

**Prisons &
Probation**

Ombudsman
Independent Investigations

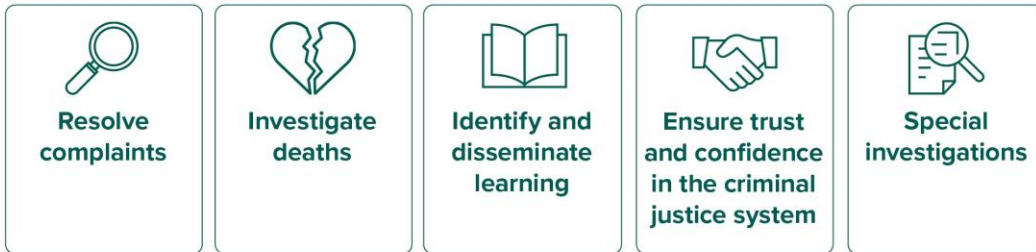
Independent investigation into the death of Mr Mark Wilkinson, a prisoner at HMP Lewes, on 22 April 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Wilkinson died of internal bleeding caused by ruptured oesophageal varices (a condition that develops when the normal blood flow to the liver is blocked) and alcohol related liver disease on 22 April 2022, while a prisoner at HMP Lewes. He was 49 years old. I offer my condolences to those who knew him.

The clinical reviewer found that the care that Mr Wilkinson received at Lewes was not equivalent to that which he could have expected to receive in the community.

Blood tests around three weeks before Mr Wilkinson died identified dangerously low haemoglobin levels, which required a blood transfusion. Mr Wilkinson refused to attend hospital for this procedure and did not attend GP appointments afterwards. Despite this, and his deteriorating condition, healthcare staff did not review him for around two weeks and did not take appropriate clinical observations.

Mr Wilkinson's pain management was not well controlled, and he did not have a care plan for his long-term health conditions which could have promoted the safe prescribing of pain relief medication.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

March 2023

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	9

Summary

Events

1. On 17 November 2021, Mr Mark Wilkinson was remanded in custody to HMP Lewes. He was later sentenced to one year and four months in prison. At the time of his imprisonment, Mr Wilkinson was diagnosed with chronic liver disease caused by alcohol cirrhosis and gastrointestinal bleeding.
2. On 2 April 2022, Mr Wilkinson told a nurse that his legs had “blown up two weeks ago” and that he had been short of breath and lightheaded. On 3 April, a prison GP asked for blood tests, which showed that Mr Wilkinson’s blood haemoglobin levels were very low and that he needed to go to hospital for a blood transfusion. Later that evening, Mr Wilkinson told an officer that he would not go to hospital. He refused two GP appointments in the following two weeks.

Events of 21 and 22 April

3. At about 10.45am on 21 April, prison staff found Mr Wilkinson in his cell with no pulse and very shallow breathing. They called a medical emergency. Three nurses went to Mr Wilkinson’s cell and found that Mr Wilkinson was no longer breathing. They began cardiopulmonary resuscitation and applied a defibrillator, which on several occasions advised not to shock.
4. At 11.22am, paramedics took over life support. At 12.35pm, they took Mr Wilkinson to hospital. He died at 9.54am on 22 April.

Findings

Clinical care

5. The clinical reviewer found that the clinical care that Mr Wilkinson received at Lewes was not equivalent to that which he could have expected to receive in the community.
6. When Mr Wilkinson refused to go to hospital for a blood transfusion, healthcare staff did not review Mr Wilkinson for nearly two weeks and did not take any clinical observations. The clinical reviewer found that Mr Wilkinson should have been referred to the Multi-Professional Complex Case Clinic (MPCCC – a care planning and risk management framework) when he chose not to attend hospital.
7. The clinical reviewer also found that Mr Wilkinson’s pain was not appropriately controlled, particularly in the last few weeks of his life when his low haemoglobin levels meant that his ibuprofen prescription was stopped. Mr Wilkinson did not have a care plan for his long-term liver cirrhosis, which the clinical reviewer found could have had a role in considering safe prescribing and providing advice and support in managing the condition.
8. It is disappointing that, despite several requests, healthcare staff have not provided the healthcare inpatient unit’s admission criteria, to determine whether Mr Wilkinson should have been transferred there when he refused to go to hospital.

