A Report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Albany in August 2012

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of the investigation into the death of a man at HMP Isle of Wight (Albany site) in August 2012. He was 75 years old and died from several chronic conditions, including diabetes. I offer my condolences to his family and friends.

The local Primary Care Trust (PCT) cluster commissioned a clinical reviewer to review the clinical care the man received at Albany.

The man was sentenced to 14 years in prison in 2004 and transferred to Albany in 2005. He had a number of conditions, including angina, diabetes, high blood pressure and he had an ulcer on his right leg. By 2011, he could no longer live on the wing and was admitted to the inpatient unit. His leg was amputated in August and he was discharged from hospital back to the inpatient unit in October 2011. His health worsened, and he died in August 2012.

I agree with the clinical reviewer that the care the man received was equivalent to what he could have expected in the community. However, the level of restraints used when he was taken to hospital for treatment was not always justified by the risk assessment.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **November 2013**

CONTENTS

Summary

The investigation process

HMP Isle of Wight

Issues

Conclusion

Recommendations

SUMMARY

1. The man was born in July 1937. He was remanded to HMP Parc on 7 December 2004 charged with a number of sexual offences against children. He was sentenced to 14 years on 14 December 2004.

2. He was transferred to HMP Albany (now part of HMP Isle of Wight) on 14 February 2005. The prison healthcare team noted that he was overweight (18 ½ stones), had diabetes, angina, high blood pressure, an ulcer on his leg and became breathless when walking. He was given a cell on the ground floor and a stability frame to help him walk.

3. He moved to the Inpatient Healthcare Unit (IHU) on 7 June 2011 because his vomiting and incontinence could not be managed on the wing. In August, the doctor discussed the option of surgery on his gangrenous leg. Despite the doctor emphasising the risks of surgery, he chose to undergo the above-knee amputation.

4. The man returned to the IHU on 26 October where he stayed for the remainder of his time in prison. He was able to get around the wing in his wheelchair and could sometimes wash himself in the bathroom, but was often helped by staff. As his health declined, the prison arranged for his cell to be kept open 24 hours a day to allow the nurses to care for him effectively.

5. His health declined throughout 2012 and, when he was diagnosed with bronchopneumonia, a palliative care plan was put in place. He died in August 2012.

6. We agree with the clinical reviewer that the man’s health was well-managed and his dignity and comfort were appropriately safeguarded throughout his illness. Contact with his wife was established as his health declined and her wishes were respected with regard to informing her of his death. We are concerned that the level of restraints used when escorting him to hospital was not justified by the risk assessment.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 24 August 2012. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact him with any relevant information. There was no response to the notices.

8. The investigator was given copies of the man's medical record and relevant aspects of his prison records. The local PCT appointed a clinical reviewer to review the clinical care the man received at Albany. He was given a copy of the man's medical record.

9. The investigator visited HMP Isle of Wight in September 2012 and met healthcare staff involved in the man's care. He wrote to the Governor with preliminary feedback after his visit.

10. HM Coroner for the Isle of Wight was informed of the investigation and provided the results of the post-mortem investigation. The Coroner will be sent a copy of this report to assist with his enquiries.

11. One of the Ombudsman's family liaison officers contacted the man's wife outlining the purpose of the investigation. She had no questions or concerns about his treatment.

12. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP ISLE OF WIGHT

1. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man was in the Albany site when he died, which holds up to 567 sex offenders and vulnerable prisoners in five cell blocks.

2. Health services at HMP Isle of Wight are commissioned and provided by the local Primary Care Trust (PCT). An Inpatient Healthcare Unit (IHU) was opened in October 2009 at the Albany site. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

Her Majesty's Inspectorate of Prisons (HMIP)

3. The last report published on HMP Isle of Wight by HM Chief Inspector of Prisons followed an unannounced inspection from 21 May – 1 June 2012. The report noted that management of long-term medical conditions and palliative care was good. It described the IHU as having a high standard of cleanliness. Patients spoken to during the inspection said they were satisfied with the care they received.

Independent Monitoring Board (IMB)

4. Each prison in England and Wales has an Independent Monitoring Board (IMB), made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.

5. In its annual report for 2011, the IMB described the challenges of the ageing population at Albany which can lead to long waiting times for chiropody and optician appointments. The IMB were concerned that the man was taking valuable space in the small IHU after his leg amputation and considered that he was well enough to return to the wing.

Previous deaths at HMP Isle of Wight

6. This office has investigated many previous deaths at what was HMP Albany, now part of HMP Isle of Wight. The majority of these deaths were as a result of natural causes, reflecting Albany's relatively elderly population. In one of the cases investigated earlier in 2012, we made a recommendation to improve escort risk assessments, which we repeat in this report. There have been a further four deaths since the man died.

