Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Wilkes, a prisoner at HMP Erlestoke, on 29 January 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Michael Wilkes died on 29 January 2020 from a hypoxic brain injury after banging his head during a heart attack at HMP Erlestoke. He was 74 years old.

The clinical reviewer found that Mr Wilkes' clinical care was not equivalent to that he could have expected to receive in the community. It is a matter of serious concern that the prison healthcare team missed crucial opportunities to identify and treat his heightened risk of cardiovascular disease, which might have prevented his death.

Poor judgement and inadequate training meant that there was a significant delay in Mr Wilkes receiving emergency medical treatment from paramedics after his collapse. Again, an effective emergency response might have prevented Mr Wilkes' death.

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 2020**

Contents

Summary

Events

1. Mr Michael Wilkes was serving six years and eight months for attempted murder and had been in prison since 2016. He transferred to HMP Erlestoke on 4 April 2017. He had no significant pre-existing medical conditions.

2. The results of a routine blood test in December 2017 were abnormal, showing, among other conditions, that Mr Wilkes was at raised risk of developing cardiovascular disease. The blood test was repeated, but Mr Wilkes did not go to his appointments and the results were never followed up. During a routine check-up in January 2019, Mr Wilkes' blood pressure was low, but healthcare staff did not follow this up.

3. At 8.42am on 23 January 2020, Mr Wilkes collapsed at a workshop and banged his head. The prison's control room operator received an emergency radio code, but had not been properly trained so did not call an ambulance. An ambulance was not called for 11 minutes. A prison manager gave the ambulance service inaccurate information about Mr Wilkes' condition, compounding the delay in emergency services reaching him.

4. When nurses first examined Mr Wilkes, they assessed that he had collapsed due to low blood sugar, despite recording his sugar levels as normal. They stood down the ambulance (which had not yet been called), without taking any further observations. Mr Wilkes eventually lost consciousness and they attempted resuscitation.

5. Paramedics finally got to the prison at 9.21am, 39 minutes after Mr Wilkes first collapsed. They transferred Mr Wilkes to hospital, but he never recovered.

6. On 29 January, life support was withdrawn and Mr Wilkes died at 8.05pm that day. Mr Wilkes died from the brain injury sustained when he collapsed from a heart attack.

Findings

Clinical care

7. The clinical reviewer concluded that Mr Wilkes' care was not equivalent to that which he could have expected to receive in the community. Mr Wilkes' death was caused by a heart attack and heart disease. The abnormal blood test results in 2017 should have prompted the prescription of statins. The clinical reviewer considered that the prescription of statins could have prevented Mr Wilkes' death. We share the clinical reviewer's concerns that abnormal blood test results were not followed up, and that the prison did not follow up Mr Wilkes' missed appointments.

Emergency response

8. PSI 3/2013 instructs staff to call an ambulance as soon as an emergency code is called. The control room operator had not had training, so did not call an ambulance. This caused a delay of 11 minutes.

9. When an ambulance was eventually called, a prison manager gave incorrect information to the ambulance service, which meant they de-prioritised the emergency, leading to a further delay in Mr Wilkes receiving life-saving treatment.

10. The nurses who responded to the emergency code quickly, and wrongly, concluded that Mr Wilkes had collapsed due to low blood sugar levels. We agree with the clinical reviewer that they should have taken a full set of observations before determining the best course of treatment.

Body-worn video cameras

11. Prison officers were wearing cameras but decided not to record the emergency response for decency reasons. Prison Service instruction requires that cameras may be redirected for decency following a risk assessment, but audio recording should continue. We are concerned that officers did not follow national instructions.

Staff support

12. Control room staff were not invited to the prison's debrief after Mr Wilkes' collapse.

Recommendations

- The Head of Healthcare should ensure that abnormal blood test results are followed up within appropriate timescales.
- The Head of Healthcare should ensure that a robust procedure is in place to ensure that prisoners are followed up when they miss appointments.
- The Governor should ensure that there are no delays in prisoners receiving emergency treatment, in line with the requirements of PSI 3/2013. In particular:
    - control room staff must be trained to request an ambulance immediately when a medical emergency response code is called; and
    - staff should understand the importance of only passing confirmed and accurate information to the ambulance service.
- The Governor should share this report with the named Custodial Manager and ensure that a senior manager discusses the Ombudsman's findings with her.
- The Head of Healthcare should share this report and clinical review with the two named nurses so that they are aware of the Ombudsman's findings.
- The Governor should ensure that staff wearing body-worn cameras activate them at the earliest opportunity during any reportable incident.

- The Governor should ensure that in line with national policy, all relevant staff should be invited to the debrief and offered appropriate and timely support after a death in custody.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Erlestoke 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 Wilkes prison and medical records.

