Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Collett, a prisoner at HMP Ford, on 11 July 2020

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 Mark Collett died on 11 July 2020 of heart failure at HMP Ford. He was 61 years old. I offer my condolences to Mr Collett's family and friends.

Mr Collett had many chronic conditions. The clinical reviewer concluded that the care he received at HMP Ford was reasonable and at least equivalent to that which he could have expected to receive in the community. However, the clinical reviewer identified some concerns about Mr Collett's reception screens and annual reviews to manage his conditions.

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 **June 2021**

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Summary

Events

1. On 6 May 2005, Mr Mark Collett was sentenced to life imprisonment for murder by joint enterprise and was sent to HMP Winchester. He transferred to HMP Ford on 6 July 2018.

2. On arrival at Ford, Mr Collett had an initial reception health screen and secondary health screen. He had a complex medical history, but the nurses did not record the full details of his medical conditions.

3. Healthcare staff saw Mr Collett regularly and reviewed his medication.

4. Around 1.50pm on 11 July 2020, a prisoner noticed that Mr Collett had not moved in his bed. He told an officer, who went to Mr Collett's cell and found him unresponsive. An officer radioed a medical emergency code and the control room immediately called an ambulance. Prison staff attended, but CPR was not attempted as it was evident that Mr Collett had been dead for some time. Paramedics arrived and at 3.00pm, they confirmed that Mr Collett had died.

5. The Coroner gave Mr Collett's cause of death as left ventricular hypertrophy (an enlarged and thickening of the heart's main pumping chamber) and coronary artery atheroma (a fatty build up on the artery walls around the heart).

Findings

6. The clinical reviewer concluded that Mr Collett's care and treatment at Ford was reasonable and at least equivalent to that which he could have expected to receive in the community.

7. The clinical reviewer found that there were, however, some shortcomings in Mr Collett's care because healthcare staff did not fully document the care he received, and he did not have regular hypertension or diabetic reviews. Mr Collett was at risk of heart failure, but healthcare staff did not complete any healthcare risk assessments for cardiovascular disease.

8. We have raised concerns about the management of long-term conditions at Ford before and the healthcare provider now needs to ensure that improvements are made.

Recommendations

- The Head of Healthcare should ensure that all newly arrived prisoners have appropriate health screens that review their medical history and identify all relevant conditions.

- The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:

    - all treatment and care are fully documented in prisoners' medical records to allow effective continuity of care; and

- clinical staff are aware of the triggers for escalation and when to organise further investigations.

- The Head of Healthcare should ensure that long-term conditions, such as diabetes and hypertension, are managed in line with the patient journey protocol for long-term conditions.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Ford informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr Collett's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Collett's clinical care at the prison. On 12 August 2020, the investigator interviewed two members of staff and a prisoner. She and the clinical reviewer jointly interviewed a nurse. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic.

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

13. One of the Ombudsman's family liaison officers contacted Mr Collett's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

14. 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.

Background Information

HMP Ford

15. HMP Ford is an open prison which houses up to 544 men. Care UK (now Practice Plus Group) provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 8.00am to 6.00pm. An Integrated Drug Treatment Service dispenses medication to prisoners at the weekend. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Ford was in June 2016. Inspectors reported that the prison was a safe, decent and respectful place where relationships between staff and prisoners were generally positive. They reported that there was a high standard of healthcare at the prison.

17. HMIP conducted a scrutiny visit to Ford in June 2020 (in line with its COVID-19 methodology) and reported that managers and staff at Ford had responded to the crisis well and were keeping prisoners relatively safe.

Independent Monitoring Board

18. 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 2018, the IMB reported that the healthcare service was of a high quality.

Previous deaths at HMP Ford

19. Mr Collett was the second prisoner to die at HMP Ford since 2019. The previous death was from natural causes.

20. In our previous investigation into a death in June 2019, we found that the prison's management of long-term conditions was poor. We recommended that the prison review the management of long-term conditions, such as diabetes and hypertension, so that prisoners received continuity of care and were reviewed in a timely manner.

