Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Collins a prisoner at HMP Isle of Wight on 30 June 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*

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 Terence Collins died on 30 June 2017 at HMP Isle of Wight from a heart attack. He was 65 years old. I offer my condolences to Mr Collins' family and friends.

The healthcare Mr Collins received at Isle of Wight was generally equivalent to that he could have expected in the community.

However, given Mr Collins' history of high blood pressure, I am concerned that his blood pressure was not monitored consistently during the more than three and a half years he spent at Isle of Wight, and that he did not have an ECG when he complained of chest pain three days before he died. Although this may have been partly due to Mr Collins' apparent reluctance to pay much attention to his health, this is the third investigation into a death at Isle of Wight in 2017 and 2018 in which we have found a failure by healthcare staff to monitor prisoners' blood pressure consistently.

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

Sue McAllister CB
Prisons and Probation Ombudsman **August 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. In 2012, Mr Terence Collins was sentenced to 16 years imprisonment for sexual offences. He was moved to HMP Isle of Wight in 2013.

2. He had a history of high blood pressure and obesity. The reception health screen at Isle of Wight found that Mr Collins' blood pressure was uncontrolled. He was offered an exercise programme to help lower this but he declined. He was prescribed medication.

3. Mr Collins' blood pressure was monitored and by November 2014, was noted as being well under control. In July 2016, Mr Collins was placed on a hypertension care plan as his blood pressure had become too high again. In March, April and June 2017, Mr Collins' blood pressure was noted as being too high.

4. Three days before his death, Mr Collins' complained about pain in his chest which he thought was due to a recent change in his blood pressure medication. He stopped taking the medication and the symptoms decreased. An appointment was made for Mr Collins to see the prison GP on 30 June.

5. On 30 June 2017, Mr Collins' cell was unlocked at 7.58am. An officer went into the cell to carry out checks and initially thought that Mr Collins was sleeping, before realising that he was unresponsive. The officer called an emergency medical code and prison officers and healthcare staff arrived. was called. When it became clear that Mr Collins had been dead for some time, the ambulance was cancelled and no attempt was made to revive Mr Collins.

6. At 9.14am, a prison GP pronounced Mr Collins dead.

Findings

Clinical care

7. The clinical reviewer was satisfied that the standard of care Mr Collins received at Isle of Wight was generally equivalent to that he could have expected to receive in the community.

8. However, he said that the monitoring of Mr Collins' blood pressure was intermittent and that, given Mr Collins' high blood pressure, he would have expected him to have an electrocardiogram (ECG) during the more than three and a half years he spent at Isle of Wight, and particularly when he reported chest pains three days before he died.

9. We agree. This is the third investigation into a death at Isle of Wight in 2017 and 2018 in which we have found that healthcare staff had failed to monitor blood pressure consistently.

Recommendations

- The Head of Healthcare should provide the Ombudsman with:
    - a copy of the review of the prison's programme of chronic disease management;
    - an account of the action that has been taken to strengthen the monitoring and surveillance systems; and
    - evidence that individual care plans are created for prisoners with hypertension to ensure monitoring and recording in line with NICE guidelines.

The Investigation Process

10. 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.

11. The investigator obtained copies of relevant extracts from Mr Collins' prison and medical records. Our investigation was suspended while police investigations took place.

12. Another investigator concluded the investigation once the case was unsuspended.

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

14. We informed HM Coroner for Isle of Wight of the investigation and she gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The investigator wrote to Mr Collins' son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. He did not respond to our letter.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. The HMPPS action plan is annexed to this report.

Background Information

HMP Isle of Wight

17. HMP Isle of Wight is an amalgamation of two former 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

18. The most recent inspection of HMP Isle of Wight was conducted 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

19. 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 2017, the IMB said that, overall, healthcare provided at the prison was at least as good as that provided to the wider population. However, there was an ongoing shortage of nurses, with agency staff covering the shortfall.

Previous deaths at HMP Isle of Wight

20. Mr Collins was the fifteenth prisoner to die of natural causes at Isle of Wight since January 2015. There have been a further 12 deaths since Mr Collins' death.

21. In our investigations into two deaths from natural causes in June and July 2018, we found that healthcare staff had failed to monitor the prisoners' blood pressure consistently.

Key Events

22. On 24 December 2012, Mr Terence Collins was sentenced to 16 years imprisonment for sexual offences. He was moved to HMP Isle of Wight on 8 October 2013.

23. Mr Collins' clinical record showed that his GP in the community had been monitoring his high blood pressure. Mr Collins was also overweight and had high levels of glucose in his urine, which is a sign of diabetes.

24. In October 2013, after arriving at HMP Isle of Wight, it was noted that Mr Collins' blood pressure was uncontrolled. He was prescribed medication. He was also offered an exercise programme to help reduce his blood pressure, which he declined.

25. In January 2014, his blood pressure was found to be too high. His medication was changed because he was unhappy with the side effects, and ten days later it was changed again for the same reason. By March, his blood pressure had improved and in October it was noted to be at a reasonable level.

26. In October 2014, Mr Collins' risk of a coronary event over the next ten years (his 'Qrisk' score) was calculated at 22.96%. He was advised to take statins to reduce his risk, but he was reluctant to take statins, or to engage in an exercise programme or make any changes to his diet. He complained of rectal bleeding.

27. The following month, Mr Collins blood pressure was noted as still being well-controlled and his rectal bleeding had reduced. Mr Collins was referred for a sigmoidoscopy to inspect the lining of his lower bowel. In December, Mr Collins declined the appointment as his symptoms had improved.

28. During 2015, Mr Collins complained of aches and pains and tingling and numbness in his arms and in December he was referred to neurosurgeons for specialist advice. He subsequently declined the appointment (in May 2016) because his symptoms had improved.

