Prisons & Probation
Ombudsman
Independent Investigations

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

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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 John Collins died on 30 October 2018 of a heart attack, while a prisoner at HMP Isle of Wight. He was having an operation to repair a broken hip, caused by a fall, when he died. He was 83 years old. I offer my condolences to Mr Collins' family and friends.

I am satisfied that the overall care that Mr Collins received at the Isle of Wight, was equivalent to that which he could have expected to receive in the community.

However, I am concerned that healthcare staff at the Isle of Wight took too long to implement a falls policy for Mr Collins. Mr Collins had several chronic and evolving medical conditions which increased his fragility and tendency to falls. He had several falls between May 2017 and May 2018, and although each fall was appropriately treated, no falls assessment was completed until August 2018.

Although it is unlikely that this delay would have changed the outcome of Mr Collins, failure to properly implement a falls policy could make a difference in future cases.

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 **September 2019**

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Summary

Events

1. On 18 July 2011, Mr John Collins received a 16-year prison sentence for sexual offences and was sent to HMP Woodhill. He was transferred to HMP Isle of Wight on 20 October 2011. Mr Collins had type 2 diabetes, high blood pressure, coronary heart disease, glaucoma in both eyes, poor mobility, deafness and used a hearing aid.

2. Mr Collins could only walk short distances using a walking stick and he used a wheelchair for longer distances. On 23 October 2012, he had the first of many social care assessments, as his need for support increased.

3. Between May 2017 and May 2018, Mr Collins had several falls on the residential wing. Prison staff documented each fall, and made appropriate referrals to healthcare staff for further care.

4. On 25 August 2018, a nurse completed a falls risk assessment. She told Mr Collins that he must call for assistance if he needed anything. His other care needs were allocated to carers and he was moved to the prison's healthcare inpatient unit. The falls risk assessment was reviewed on 7 October.

5. At 3.30pm, on 24 October, Mr Collins pressed his personal alarm and was found by staff sitting on the floor of his cell near the toilet. A healthcare assistant checked Mr Collins and noted no apparent injuries. A doctor reviewed him later that day, and noted that he could bear weight on his leg. The doctor prescribed antibiotics for Mr Collins' infected leg ulcers.

6. On 29 October, Mr Collins complained of hip pain. A nurse reviewed him and saw that he had a shortened and rotated right leg. Mr Collins was taken to hospital and he was diagnosed with a broken right hip.

7. At around 2.00pm, on 30 October, Mr Collins was taken into surgery to have his broken hip repaired. During the operation, Mr Collins had a heart attack and he died. Mr Collins' death was confirmed at 5.35pm.

8. The post-mortem report gave the cause of death as 1a) cardiac arrest (heart attack) and 1b) hypertension (high blood pressure) and cardiac amyloidosis (a build up of abnormal protein in the heart).

Findings

9. The clinical reviewer concluded that the overall care Mr Collins received at the Isle of Wight was equivalent to that which he could have expected to receive in the community.

10. Mr Collins had a number of chronic and evolving medical conditions, which made him increasingly fragile and prone to falls.

11. Care UK has a comprehensive policy for the management of slips, trips and falls. Mr Collins had several falls between May 2017 and May 2018. Although each

fall was appropriately treated, there is no evidence in the clinical record that a falls assessment was carried out until August 2018.

12. Appropriately, the prison did not apply restraints when Mr Collins was taken to hospital on 29 October.

Recommendations

- The Head of Healthcare should ensure that:
  - the Care UK Slips Trips and Falls policy is implemented, including the use of the Falls Risk Assessment template, and
  - a regular audit of documented falls is introduced.

The Investigation Process

13. 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.

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

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

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

17. 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 responded to say that she had no matters she wanted to raise.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified a minor factual inaccuracy which has been amended in this report. The HMPPS action plan is annexed to this report.

19. We provided Mr Collins' next of kin with a copy of our initial report. She did not identify any factual inaccuracies.

Background Information

HM Prison Isle of Wight

20. 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

21. 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

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 2017, the IMB said that the prison continued to provide a standard of healthcare which was at least as good as in the wider population, and that social care was proceeding well. The IMB raised concerns for the fifth year in a row that lack of funding for building work meant that disabled prisoners did not have the same access to areas of the prison as able-bodied prisoners.

Previous deaths at HMP Isle of Wight

23. Mr Collins was the twelfth prisoner to die of natural causes at Isle of Wight since October 2016. There has been one natural cause death since Mr Collins' death. There are no similarities with those deaths.