21. The prison's healthcare provider at that time, Sussex Partnership NHS Foundation Trust, told us in response that they had reviewed the management of Long-Term Conditions (LTC) in November 2019 and had produced a patient journey protocol for all LTCs. This included a LTC review algorithm and detailed information on all work streams.

Key Events

22. On 6 May 2005, Mr Mark Collett was sentenced to life imprisonment for murder by joint enterprise. He was sent to HMP Winchester. He transferred to HMP Ford on 6 July 2018.

23. Mr Collett had a history of hyperlipidaemia (too many fats in the blood), stroke, gastro-oesophageal reflux disease (GORD), hiatus hernia, impaired vison, diabetes, epilepsy, hypertension, arthritis and sleep apnoea (for which he used a continuous positive airway pressure (CPAP) machine when sleeping).

24. A nurse completed Mr Collett's reception screen. She noted some of his medical conditions as impaired vision, diabetes, epilepsy, hypertension, high cholesterol and sleep apnoea. There is no record of her checking his observations, referring him for diabetic checks, offering any health screens or noting his outstanding appointments.

25. On 17 July, a nurse discussed Mr Collett's diabetic care with him. Mr Collett said that he would try to lose weight because he was morbidly obese and wanted to improve the management of his diabetes. He said that he had a fear of needles so was unwilling to consider this as an option for managing his diabetes. The nurse completed a diabetic service hospital referral for advice about alternatives to insulin and Mr Collett's ongoing diabetic care. She told the investigator that diabetic care at the prison included an initial assessment, blood tests and an ECG.

26. A nurse completed Mr Collett's second reception screen on 18 July. He did not note his medical conditions, outstanding treatments or necessary clinic referrals to monitor and manage his conditions.

27. On 25 July, a prison GP completed a hypertension review and prescribed appropriate medication. Healthcare staff saw Mr Collett regularly to review and administer his medication. Mr Collett was involved in discussions about his medication and treatment.

28. In October, Mr Collett attended hospital for a diabetic assessment. The hospital consultant recommended a referral to a weight management course, blood glucose levels monitoring and that his medication should be adjusted. There is no recorded evidence that healthcare staff actioned this advice.

2019

29. In April, a prison GP noted that Mr Collett's diabetes was poorly controlled, and a nurse completed an epilepsy review. Mr Collett complained of pain in both his hands and ankles. The GP arranged a series of blood tests. The test results showed that Mr Collett had borderline arthritis and his diabetes test results were abnormal but expected.

30. In June, a prison GP completed another hypertension review. He noted that Mr Collett's blood pressure was well controlled and that he was losing weight. The GP reviewed and amended his hypertension medication.

31. Mr Collett had another hospital review in August. The hospital consultant noted that he was clinically well, had lost weight and, after medication changes, his blood sugar levels had improved significantly. Mr Collett was scheduled to have another hospital review in six months.

2020

32. On 28 May, Mr Collett was offered an alternative regime, which included 12 weeks of shielding in response to the COVID-19 pandemic.

33. A prisoner in the cell next door to Mr Collett said that they were friends. He said that he last saw Mr Collett at approximately 9.00pm on Friday night, when he went to use the telephone.

Events of Saturday 11 July

34. At 11.30am, staff conducted a visual roll check. They did not note anything unusual. At lunchtime, the prisoner noticed that Mr Collett had not left his cell, so he collected both their lunches and planned to give Mr Collett his food when he saw him. He looked through Mr Collett's door flap and saw him sleeping.

35. The prisoner said that after he had eaten his lunch at 1.00pm, he looked through the door flap of Mr Collett's cell and saw him sleeping with his CPAP mask on. He checked again at 1.50pm and noticed that Mr Collett had not moved, and his skin was very pale. He went to find officers to alert them. He met an Offender Supervisor (OS) outside the houseblock and told her that he thought his next-door neighbour was dead.