15. The investigator interviewed three members of prison staff at HMP Erlestoke on 28 March 2020.

16. NHS England commissioned an independent clinical reviewer to review Mr Wilkes' clinical care at the prison. The clinical reviewer interviewed five members of the healthcare team at HMP Erlestoke on 26 March.

17. We informed HM Coroner for Wiltshire and Swindon of the investigation. The coroner provided us with the cause of death. We have sent the coroner a copy of this report.

18. Mr Wilkes had no known next of kin and there has, therefore, been no family involvement in this investigation.

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

Background Information

HMP Erlestoke

20. HMP Erlestoke in Wiltshire is a Category C training prison which holds sentenced prisoners. Erlestoke's aim is to reduce prisoners reoffending by preparing them for release through accredited intervention programmes, skills and vocational-based training and education in a pro-social environment.

21. Inspire Better Health provide integrated primary healthcare, primary and secondary mental healthcare and substance misuse services.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Erlestoke in June and July 2017. Inspectors reported that new arrivals received a comprehensive initial health screening with a shorter follow-up secondary assessment within seven days.

23. Prisoners could see nurses in daily nurse-led clinics, including a triage clinic. Care of patients with long-term conditions was reasonable with effective liaison between nurses and GPs, but nurse-led care for long-term conditions needed to mirror community practice.

Independent Monitoring Board

24. 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 April 2018 to March 2019, the IMB reported that healthcare provision met the required standards and the provision of mental health care had improved. The prison's goal of a health service equivalent to that in the community was largely achieved and fears expressed in last year's report that standards may be declining had not been realised.

25. Waiting times for GP appointments averaged 21 days. However, the prison had introduced a "see and treat" system where applications for medical treatment were collected daily, leading to a swift treatment of minor ailments.

Previous deaths at HMP Erlestoke

26. The last death from natural causes at Erlestoke was in June 2016. Since then there have been two deaths, one self-inflicted in August 2019 and Mr Wilkes'. There were no similarities between Mr Wilkes' death and the previous deaths.

Key Events

27. On 21 December 2016, Mr Michael Wilkes was charged with attempted murder and sent to HMP Exeter. He was sentenced to six years and eight months on 2 February 2017.

28. Mr Wilkes transferred to HMP Erlestoke on 4 April 2017. He was a non-smoker and did not take any prescribed medication. During an initial health screen, Mr Wilkes did not report any pre-existing medical conditions, except eczema and psoriasis.

29. A routine blood test in December 2017 showed that Mr Wilkes was possibly pre-diabetic and had raised cholesterol and poor kidney function, among other possible complications. The test highlighted that he had a raised risk of developing cardiovascular disease and should be prescribed statins. A prison GP made a note on Mr Wilkes' medical record to discuss his cardiovascular risk with him at his next booked appointment on 11 December. She arranged to repeat his abnormal blood test in four weeks' time. Mr Wilkes did not attend his appointment with a prison GP on 11 December.

30. A prison GP reviewed Mr Wilkes' eczema on 27 December. She did not discuss his abnormal blood results or prescribe statins.

31. Mr Wilkes' blood test was repeated on 29 December, as planned. The prison GP reviewed the blood results on 2 January 2018, and recorded them, again, as abnormal. She requested that the blood results be repeated again (for a third time), a week later, before anyone spoke to Mr Wilkes about the results.

32. Mr Wilkes did not go to his blood test appointment on 9 January. A medical administrator recorded in his medical record, "Did not attend for bloods appointment ... cannot see that an appt slip was sent." No one followed up the missed appointment. There is no evidence that his raised cardiovascular risk or abnormal blood results were ever treated, or even discussed with Mr Wilkes.

33. The next significant entry in Mr Wilkes' medical record was a routine health screen a year later, on 31 January 2019. A Healthcare Assistant took Mr Wilkes' height, weight, and blood pressure. Although she recorded that Mr Wilkes' blood pressure was low at 89/64, she did not refer him for review or treatment.

23 January 2020

34. On the morning of 23 January 2020, Mr Wilkes went to his job in a workshop, packing screws and nuts. He arrived at 8.40am and greeted the workshop instructor. At 8.42am, prisoners told the workshop instructor that Mr Wilkes had collapsed and banged his head on the concrete floor. She radioed an emergency code blue (used for when someone has collapsed and is not breathing). A minute later, she radioed a code red (an emergency involving bleeding) because Mr Wilkes was conscious, but had cut his head.

