Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alec Henney, a prisoner at HMP Isle of Wight, on 28 March 2023

A report by the Prisons and Probation Ombudsman

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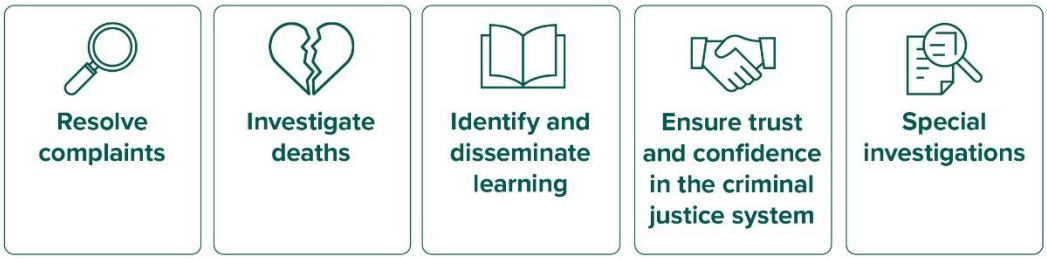
OUR VISION

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

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. 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.

3. Mr Alec Henney died in hospital of pneumonia caused by lung cancer on 28 March 2023, while a prisoner at HMP Isle of Wight. He was 65 years old. We offer our condolences to Mr Henney's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Henney received at HMP Isle of Wight was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer made three recommendations which were not directly related to Mr Henney's death but which the Head of Healthcare and Governor will need to address.

5. She highlighted examples of good practice such as the regular discussions and ongoing care provided to Mr Henney when he was admitted to the healthcare unit.

6. However, she noted that an end-of-life care plan was not in place, including for pain management. She also noted delays in organising an X-ray for Mr Henney. While this might not have changed the outcome for him, it delayed his access to earlier assessment, diagnosis and treatment.

7. Isle of Wight did not appropriately keep records about the use of restraints on Mr Henney. This prevented us being able to assess whether the use of restraints was appropriate.

Recommendations

- **The Governor should remind staff of the importance of retaining paperwork about the use of restraints so that it is available to the PPO if required.**

The Investigation Process

8. HMPPS notified us of Mr Henney's death on 28 March 2023.

9. Health Inspectorate Wales (HIW) commissioned an independent clinical reviewer to review Mr Henney's clinical care at HMP Isle of Wight.

10. The PPO investigator investigated the non-clinical issues relating to Mr Henney's care.

11. The PPO family liaison officer wrote to Mr Henney's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She was concerned about how Mr Henney was informed of his cancer diagnosis and the use of restraints during hospital stays.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

13. Mr Henney's family received a copy of the draft report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

Previous deaths at HMP Isle of Wight

14. Mr Henney was the fifteenth prisoner to die at HMP Isle of Wight since March 2021. Of the previous deaths, 11 were from natural causes, and two were self-inflicted. There are no similarities between the findings in our investigation into Mr Henney's death and the findings from our investigations into the previous deaths.

Key Events

15. On 4 March 2022, Mr Alec Henney was convicted of sexual offences and was sentenced to seven years imprisonment. He was sent to HMP Isle of Wight on 4 October 2022.

16. On 1 December, Mr Henney was admitted to the healthcare unit for chest pain and breathing difficulties. A nurse assessed him and found that his observations were within normal ranges. She made an appointment for him to see a GP the next day.

17. On 2 December, the GP noted that Mr Henney needed a chest X-ray and blood tests. The chest X-ray was not booked.

18. On 22 December, Mr Henney said that he had ongoing chest pain. A pharmacist, who was also an Advanced Clinical Practitioner operating at Isle of Wight, requested a chest X-ray.

19. On 9 January 2023, a prison paramedic saw Mr Henney for ongoing chest and abdominal pain. It was noted that the referral from the pharmacist had not been accepted.

20. On 18 January, Mr Henney attended the hospital for the chest X-ray.

21. On 23 January, a GP at Isle of Wight phoned Mr Henney in his cell and told him that he had lung cancer. Wing staff were not told this call was to take place.

22. On 23 February, Mr Henney agreed to be moved to the healthcare wing having previously declined on multiple occasions.

