PRISONS AND PROBATION OMBUDSMAN
for England and Wales

Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Isle of Wight in March 2013

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 investigation report into the death of a man, a prisoner at HMP Isle of Wight who died in March 2013 at hospital from lung cancer. He was 70 years old. I offer my condolences to his family and friends.

A review was carried out of the clinical care the man received at HMP Isle of Wight. Staff at HMP Isle of Wight cooperated fully with the investigation.

The man arrived at HMP Isle of Wight in July 2006, and had a history of high blood pressure. He was a heavy smoker and over the next few years was treated for a number of different illnesses. In November 2012, he suffered a gastrointestinal haemorrhage and was taken to hospital as an emergency. While there, he had a chest scan and a shadow was found on his lungs. Further investigations confirmed he had lung cancer which had spread to his chest and liver, and was inoperable. He wished to remain on his wing rather than be admitted into the prison inpatient health unit or hospital. He initially declined chemotherapy. On 1 March, he was taken to hospital as his condition had deteriorated significantly and died not long after midnight.

Although the man was initially reluctant to accept his diagnosis, the clinical reviewer indicates, and I agree, that it would have been better to have had an agreed end of life care plan, which might also have included arrangements to keep his family informed of his condition. However, I am satisfied that overall he received a standard of care at the prison which was equivalent to that he would have expected to receive in the community.

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 **December 2013**

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SUMMARY

1. On 18 July 2006, the man transferred from HMP Birmingham to HMP Isle of Wight. At his reception health screen he said he was a smoker and had high blood pressure, for which he took prescribed medication.

2. Over the next six years the man was treated for a range of illnesses, including shingles, a prostate issue, transient ischaemic attacks (TIAs or strokes), high blood pressure, chronic obstructive pulmonary disease, (COPD) kidney problems and peripheral vascular disease (circulatory problems).

3. The man's COPD deteriorated on 4 November 2012, but he did not want to be admitted to the prison's healthcare inpatient unit. He told a doctor on 6 November that he had black diarrhoea and had been vomiting dark matter and blood. The doctor diagnosed a gastrointestinal haemorrhage (bleeding within the stomach or gut) and he was admitted immediately to hospital where he had a blood transfusion and an urgent gastroscopy which found ulceration in his stomach and duodenum. He was discharged on 16 November.

4. The man returned to hospital on 29 November for a scan which identified a large shadow on his lung. Doctors told him that the provisional diagnosis was lung cancer. The next day, he told a prison nurse he thought his diagnosis was a mistake as he did not feel ill. The nurse encouraged him to attend a cancer support group held in the prison.

5. A lung biopsy taken on 3 January 2013 confirmed that the cancer had spread to the man's chest and liver. He declined to have chemotherapy. On 15 January, he did not attend his prison GP appointment, or a subsequent oncology appointment.

6. On 28 February, wing staff reported that the man seemed vague and was slurring his speech, but he said he felt well enough to attend a planned hospital appointment. A cancer nurse specialist at the hospital tried to persuade him that he needed to be in hospital as he was so unwell, but he refused to be admitted and returned to the prison.

7. The next day, a nurse saw the man and noted his speech was slurred, his legs were beginning to leak fluid and his pulse was irregular. He was taken to hospital by emergency ambulance where his condition continued to deteriorate and he suffered a cardiac arrest. All attempts at resuscitation failed and he was pronounced dead at 12:20am.

8. We make two recommendations about end of life care planning and contact with families.

THE INVESTIGATION PROCESS

9. This office was notified of the man's death on 2 March 2013. Notices were issued informing staff and prisoners at HMP Isle of Wight about the investigation and asking anyone with relevant information to contact the investigator. No one responded.

10. The investigator visited the prison on 11 March and collected relevant prison documents about the man. He spoke to the duty governor and the operational manager responsible for safer custody.

11. The local Primary Care Trust appointed a clinical reviewer to review the man's care at the prison.

12. The investigator and clinical reviewer interviewed a doctor, a clinical manager, a nurse and two prison officers at the prison on 13 June.

