therapy and he was returned to Isle of Wight the same day.

40. On 3 September, Mr Collings saw the respiratory specialist who prescribed steroids. On 9 October, Mr Collings complained of feeling unwell with a headache and fever. He refused to have a chest X-ray. The next day, Mr Collings refused to go to hospital for further investigation. A prison GP prescribed antibiotics for a suspected lung infection.

41. On 5 November, Mr Collings' breathing deteriorated and his oxygen saturation level was 85% (low). Mr Collings agreed to be admitted to hospital. Hospital doctors gave him oxygen therapy. Mr Collings discharged himself from hospital on 8 November.

42. On 14 November, prison staff found Mr Collings unresponsive in his cell. His oxygen saturation level was 42% (very low) and he was taken to hospital by emergency ambulance. Hospital doctors gave Mr Collings oxygen therapy and he was returned to Isle of Wight on 16 November.

43. Mr Collings' respiratory condition continued to deteriorate. On 3 December, he was admitted to hospital again with low oxygen saturation levels and was returned to Isle of Wight on 8 December.

44. A prison GP assessed Mr Collings when he was returned to Isle of Wight. He noted that Mr Collings' respiratory failure was exacerbated by illicit substance misuse. The GP made a referral to the Substance Misuse Service.

45. On 14 December, a prison nurse assessed Mr Collings who said he was taking tramadol and gabapentin illicitly. Mr Collings said he had been drug free for approximately three years but had recently relapsed. His urine tested positive for tramadol and the nurse made a note to discuss Mr Collings' case at the healthcare MDT on 16 December. The MDT agreed that Mr Collings could start a carefully monitored opiate detoxification programme on the inpatient unit.

46. The same day Mr Collings was admitted to the inpatient unit with chest pain. The results of an electrocardiogram (ECG – a test to monitor the heart's rhythm) were normal. On 17 December, a prison GP prescribed lofexidine (a non-opioid drug) for tramadol detoxification. On 18 December, Mr Collings refused to remain on the inpatient unit and returned to the wing.

47. On 23 December, a prison nurse saw Mr Collings who said he was no longer using tramadol but had taken gabapentin. The nurse advised Mr Collings to contact the Substance Misuse Service for advice and support.

Events of 9 January 2016

48. At approximately 12.09pm, a prison officer asked healthcare to assess Mr Collings in his cell. A prison nurse attended and Mr Collings was sitting on his bed. His oxygen saturation level was 56% (very low). The nurse gave Mr Collings oxygen therapy which increased Mr Collings' saturation level to 86%. Mr Collings denied taking an illicit substance. He refused admission to the inpatient unit for observation.

49. At 2.50pm, the nurse returned to assess Mr Collings and found him unresponsive. The nurse called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and the control room immediately called for an ambulance. The nurse gave Mr Collings oxygen therapy which increased his saturation level to 91%. The paramedics arrived at 2.54pm and took control of Mr Collings' care. They decided to take Mr Collings to St Mary's Hospital. Two prison officers accompanied Mr Collings and did not use restraints. A prison manager, telephoned Mr Collings' mother and told her he was in hospital.

50. Mr Collings' condition continued to deteriorate and he died at 2.26pm on 10 January.

Contact with Mr Collings' family

51. After Mr Collings' admission to hospital on 15 November 2015, the prison appointed a prison manager, as the family liaison officer (FLO). The FLO arranged for Mr Collings' mother, his nominated next of kin, to visit Mr Collings in hospital.

52. After Mr Collings' admission to St Mary's hospital on 9 January 2016, the FLO contacted Mr Collings' mother again and offered support. Mr Collings' mother did not wish to visit the hospital and said she would telephone them for updates on Mr Collings' condition.

53. After Mr Collings' death on 10 January, the FLO telephoned Mr Collings' mother and informed her of his death. The FLO offered condolences and support. On 12 January, the FLO visited Mr Collings' mother at home.

54. The FLO remained in contact with Mr Collings' mother until Mr Collings' funeral on 3 February. The prison contributed towards the cost in line with Prison Service Instructions.

Support for prisoners and staff

55. After Mr Collings' 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.

56. The prison posted notices informing other prisoners of Mr Collings' 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 Collings' death.

Post-mortem report

57. The post-mortem report found that Mr Collings had died from chronic respiratory failure and idiopathic pleural fibrosis (scarring of the lungs from unknown cause). The report also found a raised level of tramadol in Mr Collings' blood. The report concluded that this medication may have worsened the effects of his natural disease.