35. When two nurses arrived a few minutes later, Mr Wilkes was sitting on a chair. He was conscious, but pale, cold to the touch and had a 5cm cut on the back of his head that needed stitches. Mr Wilkes could not explain why he had collapsed,

but said that he had not eaten breakfast that morning. The nurses took his blood sugar, which was within the normal range for someone who had not eaten. (A normal blood sugar level is between 4.0 to 5.4 mmol/L when fasting and up to 7.8 mmol/L two hours after eating. Mr Wilkes' blood sugar level was 4.3mmol/L.) Nevertheless, they assessed that he had collapsed with low blood sugar.

36. At 8.46am, an Operational Support Grade (OSG), in the prison's control room, contacted the workshop asking for an update. She was told by an officer (who was on the phone in the workshop) that nurses were still assessing Mr Wilkes. The officer asked the nurses if Mr Wilkes still needed an ambulance. At 8.52am, both nurses agreed that an ambulance was no longer needed. They had only checked his blood sugar level and not carried out any other clinical observations on Mr Wilkes at this point.

37. Shortly afterwards, Mr Wilkes became unresponsive. The nurses could not find his pulse and thought he had stopped breathing. Mr Wilkes was laid on the floor and both nurses started CPR (cardio pulmonary resuscitation).

38. An officer in the workshop radioed the control room and asked them to call an ambulance. An OSG called the ambulance service at 8.53am (the first call to the emergency services) and put the call through to a Custodial Manager (CM) who was in the workshop. The CM spoke to the ambulance call handler to confirm Mr Wilkes' age and that he had fallen and banged his head. According to the ambulance service log, she explained that she did not know his medical history. Nevertheless, she suggested that Mr Wilkes had "fitted" and "completely zoned out, like, kind of like an epileptic style in his face". She did not mention that nurses were carrying out CPR. The ambulance call handler graded the call as a category three incident, with a response time of up to 120 minutes.

39. At 9.02am, an OSG called the ambulance service. The OSG put the call through to the workshop. When an officer explained to the call handler that CPR was being carried out, the incident was upgraded to a category one incident, with a response time of up to seven minutes.

40. The first ambulance arrived at 9.21am followed by a second ambulance at 9.35am. Two first response vehicles got to the prison at 9.45am and 9.53am. Paramedic crew continued advanced life support and, once Mr Wilkes' condition stabilised, they transferred him to hospital less than half an hour later. Mr Wilkes was not restrained during his escort to hospital.

41. When Mr Wilkes arrived at hospital, he was taken to the Intensive Care Unit. Mr Wilkes' condition remained unchanged and, on 29 January, it was decided that life support should be withdrawn. The Governor and the prison chaplain went to the hospital. Mr Wilkes died at 8.05pm that day.

Contact with Mr Wilkes' family

42. Mr Wilkes did not provide next of kin details when he came to prison. The prison contacted the police, the probation service and Mr Wilkes' solicitor to establish if he had any living relatives, but they could not find any next of kin.

Support for prisoners and staff

43. After Mr Wilkes was taken to hospital, a prison manager debriefed officers and healthcare staff in the workshop to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. On 29 January, the Governor and prison chaplain went to the hospital to support bed watch officers when Mr Wilkes' life support was turned off.

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

Post-mortem report

46. Mr Wilkes did not have a post-mortem examination. The Coroner accepted the cause of death given by the hospital. The hospital recorded that Mr Wilkes died of hypoxic brain injury caused by a cardiac arrest, which was in turn caused by myocardial infarction and ischaemic heart disease.

Findings

Clinical care

47. The clinical reviewer concluded that Mr Wilkes' care was not equivalent to that which he could have expected to receive in the community. There were missed opportunities to identify and treat Mr Wilkes' risk of cardiovascular disease in 2017 and 2019.

48. We are concerned that indications of Mr Wilkes' risk of cardiovascular disease were not effectively followed up by the prison. His abnormal blood test results in 2017 were never discussed with him or further investigated. After his first blood test results, the doctor indicated that he should be prescribed statins to manage the risk, but he never was. It is particularly concerning that the clinical reviewer considered that earlier intervention (the prescription of statins) could have changed the outcome in this case. In 2019, Mr Wilkes' low blood pressure was recorded, but no action taken to refer him for review or treatment.

49. The prison missed crucial opportunities to identify and treat Mr Wilkes' heart disease. We make the following recommendation:

    The Head of Healthcare should ensure that abnormal blood test results are followed up within appropriate timescales.

50. The Head of Healthcare told the investigator that there are procedures to follow up with prisoners who do not go to booked appointments. Initially, Mr Wilkes should have been written to with an alternative appointment, and if he missed that appointment, he should have been asked to book a new appointment.

