Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Willis, a prisoner at HMP Isle of Wight, on 21 September 2023

A report by the Prisons and Probation Ombudsman

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

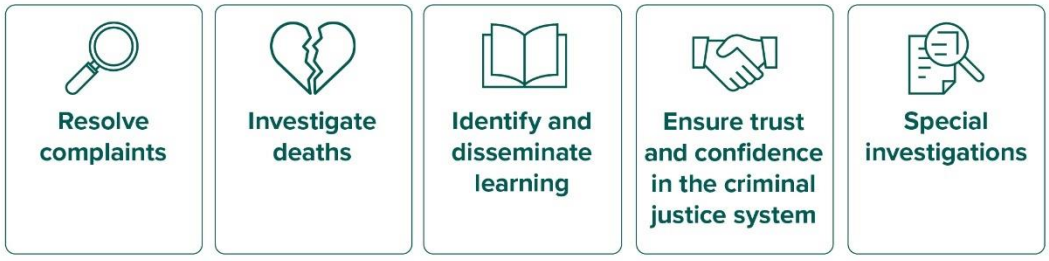
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

he 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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Donald Willis died from a stroke on 21 September 2023 at HMP Isle of Wight. He was 85 years old. I offer my condolences to Mr Willis' family and friends.

The clinical reviewer found that the care Mr Willis received at Isle of Wight was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. On 25 November 2022, Mr Donald Willis was sentenced to 16 years imprisonment for sexual offences. On 24 January 2023, he was moved to HMP Isle of Wight.

2. Mr Willis had high blood pressure and was prescribed medication to lower it. He was not always compliant with taking his medication.

3. On 8 September 2023, an officer found Mr Willis lying on his cell floor during the morning welfare checks. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff in the control room to call an ambulance) and healthcare staff attended the cell.

4. The healthcare team checked Mr Willis' clinical observations, which were normal. Mr Willis told the healthcare team that he had got up to go to the toilet in the night and slid down between his bed and his table and was unable to get up. He had no apparent injuries but did have a small pressure area on the left side of his temple. Mr Willis was not in any pain and told them that he had not hit his head.

5. As Mr Willis' condition was stable, the healthcare team stood down the ambulance and told officers that if his condition deteriorated, he should be taken to the prison's inpatient unit and the healthcare team should be contacted.

6. At around 8.30am, Mr Willis' condition deteriorated, and staff called a code blue. When the healthcare team arrived, they found Mr Willis had a droop to his mouth and was unable to raise his left hand. Mr Willis was taken to hospital by ambulance and was treated for a stroke.

7. On 12 September, Mr Willis was discharged back to the inpatient healthcare unit at Isle of Wight, where he was cared for in an end-of-life suite.

8. Mr Willis' health continued to deteriorate and on 21 September he died.

Findings

9. The clinical reviewer concluded that the care Mr Willis received was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She found that the care Mr Willis received following his stroke on 8 September 2023 was of a high standard, specifically the communications and joint working with a hospice who the healthcare team worked with to develop an end-of-life care plan for Mr Willis. This is reflective of high quality and compassionate care.

10. We make no recommendations.

The Investigation Process

11. HMPPS notified us of Mr Willis' death on 21 September 2023.

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

13. The investigator obtained copies of relevant extracts from Mr Willis' prison and medical records.

14. The investigator interviewed two members of staff on 22 November and 19 December.

15. NHS England commissioned an independent clinical reviewer to review Mr Willis' clinical care at Isle of Wight.

16. We informed HM Coroner for Isle of Wight of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Willis' wife to explain the investigation and to ask if she had any matters she wanted us to consider. Her daughter responded on her behalf and asked to know more of the timeline of Mr Willis' poor heath and whether he had a COVID-19 booster. We have addressed these questions in our report and the annexed clinical review.

