Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Collins a prisoner at HMP Oakwood on 19 August 2017

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 Michael Collins died on 19 August 2017 of ischaemic heart disease while a prisoner at HMP Oakwood. He was 74 years old. We offer our condolences to Mr Collins' family and friends.

Mr Collins received a mixed standard of care while at Oakwood. The day to day management of his conditions was of an acceptable standard. However, there is no evidence of any long-term management of his conditions. We do not consider, therefore that, overall, he received the standard of care he could have expected 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.

Elizabeth Moody
Acting Prisons and Probation Ombudsman March 2018

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Summary

Events

1. On 17 December 2015, Mr Michael Collins was sentenced to 8 years and 3 months imprisonment for sexual offences. He was sent to HMP Hewell. On 18 February 2016, he was transferred to HMP Oakwood.

2. Mr Collins had a history of heart disease and heart attacks, for which he had stents inserted into the arteries of the heart to improve the blood flow. He also had asthma and type 2 diabetes, and had had a stroke in the past, which had left him with weakness in the left side of his body and poor mobility.

3. In January 2017, Mr Collins complained of pains in his chest and a feeling of pins and needles in his right arm. After a review by paramedics, he was taken to hospital by emergency ambulance. Hospital staff diagnosed that Mr Collins had had a heart attack and he remained in hospital as an inpatient. He had surgical intervention to clear blockages from the arteries in his heart and was transferred back to Oakwood.

4. In July, Mr Collins contracted a bacterial infection. He was taken to hospital for review, where he remained as an inpatient. Hospital staff treated his symptoms, and he stabilised but he then deteriorated rapidly.

5. Mr Collins died at 9.30am on 19 August.

Findings

6. The clinical reviewer considered that Mr Collins received a standard of care that, overall, was not equivalent to that which he could have expected to receive in the community.

7. We agree with the clinical reviewer that there is no evidence in Mr Collins' medical records of any forward planning or systems in place to manage his long-term conditions.

Recommendations

- The Head of Healthcare should ensure that care pathways and an active care management system, or an equivalent system is put in place to manage long-term health conditions in line with guidance from the National Institute for Health and Care Excellence.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

11. We informed HM Coroner for South Staffordshire District of the investigation. We have sent the coroner a copy of this report.

12. The investigator wrote to Mr Collins' next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

13. The investigation has assessed the main issues involved in Mr Collins' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Oakwood

15. HMP Oakwood opened in 2012. It is near Wolverhampton and managed by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.

16. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. Healthcare staff are on duty from 7.00am to 8.00pm on weekdays and from 7.30am to 5.30pm on weekends.

HM Inspectorate of Prisons

17. The last inspection of HMP Oakwood was in December 2014. Inspectors reported that health services, including care for older prisoners, had much improved since the last inspection. There were some chronic staff shortages in healthcare, which did affect some areas of delivery, and agency staff were used to fill the shortages. Care planning was well developed and clinical records were good.

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 March 2017, the IMB reported that staff turnover was quite high, with the number of officers under the age of 25 increasing. The change of healthcare contractor in April 2016 went reasonably well but there was an ongoing problem with a shortage of nurses and a reliance on agency nurses. The number of hospital appointments that needed rearranging because of escort issues had decreased compared to the year before.

Previous deaths at HMP Oakwood

19. Mr Collins was the seventh prisoner to die at HMP Oakwood since January 2017. There has been one further death from natural causes since. We have previously made a recommendation about the need to review the management of prisoners with long-term health conditions.

Findings

The diagnosis of Mr Collins' terminal illness and informing him of his condition

20. On 17 December 2015, Mr Michael Collins was sentenced to 8 years and 3 months in prison for sexual offences. He was sent to HMP Hewell.

21. Mr Collins arrived into prison with a number of pre-existing medical conditions. He had a history of heart disease and had had two heart attacks, one in 2006 for which he needed surgical intervention to insert three stents into the arteries to improve blood flow), and one in 2009. He had previously had a stroke, leaving him with left side weakness, poor mobility requiring the use of a walking stick to mobilise while in his cell, and a wheelchair for longer distances. He also had asthma (for which he was prescribed a Salbutamol inhaler) and type 2 diabetes.

22. Mr Collins' vital observations were recorded and noted as being within a normal range. He was noted as being an ex-smoker who drank moderately before being sent to prison.

23. Prior to his imprisonment, Mr Collins was under the care of the dermatology team at hospital. The team had been treating him for extensive dermatitis. Healthcare staff liaised with hospital staff and agreed to administer a course of 8 methotrexate injections at the prison as part of the treatment.

24. Healthcare staff assigned Mr Collins a carer to assist with daily tasks (a voluntary role carried out by other prisoners). There is no evidence in Mr Collins' medical records that he had been placed under the care of specialised clinics within the prison to manage his long-term conditions.

25. On 18 February 2016, Mr Collins was transferred to HMP Oakwood. Healthcare staff noted his pre-existing medical conditions and reviewed his medication. They referred him to the dermatology clinic at hospital to enable ongoing care for his skin condition. Mr Collins had little significant contact with healthcare in the months that followed.

