Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Isle of Wight (Parkhurst), in April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

August 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Isle of Wight (Parkhurst). He died in hospital in April 2009, with his wife at his side. He was 63 years old. He spent the last three months of his life as an inpatient at hospital, having been diagnosed with leukaemia in January 2009. The cause of his death was found to be bronchopneumonia due to common acute lymphoblastic leukaemia.

I offer my sincere sympathy and condolences to the man's wife and family, and to all who have been affected by his loss. In addition, I must apologise to them for the delay to issuing this report.

The investigation was carried out by one of my colleagues. An independent review of the man's medical care in prison was led by a clinical reviewer on behalf of the local Primary Care Trust. As ever, I am most grateful to him for his assistance.

I would also like to thank the Governor and staff of HMP Isle of Wight for their co-operation during the course of the investigation. My particular thanks go to the Head of Safer Custody at the Parkhurst site, for liaising with the investigator.

My report finds that the man received good quality healthcare, equivalent to that he would have expected to have received in the community. However, I make a total of five recommendations on areas including the availability of wheelchairs to prisoners returning from hospital and the use of restraints in hospital on prisoners who have been diagnosed with a terminal illness.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **August 2010**

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SUMMARY

Having absconded from HMP Grendon in 1992, the man returned to custody in November 2004. He was diagnosed with spondylitis (inflammation of the vertebrae) in May 2005, and was seen periodically by specialists and prison doctors on account of this condition over the next three years. He moved permanently to HMP Parkhurst in December 2006.

On 23 November 2008, the man reported a sharp, stabbing pain in his left side. An appointment was made for him to see a prison doctor the following day, but he did not attend. Although local procedures at Parkhurst indicate that the appointment should be rescheduled if a patient fails to attend, it does not appear as though this happened. I recommend that healthcare staff should investigate the reasons behind such events.

After again complaining of pain in his side in mid-December, the man was seen in his cell by a nurse on 21 December. The nurse found a lump on the man's stomach and asked that a prison doctor see him the following day. A prison doctor subsequently saw him on both 22 and 23 December and, as the lump was more noticeable and his pain was becoming more severe, he was admitted to hospital for further investigation.

After various tests the man was provisionally diagnosed with lymphoma (a cancer that begins in the white blood cells of the immune system). However, on 4 January 2009, he discharged himself against medical advice. Although he was taken by wheelchair from his ward to a taxi, one was not offered on his return to the prison to take him back to C wing. The clinical review panel felt that it was clear that he would have required a wheelchair, and I make a recommendation to the Governor on this subject.

The man returned to hospital on 19 January for further tests and, two days later, his diagnosis was confirmed as leukaemia (cancer of the bone marrow and white blood cells). He remained in hospital for the rest of his life. In February, an application for early release on compassionate grounds was submitted by the then Governor to the National Offender Management Service (NOMS). This initial application was refused on 10 March, the main reason being that his life expectancy was, at the time of the application, dependent on how well he responded to treatment.

A revised medical assessment was submitted on 2 April. On this occasion, the man's prognosis did meet the criteria and his early release was approved by the Department of Health's medical advisors and the Parole Board. Sadly, the decision was not made until after his death in April, following a sudden deterioration the previous day. Amongst my five recommendations, I propose to the Governor that he advises NOMS should a patient with an outstanding application for early release on compassionate grounds suffer a significant deterioration.

THE INVESTIGATION PROCESS

1. The investigation was opened on 15 April 2009 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. One prisoner wrote to the investigator as a result.

2. The investigator was given access to the man's prison files, including the medical record. He visited the prison on 22 June and 25 June and interviewed two members of staff. A clinical review panel was arranged by the clinical reviewer on behalf of the local Primary Care Trust. The panel, including the investigator and the clinical reviewer, met on 22 June to discuss the medical care provided by the prison. Following the meeting a clinical review report was written, which I include with this report as Annex 1.

3. One of my family liaison officers telephoned the man's wife on 6 May to inform her of the investigation and give her the opportunity to raise any questions or concerns she had about his death. The family liaison officer and the investigator subsequently met with her on 28 May. She raised the following issues that she wished the investigation to address:

    - Her husband was asking for blood tests for several months before they were eventually carried out and he was diagnosed with leukaemia. She asked why these tests were not done sooner.

    - Her husband kept collapsing in pain and was repeatedly taken to hospital where he was treated for a bad back. She felt that there was a delay to identifying the true cause of her husband's pain, which prevented him getting the treatment he needed at the earliest opportunity.

    - On one occasion when he returned to prison from hospital, her husband had been refused a wheelchair despite being too ill to walk. A female prison officer had allegedly told him, "You are only a prisoner so you can walk." She said that her husband therefore had to crawl back to his cell.

    - Her husband was handcuffed in hospital despite being "very weak and skeletal".

    - Prison officers on escort duty were asked to wear aprons to protect her husband against infection, but did not always do so.

    - Visiting her husband in hospital was both time consuming and costly for her. She queried whether her husband could have been moved somewhere closer to home.

4. The family liaison officer also spoke to one of the man’s sons on 6 May. He told her that he was concerned about the risk of infection to his father because of the constant presence of two prison officers in his hospital room. He also expressed his concerns about the incident in which his father allegedly had to crawl back to his cell because he was refused a wheelchair.