18. We shared our initial report with HMPPS. They found no factual inaccuracies.

19. We sent a copy of our initial report to Mr Willis' daughter. She pointed out some factual inaccuracies in the clinical review, which has been amended and is annexed to this report. She also raised a query which has been answered in a separate letter.

Background Information

HMP Isle of Wight

20. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds around 1,000 men. Practice Plus Group provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Isle of Wight was in September 2022. Inspectors reported that the prison outcomes for safety, respect, and rehabilitation and release planning had declined. Staff shortages of both prison officers and more specialist disciplines was undermining much of the prisons work and attempts at improvement. Over a third of officers were not available for work in the units, which limited the delivery of the day-to-day regime and led to prisoners spending too long locked in cells.

Independent Monitoring Board

22. 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 December 2022, the IMB reported that persistent staffing shortages across the entire prison staff had slowed the return to a normal regime following COVID-19. This resulted in prisoners continuing to be locked up for considerable periods of time and detrimentally affected prisoners' access to healthcare appointments.

Previous deaths at HMP Isle of Wight

23. Mr Willis was the thirty-fourth prisoner to die at Isle of Wight since September 2020. Of the previous deaths, 27 were from natural causes, four were self-inflicted and two were from unknown causes.

Key Events

24. On 25 November 2022, Mr Donald Willis was sentenced to 16 years imprisonment for sexual offences. On 24 January 2023, he was moved to HMP Isle of Wight.

25. Mr Willis had hypertension (high blood pressure). He had been prescribed medication (indapamide) for this at his previous prison, but he had decided to stop taking it as he said it interacted with his other medication.

26. On 8 February, a nurse saw Mr Willis and noted that his blood pressure was high. She started him on weekly blood pressure monitoring and spoke to him about healthy lifestyle choices and the risk of stroke. She created a hypertension care plan.

27. On 15 February, healthcare staff carried out a cardiovascular risk score assessment (QRISK2) for Mr Willis, which showed that he was at a high risk of having a stroke or a heart attack in the next ten years.

28. Mr Willis had several further high blood pressure recordings. On 24 February, a GP prescribed indapamide.

29. On 6 April, Mr Willis told healthcare staff that he had not taken his indapamide for one week. The healthcare team checked his blood pressure which was high.

30. On 24 April, a GP reviewed Mr Willis' blood pressure reading. The GP suggested that Mr Willis should take an additional medication to help lower his blood pressure. Mr Willis did not want to take any more medication. He said that he had white coat syndrome (when blood pressure is raised due to the stress of a clinical environment) and had missed his medication for ten days which is why his blood pressure was high. Mr Willis asked to resume taking indapamide and the GP agreed.

31. On 20 July, Mr Willis saw the health care team in a clinic. The healthcare team suggested further medication for high blood pressure and a daytime ambulatory blood pressure monitor (enables blood pressure to be recorded during normal daily routine activities and sleep). Mr Willis declined both. Staff assessed that Mr Willis had capacity to make his own decisions.

32. On 27 July, Mr Willis saw a GP to discuss his high blood pressure. He told the GP that he had severe white coat syndrome and his blood pressure was normally okay. He did not want any further blood pressure medication.

8 September

33. An officer found Mr Willis lying on his cell floor during the morning welfare checks. The officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff in the control room to call an ambulance) and healthcare staff attended the cell. The Head of Safety completed an escort risk assessment (ERA) for Mr Willis to be taken out on an emergency ambulance escort. He assessed that restraints should be applied (a single set of handcuffs).

34. The healthcare team checked Mr Willis' clinical observations, which were normal. Mr Willis told the healthcare team that he had got up to go to the toilet in the night and slid down between his bed and his table and was unable to get up. He had no apparent injuries but did have a small pressure area on the left side of his temple. Mr Willis was not in any pain and told them that he had not hit his head.

