Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clive Collins, a prisoner at HMP Isle of Wight, on 8 March 2021

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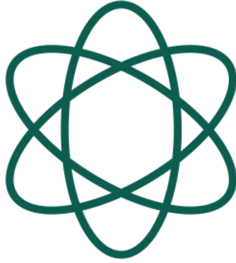
Our vision

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

OGL

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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 Clive Collins, who was 79 years old, died in hospital from pneumonia on 8 March 2021, while a prisoner at HMP Isle of Wight. We offer our condolences to Mr Collins' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Collins received at Isle of Wight was equivalent to that which he could have expected to receive in the community. He noted that there was excellent communication between prison healthcare staff and Mr Collins' next of kin. He made no recommendations.

5. We are concerned that staff used restraints on Mr Collins when he was taken to hospital. He was a frail, unwell man with poor mobility and we do not consider that the use of restraints was proportionate to the risk he posed.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Head of Healthcare should ensure that healthcare staff complete the medical section of the escort risk assessment fully and accurately.
- The Governor should share this report with the two managers who authorised the use of restraints and discuss the Ombudsman's findings with them.
- The Head of Healthcare should share this report with the nurse who completed the healthcare section of the escort risk assessment and discuss the Ombudsman's findings with her.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Collins' clinical care at HMP Isle of Wight.

7. The PPO investigator has investigated the non-clinical issues in Mr Collins' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The PPO's family liaison officer wrote to Mr Collins' next of kin to explain the investigation. She did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. Their action plan is annexed to this final report.

Previous deaths at Isle of Wight

10. Mr Collins was the 13th prisoner to die at Isle of Wight since March 2019. Seven of the previous deaths were from natural causes and five were self-inflicted. We have previously expressed concern about the unjustified use of restraints on sick and elderly prisoners. In response to the points we raised, the Governor reviewed the decision-making process in the use of restraints in 2019, and implemented measures to raise the awareness of staff to their responsibilities. Following this, the issue of inappropriate use of restraints had not come to our attention until the case of Mr Collins.

Key Events

11. On 10 August 2017, Mr Clive Collins was sentenced to 10 years imprisonment for sexual offences. He was moved to HMP Isle of Wight on 8 February 2018.

12. Mr Collins had several long-term health conditions including atrial fibrillation (a heart condition which causes it to beat irregularly), ischaemic heart disease (a restriction in the blood supply to the heart due to blockages in the arteries), chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), hypertension (high blood pressure) and diabetes. Mr Collins had poor mobility and used a rollator (a wheeled walking aid).

13. On 4 March 2021, an officer contacted healthcare staff to tell them that Mr Collins had felt unwell during the previous night and could not collect his medications. A prison GP saw him that morning and thought his problems were consistent with his existing heart and lung problems.

14. Over the following night and into the morning of 5 March, Mr Collins' condition deteriorated and he had a high temperature and problems with his breathing. He was put into precautionary isolation in case he had been infected with COVID-19.

15. At 10.05am on 5 March, a nurse visited Mr Collins and took his clinical observations. He complained of chest pain and of feeling very poorly. His blood oxygen level was very low, his temperature was very high and both his heart rate and breathing rate were raised. The nurse immediately consulted with the GP and an ambulance was called. Mr Collins was taken to hospital. He was accompanied by two officers and was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist).

16. Mr Collins was transferred to the hospital intensive care unit (ICU) on 6 March but did not respond to treatment. He died two days later.

17. A post-mortem examination found that Mr Collins died from pneumonia, caused by COPD. Ischaemic heart disease was given as an underlying issue which contributed to but did not cause the death.

Non-Clinical Findings

Use of restraints

18. When prisoners leave prison (for example, to go to hospital), staff complete a risk assessment to determine the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public which must 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.

19. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

20. The nurse who saw Mr Collins on the morning of 5 March and called for a doctor, filled out the clinical part of the risk assessment form for Mr Collins' transfer to hospital on 5 March. In response to the question: "Are there any medical objections to restraints being used?", she did not indicate yes or no, but wrote, "frailty / poor mobility". On the next part of the form she indicated that Mr Collins' medical condition would not restrict his ability to escape. Under the section, "Does the prisoner have any mobility issues which may affect the use of restraints, i.e. wheelchair user, crutches, walking stick etc?", she again did not indicate yes or no, but wrote, "uses Zimmer frame". To the question, "Any other medical conditions likely to influence the escort?", the nurse circled "No".

21. The authorising manager, a custodial manager, wrote that on the basis of his age and the use of a Zimmer frame, it would be appropriate for Mr Collins to be restrained with only an escort chain. He noted on the form that the duty governor had been informed and agreed.

22. Mr Collins was only restrained for a relatively short time, as his restraints were removed at around 7.00pm on 5 March to allow for his medical treatment and they were not reapplied. Nevertheless, we are concerned that he was restrained at all given he was a very unwell 79-year old man with poor mobility. We consider that the nurse should have provided more detail about Mr Collins' medical condition (his severe COPD and heart condition clearly did affect his ability to escape), but even without that detail, there was sufficient information for the authorising manager to question the need for restraints. We recommend:

    The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

    The Head of Healthcare should ensure that healthcare staff complete the medical section of the escort risk assessment fully and accurately.

The Governor should share this report with the two managers who authorised the use of restraints and discuss the Ombudsman's findings with them.

The Head of Healthcare should share this report with the nurse who completed the healthcare section of the escort risk assessment and discuss the Ombudsman's findings with her.

Louise Richards **January 2022**
Assistant Ombudsman

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