5. I hope that this report helps to clarify any issues that might remain unclear for the man’s wife and children, and helps them to better understand what happened in the time leading to his death.

HMP ISLE OF WIGHT

6. HMP Isle of Wight was inaugurated on 1 April 2009, just eight days before the man died. It is an amalgamation of three prisons in a cluster just outside Newport on the Isle of Wight. The three sites are approximately equal in size, with a total operational capacity of just under 1,700 places. The Camp Hill site is a category C training prison, Albany is a category B training prison for sex offenders, and Parkhurst is a category B training prison. Before he moved to hospital as an inpatient, he lived on the Parkhurst site.

7. The prison governor took up post following the amalgamation of the three sites. Each site has its own manager, who reports to the governor. Health services at Isle of Wight are commissioned by the local Primary Care Trust. Healthcare is clustered between the three sites (as was also the case when the three sites operated as three separate prisons), with inpatient facilities available on the Parkhurst site.

8. The healthcare centre on the Parkhurst site consists of a primary care service and 24 hour inpatient care with 12 beds. There are three nurses on duty from 7.30am to 6.00pm Monday to Friday. During weekends and evenings, there are two healthcare staff on duty. The inpatient unit has three healthcare staff on duty throughout the day and one qualified nurse overnight. Doctors from Medina Healthcare, a local community practice, attend Parkhurst for four three-hour sessions each week. Evenings and weekends are covered by on call doctors from the same community practice. Prisoner-patients with more serious conditions or clinical needs are referred to the local hospital.

9. Parkhurst was last inspected by HM Chief Inspector of Prisons in December 2008. She described Parkhurst as a “failing prison” and expressed particular concern about the prison’s work in the areas of safety, violence and bullying. She thought that health services at the prison were “unacceptably weak”. She also noted that only three members of prison staff had come forward to be trained to push wheelchairs. She recommended that “staff should be prepared to assist prisoners with disabilities to access the regime, including pushing wheelchairs”.

10. In their annual report for 2007/08, Parkhurst’s Independent Monitoring Board (IMB) made the following comments about healthcare:

    “Throughout the year there have been administrative problems and lack of staff who are practised in dealing with the health care demands peculiar to the prison community, in both mental and physical conditions. The few established staff have worked excess hours and are dedicated to deliver a reasonable level of healthcare. However, there have been a number of areas of concern with peripheral medical services that have spasmodic problems in delivery.”

11. My office investigated two deaths in custody at Parkhurst in 2008, one of which was due to natural causes. Since the man died there has been one further death of a prisoner at the Parkhurst site, which was also due to natural causes. My report into the death from natural causes in 2008 included a recommendation that a review be held of the communication of clinical information between prison healthcare and the hospital.

KEY FINDINGS

12. On the day of his arrival at Lewes on 17 November 2004, the man underwent a first reception health screen (a routine health screen for all new arrivals into prison). He told the nurse that he had had bronchitis recently and used an inhaler, but was otherwise described as a "fit and healthy man". He also said that he had broken one of his vertebrae (a bone in the spine) around 20 years previously.

13. After five months in prison, the man complained of pain in his back around the area that he had previously damaged. The prison doctor ordered an x-ray, which took place on 5 May 2005. The x-ray showed he had spondylitis (inflammation of one or more vertebrae). He was advised to undertake a course of remedial work in the gym and was prescribed a course of diclofenac (an anti-inflammatory medication).

14. The man transferred to Parkhurst on 15 November. At a consultation with a prison doctor, on 3 January 2006, he said that diclofenac tended to upset his stomach. He said that surgery had been discussed when he was being treated in Spain prior to his arrest and that he was still keen to pursue this option. The prison doctor made a referral to hospital to consider the matter further.

15. An appointment was made with a spinal specialist at the hospital on 29 March. After examining the man, the consultant suspected a root compression (whereby the disc between vertebrae presses on the nerve root in the spinal column) of one of his vertebrae, and arranged for an MRI scan of his neck. The scan went ahead at hospital on 15 June, and the man attended an outpatient appointment on 11 September to discuss the results. These showed extensive disc degeneration between two of his vertebrae. He reiterated his preference to have surgery, but the consultant said that he would have to discuss it further with colleagues before deciding which option to pursue.

16. The man returned to Lewes on 31 October, in order to be closer to the court where his trial was taking place. He was convicted on 3 November, and returned to Parkhurst a month later for an outpatient appointment at hospital. At the clinic, on 20 December, the consultant discussed the recent scans and the options available. His advice to the man was that, as his pain was mainly in his neck and upper back, there was no surgical procedure available to lessen it. The consultant suggested that he should undertake rehabilitative exercise, and take anti-inflammatory and pain relief medications.

17. On 26 January 2007, nursing staff were called to the man's cell in an emergency after he collapsed with pain in his kidney area. An ambulance was called and he was taken to hospital. He was discharged the following day, having been prescribed a course of diazepam (a sedative commonly known by the brand name Valium). Although there was no discharge note from the hospital in his medical record, following a consultation with him

two days later the prison doctor recorded that the most likely diagnosis was a muscle spasm secondary to his spinal condition. She increased his prescription of codeine (a strong painkiller that he was taking for his back pain) to eight tablets a day rather than four.

