

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Salmon a prisoner at HMP Isle of Wight on 2 June 2018

A report by the Prisons and Probation Ombudsman

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 Salmon died in hospital on 2 June 2018 of sepsis, pneumonia and congestive heart failure due to an enlarged heart while a prisoner at HMP Isle of Wight. He was 83 years old. I offer my condolences to Mr Salmon's family and friends.

The investigation found that healthcare staff did not monitor Mr Salmon's high blood pressure in accordance with his care plan. However, I am satisfied that this had no impact on his death and that overall, the care Mr Salmon received was equivalent to that which 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.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

December 2018

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Summary

Events

1. Mr Michael Salmon was sent to prison in February 2015. He spent time at HMP Bullingdon before being moved to HMP Isle of Wight in February 2017.
2. Mr Salmon had a history of high blood pressure which healthcare staff managed with a care plan. This said his blood pressure should be monitored every week.
3. In April 2018, Mr Salmon complained of severe, black diarrhoea with a fever. A prison nurse arranged for an emergency ambulance to take Mr Salmon to the Hospital.
4. The results of an endoscopy (an examination of the inside of the body using a small camera) revealed that Mr Salmon had a bleeding duodenal ulcer. Hospital doctors applied clips to stop the bleeding and treated Mr Salmon with intravenous antibiotics.
5. On 22 April, Mr Salmon was moved to the hospital's high dependency unit. Hospital doctors decided that Mr Salmon needed a heart valve replacement and inserted a chest drain to remove fluid from his lungs.
6. Mr Salmon's condition deteriorated and hospital doctors decided he was no longer suitable for a heart valve replacement and could return to prison for palliative care.
7. On 1 June, Mr Salmon was moved to another hospital pending his return to prison. However, his condition continued to deteriorate and he died at 7.45pm on 2 June.
8. The coroner gave Mr Salmon's cause of death as sepsis, pneumonia and congestive heart failure caused by an enlarged heart

Findings

9. Despite having a hypertension care plan that said his blood pressure should be monitored weekly, there is no record that staff took Mr Salmon's blood pressure between March and November 2017. We are satisfied that this had no impact on Mr Salmon's death but it is important that staff follow NICE guidelines.
10. Overall, we are satisfied that the care Mr Salmon received at the prison was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.

The Investigation Process

11. 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.
12. The investigator obtained copies of relevant extracts from Mr Salmon's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Salmon's clinical care at the prison.
14. We informed HM Coroner for Isle of Wight of the investigation who gave us the preliminary cause of death. We have sent the coroner a copy of this report.
15. The investigator wrote to Mr Salmon's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
16. 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. The action plan has been annexed to this report.

Background Information

HMP Isle of Wight

17. 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

18. 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

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 their latest annual report, for the year to 31 December 2016, the IMB said that it continued to be impressed by the standard of healthcare provided by Care UK.

Previous deaths at HMP Isle of Wight

20. Mr Salmon was the 20th prisoner to die at Isle of Wight since June 2015 which is not remarkable, given the prison's population. Twenty of these deaths were from natural causes and two took their own lives. There have been two natural causes deaths since. There were no similarities between Mr Salmon's death and previous deaths at Isle of Wight.