13. The investigator informed HM Coroner for the Isle of Wight of the investigation, who provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

14. One of the Ombudsman's family liaison officers contacted the man's sister and sons to explain the purpose of the investigation. They had no specific issues for the investigation to consider.

HMP ISLE OF WIGHT

15. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man was at the Albany site, which holds up to 567 men mostly convicted of sex offences.

16. Health services at HMP Isle of Wight are commissioned and provided by the local Primary Care Trust (PCT). An inpatient healthcare unit (IHU) at the Albany site caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons (HMIP)

17. HMIP conducted an announced full follow-up inspection of HMP Isle of Wight in May 2012. They found that health services had improved considerably from their previous inspection, although there were some delays in accessing primary care services for prisoners at Albany. Inspectors also found that there were good care arrangements for men with palliative care needs.

18. The inspection found that prisoners with chronic (long term) diseases were reviewed regularly and there were suitable nurse-led clinics for prisoners with respiratory diseases.

Independent Monitoring Board (IMB)

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure proper standards of care and decency. The IMB annual report for 2012 noted that a range of treatments and care programmes were delivered to a very high standard. The IMB also noted that the relationship between prison healthcare services and prison service staff was good, and that healthcare staff were engaged in all aspects of the prison community and had a very high profile.

Previous deaths at Albany

20. There were 13 deaths from natural causes at the Albany site between 2011 and the man's death. We have previously made recommendations about appointing a member of staff to liaise with families when a prisoner is terminally ill.

KEY EVENTS

21. The man was convicted of serious sexual offences in 2005 and was sentenced to 12 years and 3 months imprisonment. He went to HMP Birmingham, where he was reported to be in good health. He had no drug or alcohol problems, but said he did not want to give up smoking. In April 2006, he was found to have high blood pressure (hypertension).

22. The man transferred to what was then HMP Albany, Isle of Wight on 18 July 2006. A nurse and a doctor saw him when he arrived. He was prescribed medication and referred to the hypertension clinic. At Albany his medication was frequently adjusted to improve and control his blood pressure. During his time at Albany he was also treated for an enlarged prostate, peripheral vascular disease (blocked veins, often caused by smoking), shingles, transient ischaemic attacks (mini-strokes) and poor kidney function.

23. On 23 June 2011, the man had a spirometry test, which confirmed that he had chronic obstructive pulmonary disease (COPD, a disease of the lungs). He was treated with inhalers (salbutamol and ipratropium) and attended nurse-led COPD clinics. He was advised several times to stop smoking, to help his lung and vascular problems.

24. The man's COPD deteriorated on 4 November 2012. He told staff that he had not been using his inhalers correctly. He was given a nebuliser of salbutamol and a course of oral steroids, but he declined to be admitted to the prison's healthcare inpatient unit. His treatment was reviewed on 12 November when his breathing was found to be improving.

25. A prison GP saw the man two days later, on 6 November, when he told the doctor that he had been suffering from black diarrhoea and had vomited dark matter and blood for the previous four days. He was breathing and eating better but felt light-headed. The doctor thought he had a gastrointestinal haemorrhage (bleeding in the stomach or gut) and sent him to the medical assessment unit at hospital.

26. At hospital the man received a blood transfusion. An urgent gastroscopy was performed, which found that he had some ulceration in his stomach and duodenum and a bacterial infection, which was the likely cause of the ulcers. He was treated with antibiotics and acid suppressant drugs. He was discharged from hospital on 16 November. Another gastroscopy six weeks later confirmed that the ulcers had healed.

27. On 29 November, the man had a computerised tomography (CT) scan of his chest and abdomen which found a large shadow on his lung. On 12 December, the GP told him what the scan had found and provisionally diagnosed lung cancer. He made an urgent respiratory clinic appointment. Despite the diagnosis, he said he felt well. The hospital cancer nurse specialist discussed the provisional diagnosis with the healthcare clinical team manager at the prison. The next day, he told one of the prison nurses that he thought the diagnosis was a mistake as he did not feel ill. She suggested he

attend a cancer support group held in the prison's healthcare centre each Wednesday. He said he would attend it if he felt the need.