18. The man next saw the prison doctor on 19 March. She noted that his breathing was "okay" but that he was using his inhaler on an ad hoc basis. He said his pain control was better since his codeine prescription had been increased. His lower back pain was settled but the pain in his neck was ongoing.

19. Two months later, the man attended hospital for a minor surgical procedure. Three small lesions were removed from his nostril, which were noted to be benign (not cancerous). He was able to return to Parkhurst the same day and was not required to return for follow up.

20. Over the following months, the man's health was reasonably settled and he had little contact with healthcare staff. His medication was reviewed regularly during this period. On 13 March 2008, he attended a review with the prison doctor. He said that his pain relief was working, although his pain was a bit worse because of a computer course he had recently started. (Presumably leaning over the keyboard caused him pain.) He said he had stopped the course and was now feeling a bit better.

21. The man next saw the prison doctor formally on 22 September. He said he had stopped smoking and was using his inhaler less often. He also told her that his back pain was reasonably well controlled and spoke of no other symptoms. A month later, on 22 October, he said he was feeling unwell and was allowed to rest in his cell for the day. His symptoms were not recorded in his prison records.

22. On 23 November, the man went to a clinic run by a nurse. He told her he was experiencing a constant sharp, stabbing pain in his left loin area (the sides between the lower ribs and pelvis and the lower back). He said that the pain had been present for two weeks and that it felt better when he was lying down. The nurse took his blood pressure and heart rate, which were both within normal limits. She recorded that he "does appear to be in a great deal of pain" and made an appointment for him to see a prison doctor the following day.

23. The appointment scheduled for 24 November did not take place, for reasons which are not clear. Two days later, the man's medication was reviewed from his notes by a second prison doctor, as part of the repeat prescription process. He did not make any changes to the man's prescribed medication.

24. The man next saw a member of healthcare staff on 19 December, at a general clinic with a second nurse. He complained of pain in his right side, which he said he had had for four weeks. He told the nurse he thought he had a kidney stone, and asked for an appointment with a

doctor. She asked him to give a urine sample at the clinic, which he refused to do. Instead, he took the pot with him and said he would bring a sample on the day of his appointment with the doctor.

25. Two days later, an officer called the primary care team leader at Parkhurst, to see the man in his cell on C wing. The officer told the investigator that he was a popular man who was often "out and about" on the wing. However, he became more withdrawn around this time and was spending more time in his cell. Although the man did not speak of any specific symptoms, the officer was concerned by his change in behaviour and thought that he should see a nurse.

26. The man told the primary care team leader he had pain in the left side of his abdomen. The team leader examined him and found a lump on the left side of his stomach which was painful to the touch. As it was a Sunday there were no prison doctors on duty. The team leader therefore noted that he would discuss his circumstances with a doctor the next day.

27. The first prison doctor saw the man in his cell the following morning. He told her that the loin pain he reported in November had settled so he did not see anyone about it. However, it had become more severe in the last week or two. He said he was now feeling tired and weak and was experiencing pain, nausea and vomiting. He also said that he was eating and drinking little. She examined the man and noted that he was feverish and had a rapid heart beat. She thought there might have been a lump around his abdomen but noted that it was difficult to tell. She thought that he might have a kidney infection, for which she prescribed a course of antibiotics. She noted that she would see him again the following day.

28. When she examined the man the next day (23 December), she found that there was a more noticeable lump in his left loin area. He was dizzy and struggling to stand up, and had not eaten. He said his pain was more severe. In light of his symptoms and the presence of the lump, she arranged for his admission to hospital for further investigation.

29. The following day, the man had a CT scan (similar to an x-ray) at hospital which showed that the lump near his abdomen was an enlarged spleen. Blood tests taken at the hospital also showed that he was anaemic (meaning he had a low number of red blood cells). The consultant haematologist made a provisional diagnosis of lymphoma (a cancer that begins in the white blood cells of the immune system).

30. The man remained at hospital as an inpatient. He was accompanied by two prison officers and cuffed to one of them by means of an escort chain (a long chain with a handcuff at each end). On 30 December, he had a blood transfusion and, the following day, a bone marrow biopsy.

31. On 4 January 2009, the man discharged himself from hospital against medical advice. He said that the hospital was too noisy and he was unable to sleep. One of the escorting officers told the investigator that he

advised the man not to discharge himself, as the hospital was the best place for him to receive the care he needed. The man, however, was adamant that he wanted to leave hospital and return to his cell. He was taken by wheelchair from his ward to a taxi, and then returned to the prison with the two escorting officers. He and the officers were dropped off in a yard outside the prison reception. This was described by the second escorting officer as a couple of minutes walk from C wing. The man's wife told my family liaison officer that her husband asked the second escorting officer for a wheelchair to go back to the wing, but was refused one. She told the investigator that he did not ask for a wheelchair. They walked slowly to C wing.

32. On his return to C wing, the man saw a nurse. She noted that he appeared anaemic and was short of breath on exertion. She tried to persuade him of the importance of being in hospital. However, he said that he just wanted to sleep as he had been unable to do so for the last three days.

