Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Carter a prisoner at HMP Isle of Wight on 23 July 2018

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 David Carter died on 23 July 2018 of a heart attack at HMP Isle of Wight. He was 59 years old. I offer my condolences to Mr Carter's family and friends.

The investigation found that Mr Carter's clinical care at Isle of Wight was below the standard that he could have expected to receive in the community. He had longstanding hypertension, controlled by medication, but there were no reviews of his blood pressure after his reception health assessments at Isle of Wight and no obvious plans in place to trigger such a review. The need to improve the management of prisoners with high blood pressure is a matter that we have raised with the prison before.

When Mr Carter was found unresponsive, prison staff carried out the resuscitation attempts professionally. However, they did not comply with the expectation set out in the local emergency response policy to inform healthcare staff of the emergency, so there was no clinical input until the paramedics arrived. While this might not have affected the outcome for Mr Carter, it is vital that if healthcare staff are on duty, they participate in the management of life-threatening incidents.

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 **March 2019**

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Summary

Events

1. Mr David Carter had been in prison since 20 March 2017, serving 12 years, for sexual offences. He had a history of hypertension (high blood pressure) and raised cholesterol, diagnosed by his community GP in 2009. Mr Carter was initially sent to HMP Wormwood Scrubs, where staff re-prescribed his medication and monitored his blood pressure.

2. On 5 December 2017, Mr Carter was transferred to HMP Isle of Wight. He lived on the Parkhurst site. At his reception health assessments, healthcare staff noted that his blood pressure was well controlled and within normal limits. Mr Carter continued to receive his medication monthly throughout 2018, but had no direct contact with healthcare staff.

3. At around 6.03pm on 23 July 2018, Mr Carter's cellmate rang the cell call bell, as he was concerned about Mr Carter. Officers went into the cell, found him unresponsive and called a code blue medical emergency. Two physical education officers performed chest compressions until paramedics arrived and took over. At 6.15pm, an officer rang a prison nurse to obtain Mr Carter's medical background to assist the paramedics. The paramedics confirmed Mr Carter's death at 6.38pm.

Findings

4. Although Mr Carter's blood pressure was stable when he arrived at Isle of Wight, staff should have continued to monitor his blood pressure, in accordance with the National Institute for Health and Clinical Excellence (NICE) guidelines on the management of hypertension. As this did not happen, Mr Carter's clinical care was not equivalent to that he could have expected to receive in the community.

5. When Mr Carter was found unresponsive, staff did not follow the local emergency protocol, which requires clinical staff to attend medical emergencies. As the prison's night nurses were based on the Albany site and used a different radio net, they were unaware of the emergency. Prison staff did not inform or collect them to assist with the resuscitation before the paramedics arrived.

6. We are satisfied that the officers performed the resuscitation attempts appropriately. However, it is essential to involve healthcare staff in emergencies, as they are trained to use a wider range of specialist equipment in the event of complications such as blocked airways.

Recommendations

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

- The Governor should ensure that staff fully comply with the local medical emergency protocol and that nurses attend medical emergencies at night.

The Investigation Process

7. 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.

8. The investigator obtained copies of relevant extracts from Mr Carter's prison and medical records and spoke informally to the Head of Healthcare and the Head of Safer Custody to obtain further background.

9. NHS England commissioned a clinical reviewer to review Mr Carter's clinical care at the prison.

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

11. The investigator spoke to Mr Carter's wife, to explain the investigation and to ask if she had any matters for the investigation to consider. Mr Carter's wife wanted to know generally about her husband's care and management and the circumstances of his death, but had no specific questions.

12. Mr Carter's wife received a copy of our initial report. She drew attention to some inaccuracies in the draft report and clinical review report. We have amended this report and responded to her directly on the other matters.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly. They accepted our recommendations and their action plan has been annexed to this report.

Background Information

HMP Isle of Wight

14. 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.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that the prison provided an appropriate range of health services and standards had improved. All new prisoners received a prompt initial health screen, a comprehensive secondary screen and GP review. Staff had good access to appropriate clinical guidance and prisoners were positive about their care. However, the management of some lifelong conditions was inadequate and some prisoners did not have a care plan or receive regular reviews.

16. Inspectors also found that appropriate emergency equipment and automated defibrillators were located on both sites, but the prison did not always have enough first aid trained officers on duty to ensure an adequate emergency response. Ambulances were called and responded promptly in emergencies.

Independent Monitoring Board

17. 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. The IMB's most recent annual report is for the year to 31 December 2017. They were satisfied with the standard of healthcare provided by Care UK and described the healthcare team as well-led and effective. However, the Board was concerned about the continuing shortage of nurses, the department was typically short of five nurses out of a complement of 21.