Key Events

24. On 18 July 2011, Mr John Collins received a 16-year prison sentence for sexual offences and was sent to HMP Woodhill. On 20 October 2011, he was transferred to HMP Isle of Wight.

25. At Mr Collins' reception screening at the Isle of Wight his health needs were appropriately identified. Mr Collins had type 2 diabetes, high blood pressure, coronary heart disease, glaucoma in both eyes, poor mobility, deafness and he used a hearing aid.

26. Mr Collins' diabetes and heart disease were managed according to NICE guidelines. The long-term monitoring of Mr Collins' glaucoma was interrupted when he entered prison custody, but when he was reviewed at a clinic in April 2015, his condition had remained stable and his treatment stayed the same.

27. Mr Collins could only walk short distances using walking stick, and he used a wheelchair for longer distances. On 23 October 2012, Mr Collins had the first of many social care assessments completed by a social worker, who noted that in addition to using a stick and wheelchair, Mr Collins could feed and dress himself.

28. In April 2013, Mr Collins complained of a tremor in his arm. Mr Collins was diagnosed with having a compressed nerve in his right arm and a minor operation released this. Parkinson's disease was also considered to be a possible cause, so in January 2015, Mr Collins was prescribed Sinemet and his symptoms improved.

29. On 5 May 2017, Mr Collins had his first recorded fall. He told staff his knee had given way.

30. On 12 July 2017, an MRI scan of Mr Collins' spine showed that his spinal canal had narrowed, compressing his nerves, weakening his legs and decreasing his mobility. Mr Collins declined surgery because of the risks involved due to his other health conditions.

31. On 31 December, Mr Collins slipped off his bed and spent some hours on the floor. A nurse from the prison's healthcare team reviewed him and found no injuries.

32. On 23 January 2018, Mr Collins fell in the shower. A prison GP examined him the same day and found no injuries. A week later, Mr Collins told a prison GP that he had hit his head when he fell and had felt dizzy ever since. The GP reduced some of Mr Collins' medication in case low blood pressure had contributed to the fall.

33. In April 2018, the Parkinson's treatment was stopped because Mr Collins was experiencing side effects. A consultant neurologist concluded that his symptoms were more likely caused by a Parkinson's type neurological condition such as circulatory disease of the brain or the rarer condition, progressive supranuclear palsy, both of which were progressive conditions with no specific treatment.

34. By April 2018 Mr Collins had become very immobile. He could stand to transfer between a bed and chair but was unsteady walking. Mr Collins also had

recurrent skin infections in his legs, leading to persistent leg ulcers that were resistant to treatment. Mr Collins had regular social care assessments to make sure his support needs were met.

35. On 20 April, Mr Collins fell in his cell, lost consciousness and cut his scalp. Mr Collins was taken to hospital and a CT scan showed no injuries.

36. On 29 May, Mr Collins fell while getting off the toilet. He bruised his chest but had no other injuries. The next day, a prison GP reviewed Mr Collins because of his recurrent falls. The GP reduced his medication further because Mr Collins said that he felt dizzy when standing up.

37. On 25 August, a nurse completed a falls risk assessment. She told Mr Collins that he must call for assistance if he needed anything and she gave him some urine bottles to use during the night. Mr Collins' other needs, including help with showering, shaving and dressing were noted and carers were allocated to these tasks, and he was moved to the prison's healthcare inpatient unit.

38. On 5 September, an occupational therapy assessment and wheelchair referral assessment were completed and a toilet seat with supports was installed in Mr Collins' cell.

39. On 7 October, a nurse reviewed Mr Collins' falls assessment and recommended that he should always have someone with him when he tried to walk. She also reminded Mr Collins to recognise his own limitations.

40. At 3.30pm, on 24 October, Mr Collins pressed his personal alarm and was found by staff sitting on the floor of his cell near the toilet. A healthcare assistant checked Mr Collins over and noted that he had no apparent injuries. She called for a nurse to help get Mr Collins back to his chair. The nurse arranged for Mr Collins to be reviewed by a doctor.

41. At approximately 7.00pm, a prison GP saw Mr Collins. The GP noted that Mr Collins could bear weight on his legs, and prescribed antibiotics for his infected leg ulcers.

42. On 25 October, a nurse completed a new falls risk assessment. He noted that Mr Collins could not walk. The nurse told the clinical reviewer that he thought that this was a combination of Mr Collins' frailty, the heavy dressings on his right leg, and being unwell due to the infected leg ulcer. He said that he did not consider the possibility of a hip fracture as Mr Collins had walked on his walking frame the day before, after his fall.