33. The following day, the primary care team leader saw the man in his cell. He also explained to the man the importance of hospital care, but he repeated that he was unable to sleep at hospital. He told the team leader that he had stopped taking his codeine tablets, although it was not recorded when he stopped taking them and why. The team leader asked him to contact staff immediately if his condition worsened.

34. The first prison doctor visited the man in his cell on 8 January. She examined him and found that his abdomen was soft, but not as sore as when she had last seen him. He said he was comfortable when he could stay still, but was unable to stand up for long. He added that he would prefer to stay in the prison until the results of his biopsy were known.

35. A week later, the prison doctor returned to C wing to see him. She noted that he was pale and had lost weight over the course of the week, although he said that he was comfortable and his pain was reasonably well controlled. He also said he had very little energy and had not been leaving his cell. She explained that the prison had been contacted by the consultant haematologist, who had arranged for him to be readmitted to hospital on 19 January for further tests. An escort risk assessment was authorised by the Head of Security at Parkhurst on 16 January. The decision was that he should again be accompanied by two officers and cuffed to one by an escort chain.

36. The man duly returned to hospital on 19 January. He was taken from C wing to reception in a wheelchair, although he told staff that he felt strong enough to make the journey to hospital by prison transport rather than in an ambulance. His mobility was described by a nurse as follows:

> "Not overly short of breath on rest but becomes breathless in a short period of time even after simple exertion like slow walking."

37. A second bone marrow biopsy was taken and the results, which were available on 21 January, showed that the man had leukaemia (cancer of the bone marrow and white blood cells). The consultant haematologist told him of this diagnosis and that, because of his age, the prognosis was not hopeful. He reportedly took the news well.

38. The following day, the man had a course of chemotherapy. He was visited in hospital by his wife and son. At the time, the plan was to wait for his condition to stabilise and then treat him as an outpatient with weekly visits to the chemotherapy suite. On 23 January, his case was discussed at the Cancer Network team meeting. It was recommended that he begin treatment with CHOP chemotherapy (a combination of three types of chemotherapy drug usually taken once every three weeks).

39. On 29 January, the man started CHOP chemotherapy. This was followed by a blood transfusion. The same day, the escort chain was removed following a visit by the Head of Security. He gave the following grounds for removing the restraints:

    "The man is not very mobile at present and is receiving increased chemotherapy. Due to the above and to maintain decency, restraints are no longer required."

40. In early February, the plan to treat the man as an outpatient was reversed. This was because his immune system had become damaged to the extent that he was at too great a risk of infection to leave hospital. He therefore remained at hospital and received chemotherapy as an inpatient. On account of his poor immune system, prison staff were asked not to attend the bedwatch if they might have cold or flu symptoms.

41. An application for early release on compassionate grounds was submitted by the then Governor on 13 February. The form requires assessments of suitability for early release from a doctor, the prison probation officer, and the Governor. The medical assessment was completed by a second consultant haematologist at the hospital. He provided the following assessment of the man's prognosis:

    "It is difficult to be exact, but you need to know that the man has a greater than 50 per cent chance of dying in 2009. His chance of surviving in three years from now is about 10 per cent. In order to achieve this he will need intensive chemotherapy … for two to three months in a row and then for over a year on and off thereafter."

42. The prison's probation officer (their name is omitted from the form) gave the following assessment of the man's risk of re-offending were he to be released:

    "I do not assess him as posing a serious risk of causing serious physical harm to the public were he to be at liberty but it should be borne in mind that for many years he has maintained contact with

those in the drug trade. Given that his illness is terminal and debilitating and he will require intensive palliative care I would suggest that his risk of re-offending is reduced to a level where release on compassionate grounds could be considered."

43. Finally, the then Governor gave the following reasons for supporting the man's early release:

    "Given the man's current life expectancy and ongoing hospital treatment, although this offence was committed whilst unlawfully at large I would support his early release in order to allow him to spend his remaining time within a more supportive and caring environment with his family rather than within custody."

44. The man's condition remained stable over the following week and he continued with his chemotherapy. At 7.30am on 23 February, the second escorting officer started a shift on bedwatch duty, along with another officer. At 8.10am, the man asked the two officers to stop talking as he wanted to sleep. At 8.35am, the second escorting officer made the following entry in the bedwatch log:

    "The man is complaining about me being on this bedwatch with him. He accuses me of making him walk to C wing when he discharged himself from hospital last time [on 4 January]. Very nasty disagreeable man, who is trying to sue the Prison Service."

45. Around 40 minutes later, she telephoned a Senior Officer (SO) at Parkhurst to discuss the situation. The SO advised that she should swap with an officer who was escorting another prisoner on a bedwatch elsewhere in the hospital. Another officer took over from the second escorting officer at around 9.50am. The man did not raise any further complaints about individual officers during his time at hospital.

46. On 27 February, the two officers accompanying the man were told by a doctor that escorting staff should be wearing an apron and gloves when on duty to reduce the risk of infection. However, three days later a nurse told the officers present that there was no need to wear an apron and gloves unless they were going to be in bodily contact with him.