Key Events

21. On 12 February 2015, Mr Michael Salmon received a 22-year sentence for sexual offences and was sent to HMP Bullingdon. He was moved to HMP Isle of Wight on 13 May 2015. On 27 October, he was returned to Bullingdon before returning to Isle of Wight on 21 February 2017.
22. A nurse completed Mr Salmon's reception health screen when he arrived at Isle of Wight and noted that he had a history of high blood pressure and a hypertension care plan. She recorded his blood pressure as 153/70 (raised) and made a referral to a prison GP. Mr Salmon took amlodipine (used to treat high blood pressure and coronary artery disease). Mr Salmon complained of knee pain caused by an injury at Bullingdon.
23. On 22 February, a prison GP assessed Mr Salmon and noted that his blood pressure was raised. He also noted that Mr Salmon had swollen ankles and considered that this was a side effect from taking amlodipine. He stopped prescribing amlodipine and arranged for a prison GP to review Mr Salmon's blood pressure in three weeks. He made a referral to the orthopaedics clinic at the hospital.
24. On 14 March, a prison GP recorded Mr Salmon's blood pressure as 128/66 (normal).
25. On 5 April, an orthopaedic specialist at the Hospital examined Mr Salmon and gave him a steroid injection in his left knee. He had another steroid injection on 21 June. The orthopaedic specialist referred Mr Salmon to an orthopaedic surgeon for a left knee replacement.
26. On 6 November, the orthopaedic clinic wrote to the prison GP and asked healthcare to monitor Mr Salmon's blood pressure for three days to assess his suitability for surgery. A prison GP recorded Mr Salmon's blood pressure as 181/99 (high). Subsequent readings were within the normal range and his ambulatory blood pressure was also normal.
27. On 19 December, a nurse recorded Mr Salmon's blood pressure as 172/70 (high). She referred Mr Salmon to a prison GP to review his blood pressure the next day. There is no evidence that this took place.
28. In February 2018, the orthopaedic clinic postponed Mr Salmon's knee replacement operation. On 20 February, a multidisciplinary team meeting reviewed Mr Salmon's medication and prescribed him tramadol (opioid painkiller used to treat moderate to severe pain).
29. On 14 April, a nurse saw Mr Salmon after he complained of severe, black diarrhoea. She noted that Mr Salmon had a fever and arranged for an emergency ambulance to take him to the hospital. Two officers accompanied Mr Salmon and did not use restraints.
30. In hospital, Mr Salmon had an endoscopy (an examination of the inside of the body using a small camera) which revealed a bleeding duodenal ulcer. During

the endoscopy, hospital doctors applied clips to stop the bleeding and treated Mr Salmon with intravenous antibiotics.

31. Hospital doctors suspected that Mr Salmon was suffering from endocarditis (a rare and potentially fatal infection of the inner lining of the heart). On 22 April, Mr Salmon was moved to the high dependency unit for further investigations. Hospital doctors decided that Mr Salmon needed a heart valve replacement.
32. Hospital doctors inserted a chest drain which removed three litres of fluid from Mr Salmon's lungs. Mr Salmon's condition deteriorated and hospital doctors decided he was no longer suitable for a heart valve replacement. Arrangements were made to return Mr Salmon to Isle of Wight for palliative care.
33. On 1 June, Mr Salmon was moved to the hospital prior to his return to prison. However, his condition continued to deteriorate and he died in hospital at 7.45pm on 2 June.

Contact with Mr Salmon's family

34. On 12 May, the prison appointed a prison officer, as the family liaison officer (FLO). He visited Mr Salmon in hospital and offered support. Mr Salmon confirmed that his brother was his next of kin and that he was aware he was in hospital. The same day, the FLO telephoned Mr Salmon's brother. He asked the FLO to telephone him when Mr Salmon died.
35. At 9.15pm on 2 June, the FLO telephoned Mr Salmon's brother to inform him of Mr Salmon's death. He offered Mr Salmon's brother his condolences and support.
36. Mr Salmon's funeral was held on 18 July. The prison contributed to the cost of the funeral in line with Prison Service policy.

Support for prisoners and staff

37. After Mr Salmon'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.
38. The prison posted notices informing other prisoners of Mr Salmon'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 Salmon's death.

Cause of death

39. The coroner gave Mr Salmon's preliminary cause of death as sepsis, pneumonia and congestive cardiac failure due to cardiomegaly (enlarged heart). The full post-mortem report was not available at the time of issuing this initial report.

Findings

Clinical care

40. When Mr Salmon arrived at HMP Isle of Wight in February 2017, nurses noted that he had a care plan to manage his high blood pressure. This said that healthcare should monitor his blood pressure every week. The clinical reviewer found no blood pressure readings between March and November 2017. In December 2017, Mr Salmon's blood pressure was raised but there was no evidence that this was reviewed as requested by a prison nurse.
41. The National Institute for Health and Clinical Excellence (NICE) guidelines on the management of hypertension indicates the importance of regular monitoring and recording of blood pressure in hypertensive patients. We note that the clinical reviewer did not consider that the lack of blood pressure monitoring contributed to Mr Salmon's death. However, it is important that healthcare staff follow NICE guidelines when managing a chronic condition. We make the following recommendation:

The Head of Healthcare should ensure that staff appropriately monitor and record blood pressure readings for prisoners with hypertension in line with national guidelines.
42. With the above exception, we are satisfied that the clinical care Mr Salmon received while at Isle of Wight was equivalent to that which he could have expected to receive in the community.

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