28. A lung biopsy taken on 3 January 2013, confirmed lung cancer. The cancer had spread to lymph nodes in his chest and to his liver. The man was offered chemotherapy which he declined and suggested that he might wait until he was released from prison the next year. The respiratory consultant referred him to a consultant oncologist on 11 January.

29. On 15 January, the man did not attend an appointment with the doctor, who intended to discuss his diagnosis and care planning with him, including the possibility of a do not resuscitate (DNR) order in case of cardiac or respiratory arrest. He also did not attend an appointment with the hospital cancer nurse specialist that day and again said he did not want chemotherapy. His personal officer noted that he had refused to go to hospital and was worried that beginning medical treatment might stop him getting a transfer to be closer to his family.

30. The doctor saw the man on 12 February, who said he had a terrible pain in his back. He was given a buprenorphine patch for pain relief to be applied once every four days. On 15 February, an appointment was arranged for him to see the cancer nurse specialist on 28 February.

31. On 21 February, the man told a nurse that his legs had been swollen for the previous week. The doctor diagnosed ankle oedema (swelling) and prescribed furosemide (a diuretic).

32. A nurse reviewed the man in his cell on 28 February, after wing staff reported that he seemed vague and was slurring his speech. He said he felt well enough to attend his appointment with the cancer nurse specialist. At hospital, the nurse increased his dexamethasone and furosemide. She considered he should be admitted to hospital but he declined. She asked healthcare staff at the prison to discuss a 'do not resuscitate' (DNR) order with him and also said that he would benefit from some oxygen.

33. The next morning, 1 March, a doctor saw the man and sought his views about resuscitation. He said he was aware of his poor prognosis but would prefer resuscitation to be attempted if he had a cardiac arrest. He said that he had now decided he wanted to have chemotherapy treatment as he had been in prison for seven years and was due for release in 12 months. The doctor said he would write to the Governor about the possibility of compassionate release. The doctor wrote a letter that afternoon. As he died so soon afterwards, there was no time to process this before his death.

34. Later that afternoon, a nurse examined the man in his cell because he appeared so unwell. She found his blood oxygen was very low, his speech was very slurred, his legs were beginning to leak fluid and his pulse was irregular. An emergency ambulance was called which left the prison at 4.52pm. Restraints were not used.

35. At hospital, the man was admitted to the medical assessment unit after a few hours of tests. Shortly after midnight, he suffered a cardiac arrest. Attempts to resuscitate him were unsuccessful and a hospital doctor confirmed his death at 12.20am.

36. The next morning the prison family liaison officer at HMP Featherstone informed the man's sister of his death. An officer from HMP Isle of Wight visited the man's sister later that afternoon and then liaised with his relatives, including offering financial assistance towards the funeral. Prisoners and staff at the Albany site of the prison were informed of his death

37. A post-mortem examination on 7 March indicated that the cause of death was disseminated non-small-cell carcinoma of the right lung. The funeral was held in Wolverhampton on 4 April.

ISSUES

Clinical care

38. The clinical reviewer found that the overall level of care given to the man while he was in prison was equivalent to that he would have received in the community. The diagnosis of cancer was an incidental finding during investigations into another serious illness, and he had not presented with symptoms which suggested that he had lung cancer.

39. We are satisfied that the man was appropriately informed of his diagnosis, and was given effective support from a specialist nurse. He was also invited to join a prisoner support group. He was given appropriate pain relief, in the form of a patch which meant that he did not need to collect medication every day. Although it might have been possible to slow the progression of his cancer through the use of chemotherapy, he initially rejected this option.