47. The application for early release on compassionate grounds was refused by the Public Protection Casework Section of the National Offender Management Service (NOMS) on 10 March. The reasons for refusal were given as follows:

    "Having carefully examined the papers and obtained evidence from the Parole Board, I am not persuaded by the available evidence that your case meets the criteria for early release. It is noted that you are undergoing treatment for your illness and that both your life expectancy and your level of risk will be predicted on how well you respond to the treatment. Further, I note that you were refused parole in August 2008

and the most recent OASys [a system for assessing the needs and risks of offenders] risk assessment classifies you as high risk of re-conviction and medium risk of harm to the public."

48. On 11 March, the second consultant haematologist emailed the then Governor and the healthcare manager at Parkhurst with an updated prognosis. This was forwarded to the Public Protection Casework Section on 12 March. In his email, the consultant haematologist said that the man's bone marrow showed "no, or very little, response to the first course of chemotherapy". He also said that the man was "likely to die within the next six months".

49. Four days later, a doctor at the hospital told the escorting staff that they must start wearing bibs and masks due to the risk of infection posed. They were told that this must continue until further notice.

50. The second consultant haematologist wrote to the then Governor on 27 March with a more detailed medical report than he had provided by email two weeks previously. He expanded on his email to say that the man was now "resistant to chemotherapy". He went on to say:

    "His prognosis therefore is now even worse than it was when his leukaemia was first diagnosed in January 2009 … The man is now unlikely to be alive in three months. In addition he most likely will remain in hospital for the rest of his rather short life."

51. This revised medical report was forwarded to the Public Protection Casework Section on 2 April. They forwarded the report to specialist medical advisors in the Department of Health on the same day. A response was received in the Public Protection Casework Section on 7 April, with the medical advisors recommending the man's early release. The application was therefore referred to the Parole Board on 8 April for their advice. They also recommended early release but the decision was not made until 14 April, five days after the man's death.

52. The man's condition deteriorated on 8 April and the escorting staff were asked by the Duty Governor to sit outside the room to allow him and his visitors to have some privacy. His condition did not improve and he died at 9.45pm the following evening, with his wife at his side.

53. The cause of death was established by a post mortem as bronchopneumonia due to common acute lymphoblastic leukaemia.

54. The man's funeral was held on 1 May and was attended by the prison's family liaison officer and the Buddhist chaplain. The investigator found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Timeliness of diagnosis

55. The man's wife told my family liaison officer that she thought her husband's leukaemia could have been diagnosed earlier. She said that he had been asking for blood tests for several months and it was only when these were done that he was diagnosed. She also said that he was treated at hospital for back pain and that there was a delay in identifying the true cause of this pain.

56. The clinical review panel met on 22 June 2009, and included the consultant haematologist at the hospital who was responsible for the man's diagnosis. The panel heard that there is "no routine blood test that would have shown that [the man] had leukaemia". In addition, there is no record in his prison notes of him ever requesting a blood test.

57. The consultant haematologist made the following comment about the timeliness of the man's diagnosis:

    > "The earliest indication of symptoms which may have related to leukaemia occurred at the end of November [2008] when [the man] started complaining of pain in his left flank. If he had been treated [at this time] it is unlikely that would have made any difference as his disease proved resistant to chemotherapy."

58. The clinical reviewer, a consultant in public health at the local Primary Care Trust, explained to the clinical review panel that the man's diagnosis was "not straightforward". Two separate bone marrow biopsies were required before a diagnosis of leukaemia was confirmed on 21 January 2009.

59. When the man first complained of pain in his left side, on 23 November 2008, an appointment was made by a nurse for him to see a prison doctor the following day. He did not attend this appointment. It is not entirely clear why he did not attend the appointment, although he later told the prison doctor that he did not see anyone about the pain he experienced in November because it settled down.

60. The primary care team leader told the panel that if a patient did not attend an appointment with a prison doctor the appointment should be automatically rebooked for the next available day. If the patient missed three or four appointments they should be interviewed to find out the reasons behind this. However, he was unable to say whether another appointment had been booked for the man on this occasion.

61. The clinical review panel subsequently made the following recommendation:

Healthcare staff should investigate why a patient does not attend an appointment with a prison doctor and an entry should be made on Vision [the electronic appointments system] highlighting this.

62. Although the panel made the above recommendation the clinical reviewer feels that, overall, the man received "good quality healthcare". He concludes that the care he received was "equivalent to that he would have received in the community".

The man's return from hospital on 4 January 2009

63. The man's wife told my family liaison officer that he was once refused a wheelchair on his return to prison from hospital, despite being too ill to walk. She added that a female prison officer had told him, "You are only a prisoner so you can walk" and he had to crawl back to his cell.

64. On 4 January 2009, the man discharged himself from hospital against medical advice. He said that he was unable to sleep as the hospital was too noisy. Although the diagnosis of leukaemia had yet to be confirmed, he had provisionally been diagnosed with lymphoma and had recently had a blood transfusion and bone marrow biopsy. He was taken from his hospital ward to a taxi by wheelchair, and then returned to Parkhurst with the two escorting officers.