Recommendations

- The Head of Healthcare should ensure that prisoners with long-term conditions are managed in line with national guidelines, including that:
 - staff regularly review those prisoners who refuse to attend hospital for emergency treatment, including taking relevant clinical observations.
 - prisoners with complex conditions are referred to the Multi Professional Complex Case Clinic; and
 - relevant care plans are created that include the monitoring of prescribed medication where there is a risk attached.
- The Head of Healthcare should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Wilkinson's prison and medical records.
11. The investigator interviewed seven members of staff at Lewes on 29 June and 30 June and two members of staff by video link on 18 July and 2 August.
12. NHS England commissioned a clinical reviewer to review Mr Wilkinson's clinical care at the prison.
13. We informed HM Coroner for East Sussex of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. We shared the initial report with the Prison Service. There were two factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Lewes

15. HMP Lewes is a local prison serving the courts of East and West Sussex. It holds up to 624 men. Practice Plus Group provides primary care services. Healthcare services are provided on a 24-hour basis. There is also a 9-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Lewes was conducted in August 2022. Inspectors reported that staff shortfalls in many areas had slowed progress in achieving better outcomes for prisoners. Primary care lacked effective clinical leadership and was too dependent on agency staff, leading to gaps in prisoner healthcare. Prisoners expressed frustration with healthcare services as clinics were cancelled routinely and communication was poor. Long-term condition management was fragmented, and services were largely reactive.

Independent Monitoring Board

17. 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 January 2022, the IMB reported that restrictions caused by the COVID-19 pandemic continued to dominate every aspect of a prisoner's life and progress towards unlocking prisoners more often during the day had been slow at times and set back due to local COVID-19 outbreaks.
18. The IMB reported that there had been a deterioration in the delivery of physical and mental health services during the year. They highlighted problems with poor communication with prisoners and long waiting lists for services and reported that these problems were because of inadequate staffing and an overdependence on agency staff.

Previous deaths at HMP Lewes

19. There were six deaths from natural causes, two of which were related to COVID-19, and three self-inflicted deaths at HMP Lewes in the two years before Mr Wilkinson's death. There has been one death from natural causes and two drug related deaths at Lewes since Mr Wilkinson's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

20. On 17 November 2021, Mr Mark Wilkinson was remanded in custody to HMP Lewes. At the time, Mr Wilkinson was diagnosed with chronic liver disease caused by alcohol cirrhosis, gastrointestinal bleeding, post-traumatic stress disorder and depression. He was also drug and alcohol dependent.
21. At his initial health screen, Mr Wilkinson told a nurse that he had previously been treated for alcohol dependence and had been drinking heavily before he came into custody. The same day, a prison GP reviewed Mr Wilkinson for alcohol dependence and prescribed chlordiazepoxide for alcohol withdrawal.
22. On 18 November, a nurse saw Mr Wilkinson because his cell mate said that his nose was bleeding, and he was coughing up blood. Mr Wilkinson told the nurse that he had had dark red blood in his stools and urine for ten years. She noted that Mr Wilkinson had a gastric problem relating to his alcohol withdrawal and advised him to drink plenty of fluid and rest. She noted that because some of Mr Wilkinson's issues were long-term, she would not refer him to a prison GP. There is no evidence that information regarding Mr Wilkinson having previous gastrointestinal bleeding was passed to a prison GP, or whether the history was checked against Mr Wilkinson's community medical records.
23. On 21 November, Mr Wilkinson told a nurse that he had back pain and that in the community he was prescribed co-codamol for pain relief. She noted that she was unable to give Mr Wilkinson co-codamol, as it needed to be prescribed. She also noted that she could not give him paracetamol or ibuprofen because his medical records showed that he had a sensitivity to these medications.
24. On 29 November, a prison GP saw Mr Wilkinson for his back pain. The GP prescribed paracetamol after Mr Wilkinson told her that he did not have a sensitivity to this. The clinical reviewer noted that in accordance with National Institute for Health and Care Excellence guidelines (NICE) paracetamol should be given in caution or at a reduced dose to people who have liver disease as it may increase liver damage. The GP said that paracetamol was given to Mr Wilkinson at a reduced dose of one to two tablets as required and no more than four tablets a day. (General practice is that that up to eight paracetamol tablets can be given in twenty-four hours.)
25. Throughout December, Mr Wilkinson refused to collect his pain relief medication because he wanted co-codamol.
26. On 8 January 2022, a prison GP prescribed ibuprofen when Mr Wilkinson had symptoms of COVID-19. (Mr Wilkinson later tested negative for COVID-19.)
27. On 19 January, a prison GP prescribed Mr Wilkinson naproxen (a stronger pain relief drug for longer term and chronic pain issues).
28. On 28 January, Mr Wilkinson was sentenced to one year and four months in prison for making a malicious telephone call and wasting police time.
29. On 17 February, a nurse reviewed Mr Wilkinson because officers said that he appeared confused overnight and had defecated on the floor of his cell. Mr