36. The prisoner and the OS went to Mr Collett's cell. The prisoner held the cell door open as the OS went in. She checked Mr Collett for signs of life and immediately radioed an emergency code blue (indicating a life-threatening incident involving breathing difficulties) and then another radio call to report a suspected death in custody. Staff in the communications room immediately telephoned for an ambulance. Prison staff responded to the emergency call.

37. The officer immediately checked Mr Collett and noted that it was evident that he had died as he was not breathing, had no pulse and his finger-tips had turned blue. His legs and torso were also covered in red patches and he was showing the early signs of rigor mortis.

38. At 2.30pm, the police arrived at the prison and the ambulance arrived at 2.50pm. At 3.00pm a paramedic confirmed that Mr Collett had died.

Contact with Mr Collett's family

39. On 11 July, the prison appointed a member of the chaplaincy team and an Offender Supervisor to act as the temporary Family Liaison Officers (FLOs). They went to Mr Collett's sister's home and told her that her brother had died. They maintained telephone contact with her until the prison appointed another FLO.

40. The prison arranged and contributed to Mr Collett's funeral in line with national instructions.

Support for prisoners and staff

41. After Mr Collett's death, a duty 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.

42. The prison posted notices informing other prisoners of Mr Collett'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 Collett's death.

Post-mortem report

43. The Coroner concluded that Mr Collett died of left ventricular hypertrophy (an enlarged and thickening of the heart's main pumping chamber which affects the heart's ability to pump blood) and coronary artery atheroma (a fatty build up on the artery walls around the heart).

44. Toxicology tests did not reveal any illicit substances.

Findings

Clinical care

45. The clinical reviewer concluded that the care and treatment Mr Collett received at Ford was reasonable and at least equivalent to that which he could have expected to receive in the community.

46. The clinical reviewer did, however, identify some concerns although these did not contribute to Mr Collett's death.

Reception screens

47. A reception health screen is important for healthcare staff to note any ongoing healthcare issues that need a referral to a hospital specialist. On arrival at Ford, staff noted some, but not all, of Mr Collett's medical conditions.

48. The clinical reviewer found that the nurses completing the reception screen and secondary screens did not record all Mr Collett's conditions that he had received medication for, failed to note his observations, complete diabetic and sleep apnoea clinic referrals or note his outstanding appointments. Also, the secondary screen was not completed within the required seven-day period. We make the following recommendation:

The Head of Healthcare should ensure that all newly arrived prisoners have appropriate health screens that review their medical history and identify all relevant conditions.

Heart condition and regular reviews

49. Mr Collett was overweight and had already had a stroke. He was at risk of having another stroke or a heart attack. The clinical reviewer found that the risk of stroke was linked to Mr Collett's medical conditions including hypertension, hyperlipidaemia (high levels of fat in his blood) and diabetes. She considered that the effective management of these conditions lowered the level of clinical risk of a recurring stroke, and that regular reviews were necessary. Healthcare staff did not review Mr Collett in line with the NICE CG (181) *Cardiovascular disease: risk assessment and reduction, including lipid modification* as they should have done.

50. Given the findings of the post-mortem, including that Mr Collett had heart disease, the clinical reviewer was concerned that healthcare staff did not fully explore the possible increased risks of cardiovascular disease. There are no records of follow up care which might have prompted further investigations. We recommend:

The Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that:

- **all treatment and care are fully documented in prisoners' medical records to allow effective continuity of care; and**

- **clinical staff are aware of the triggers for escalation and when to organise further investigations.**

51. Mr Collet's treatment options were limited to managing his symptoms. He should have had regular reviews. The clinical reviewer concluded that the care he received for the management of his diabetes was of a reasonable standard. However, as the records were not comprehensive, the clinical reviewer could not give assurances that the care Mr Collett received was in line with NICE guideline NG 28 *Type 2 diabetes in adults management*, because he was not offered annual epilepsy or diabetic reviews in order to effectively manage these conditions. We make the following recommendation:

The Head of Healthcare should ensure that long-term conditions, such as diabetes and hypertension, are managed in line with the patient journey protocol for long-term conditions.

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