Previous deaths at HMP Isle of Wight

18. There have been 21 deaths at Isle of Wight since January 2016. Sixteen were from natural causes, four prisoners took their own lives and we are awaiting the cause of death on another. We have made a previous recommendation to Isle of Wight about the need to monitor prisoners with high blood pressure.

Key Events

19. On 20 March 2017, Mr David Carter was convicted of sexual offences and remanded to HMP Wormwood Scrubs. It was his first time in prison. (On 18 April, Mr Carter was sentenced to 12 years in prison.)

20. At his initial health screen, healthcare staff noted that Mr Carter had hypertension (high blood pressure), but was otherwise fit and well. A few days later, the prison received his community GP records which confirmed that he had been diagnosed with high blood pressure and high cholesterol in 2009. His GP had reviewed him at least annually. In 2013, he had declined statins to address his high cholesterol levels and was advised to make lifestyle changes, such as stopping smoking, losing weight, healthy eating and taking exercise.

21. Prison healthcare staff reviewed and re-prescribed Mr Carter's medication, amlodipine, and checked his blood pressure several times in the following months. He settled well, working as a painter and cleaner and became a trusted prisoner.

22. On 5 December 2017, Mr Carter was transferred to HMP Isle of Wight. During a health assessment the following day, a nurse noted that his blood pressure was within acceptable limits. A prison GP reviewed him and recorded that his high blood pressure was well controlled by medication. The GP requested blood tests and an electrocardiogram (ECG – a test to check the heart's rhythm and electrical activity). Healthcare staff identified no additional health issues at that time and continued Mr Carter's existing medication.

23. Mr Carter was unhappy about the move because of the distance from his family. As a precaution, Wormwood Scrubs had started suicide and self-harm prevention measures immediately before his transfer. Staff at Isle of Wight continued monitoring him under these provisions for a few days after his arrival.

24. Blood tests taken on 18 December showed that Mr Carter's cholesterol level was above the expected limits, but staff noted no further action was required. The ECG results were normal.

25. On 10 January 2018, a nurse wrote to Mr Carter, offering him the opportunity to attend the prison's healthy lifestyle programme. (This is a wellbeing approach to help motivate the men to take responsibility for improving their health and is an additional service to healthcare clinics.) There is no record of whether he responded, or whether staff followed up the invitation.

26. At Isle of Wight, Mr Carter became part of the horticultural team and was described as a model prisoner. There is no record of any direct contact with healthcare staff after January 2018, but they continued to prescribe his medication monthly and Mr Carter kept it in his cell.

27. At around 6.03pm on 23 July, Mr Carter's cellmate rang the cell call bell. He told an officer and supervising officer (SO) that Mr Carter was unresponsive and had wet himself. They went into the cell and the SO radioed a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing).

The control room log showed that an ambulance was called immediately and a defibrillator was requested at 6.05pm.

28. Two physical education officers heard the code blue call and another message shortly afterwards requesting a defibrillator. They went to the cell with the defibrillator from the gym office. As Mr Carter was not breathing, they began cardiopulmonary resuscitation (CPR). They gave chest compressions, but found it difficult to give rescue breaths as he had vomited and his airway was blocked. They tried to clear his airways several times by placing him on his side. During the resuscitation process, the defibrillator advised them to shock Mr Carter two or three times. At one point, they thought there were signs of life, but found no pulse when they checked.

29. Two ambulances arrived at 6.09pm. The paramedics reached the cell at 6.16pm and took over the resuscitation attempts.

30. A nurse noted in the medical record that at approximately 6.15pm, a prison officer had asked her for Mr Carter's medical history and she had relayed this to the wing. (The time stated is slightly at odds with that given in the incident log for the arrival of the paramedics.) She added that healthcare had not been informed of the emergency, therefore no nurses had attended.

31. At 6.38pm, the paramedics confirmed Mr Carter's death.

Contact with Mr Carter's family

32. Due to the time and the distance between the prison and Mr Carter's home in Essex, Isle of Wight's family liaison officer (FLO) asked HMP Chelmsford to inform Mr Carter's wife of his death. Chelmsford's FLO received no reply when she went to the address listed for his next of kin and called the landline telephone number. She then rang the mobile number and found that Mr Carter's wife and family were on holiday abroad. She had no option but to break the news by telephone. His wife was shocked as she had spoken to Mr Carter at 5.00pm, an hour before he was found unwell.

33. The next day, Isle of Wight's FLO spoke to Mr Carter's wife. He visited her when she returned home and offered continuing support. Mr Carter's funeral was held on 29 August. In line with Prison Service policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

34. After Mr Carter's death, the Head of Safer Custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer the support of the care team.