26. On 6 July, a First Line Manager (FLM) noted Mr Collins was experiencing chest pains. She called an emergency code blue (indicating a prisoner is unconscious, not breathing or is having breathing difficulties). A nurse responded. When she arrived at his cell Mr Collins was sitting down, clutching his chest. Paramedics attended and reviewed him and carried out an electrocardiogram (ECG) the results of which did not indicate anything of note. They did not consider an admission to hospital was necessary and told healthcare staff to monitor him and telephone for an ambulance if his condition deteriorated.

27. On 17 January 2017, a Prison Custody Officer (PCO) called an emergency code blue on his radio. Mr Collins had complained of pains in the left side of his chest and a feeling of pins and needles in his right arm. A healthcare assistant was the first member of healthcare staff to respond to the call. She recorded Mr Collins' blood pressure as being 78/54 (a normal blood pressure reading is between 90/60 and 120/80). His pulse was recorded at 45 beats per minute rising to 59 (a reading of between 60-100 bpm is considered normal). She noted his oxygen

saturation level was 92% (the level of oxygen being carried by the blood stream; a normal level is 95-100 %).

28. Paramedics arrived and carried out an ECG. The results indicated an irregular heartbeat. Mr Collins was taken to hospital by emergency ambulance. Hospital staff later diagnosed Mr Collins as having had a heart attack. He remained in hospital as an inpatient.

29. On 24 January, Mr Collins underwent a rotablation (a surgical procedure in which a tiny rotating drill is inserted through a catheter into the arteries that supply blood to the heart, in order to clean out any blockages and improve blood flow; a stent is then fitted to keep the artery open). He was transferred back to Oakwood the following day.

30. On 6 March, the cardiology team at the hospital reviewed Mr Collins. They carried out an ECG. The results indicated that he had an irregular heartbeat. As Mr Collins had an allergy to aspirin (which is usually prescribed to patients with heart disease to prevent blood clotting), he was prescribed ticagrelor and rivaroxaban. The consultant cardiologist considered there was nothing more they could do about the irregular heartbeat and he discharged Mr Collins from hospital back to the primary care of the prison. He planned to review him in a year. There is no evidence that healthcare staff at Oakwood created a care plan for his irregular heartbeat.

31. On 11 March, a nurse created a diabetes care plan. However, there is no evidence in Mr Collins' medical records that healthcare staff referred Mr Collins to long-term clinics at the prison to provide pro-active management of his condition.

32. On 1 April, a nurse reviewed Mr Collins after he complained of pain in his ear. The nurse noted there was a yellow discharge coming from the ear. He made a referral to another nurse for her opinion as to the cause of the infection. She reviewed him the following day and diagnosed otitis externa (an inflammation of the ear canal caused by infection), and referred him to a prison GP for a further review.

33. The prison GP reviewed Mr Collins on 5 April. He prescribed him gentamicin antibiotic ear drops (used to reduce infections in the ear canal). He asked a nurse to review him again on 10 April.

34. A nurse reviewed Mr Collins as arranged. She noted little improvement in his condition. She gave him paracetemol and brufen for the pain and asked the prison GP to review him with a view to repeating the prescription for ear drops.

35. The prison GP reviewed Mr Collins the following day. He made a repeat prescription for the antibiotic ear drops and prescribed a course of amoxicillin antibiotics. He considered that a sample of the discharge from Mr Collins' ear would assist him to diagnose the cause. However, there were no swabs available to collect a sample. He asked healthcare staff to order replacements.

36. On 13 April, a nurse reviewed Mr Collins to check for any improvement in his condition. He noted Mr Collins appeared "feverish". He was unable to take his temperature, as the thermometer was not working.

37. On 16 April, a nurse reviewed Mr Collins. She noted there was no improvement in his ear infection and he had developed a sore throat. She checked his vital observations, the results of which were normal. She spoke with a prison GP about the lack of improvement in Mr Collins' ear. He prescribed a seven-day course of clarithromycin (an antibiotic used to treat bacterial infections).

38. The swabs arrived at the prison on 20 April. A sample was taken and an anaerobic bacterial infection was found (a bacterium that occurs naturally in the body that can cause infection, typically after an injury or trauma has occurred). A prison GP changed Mr Collins' prescription of antibiotics to co-amoxiclav, an antibiotic specifically used for such an infection.

39. On 27 April, a paramedic at the prison reviewed Mr Collins after he complained of severe pain in his ear. The paramedic checked his observations but was unable to record his temperature because there were no probes available. He decided to send Mr Collins to hospital for further review.

40. Hospital staff referred Mr Collins to the emergency Ear Nose and Throat (ENT) clinic and he was seen the following day after spending the night in hospital. They diagnosed an outer ear infection caused by Pseudomonas (a bacterium, commonly found in the body, which rarely affects healthy individuals but can cause infections in those in poor health). They inserted a wick (a piece of gauze) soaked in gentamicin into his ear and prescribed anti-inflammatory ear drops. He was discharged from hospital and was transferred back to Oakwood the same day.