ISSUES

The diagnosis of the man's terminal illness

13. The man was born in July 1937. He was remanded to HMP Parc on 7 December 2004 charged with a number of sexual offences against children. He told the nurse when he arrived at the prison that he had been diagnosed with angina, high blood pressure, diabetes and had an ulcer on his leg. He was sentenced to 14 years in prison on 14 December.

14. The man transferred to HMP Albany (now part of HMP Isle of Wight) on 14 February 2005. He was assessed at Albany on 29 April 2005 using the Alzheimer's Disease Assessment Scale. The assessment noted that he was overweight (18 ½ stones), had diabetes, angina, high blood pressure, had an ulcer on his leg and became breathless when walking. His blood glucose levels were within acceptable limits and he was not thought to be suffering from depression. He was given a cell on the ground floor and a stability frame to help him walk.

15. The man's health deteriorated significantly after his leg was amputated in August 2011. He made a limited recovery in the IHU, but by the summer of 2012, healthcare staff considered that he was reaching the end of his life. Palliative care was begun on 20 August as his prognosis became terminal.

16. The clinical reviewer is content that the timing of this assessment was appropriate, given the change in the man's condition. He writes in his review: "the diagnosis of terminal illness was made appropriately".

Informing the man about his condition and treatment

17. The man's diabetes led to gangrene in his foot which worsened significantly in summer 2011. A doctor explained that surgeons were concerned about his foot, but his poor kidney function made surgery a risk. He discussed the options with him. The gangrene would eventually prove fatal but he would have better quality of life until then, or he could have the amputation with the associated risks. The doctor explained that he chose the operation as he had a strong will to live to be released and see his family.

18. The man returned to the IHU following the operation. His health became worse and in summer 2012 a nurse told the investigator that the time between health crises had become shorter. The healthcare team concluded that he was nearing the end of his life. The nurse spoke to him about his wishes regarding the end of his life and he signed a 'Do Not Resuscitate' form after this discussion. The clinical reviewer comments: "In his final illness, he was also involved in the decision not to actively be resuscitated should he suffer cardiac arrest".

19. We concur with the clinical reviewer when he writes: "The man was given full information about his condition and treatment".

The man's medical appointments and treatment of the prisoner

20. The man's diabetes initially proved difficult to control and he was referred to the hospital's diabetes clinic. His kidney function also deteriorated and renal specialists were consulted. In 2007, he had severe internal bleeding from a duodenal ulcer which required surgery to control it. In 2009, he required emergency treatment to remove large amounts of excess fluid from his body which had caused swelling of his legs.

21. In 2011, the man developed an infection in his left heel (caused by circulatory problems and diabetes) which was treated with antibiotics for six weeks. This chronic condition can result in amputation, but the clinical reviewer considers that "… it was managed appropriately by the Prison Healthcare Team, supported by the vascular surgeons". The antibiotic medication led to a bowel inflammation which was treated in hospital. He went to hospital on 9 June and returned on 18 July. His heel improved for a short time following this treatment.

22. The man continued to be unwell into August and a doctor diagnosed bronchopneumonia. The doctor noted in the medical record that he would require surgery on his leg in order to survive, although he:

> "… has been under the care of vascular and orthopaedic surgeons for months and they have not advised surgical intervention. Put prospect of surgery to patient and he wants to go for it. Therefore referred to surgical registrar for transfer to A&E and anaesthetic review."

23. The man's leg was amputated mid-thigh on 18 August. Although rehabilitation was attempted during his time in hospital, his continuing health problems and varying levels of motivation meant that a prosthetic limb was not considered appropriate.

24. His health declined throughout 2012 and, by the summer, it was clear that he did not have long left to live. The clinical reviewer writes of the precautionary tests undertaken at this time:

> "He underwent scans and other investigations in the weeks before his death to make sure that there were no other treatable reasons for the decline in his health."

25. A doctor diagnosed bronchopneumonia in August and palliative care was started on 20 August. From then on, the man was subject to observations every 30 minutes. One morning a few days later, a nurse noted that he had no vital signs. He was confirmed dead at 4.30am by the doctor.

26. The man received a range of care from the healthcare staff due to his varied conditions. We agree with the clinical reviewer's conclusion: "Following his diagnosis, his appointments and treatment were conducted to an appropriate standard".

The man’s pain relief and medication

27. The man did not always tell staff when he was in pain. He would sometimes claim to be pain-free but the difficulty of his movements would suggest otherwise. The nurses said that he was not on a continual prescription of analgesia throughout his time in IHU, but had it when he needed it.

28. A syringe driver was set up on 21 August 2012 to provide the man with a steady and consistent level of pain relief. (A syringe driver is a small portable pump that can be used to give a continuous dose of painkilling medication.) The clinical reviewer identifies no issues with the management of his pain. He writes:

> “He was given stronger pain relief as required and when he was unable to take oral medication, a syringe driver was used. He was provided with appropriate pain relief and medication.”