65. The second escorting officer told the investigator that the man did not ask for a wheelchair to go from the prison's reception to his cell on C wing. She added that he was able to walk to C wing, although he was "struggling a bit" and was going "really slowly". The first escorting officer also said that he did not recall the man asking for a wheelchair. He witnessed him walk the first 10 or 15 yards back towards his cell, before leaving to return the escort bag to the security department. He recalled that he was walking upright but slowly.

66. Although he had earlier required a wheelchair to get to his taxi, the second escorting officer did not offer or ask the man if he needed one on his return to Parkhurst. She was uncertain when asked by the investigator if she would know how to obtain a wheelchair if she felt one was needed. She also said that she had not been "trained" to push one. The healthcare manager at HMP Isle of Wight told the clinical review panel that "there is no reason why anyone cannot make a reasonable assumption that a patient needs a wheelchair". The panel concluded that it was "clear that the man would have needed a wheelchair at this point".

The Governor should encourage staff to offer a wheelchair to those prisoners returning from outside hospital who required similar assistance whilst in hospital.

67. HM Chief Inspector of Prisons found during her inspection of Parkhurst in December 2008 that only three staff in the prison had volunteered to be trained to push wheelchairs. She made the following recommendation:

> "Staff should be prepared to assist prisoners with disabilities to access the regime, including pushing wheelchairs."

68. Her report was published in May 2009, shortly after the man's death. This recommendation was accepted and additional staff were trained in July 2009. I encourage the Governor to continue with this programme. In any event, I would expect staff to act with compassion towards prisoners who find it difficult to walk around the prison for medical reasons, whether they have received specific training about how to push a wheelchair or not.

Cuffing in hospital

69. The man's wife told my family liaison officer that her husband was handcuffed in hospital despite being "very weak and skeletal". The decision on whether or not to cuff a prisoner is made by means of an escort risk assessment form, with the final decision being made by someone of governor grade. The risk assessment considers factors such as the prisoner's escape risk and the risk to the public if they did escape. An assessment of the prisoner's physical capacity to escape unaided is also considered.

70. An escort risk assessment was conducted on 16 January 2009, three days before the man returned to hospital. The Head of Security authorised a two officer escort and indicated that the man should be cuffed to one by means of an escort chain. These were the same arrangements that had been in place during his previous inpatient stay in late December 2008.

71. On the day of his admission to hospital (19 January), a nurse described the man as "becoming breathless in a short period of time even after simple exertion like slow walking". Two days after his admission, a diagnosis of leukaemia was confirmed, with a prognosis described by the consultant haematologist as "not hopeful". He began chemotherapy on 22 January, with a second course on 29 January. Following a review of the risk assessment, the escort chain was removed on the evening of 29 January.

72. As I frequently reflect in my reports, the decision on whether to cuff a prisoner at hospital is a difficult one. The balance between decency and security can be hard to find. In this case, it must be remembered that the man had spent over 12 years on the run after absconding from prison in 1992. Nevertheless, he was a very ill man who got out of breath after slow walking and who had been diagnosed with a life threatening illness with a poor prognosis. He started chemotherapy on 22 January 2009, almost immediately after the diagnosis of leukaemia was confirmed. Given his condition, I judge that the presence of the two prison officers would have been an appropriate security arrangement at this time.

A full risk assessment, including an assessment about the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner in outside hospital experiences a significant change in circumstances.

Events of 23 February 2009

73. On 23 February, the second escorting officer was on bedwatch duty accompanying the man in hospital. Having started her shift at 7.30am, she made the entry in his bedwatch record at 8.35am that I have quoted above at paragraph 46 and which I reproduce here:

    "The man is complaining about me being on this bedwatch with him. He accuses me of making him walk to C wing when he discharged himself from hospital last time. Very nasty disagreeable man, who is trying to sue the Prison Service."

74. In the next hour, she telephoned a SO at Parkhurst for his advice. It was agreed that she should swap with an officer who was escorting another prisoner elsewhere in the hospital. Given that the relationship between the man and the officer was clearly strained, this was a sensible decision. It does not appear as though there were any further problems between the man and his escorting officers.

75. Although I found that the majority of the entries in the bedwatch log were appropriate and suitable, I do not consider the escorting officer's reference to a "very nasty disagreeable man" to have been necessary, professional or respectful.

    The Governor should remind staff that entries made in bedwatch logs should be professional, appropriate and respectful.

Risk of infection posed by escorting staff

76. Both the man's wife and son expressed concern that the presence of prison officers in his hospital room contributed to the risk of infection. The man's wife told my family liaison officer that the officers on escort duty were asked to wear aprons to protect him against infection, but did not always do so.

77. The bedwatch records indicate that staff received conflicting advice on whether they should wear protective clothing. On 27 February, the escorting officers were told by a hospital doctor that they should wear an apron and gloves when on duty to reduce the risk of infection. Three days later, however, a nurse told prison staff that there was no need to wear an apron and gloves unless they were going to be in physical contact with the man. On 15 March, escorting staff were told by a doctor that they must wear bibs and a mask until further notice.