41. On 11 May, Mr Collins returned to hospital for the wick to be removed. Hospital staff noted the infection had improved. They reviewed him again on 25 May and noted further improvement. Healthcare staff continued to monitor Mr Collins and apply the ear drops.

42. On 15 June, while reviewing Mr Collins, a nurse noted he had a pressure sore on his left hip. She created an older person's care plan and ordered a pressure relieving mattress, which arrived on 20 June. She advised that he be checked twice weekly for any further pressure sores.

43. On 9 July, a PCO noted that Mr Collins felt unwell. She took him to be reviewed by a nurse, who took his observations and noted that his blood pressure was 55/30, (a very low reading), and his pulse was 48 BPM, (a low reading). The nurse decided to send Mr Collins to hospital by emergency ambulance for a further review. Mr Collins was accompanied by two PCOs and no restraints were used.

44. Hospital staff could not find a cause for Mr Collins' condition but noted his blood sugar level was low, as was his blood pressure. They gave him intravenous fluids and antibiotics through a nasogastric tube in an attempt to improve his condition. However, they noted his condition was continuing to deteriorate. He remained in hospital as an inpatient, unrestrained and accompanied by one PCO.

45. On 2 August, hospital staff diagnosed Mr Collins with an infection caused by Staphylococcus aureus (a common bacterial infection that can become difficult to

treat in patients in poor health). Despite continued efforts by hospital staff, Mr Collins' condition continued to deteriorate over the days that followed.

46. On 19 August, at 9.30am, Mr Collins died. Hospital staff confirmed his death at 09.53am.

Mr Collins's clinical care

47. We agree with the clinical reviewer that while there was some good work by healthcare staff at Oakwood, such as regular reviews and timely referrals to secondary care providers, overall, the care he received was not equivalent to that which he could have expected to receive in the community.

48. Mr Collins arrived into prison as an elderly prisoner with pre-existing medical conditions. He also had limited mobility. Healthcare staff correctly identified these issues, though there is no evidence in his medical records that any long-term management of those conditions was considered or put in place.

49. The clinical reviewer considers that Mr Collins' longer term medical conditions were not well managed at Oakwood with a lack of forward planning and management. We make the following recommendation:

The Head of Healthcare should ensure that care pathways and an active care management system, or an equivalent system is put in place to manage long-term health conditions in line with guidance from the National Institute for Health and Care Excellence.

Mr Collins' location

50. Mr Collins lived in a single cell on a house block. He felt supported by his friends and had assistance from his disability orderlies. Nurses reviewed him regularly to ensure he was coping, taking his medication and managing his pain.

51. As Mr Collins' condition deteriorated, healthcare staff provided him with specialist equipment including a pressure sore relieving mattress, mobility aids and a personal alarm to enable him to attract the attention of staff if he needed to.

52. We are satisfied that Mr Collins was appropriately located throughout his illness and his needs were met in line with his wishes.

Restraints, security and escorts

53. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

54. When Mr Collins was admitted to hospital on 9 July, he was escorted by one prison custody officer and was unrestrained.

55. Appropriately, while he remained in hospital as an inpatient until his death, no restraints were applied and the risk assessments took account of his health and risk to the public.

Contact with Mr Collins' family

56. Following his admission to hospital on 9 July 2017, Mr Collins' family were notified of his condition. They were able to visit him regularly while he was an inpatient.

57. The prison appointed the Head of Safer Custody and a FLM as Family Liaison Officers. They were informed of Mr Collins' death at 9.40am on 19 August.

58. The family had asked that if anything should happen to Mr Collins while he was in hospital, the prison should contact one of his sons to break the news as his wife was in poor health.

59. At 11.45am, the Head of Safer Custody telephoned Mr Collins' son to inform him of his father's death. However, his son's wife answered the telephone and told her that she knew Mr Collins had died and that she would tell the rest of the family.

60. At 11.55am, Mr Collins' wife spoke to the Head of Safer Custody to discuss the details of her husband's death and they agreed that further contact should be made via her son and daughter in law. She offered to attend the hospital with the family to give them support, but they declined her offer.

61. Following Mr Collins' death, the Family Liaison team remained in contact with the family offering them support and advice. They met the family to discuss any issues they may have following Mr Collins' death and answered any questions they had about his care while in prison and subsequently when he was admitted to hospital.

62. Mr Collins' funeral was held on 6 September. The prison contributed to the funeral costs in line with national policy.

63. We are satisfied there was good, supportive liaison with Mr Collins' family.

Compassionate release

64. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

65. While an inpatient in hospital, Mr Collins responded to treatment and his condition stabilised.

66. Shortly before his death, his condition began to deteriorate. As it became clear that his condition would not improve and he was likely to die, healthcare staff began the process of collating the necessary information to make an application for compassionate release. However, his condition deteriorated at such a pace there was no time to process and submit the application.

67. We are satisfied that the prison appropriately considered compassionate release for Mr Collins.

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