The man’s location

29. When the man first came to Albany, he lived on a residential wing in the prison but spent some time in the IHU when he became unwell. On the wings, prisoners with disabilities have buddies assigned to them in case of an emergency evacuation, and to help them with day to day tasks. Buddies volunteer for the role. He moved to the IHU on 7 June 2011 following a bout of illness where his vomiting and incontinence became too much for officers and buddies to manage appropriately.

30. During the man’s time in the IHU, he was in a room with a hospital bed. He returned to the IHU from a hospital stay on 26 October, and stayed in the IHU for the remainder of his time in prison. A sling hoist and pressure relieving mattress were arranged (although the sling hoist was not needed regularly). He claimed to be willing to move independently but his motivation varied from day to day. He was able to get around in his wheelchair and would sometimes wash himself in the bathroom.

31. The Head of Operations authorised staff to leave his cell unlocked 24 hours so they could get in and out to treat him easily and quickly. The paperwork completed by him provided the following justification:

> “Health
>
> The man needs nursing care throughout the 24 hour period he is incontinent of urine and faeces and needs regular checking and cleaning up, he is unable to mobilise on his own as he has had an amputation of his left leg.
>
> Risk Assessment
>
> I have assessed all the information available to me including consultation with NHS staff. There are no security risks and with mobility being non-existing due to amputation of leg he requires nursing staff to move him I am authorising cell door to remain open 24/7. “

32. The prison has two Kings Fund Garden rooms specifically designed for prisoners coming to the end of their lives. The man did not move to one of these at any stage, because he said he considered his cell his home. The following entry in his end of life car plan explains this: "He has not moved from current bedroom as consensus opinion is that this is his home". The Kings Fund rooms did not offer additional facilities as he already had a hospital bed that could adapt from a sitting to a lying position; he had a pressure relieving mattress and was unlocked 24 hours a day.

33. We agree with the clinical reviewer that appropriate decisions were made about the most suitable location for the man.

Compassionate release

34. All prisoners who have not reached their automatic release date, conditional release date or parole eligibility date may apply for early release on compassionate grounds for medical reasons. In order to be released on compassionate grounds, a prisoner must have a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

35. The man wanted to be released on compassionate grounds so he could see his family again. The application was begun in late July when he went into hospital after suffering a suspected stroke on 25 July 2012. A multi-agency meeting was held on 1 August 2012 to discuss the issues involved. The probation officer noted that, although he had gone into hospital in poor health, he had recovered well from serious health setbacks in the past.

36. It was noted that the man had been refused early release on parole licence earlier in the year due to doubts that his risk could be safely managed in the community. The probation officer wrote that his wife would be unable to care for him at her home because of his health needs, and expressed concerns about possible re-offending if he went to a nursing home. (This is surprising given his limited mobility and poor health.) The probation officer's report ended by not recommending compassionate release, noting that his nursing needs could be better met at the IHU.

37. The Modern Matron attended the meeting on 1 August and wrote in an email the day before the meeting:

> "… he is still an unwell man and he is for palliative care on return but could not say how long he has left to live, but I would say it is not imminent. I know that you may not find this very helpful but it is really difficult to put a length of time on his life."

38. A doctor gave a medical overview in writing. He wrote that the man was very ill and unlikely to live beyond six months. The doctor wrote that he considered him unable to re-offend and not a danger to the public. He explained to the investigator that it was difficult to give an accurate life expectancy due to the number and nature of conditions that he had.

39. The meeting did not support compassionate release to a nursing home due to the potential risk of re-offending if he recovered; the difficulty in locating the man in the community and lack of a definitive life expectancy. As the doctor had concluded that his risk to the public was diminished by his physical condition, we are surprised that risk was still considered a factor.

40. The investigator was told that the compassionate release application documents were never progressed from the prison because the early release criteria had not been met. Due to the deterioration in the man's health and lack of a clear life expectancy, no further progress had been made by the time of his death. The clinical reviewer sums up the last few weeks of his life as follows:

> "As his condition deteriorated, he was cared for in his usual room in healthcare, as that had effectively become his home. An application for early release was unsuccessful, and he died peacefully of bronchopneumonia being cared for by people he knew well."

41. As the man did not have a clear prognosis, we do not consider that the prison acted unreasonably in not taking forward his compassionate release application.

Palliative care plans

42. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. There are various examples of end of life care pathways, including the Liverpool Care Pathway (LCP). The LCP includes a template which staff involved in caring for a dying prisoner complete.