40. There was no end of life care plan for the man. The clinical reviewer considers that the inpatient healthcare unit has suitable facilities to offer 24 hour end of life care, but opportunities to discuss his long-term and end of life care were not taken. We accept that the opportunity for these discussions was limited. Initially, it appears that he was in denial about his diagnosis which might have made it difficult to have involved him at an early stage. However, end of life planning should have begun and involved him as appropriate. We make the following recommendation:

    The Head of Healthcare should ensure that a multidisciplinary team implements an end of life care plan for prisoners diagnosed with a terminal illness.

41. The clinical reviewer has also considered several other aspects of the man's care while he was at Albany. In general, she considers that he was treated in an appropriate and timely manner. He was advised to stop smoking on several occasions, but declined to do so. His medication for high blood pressure was adjusted frequently, and his renal function regularly monitored. His other medical problems, including enlarged prostate, COPD and shingles, were also treated appropriately.

42. The clinical reviewer has identified a number of further areas for improvement including the use of ACE inhibitors (which help control high blood pressure) and non-steroidal anti-inflammatory medication and antacids (to counter indigestion). As these matters do not relate directly to the circumstances of the man's death, we do not include them in this report but refer the Head of Healthcare to the clinical review.

Family liaison

43. The man was diagnosed with cancer in December 2012. Although it is not clear from his medical records that he was told how long he might expect to live, it was apparent that the cancer had spread from his lungs and his prognosis was poor. He was offered chemotherapy but declined.

44. Prison Rule 22(1) states:

> 'Notification of illness or death
>
> '22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

45. The man did not receive any visits while he was at the prison but he kept in touch with one of his sons, his sister and his daughter by telephone. It is not clear what he told them about his diagnosis. However, it is apparent that that the prison did not appoint a member of staff to discuss his diagnosis and care with his family. Prison Service Instruction 64/2011 requires prisons to 'ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill'. Even if a member of staff had not been nominated we would have expected the prison to have contacted his family, in line with Prison Rule 22, when he was taken to hospital as an emergency on 28 February. In a report into the death of a prisoner at Albany which we issued in March 2013, we encountered a similar issue and made a recommendation, which we repeat below. He died before the prison received that report. In their response to the recommendation, Albany said that:

> "The Health Care Manager will inform the Safer Custody Team / FLO Coordinator of any seriously ill prisoner that will require an FLO to be allocated in order to keep family fully informed. Current checks confirm that contact with families is taking place and is common practice unless alternative arrangements have been agreed with the Next of Kin."

As this did not happen in this case we repeat the recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that there are appropriate and effective arrangements to enable families to obtain information about them.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a multidisciplinary team implements an end of life care plan for prisoners diagnosed with a terminal illness.

2. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that there are appropriate and effective arrangements to enable families to obtain information about them.

ACTION PLAN: The Man – HMP Isle of Wight

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that a multidisciplinary team implements an end of life care plan for prisoners diagnosed with a terminal illness.	Accepted	In line with the recommendations of the review of the Liverpool Care Pathway (LCP) led by Baroness Neuberger (published in July 2013 entitled "More Care – Less Pathway"), consideration is being given to the best way to respond in a prison setting to the development of a new system of end-of-life care tailored to the needs of individual patients which places a much greater emphasis on involving families. This can pose particular issues within a prison context and these aspects will be considered very carefully within the local Clinical Quality Governance Group as part of how best to respond to the overall recommendations of the report. In the meantime, the establishment will ensure that appropriate plans are in place within the parameters of both longer term palliative care (which focuses on the relief of pain and other symptoms and problems experienced in serious illness) and end of life care (which relates to the care of a patient where death is imminent or within a few days and aimed at ensuring a pain free, dignified and peaceful death).	Completed and Ongoing	
2	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are	Accepted	The Health Care Manager will inform the Safer Custody Team/ Family Liaison Officer (FLO) Coordinator of any seriously ill prisoners who will require an FLO to be allocated in order to keep their	Completed	

	informed as soon as possible and that there are appropriate and effective arrangements to enable families to obtain information about them.		family fully informed. Current checks confirm that contact with families is taking place and is common practice unless alternative arrangements have been agreed with the Next of Kin. This is monitored at morning meetings and through the establishment Safer Custody meetings.		