78. A deputy charge nurse at the hospital told the clinical review panel that the presence of prison staff in the man's room "would not have contributed to his illness [as] they never really had any contact with him". The consultant haematologist agreed, and told the panel:

> "The infection the patient gets is generally from their own body. Unless you are physically touching the patient, coughing over them, then it is not a significant problem."

Early release on compassionate grounds

79. Chapter 12 of Prison Service Order (PSO) 6000 sets out the following criteria for early release on compassionate grounds:

- the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; <u>and</u>
- the risk of re-offending is past; <u>and</u>
- there are adequate arrangements for the prisoner's care and treatment outside prison; <u>and</u>
- early release will bring some significant benefit to the prisoner or his/her family.

80. Paragraph 12.4.1 of PSO 6000 provides the following guidance to applicants:

> "Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits, but three months may be considered to be an appropriate period. It is therefore essential to try to obtain a clear medical opinion on the likely life expectancy."

81. An application for early release on compassionate grounds was submitted to the Public Protection Casework Section of NOMS on 13 February 2009. A prognosis submitted with this application indicated that the man had a "greater then 50 per cent chance of dying in 2009". The application was refused on 10 March, as his life expectancy and level of risk were, at the time, dependent on how well he responded to chemotherapy. Given that his prognosis at the time did not meet the guidelines in paragraph 12.4.1 of PSO 6000, I do not consider this to have been an unreasonable decision.

82. An updated medical report was submitted to the Public Protection Casework Section on 12 March. This report advised that the man had shown "no, or very little, response to the first course of chemotherapy" and that he was "likely to die within the next six months". Again, this prognosis could not strictly be said to meet the guidelines set out in PSO 6000.

83. A final medical report was submitted on 2 April, with a revised prognosis indicating that the man was "unlikely to be alive in three months". Specialist medical advisors in the Department of Health recommended his early release to the Public Protection Casework Section on 7 April. The application was then forwarded to the Parole Board, who also recommended early release. However, their recommendation was made on 14 April, five days after he died. The caseworker responsible for the man's application in the Public Protection Casework Section told the investigator that the final stage in the process would then have been to put a submission to the Minister asking her to formally grant his release. The caseworker added that they did not hear of his death until they were preparing this submission.

84. Paragraph 12.8.1 of PSO 6000 gives the following advice on the timescales involved in determining an application for early release on compassionate grounds (the italics signify that the action is a mandatory requirement):

> "A decision will usually be made within two weeks, but more quickly if the circumstances require it. *If there is a medical application involving a very short life expectancy, the [Public Protection Casework Section] must be alerted by telephone at an early stage.*"

85. As the final medical report was submitted on 2 April, the Public Protection Casework Section was on target to achieve a decision within the two week timescale outlined in PSO 6000. However, the man's health deteriorated significantly on 8 April and he sadly died before his release could be approved. The caseworker told the investigator:

> "Had the updated medical report said that [the man] had only a matter of days left to live then it may have been possible to grant his release by the 9th because in the most urgent cases we will go straight to the Minister rather than the Parole Board on the assumption that the prisoner is so gravely ill that he no longer poses a risk to the public."

86. There was sadly little time between the deterioration in the man's health on 8 April and his death the following evening. However, his deterioration could have been communicated to the Public Protection Casework Section. In a future situation, emergency compassionate release before the prisoner's death may give them a final few days of private time with their loved ones.

    The Governor should ensure that staff alert the Public Protection Casework Section when a prisoner with an outstanding application for early release on compassionate grounds suffers a significant deterioration.

87. The man's wife told my family liaison officer that it was time consuming and costly for her to visit her husband in hospital. She queried whether her husband could have been moved somewhere closer to home.

88. The clinical review panel heard that a move to the town on the south coast where the man's wife lived would not have been beneficial for clinical purposes. The consultant haematologist told the panel that the region's acute leukaemia chemotherapy unit is in Southampton and patients with acute leukaemia would normally be treated in this unit. However, in the man's case it was felt that his treatment could be provided on the Isle of Wight.

FAMILY RESPONSE TO THE DRAFT REPORT

89. I received a number of comments from the man's wife, via her solicitor, on the draft report, which I have discussed below. I hope that my response helps to clarify any outstanding issues that she might have.

Healthcare at Parkhurst in autumn 2008

90. The man's wife queried the entry made in his medical record on 22 October 2008, which said "telephone encounter from wing to say inmate is unwell and will RIC [rest in cell] for 24 hours". She asked who the member of staff was who telephoned from the wing and whether any follow up measures should have been employed by healthcare staff.

91. It is not clear from prison records which member of staff made the above telephone call on 22 October. The investigator asked the clinical reviewer for his view on these events. He replied as follows:

    "Healthcare are routinely told when an inmate feels unwell and rests in their cell for 24 hours. Healthcare sees prisoners if wing staff are concerned or prisoners have specific symptoms, but not otherwise. The equivalent in the community would be an individual who did not feel well enough to go to work but not unwell enough to see their GP that day or go to A&E."

92. The man did not rest in his cell on any additional days and did not request a medical appointment for several weeks. Given the clinical reviewer's comments, I am satisfied that staff acted reasonably in these circumstances.