Wilkinson told her that he had not drunk anything that day and had only eaten a small amount of food that morning. She thought that Mr Wilkinson was dehydrated and suffering with loose stools. She planned for him to be reviewed by a prison GP, but an appointment was not made.

30. On 2 April, a nurse saw Mr Wilkinson because he said that he had chest pain. She noted that Mr Wilkinson appeared to be under the influence of alcohol. Mr Wilkinson told her that his legs had “blown up two weeks ago” and that he had felt short of breath and lightheaded. She noted that he could have oedema (a build-up of fluid which causes the affected tissue to become swollen). She noted that Mr Wilkinson had a prison GP appointment booked for 6 April, and that she would task the GP to review his medication for oedema. On 3 April, a prison GP asked for blood tests but did not see Mr Wilkinson.
31. On 4 April, a prison GP received a telephone call from the hospital laboratory, who told her that Mr Wilkinson’s haemoglobin levels were very low. The results meant that Mr Wilkinson required a blood transfusion. The GP spoke to him about this. Mr Wilkinson told her that he had been losing blood from his mouth, ears and anus for ten years. The GP stopped Mr Wilkinson’s prescription of naproxen due to the increased risk of bleeding and his low haemoglobin levels.
32. Later that evening, Mr Wilkinson told an officer that he would not go to hospital for the blood transfusion. During the night, a nurse noted that he asked the night patrol officer on the wing where Mr Wilkinson lived to monitor him for any deterioration of his health. The nurse did not visit Mr Wilkinson in his cell.
33. On 5 April, three nurses saw Mr Wilkinson in his cell and asked him if he would go to hospital. Mr Wilkinson told the nurses that he would not go to hospital in handcuffs. (There is no record that prison staff completed an escort risk assessment. A safety hub manager told us that if a prisoner refused to go to hospital for an appointment the risk assessment is destroyed.) Mr Wilkinson told the nurses that he would be released in two weeks and would go to hospital then. (Mr Wilkinson was not actually due for release until 17 July.) The clinical reviewer found no evidence that healthcare staff assessed Mr Wilkinson’s mental capacity in accordance with the Mental Capacity Act 2005.
34. On 6 April, a nurse carried out a mental health assessment and noted that Mr Wilkinson had symptoms consistent with psychosis. Mr Wilkinson told the nurse that he had a history of bipolar disorder. The nurse referred Mr Wilkinson to a psychiatrist.
35. On 7 April, Mr Wilkinson refused to attend an appointment with a prison GP.
36. On 14 April, Mr Wilkinson refused to attend another GP appointment.
37. On 18 April, a nurse reviewed Mr Wilkinson, who still had swollen legs. Mr Wilkinson declined to see a GP and said that he was “going home” next week. The nurse did not take his clinical observations. A prison GP noted that Mr Wilkinson had capacity to refuse to go to hospital, but she did not see him to make that conclusion.