43. The LCP was first begun on 13 August 2011, following a long period of illness. The man had been unwell for a number of weeks and was experiencing bouts of sickness and confusion. This was stopped when he recovered.

44. A LCP was implemented again for the man on 20 August 2012 due to his failing health. The documents noted him to be suffering from diverticulitis (a digestive disease). On the initial assessment form, he was noted not to be in pain, not confused and conscious. He had signed a DNR (Do Not Resuscitate form). The care pathway priorities were listed as:

> "To provide pain relief when needed, maintain skin integrity, nutrition/hydration, maintain catheter potency, personal hygiene needs."

45. The nurses explained to the investigator that the healthcare department met each morning (with the doctors) to discuss the care for the prisoners in the IHU. The care pathway was monitored by staff each day. The following was recorded on 21 August: "Regular check on the man's general condition. Appears peaceful, no visual signs of distress". He was frequently incontinent and this was cleaned and treated by staff each time it occurred. Mouth care

was also provided to prevent a build up of phlegm. Over the next few days this care continued to be provided to him. The chaplaincy also visited him regularly, at least daily.

46. We agree with the clinical reviewer that there were appropriate palliative care plans and end of life pathways for him.

Liaison with the man's family

47. A Senior Officer (SO) explained that, as the prison's family liaison officer, he had first spoken to the man's wife in 2010. He said that he spoke to her whenever his situation changed, such as when he underwent the leg amputation in August 2011.

48. The SO said that the man's wife asked to be contacted by telephone in the event of her husband's death. She did not want to be contacted in the middle of the night. After his death in August, the SO waited until the morning to contact her, in line with her wishes.

49. The prison returned the man's property to his wife and took care of all the funeral arrangements. When the Ombudsman's family liaison officer contacted the man's wife she said she had been grateful for the support offered to her by the prison. We are satisfied that there was appropriate family liaison.

Restraints, security and bed watch

50. When a prisoner is taken out of the prison, a risk assessment should be carried out to decide the level of restraints to be applied. The assessment informs the decision about the number of escorting officers and the type of restraint to be used, if they are needed. The risk assessment should effectively balance security needs with the health and dignity of the prisoner, and be reviewed by prison managers each day that a prisoner is in hospital and amended as necessary. The assessment should include medical opinion about how the prisoner's condition impacts on his risk.

51. The investigator reviewed the restraint risk assessment documents for the man's hospital visits between May and July 2012. In each one, healthcare staff referred to his leg amputation but did not object, on medical grounds, to restraints being used. They also did not raise any other medical concerns that might influence the escort, or reflect on whether risk of escape was reduced by his medical condition.

52. The section completed by the security staff (section 3) noted on each occasion that the man's escape potential was low, and the overall assessment of risk was low. The initial recommendation in most of the risk assessments was for two officers and for him to be double cuffed (hands cuffed together and one hand cuffed to an officer). However, in all of the risk assessments, the senior manager's decision was for him to be restrained by an escort chain, due to his use of a wheelchair. (An escort chain is approximately six foot long with a handcuff at each end. The prisoner wears one cuff and an officer the other.)

53. The man had one leg, was 74 years old and was suffering from a number of medical conditions. The risk assessment noted that his escape potential and overall risk was low, and his general behaviour in prison was noted in other documents to have been consistently good over the preceding years. We do not think the use of restraints was justified by the risk assessment.

54. There is a concordat between the National Offender Management Service (NOMs) and the NHS, agreed in 2008, regarding security arrangements for prisoners at outside hospital. The concordat covers the use of restraints and states:

> "using handcuffs or other restraints on terminally ill or seriously ill prisoners is considered inhumane by the courts, unless justified by security considerations"

55. We do not believe the risk assessment fully took into account the individual circumstances in this case and consider that the use of restraints was not justified by the risk presented by the man at the time of his visits to hospital.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

CONCLUSION

56. The man was unwell when he entered prison but his conditions could initially be treated on a residential wing. When this became impossible, he moved to the prison's inpatient healthcare unit (IHU) where he was cared for by healthcare staff.

57. Overall, we agree with the clinical reviewer:

    "The care given to the man was equivalent to that he would have expected to have received from normal NHS healthcare."

    However, we are concerned that the level of restraints used for hospital visit was not justified by the risk assessment.

RECOMMENDATIONS

1. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

ACTION PLAN: The Man – HMP Isle of Wight

Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.	**Accepted**	The Head of Security has reviewed escort risk assessment to enhance the medical contribution section to better inform the decision making process in relation to the appropriateness of restraints. Additional information has been provided to Operational Managers to assist them in making decisions with regard to the use of restraints for escorts and bed watches. The recently appointed Head of Security and Intelligence is undertaking a wider review of the management of escorts and bed watches part of this review is to identify good practice with regard to the risk assessment process.	**Completed** **March 2013**	