23. On 6 March, Mr Henney was taken to hospital, restrained, for a chest infection and possible sepsis. He was diagnosed with advanced bone metastasis. (The cancer had spread from its original location to the bones.) He was admitted to hospital for treatment. (The prison could not provide the paperwork related to the use of restraints for this hospital visit, so we were unable to consider whether appropriate decisions had been made.)

24. On 14 March, during his hospital stay, Mr Henney complained that his restraints were too tight. The escort officer on the bedwatch checked the cuffs and advised that they would not be removed. Mr Henney complained about the use of restraints during his time in hospital.

25. On 15 March, having undergone emergency palliative radiotherapy, Mr Henney returned to the healthcare unit at Isle of Wight. His cancer had spread further to his brain, skin and spine. The hospital oncology department told Mr Henney that his cancer could not be cured.

26. On 22 March 2023, a nurse found Mr Henney collapsed in bed. He had difficulty breathing but was still able to talk. The nurse calculated a National Early Warning Score (NEWS2, a tool used to assess clinical deterioration) of 10, which indicated that he needed to be assessed urgently in hospital.

27. Mr Henney was taken to hospital by ambulance, escorted by two prison officers and initially without restraints. That day, the Head of Offender Management Services decided to restrain Mr Henney with an escort chain (a long chain with a handcuff at each end, with one attached to the prisoner and the other to an officer). Again, the prison could not locate the documentation and the Head of Offender Management Services could not explain why they made the decision to restrain Mr Henney.

28. The restraints were removed shortly afterwards due to Mr Henney's poor health and frailty.

29. A few hours later, Mr Henney was discharged from hospital and returned to Isle of Wight.

30. On 24 March, Mr Henney was returned to hospital by ambulance because of low oxygen saturation levels. He was struggling to breathe and had a NEWS2 score of six (indicating medium clinical risk). Mr Henney was escorted by two officers and not restrained on this occasion.

31. On 27 March, the hospital said that Mr Henney had a prognosis of two days. His daughter was informed, and a visit was arranged for her to see Mr Henney the following day.

32. At 8.25am on 28 March, Mr Henney was pronounced dead. The family liaison officer called his daughter to tell her that he had died.

Post-mortem report

33. The post-mortem report concluded that Mr Henney died of pneumonia caused by metastatic adenocarcinoma of the lung (lung cancer which has spread to other parts of the body) and chronic obstructive pulmonary disease (COPD, a lung disease). Severe fatty change of the liver was also listed as a contributory factor.

Inquest

34. At an inquest held on 23 October 2025, the Coroner concluded that Mr Henney died of natural causes.

Non-clinical findings

Restraints, security and escorts

35. Isle of Wight did not keep proper records of their restraints decisions about Mr Henney. The paperwork about Mr Henney's hospital stay from 6 to 15 March (when he complained about the restraints that were used) was missing. In the absence of records, we were unable to assess whether the use of restraints was appropriate.

36. When Mr Henney was taken to hospital on 23 March, he was restrained with an escort chain. Mr Henney's cancer was advanced, and it had spread by this point. In the prisoner escort record, Mr Henney was documented as being extremely weak. We have seen no evidence to justify the decision to restrain him in the days before he died. While we accept that restraints were removed shorty after Mr Henney's health deteriorated, we were unable to ascertain why Mr Henney was restrained because of the lack of records. We therefore make the following recommendation:

    The Governor should remind staff of the importance of retaining paperwork about the use of restraints so that it is available to the PPO if required.

Governor and Head of Healthcare to note

Communication about Mr Henney's diagnosis

37. Mr Henney was informed of his cancer diagnosis by phone at 7.00pm on 23 January. It is unclear whether he was alone or with his cellmate at the time. Healthcare staff had not told prison staff that this call was to take place and prison staff were only told about it by another prisoner the following day. Prison staff saw Mr Henney that day to offer support.

38. The GP operating at Isle of Wight told us that the healthcare team told Mr Henney his cancer diagnosis by telephone because they could not accommodate a face-to-face appointment with him until after he had been sent for an urgent cancer appointment. This was considered a better option.

39. We recognise that there is no policy in place about how best to inform prisoners of their diagnoses. However, we consider that the way Mr Henney was told of such a serious diagnosis - by telephone in his cell, in the evening and without wing staff being alerted of the call so they could support him afterwards - did not take into account his potential wellbeing and safety following the news.

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

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