

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Cooper, a prisoner at HMP Isle of Wight, on 18 March 2021

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Derek Cooper died of heart disease on 18 March 2021 while a prisoner at HMP Isle of Wight. He was 73 years old. We offer our condolences to Mr Cooper's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Cooper received at Isle of Wight was equivalent to that which would have been received in the community.
5. The clinical reviewer said that the healthcare handover between HMP Bedford and HMP Isle of Wight supported good continuous care for Mr Cooper's complex health concerns. She also said that the arrangements for shared care planning were good.
6. However, she was concerned that there is no record of guidance given to prison staff when Mr Cooper declined a recommended move to the healthcare unit, and his care plan was not revisited. The clinical reviewer was also concerned that healthcare staff did not conduct face to face checks with Mr Cooper on the wing when there were concerns about his health.
7. The clinical reviewer made three recommendations related to Mr Cooper's death, which we have reflected in the two recommendations below. She made one further recommendation, which was not directly related to Mr Cooper's death, but that the Head of Healthcare will need to address.
8. We did not identify any non-clinical issues of concern.
9. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- The Governor and Head of Healthcare should ensure that there is effective and documented communication and care planning between healthcare and prison staff when there are concerns about a prisoner's health.
- The Head of Healthcare should ensure that welfare checks carried out by health staff are carried out in person, where appropriate

The Investigation Process

10. NHS England commissioned a clinical reviewer to review Mr Cooper's clinical care at HMP Isle of Wight.

11. The PPO investigator has investigated the non-clinical issues in Mr Cooper's care, including his location, COVID-19 measures, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Isle of Wight

13. In the two years before Mr Cooper's death there were eight deaths from natural causes (two of which were related to COVID-19) and five self-inflicted deaths at Isle of Wight.
14. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

15. On 23 November 2018, Mr Derek Cooper was convicted of sexual offences and sentenced to 12 years in prison. He was sent to HMP Bedford and was transferred to HMP Isle of Wight on 20 February 2019.
16. Before he entered prison, Mr Cooper had been diagnosed with complex health issues including Chronic Obstructive Pulmonary Disease (a lung condition causing breathing difficulties), asthma, diabetes, clinical obesity, high blood pressure and essential tremor (disorder of the nervous system which causes shaking). In 2019, Mr Cooper was also diagnosed with ischaemic heart disease (narrowing of the blood vessels supplying the heart).
17. On 1 April 2020, Mr Cooper was assessed as being clinically vulnerable from COVID-19 due to his health problems. Mr Cooper agreed to self-isolate and was supported to do this in line with local policy. The clinical reviewer found that during COVID-19 restrictions the prison continued to facilitate Mr Cooper's hospital appointments and his shared care arrangements.
18. On 17 March 2021, Mr Cooper became unwell with a painful lump and a slight cough. He was seen urgently by a nurse and a prison GP, who diagnosed him with a chest infection. The clinical reviewer was concerned that Mr Cooper was not tested for COVID-19, as coughing is a potential symptom of the virus.
19. The prison GP recommended that Mr Cooper be moved to the healthcare wing for monitoring. However, Mr Cooper wanted to stay in his own cell and healthcare staff asked prison staff on the wing to check on Mr Cooper regularly and call them if he deteriorated. The clinical reviewer said that there is no record of the guidance given to prison staff on how often to conduct checks or what to check for.
20. Later, on 17 March, a nurse called the wing at 8.50pm and asked staff how Mr Cooper was. There is no record of who she spoke to or what she was told. She did not see Mr Cooper herself.
21. At midnight, an officer was completing night checks and was concerned that Mr Cooper did not respond as usual. She called a nurse to the wing, who found Mr Cooper was on the floor complaining of chest pain. His NEWS2 score was 13. (NEWS2 is a tool used to detect acute illness, a score of 5 or more means that an urgent clinical review is needed.) The nurse asked for an emergency ambulance and administered oxygen and medication for his heart and angina.
22. Mr Cooper was taken to St Mary's Hospital in an ambulance at 1.02am. He stopped breathing at 6.27am and hospital staff were unable to resuscitate him. Mr Cooper died at 6.55am on 18 March from heart failure.

Post-mortem report

23. The post-mortem report concluded that Mr Cooper died from severe coronary artery atheroma (narrowing of the arteries) and cardiomegaly (an enlarged heart). He also had longstanding diabetes and obesity which did not cause but contributed to his death.

Clinical Findings

24. The clinical reviewer concluded that the care Mr Cooper received was of a reasonable standard and equivalent to that he could have expected to receive in the community.
25. The clinical reviewer was not satisfied that healthcare staff gave clear guidance to officers when asking them to monitor Mr Cooper. Mr Cooper refused to move to the healthcare unit against advice and the clinical reviewer found no evidence that healthcare staff made a clear clinical plan in light of this. There is no evidence that welfare checks were carried out by healthcare staff in person to monitor any clinical deterioration. She made three recommendations.

Sue McAllister CB
Prisons and Probation Ombudsman

October 2021

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