Events of 21 and 22 April

38. At about 8.20am on 21 April, Officer A unlocked Mr Wilkinson's cell so that he could collect his medication. He told us that Mr Wilkinson appeared to be his normal self. Another officer saw Mr Wilkinson at the medication hatch and said that he was polite, "rambling" to other prisoners and seemed to be in good spirits.
39. At about 10.45am, Officer B looked through the observation of Mr Wilkinson's cell. She saw that he was slouched over his desk facing away from the door and did not respond or move when she called his name. She could not see Mr Wilkinson's chest move and was unsure whether he was breathing. She shouted for staff and Officer A, who was nearby, went to the cell and opened the door.
40. Officer A went into the cell and found that Mr Wilkinson had a pulse but that his breathing was very shallow. He radioed a medical emergency code blue and placed Mr Wilkinson on the floor of his cell in the recovery position.
41. A nurse went to Mr Wilkinson's cell with two colleagues. He found that Mr Wilkinson was not breathing and did not have a pulse. He checked Mr Wilkinson's airway and gave him oxygen while another nurse started chest compressions. Another nurse applied a defibrillator, which on several occasions advised not to shock and to continue chest compressions.
42. Two custodial managers carried out chest compressions in rotation with the nurses.
43. At 11.22am, ambulance paramedics arrived and took over life support. At 12.35pm, the paramedics left the prison and took Mr Wilkinson to the Royal Sussex Hospital, Brighton.
44. Mr Wilkinson remained in hospital in a coma. At 9.54am on 22 April, Mr Wilkinson died.

Contact with Mr Wilkinson's family

45. On 21 April, Lewes appointed a family liaison officer (FLO). The FLO was unable to find a next of kin for Mr Wilkinson. Mr Wilkinson's funeral took place on 23 May, and the prison paid for its cost in line with national instructions.

Support for prisoners and staff

46. After Mr Wilkinson's death, the deputy governor 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.
47. Prison staff posted notices informing other prisoners of Mr Wilkinson'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 Wilkinson's death.

Post-mortem report

48. A post-mortem examination established that Mr Wilkinson died of an internal haemorrhage (bleeding) as a result of ruptured oesophageal varices (a condition that develops when the normal blood flow to the liver is blocked) and alcoholic cirrhosis of the liver.

Inquest

49. At an inquest held on 4 April 2024, the Coroner concluded that Mr Wilkinson died from natural causes.

Findings

Clinical care

50. The clinical reviewer found that the clinical care that Mr Wilkinson received at Lewes was not equivalent to that which he could have expected to receive in the community.
51. From 4 April, Mr Wilkinson consistently refused to go to hospital for a blood transfusion and chose not to attend appointments with the prison GP. The clinical reviewer found that in the following three weeks no clinical observations were taken. She found that this was concerning given Mr Wilkinson's dangerously low haemoglobin levels and deteriorating condition. The clinical reviewer concluded that healthcare staff should have visited Mr Wilkinson to complete clinical monitoring.
52. The clinical reviewer found that Mr Wilkinson's complex health conditions and refusal to attend hospital should have led to a referral to the Multi-Professional Complex Case Clinic (MPCCC, a care planning and risk management framework). She found that discussion at an MPCCC meeting should have resulted in the completion of a care and risk management plan for the purposes of ongoing clinical monitoring.
53. The clinical reviewer also identified issues with Mr Wilkinson's pain management. His liver condition meant that he was appropriately prescribed paracetamol below the maximum dose. However, the clinical reviewer found that this meant that his pain was not always sufficiently under control. The clinical reviewer also found that ibuprofen and naproxen were inappropriately prescribed given Mr Wilkinson's history of gastrointestinal bleeding. While they were appropriately stopped when his low haemoglobin levels were known, this meant that Mr Wilkinson no longer had sufficient pain relief. The clinical reviewer concluded that a multi-agency and person-centred approach should have been taken to Mr Wilkinson's pain management.
54. Mr Wilkinson did not have a care plan in place for his long-term liver cirrhosis. The clinical reviewer identified that this condition is primarily managed by secondary healthcare services but found that healthcare staff at Lewes had a role in considering safe prescribing and providing advice and support in managing the condition.
55. Prison Service Instruction (PSI) 58/2010 requires prisons to collate and provide copies of documents requested by Prisons and Probation Ombudsman investigation teams. The clinical reviewer made several requests to see the healthcare inpatient unit admissions policy, to determine if Mr Wilkinson should have been transferred there once his seriously low haemoglobin levels were known and he was refusing to go to hospital. This policy has not yet been provided. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with long-term conditions are managed in line with national guidelines, including that:

- **staff regularly review those prisoners who refuse to attend hospital for emergency treatment, including taking relevant clinical observations.**
- **prisoners with complex conditions are referred to the Multi Professional Complex Case Clinic; and**
- **relevant care plans are created that include the monitoring of prescribed medication where there is a risk attached.**

The Head of Healthcare should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

**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 | 020 7633 4100