Findings

Clinical care

58. When Mr Collings complained of a reduced appetite and night sweats in April 2011, prison GPs quickly referred him to St Mary's Hospital for further investigations. Mr Collings saw a hospital specialist regularly but his clinical diagnosis remained unclear.

59. The clinical reviewer commented that Mr Collings was a young man with a very serious lung condition which eluded diagnosis and was not treatable. Mr Collings' lung capacity was severely reduced which made him short of breath. Prison and healthcare staff were aware of the seriousness of Mr Collings' medical condition and managed his care well.

60. We are satisfied that healthcare staff could not have prevented Mr Collings' death and that he received a standard of care equivalent to that which he could have expected to receive in the community.

Illicit substances

61. The post-mortem report noted that Mr Collings had a raised level of tramadol in his blood. Mr Collings had never been prescribed tramadol in prison and so clearly obtained this substance illicitly. Although there is no evidence to suggest that substance misuse caused Mr Collings to develop a respiratory disease, the post-mortem report indicates that using tramadol may have worsened the effects of his natural disease.

62. In 2015, Isle of Wight introduced a Drug and Substance Policy to tackle the threat that intoxicating substances had on the safety of prisoners and staff, and the good order and discipline of the prison. The Policy focuses on informing prisoners of the risk of these substances, reducing access to them, punishing those involved and supporting those prisoners using them. The Policy states that prisoners who have misused drugs will have access to services appropriate to their needs.

63. One method of supporting prisoners using intoxicating substances is to refer them for a substance misuse assessment. We are satisfied that Isle of Wight appropriately referred Mr Collings to the prison's Substance Misuse Service in August 2012 and December 2015.

64. We are concerned that the presence of non-prescribed drugs in Mr Collings' blood demonstrated a failure with the prison's drug supply and demand reduction strategy. The Head of Safer Custody at the time of Mr Collings' death, told us from June 2016 he was responsible for the prison's drug strategy and he intended to address the availability of illicit medication in the prison.

65. Since Mr Collings' death in January 2016 there have been seven deaths from natural causes and two self-inflicted deaths at Isle of Wight. We note that the circumstances of these deaths were not related to non-prescribed medication or illicit substances.

66. The Head of Security told us that Isle of Wight has introduced measures to reduce the supply and demand of non-prescribed medication in the prison. Healthcare staff supervise prisoners who are prescribed controlled medication such as tramadol. During 2017, four amnesties took place to enable prisoners to return non-prescribed medication to healthcare without punishment. Prisoners are required to sign a medication compact to confirm that their prescribed medication is contained within a labelled box with a maximum supply of 28 days.

67. Isle of Wight has also introduced measures to ensure that prisoners are aware of the risks associated with taking non-prescribed medication and illicit substances. This includes a weekly non-compliance clinic. The Head of Security said that the Security Department and healthcare have adopted an integrated approach towards managing substance misuse.

68. We are satisfied these measures indicate a more robust implementation of the local drugs strategy. We do not consider it necessary to make a recommendation about this issue.

Contact with Mr Collings' family

69. Prison Service Instruction (PSI) 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source. If the next of kin live a long distance away, consideration must be given to requesting the assistance of a family liaison officer from the nearest prison.

70. When Mr Collings was admitted to St Mary's Hospital on 15 November 2015, the prison FLO informed his mother, his nominated next of kin, and offered support. Mr Collings' mother visited Mr Collings in hospital and met with the FLO.

71. On 9 January 2016, Mr Collings was admitted to hospital again. The FLO telephoned Mr Collings' mother who said she would not visit at this time and would contact the hospital regularly for information about Mr Collings' condition.

72. Mr Collings' mother lived in Wales, approximately 215 miles from the prison. At the time of Mr Collings' death on 10 January, the FLO was concerned that Mr Collings' mother would telephone the hospital and a member of staff would inform her of her son's death. The FLO told us he considered asking a FLO from HMP Swansea to visit Mr Collings' mother. However, he was concerned that this would cause her additional stress. The FLO told us he considered it appropriate to telephone her to break the news of Mr Collings' death. He felt this was the most sensitive approach as he had previously met with Mr Collings' mother at the hospital and spoken to her on the telephone. We note that the FLO visited Mr Collings' mother on 12 January.

73. In the circumstances, we consider that the FLO's decision to break the news of Mr Collings' death by telephone was reasonable and ensured that Mr Collings' mother did not find out about her son's death from another source.

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