51. There is no evidence that healthcare staff sent Mr Wilkes the first letter when he missed his GP appointment or blood test, or that follow up appointments were made. As a result, healthcare concerns raised by the abnormal blood results were not addressed.

52. The Head of Healthcare said that, at that time, appointment letters were sent to the wing and prison officers would deliver them by hand. She said that this was not always reliable and healthcare staff now deliver healthcare letters directly to prisoners.

    The Head of Healthcare should ensure that a robust procedure is in place to follow up with prisoners when they miss appointments.

Emergency Response

53. A code blue was called at 8.42am when Mr Wilkes collapsed. This was changed to a code red at 8.43am. PSI 3/2013 instructs staff to call an ambulance as soon as an emergency code is called. An OSG did not call an ambulance when she received the first emergency codes. An ambulance was not called until 8.53am, 11 minutes after Mr Wilkes collapsed.

54. The OSG was new to the Prison Service and had only been at Erlestoke for about seven weeks when Mr Wilkes collapsed. She said at interview that, before

Mr Wilkes' death, she did not know she needed to call an ambulance for every emergency code. She said that her shift on 23 January was only her third time working in the control room and that she had not had any official training.

55. When an ambulance was finally called, a CM spoke to the ambulance service to confirm Mr Wilkes' details and went on to give her assessment of his condition. The CM is not a healthcare professional and should not have described Mr Wilkes collapse as 'a fit' without confirmation of this by healthcare staff. She did not mention that resuscitation was underway at the time. Her assessment of his condition informed the ambulance service's decision to de-prioritise the incident. They upgraded the incident as soon as they understood the severity of Mr Wilkes' condition and their response time reduced accordingly.

56. Mr Wilkes' condition was critical and any delay in receiving emergency treatment could have altered the outcome in this case. Therefore, we make the following recommendation:

The Governor should ensure that there are no delays in prisoners receiving emergency treatment, in line with the requirements of PSI 3/2013. In particular:

- **control room staff must be sufficiently trained to request an ambulance immediately when a medical emergency response code is called; and**
- **staff should understand the importance of giving accurate information to the ambulance service.**

The Governor should share this report with the named Custodial Manager and ensure that a senior manager discusses the Ombudsman's findings with her.

57. Both nurses looked at Mr Wilkes' head (which needed stitches) and took a finger prick blood sugar level test, which was normal. As Mr Wilkes said he had not eaten breakfast, they assessed that he had collapsed because of a hypoglycaemic faint (from low blood sugar), despite the normal result. The clinical reviewer was concerned about the nurses' assessment, because the recorded level would not normally be considered low enough to cause a hypoglycaemic collapse.

58. At 8.52am, without taking any other clinical observations, both nurses decided that Mr Wilkes did not need an ambulance. The nurses should have taken a full set of observations when they first examined Mr Wilkes. We agree with the clinical reviewer that they should certainly not have cancelled the ambulance without a full picture of his clinical condition. On this occasion, the ambulance had not actually been called at this point for the reasons set out above, but in other cases such a decision could have directly affected the outcome. We make the following recommendation:

The Head of Healthcare should share this report and clinical review with the two named nurses so that they are aware of the Ombudsman's findings.

Body-Worn Video Cameras (BWVCs)

59. Prison officers have the use of body-worn cameras but decided for decency reasons not to record the emergency response when Mr Wilkes collapsed. PSI 4/2017 says:

> "On attending an incident involving medical intervention BWVC users must consider any sensitivities of the circumstances. This is particularly relevant when attending an incident where a prisoner is receiving lifesaving medical intervention. Users will conduct a dynamic risk assessment and where no threat to the safety or security of others exists users must maintain audio capture but should consider non-intrusive capturing of the medical intervention. This may be the camera lens being directed at the head and shoulders of the staff involved, and occasional direct capture of the medical procedure, with an audio commentary of the events as they unfold."

60. Officers wearing body-worn video cameras should have risk assessed the situation and used their cameras accordingly. From the evidence reviewed in this investigation, there was no reason not to have used cameras at all. We make the following recommendation:

The Governor should ensure that staff wearing body-worn cameras activate them at the earliest opportunity during any reportable incident.

Support for prisoners and staff

61. When Mr Wilkes was taken to hospital, the Governor held a debrief with staff from the workshop. Two OSG's were working in the control room that morning and were badly affected by his collapse. Neither was invited to the debrief. A member of the prison care team telephoned an OSG that evening. She explained to the care team how difficult she had found the incident but had not receive the support she needed. The care team did not call the OSG.

62. We make the following recommendation:

The Governor should ensure that in line with national policy, all relevant staff, should be invited to the debrief and offered appropriate and timely support after a death in custody.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141