29. In March 2016, persistently raised blood sugar levels indicated that Mr Collins was just within the prediabetic range.

30. In July 2016, Mr Collins was placed on a hypertension care plan as his blood pressure had risen again. He was reviewed on 8 August and his blood cholesterol was found to be slightly high (although the level was not recorded in his medical notes).

31. On 10 March 2017, during a visit to a rheumatologist, he was diagnosed with early arthritis and his blood pressure was noted as being uncontrolled again.

32. On 20 April, a prison GP noted Mr Collins' high blood pressure. He made changes to his medication, taking into account the side effects he had experienced with other medication.

33. On 13 June, a prison GP noted that Mr Collins' blood pressure had improved but was still too high. He therefore increased the dosage of his medication and diagnosed him with hypertension.

34. On 27 June, a nurse saw Mr Collins as he was complaining of about pains in the left side of his chest which he thought were due to the increase in medication on 13 June. He said that the pain had subsided after he stopped his medication. A GP appointment was made for 30 June to discuss the matter further.

Events of 30 June 2017

35. On 30 June, at 7.58am, Mr Collins' cell was unlocked electronically. At approximately 8.35am, an officer was carrying out cell checks on Mr Collins' landing. When he opened the door to Mr Collins' cell, he saw Mr Collins lying on his bed, naked, and assumed he was asleep. The officer entered the cell and began his checks, which included checking the lights, cell bell and the general condition of the cell. As Mr Collins had not stirred, the officer called to him two or three times. He did not respond and the officer noted that Mr Collins' skin had become mottled and he was cold to touch and rigour mortis was present. He thought that Mr Collins was dead.

36. At 8.40am, the officer called a code blue medical emergency on his radio and the control room called an ambulance. Within 30 seconds, other prison officers arrived at the cell, along with healthcare staff. When they arrived, it was clear that Mr Collins was dead, so the ambulance was cancelled.

37. At 9.14am, a prison GP pronounced Mr Collins dead.

38. The cell was sealed. Not long after the alarm had been raised, a prisoner told an officer that he had seen medication boxes and blister packs for tablets on the landing three floors down and directly below Mr Collins' cell. As this raised the possibility that Mr Collins may have taken the tablets and then thrown the containers over the railings to the landing below, the police seized the containers and conducted an investigation. The police subsequently concluded that there did not appear to have been any suspicious circumstances surrounding Mr Collins' death.

Post-mortem report

39. A post-mortem examination concluded that the cause of Mr Collins death was haemopericardium and ruptured myocardial infarction (a massive heart attack). The toxicology report showed no alcohol in Mr Collins' blood and only therapeutic levels of medication.

Contact with Mr Collins' family

40. On the morning of Mr Collins' death, the prison appointed a supervising officer as the prison's family liaison officer (FLO). Mr Collins' next of kin was his son, who lived in Bournemouth. The FLO was unable to obtain a car to visit the next of kin so staff at HMP Guys Marsh, which was closer to Mr Collins' son's home, agreed to go to his home and break the news of Mr Collins' death.

41. When they arrived at the address, Mr Collins' ex-wife, the mother of his son, was present. Isle of Wight gave permission for her to be told of Mr Collins' death. Mr Collins' son arrived soon afterwards and was told of his father's death. They were also given the contact details of the FLO at Isle of Wight.

42. The following day, the FLO telephoned Mr Collins' partner and introduced himself, offering support and advice. The FLO kept in regular contact with the family and, on 26 July, the family agreed that they would like the prison chaplaincy to conduct Mr Collins' funeral service.

43. The funeral took place on 8 August and the prison contributed to the funeral costs in line with Prison Service instructions.

Support for prisoners and staff

44. After Mr Collins' 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.

45. The prison posted notices informing other prisoners of Mr Collins' 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 Collins' death.

Findings

Clinical care

46. The clinical reviewer was satisfied that in general the care Mr Collins received at Isle of Wight was generally equivalent to that which he could have expected to receive in the community. However, the monitoring of Mr Collins' blood pressure was intermittent and he did not have an ECG carried out while in prison.

47. The clinical reviewer considered that the intermittent nature of Mr Collins' blood pressure monitoring may have been due, in part, to Mr Collins' apparent reluctance to pay much attention to his health. He was offered medication advice and lifestyle intervention programmes on several occasions, which he ignored or declined.

48. The clinical reviewer considered that Mr Collins should have had an ECG at some point, given his high blood pressure. It would also have been reasonable to expect that an ECG would have been carried out when Mr Collins complained of chest pain, even his pain had subsided by the time he was seen.

49. The clinical reviewer said, however, that an ECG would not necessarily have shown any changes and would almost certainly not have affected the outcome for Mr Collins.

50. We are, however, concerned that this is not the only investigation into a death at Isle of Wight where we have found that healthcare staff had failed to monitor the prisoner's blood pressure consistently.

51. In two other investigations (into deaths in June and July 2018) we recommended that the Head of Healthcare should ensure that care plans are created for prisoners with hypertension to ensure monitoring and recording in line with NICE guidance. The Head of Healthcare accepted our recommendations and undertook to implement them by the end of March 2019. Following our investigation into Mr Collins' death, the Head of Healthcare also told the clinical reviewer that the prison's programme of chronic disease management has been reviewed and this has resulted in a strengthening of their monitoring and surveillance systems.

52. We recommend that:

The Head of Healthcare should provide the Ombudsman with:

- **a copy of the review of the prison's programme of chronic disease management;**
- **an account of the action that has been taken to strengthen the monitoring and surveillance systems; and**
- **evidence that individual care plans are created for prisoners with hypertension to ensure monitoring and recording in line with NICE guidelines.**

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