93. In addition, the man's wife expressed concern about the events of 23-24 November 2008, when he did not attend a scheduled appointment. As I have discussed in paragraphs 61-63, it is not clear why he did not attend this appointment, although he did indicate that his symptoms improved around this time. I recommended that healthcare staff should investigate if a patient does not attend an appointment and make a record on the electronic system. This recommendation was accepted.

94. The man's wife went on to ask whether different action during the events described in the above paragraphs would have had an impact on the timeliness of her husband's diagnosis or on his life expectancy.

95. As I have noted in paragraph 59, the consultant haematologist in charge of the man's care at hospital, told the clinical review panel that "the earliest indication of symptoms which may have related to leukaemia occurred at the end of November 2008". He went on to say that, had the man been treated at this time, "it is unlikely to have made any difference as his disease proved resistant to chemotherapy".

96. The clinical reviewer also addressed the timeliness of the diagnosis at the clinical review panel. He reiterated that the diagnosis was "not straightforward" and, had the diagnosis been made a month earlier, it was "unlikely to have made any difference".

Conduct of staff on bedwatch duty

97. The man's wife expressed concern that some staff conducted themselves inappropriately whilst on bedwatch duty at hospital. She said that some staff would interrupt her conversations with her husband or would have to be asked to give up a seat next to him for her. She also said that some staff ate meals in the room, contrary to advice given by nursing staff on 25 February. (An entry in the bedwatch log indicates that officers were told it "would be better" to eat meals in the hospital canteen.) She also reiterated her concerns that staff did not follow the instructions they were given with regard to wearing protective clothing.

98. Whilst escorting staff might have been told it "would be better" to eat meals in the hospital canteen, this is not particularly practical. Staff are present in hospital to escort a prisoner and it would be inappropriate for one or both to leave the prisoner in order to eat in another part of the hospital. However, they cannot be expected to undertake a long shift without eating something.

99. In paragraph 80 I have quoted staff at the hospital who thought that the presence of prison officers would not have contributed to the risk of infection. However, as I have also indicated in paragraph 79, it is clear that prison staff received conflicting advice regarding the use of protective clothing.

100. In considering the above, it appears that there was some uncertainty about what could and what could not be expected of escorting staff at hospital. The Governor might wish to establish a protocol with the hospital to clarify such issues in future.

Release on temporary licence

101. The man's wife asked whether it was necessary for escorting staff to be present in the hospital room when she visited, particularly when her husband's condition deteriorated. As I have noted in paragraph 54, the escorting officers were asked to sit outside his room on 8 April, when his condition worsened. At the time, an application for early release on compassionate grounds had been submitted and was being considered. On 27 March, a prognosis suggesting that he was "unlikely to be alive in three months" had been provided by the second consultant haematologist to support this application. Whilst this application was outstanding, it would not have been unreasonable to consider releasing him on temporary licence. The Governor might wish to consider such a release in similar future circumstances.

CONCLUSION

102. After reporting pain in his sides in late 2008, the man was diagnosed with leukaemia in January 2009. He remained in hospital following his diagnosis and died in April 2009. The clinical review panel has found that he received good quality healthcare, equivalent to that which he would expect to receive in the community.

103. Although I judge that the man received a good standard of healthcare whilst in prison, there were some areas in which more could have been done. On his return from hospital on 4 January 2009, both the clinical review panel and I think it would have been apparent that he needed a wheelchair to get to his cell on C wing. Although there is a conflict in the evidence as to whether he asked for a wheelchair, it is apparent that he was not offered one. Amongst my five recommendations, I ask the Governor to encourage staff to offer wheelchairs to patients who have needed them in hospital. The Prison Service's 'decency agenda' and common compassion towards prisoners surely require no less, whether staff have received specific training about how to push a wheelchair or not.

RECOMMENDATIONS

1. Healthcare staff should investigate why a patient does not attend an appointment with a prison doctor and an entry should be made on Vision [the electronic appointments system] highlighting this.

   Accepted – staff guidelines have been produced with the appropriate actions needed to take place. Guideline is kept in all clinical areas and all staff will be aware of the process and recording. This is now part of the new staff induction pack.

2. The Governor should encourage staff to offer a wheelchair to those prisoners returning from outside hospital who required similar assistance whilst in hospital.

   Accepted – this issue should be raised by the Governor at the POA management meeting. A notice to staff should be issued making it clear to all staff that pushing wheelchairs is a decency issue and therefore a legitimate expectation to assist prisoners who they have a duty of care to. Staff are to be allocated training via the training department.

3. The Governor should remind staff that entries made in bedwatch logs should be professional, appropriate and respectful.

   Accepted – managers conducting bedwatch checks to challenge and inform staff that are not making appropriate entries in occurrence logs.

4. A full risk assessment, including an assessment about the use of restraints, should be prepared by staff and considered by the Duty Governor when a prisoner in outside hospital experiences a significant change in circumstances.

   Accepted – duty governors must ensure that risk assessments are reviewed to take into account the prisoner's medical condition.

5. The Governor should ensure that staff alert the Public Protection Casework Section when a prisoner with an outstanding application for early release on compassionate grounds suffers a significant deterioration.

   Accepted – the Director of Offender Management (of the Isle of Wight) will produce a procedural document that will be published to all operational managers.