35. The healthcare team stood down the ambulance and offered for Mr Willis to go to the prison's inpatient healthcare unit (IHU) for monitoring. Mr Willis declined this. The healthcare team agreed with Mr Willis and officers that if his condition deteriorated, he should be taken to the IHU and the healthcare team should be contacted.

36. At around 8.30am, Mr Willis' condition deteriorated, and staff called a code blue. When the healthcare team arrived, they found Mr Willis had a droop to his mouth and was unable to raise his left hand.

37. As a second code blue had been called, the Head of Safety went to Mr Willis' houseblock and spoke to two members of the healthcare team. The healthcare team said that both code blues had been for Mr Willis, his condition had deteriorated, and an ambulance was on the way. The Head of Safety then completed an updated ERA which advised that restraints should not be applied to Mr Willis due to his condition and age.

38. Despite the updated ERA, officers handcuffed Mr Willis for his transfer to hospital. When he arrived at hospital, staff placed Mr Willis on 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), which was not removed until 6.00pm that evening, when escort officers received approval from the duty governor to remove restraints. Mr Willis was admitted to hospital and was treated for a stroke.

39. While in hospital, Mr Willis had a CT scan which showed he had a blockage in his carotid artery which had caused a stroke. His condition was stable however his ability to communicate and mobilise had severely declined.

40. On 11 September, doctors put a Do Not Attempt Resuscitation order in place for Mr Willis. They agreed that he was no longer for active treatment and started him on palliative care.

41. On 12 September, Mr Willis was discharged back to the inpatient healthcare unit at Isle of Wight, where he was cared for in an end-of-life suite.

42. Mr Willis' health continued to deteriorate and on 21 September he died.

Contact with Mr Willis' family

43. On 11 September, the prison appointed a family liaison officer (FLO) for Mr Willis, given his deteriorating condition. Mr Willis had a next of kin on file, however it was recorded that they were no longer in contact.

44. On 15 September, the FLO contacted Mr Willis' next of kin, his wife, and informed her of his poor health.

45. On 21 September, the deputy family liaison officer contacted Mr Willis' wife to inform her that he had died. The prison contributed towards the cost of Mr Willis' funeral and arranged for his belongings to be returned to his family.

Support for prisoners and staff

46. After Mr Willis' death, a prison manager debriefed the staff involved in his care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Willis' death and offering support.

Post-mortem report

48. The post-mortem concluded that Mr Willis died of an ischemic stroke *(*when the blood supply to part of the brain is blocked). Ischemic heart disease (heart problems caused by narrowed heart arteries), chronic kidney disease (where the kidneys do not work as well as they should) and pulmonary thromboembolism (a blood clot in the lungs) were also listed as contributing factors.

Findings

Clinical care

49. The clinical reviewer concluded that the care Mr Willis received at Isle of Wight was of a reasonable standard that was equivalent to the care he could have expected to receive in the community.

50. She found that the care Mr Willis received after his stroke on 8 September was of a high standard. In particular, there was good communication between prison healthcare staff and a local hospice to develop an end of life care plan for Mr Willis. She noted that the care given to Mr Willis in the last days of his life appeared to be compassionate and caring.

51. The clinical reviewer made some recommendations unconnected to Mr Willis' death which the Head of Healthcare will wish to address.

Restraints, security and escorts

52. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. 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. It said 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.

53. When the first code blue was called for Mr Willis, the Head of Safety assessed that restraints (a single set of handcuffs) should be applied for his transfer to hospital. However, after the second code blue was called and he realised that Mr Willis' condition had deteriorated, the Head of Safety updated the ERA to show that restraints should not be applied. This demonstrated that he had considered Mr Willis' health and mobility and he made the appropriate decision that Mr Willis should not be restrained when taken to hospital. This was good practice.

54. However, in spite of the updated ERA, Mr Willis was taken to hospital in restraints. This should not have happened. We bring this issue to the Governor's attention.

Inquest

55. At the inquest, held on 2 December 2025, the Coroner concluded that Mr Willis died from natural causes.

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