35. Mr Carter's cellmate was moved to another cell and received support. All the prisoners on Mr Carter's house unit were immediately checked and offered support. The next morning, all other prisoners were informed of Mr Carter's death and reminded of the support available. Staff also posted notices in the residential units. They reviewed the most vulnerable men, including those assessed as being at risk of suicide or self-harm, in case they had been adversely affected by his death.

Post-mortem report

36. The report of the post-mortem examination concluded that Mr Carter's death was due to, 1a) Myocardial Infarction; 1b) Coronary Artery Atheroma, Thrombosis (a heart attack caused by 'hardening' or 'furring up' of the arteries which reduces the blood supply to the heart and a blood clot).

37. The pathologist noted evidence of left ventricular hypertrophy (enlargement and thickening of the walls of the heart's main pumping chamber) due to hypertension. There was no evidence of alcohol or drugs.

Findings

Clinical care

38. When Mr Carter was remanded to Wormwood Scrubs, healthcare staff recorded that he had high blood pressure and they reviewed him periodically. When he moved to Isle of Wight, healthcare staff who conducted his reception health screens found that his blood pressure was well controlled and within normal limits. They continued to prescribe his medication, but no care plans were put in place and there were no further reviews of his blood pressure.

39. In January 2018, Mr Carter was invited to a healthy lifestyle programme. The Head of Healthcare explained that this is an additional service to the healthcare clinics. She said that Care UK adopt a wellbeing approach, in which they encourage the men to set their own targets and to take responsibility for their own care. There is a full-time health trainer who assists them to complete an assessment and set goals. The trainer keeps in contact and helps to motivate them. There is no evidence that Mr Carter responded to, or participated in the programme.

40. The Head of Healthcare acknowledged that Mr Carter should have been subject to chronic disease management for his hypertension. She said there was a system of cross indicators to alert GPs to those who need to be reviewed. However, as the medical record was closed after Mr Carter's death, it was no longer possible to determine whether there had been an alert for him. She was not aware of any evidence to suggest that Mr Carter had refused to engage with healthcare.

41. High blood pressure, if untreated, increases the risks of problems such as heart attacks and strokes. 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. Although Mr Carter's blood pressure was stable when he arrived at Isle of Wight and he received regular medication, healthcare staff should have implemented care plans and continued monitoring his blood pressure, in accordance with these guidelines.

42. We agree with the clinical reviewer's conclusion that, while there is no evidence that the absence of blood pressure monitoring affected the outcome for Mr Carter, the standard of care provided at Isle of Wight was not the equivalent of that which he could have expected to receive in the community. We revise and repeat a recommendation that we made after a previous death at Isle of Wight.

    The Head of Healthcare should ensure that staff put in place care plans and appropriately monitor and record blood pressure readings for all prisoners with hypertension, in line with national guidelines.

Emergency response

43. Isle of Wight's medical emergency protocol states that, in the event of a medical emergency, after contacting the ambulance service the control room should deploy clinical staff to the incident.

44. The resuscitation attempts on 23 July, were initially led by two physical education officers. The paramedics arrived at the cell 13 minutes after the code blue was called and took over. The nurses on duty were not informed of the incident at the outset, nor asked to assist, but staff telephoned them for details of Mr Carter's medical history after the paramedics had arrived.

45. Mr Carter lived on the Parkhurst site and the night nurses were based in Albany. Although the nurses hold radios, each site has a separate radio net, so they would not have heard a code blue called on the Parkhurst net. The Head of Healthcare did not know why healthcare staff had not been called to the emergency response. She said that the correct out of hours emergency procedure is that the prison's night manager should alert the nurses and escort them to the other site.

46. The duty manager during the incident thought that the nurses had been informed. He said that as the prison was opposite the accident and emergency department of the local hospital, the ambulance had arrived very quickly. He added that it might have taken the nurses over 25 minutes to reach the site, taking into account the time to send someone from Parkhurst to Albany to escort them and getting through multiple gates.

47. There is no reason to doubt the proficiency of the officers who conducted the resuscitation attempts and nothing to indicate that the attendance of the nurses would have changed the outcome. However, in a life-threatening situation it is essential that staff follow the expected emergency procedures to provide the optimum level of care. We strongly believe that healthcare staff must be included in dealing with medical emergencies, if they are available, as they have the requisite skills to deal with a range of clinical problems, as well as access to specialist equipment, such as airways, oxygen and suction equipment. Despite the hospital's close proximity to the prison, there is no guarantee that ambulances will arrive before the prison nurses. We make the following recommendation:

The Governor should ensure that staff fully comply with the local medical emergency protocol and that nurses attend medical emergencies at night.

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