43. On 26 October, a prison GP reviewed Mr Collins and noted that his mobility had decreased since his fall. The GP told the clinical reviewer that he assumed the decrease in mobility was due to Mr Collins' frailty and leg infection. He said that Mr Collins had his leg ulcers redressed daily, involving staff moving his right leg, and Mr Collins did not complain of any pain. He also said that he did not see any of the usual deformity of rotation commonly seen in hip fractures.

44. At 4.00am, on 28th October, Mr Collins' personal alarm was pressed, but when staff checked on him, he was asleep in his chair. Later that day, a nurse noted

that Mr Collins was sleepier than usual and that staff were having difficulty moving or even sitting him up.

45. On 29 October, Mr Collins complained of hip pain. A nurse reviewed him and saw that he had a shortened and rotated right leg. She consulted a prison GP, who advised that Mr Collins should be taken to hospital. Mr Collins was taken to St Mary's Hospital. He was not restrained at any time due to the nature of his injury and his age.

46. The hospital found that Mr Collins had a fractured right hip.

47. At around 2.00pm, on 30 October, Mr Collins was taken into surgery to have his hip repaired. During the operation Mr Collins had a heart attack and he died. Mr Collins' death was confirmed at 5.35pm.

Contact with Mr Collins' family

48. When Mr Collins died, the prison's family liaison lead was appointed as the Family Liaison Officer (FLO), and an Operational Support Grade (OSG) was appointed as the deputy FLO.

49. Mr Collins did not have contact with his family while in prison. Mr Collins' daughter was his next of kin and her children were the victims of his offending.

50. At 3.30pm, on 30 October, the FLO called Mr Collins' daughter on the phone number recorded in Mr Collins' prison records, but the number was no longer available. Mr Collins did not have any other phone numbers listed in his records, and his Probation Officer was unable to provide any contact details for the next of kin that day.

51. On 31 October, the FLO phoned the police and asked if they could locate Mr Collins' next of kin. Later that day, Mr Collins' Probation Officer provided a mobile number for Mr Collins' daughter (obtained from the victim liaison officer), but there was no answer when the FLO called. At midday, the police had tried the address listed for Mr Collins' daughter, but no one of that name lived there.

52. On 1 November, the FLO contacted Mr Collins' daughter, and offered support and advice.

53. Mr Collins' funeral was held on 14 November 2018. No one from the prison attended at Mr Collins' daughter's request. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

54. The prison posted notices informing other prisoners and staff 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.

Post-mortem report

55. The post-mortem report gave the cause of death as a cardiac arrest (heart attack) caused by hypertension (high blood pressure) and cardiac amyloidosis (a

build up of abnormal protein in the heart). The report concluded that the fracture and surgical operation to repair his hip did not cause or contribute to Mr Collins' death.

Findings

Clinical care

56. The clinical reviewer concluded that the overall care Mr Collins received at the Isle of Wight was equivalent to that which he could have expected to receive in the community. Mr Collins had several chronic and evolving medical conditions, which caused increased fragility and a tendency to falls.

57. A few days before his death, Mr Collins had an unwitnessed fall that resulted in a fractured hip. Although there was a delay in diagnosis, there was no initial leg deformity and staff could move his limb for dressing without Mr Collins complaining of being in pain. The clinical reviewer said that a more detailed examination might still have missed the fracture. Even if the fracture had been found sooner, it is possible that Mr Collins still would have had a heart attack during surgery. The only clear consequence of his delayed diagnosis, was some increased immobility straight after the fall. The clinical reviewer is satisfied that there were no obvious detrimental consequences of any delay.

58. Mr Collins had high blood pressure and coronary heart disease. These were managed within NICE guidelines. A post-mortem examination found that the cause of Mr Collins' heart failure was identified as cardiac amyloidosis, which does not reliably show on a routine investigation. Although this specific cause of his heart failure was not established before his death, the clinical reviewer is satisfied that Mr Collins' symptoms were adequately controlled by the care he was already receiving for his coronary heart disease.

59. Care UK has a comprehensive policy for the management of slips, trips and falls. Mr Collins had several falls between May 2017 and May 2018, and each fall was appropriately treated. However, there is no evidence in the clinical record of any falls assessment having been carried out until August 2018. Given the frequency of Mr Collins' falls, we consider that a falls assessment should have been completed much sooner. We make the following recommendation:

    The Head of Healthcare should ensure that:

    - **the Care UK Slips Trips and Falls policy is implemented, including the use of the Falls Risk Assessment template, and**
    - **a regular audit of documented falls is introduced.**

Use of restraints

60. 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.

61. Mr Collins was not restrained when he was taken to hospital on 29 October 2018. We are satisfied that the prison appropriately considered the use of restraints.

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