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 September 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, who died of liver cancer on 3 September 2013 at HMP Isle of Wight. He was 78 years old. I offer my condolences to those who knew him.

The man was diagnosed with cancer in May 2013. He was referred appropriately when he reported his symptoms and there was no delay in his treatment. Although there was some difficulty obtaining recommended pressure relieving equipment, overall the man received very good end of life care.

Once again I have found that restraints were used unnecessarily on an older, terminally ill prisoner at HMP Isle of Wight. This is an issue I have raised a number of times previously at the prison and, despite recommendations being accepted, the practice continues. The Governor needs to ensure that elderly, dying men are treated with appropriate dignity and compassion at the end of their lives.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2014**

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SUMMARY

1. The man was remanded to HMP Lewes in October 2007. In November he was convicted of sexual offences and he transferred to HMP Albany on 28 December 2007. The man suffered with some longstanding medical conditions

2. In April 2013, the man reported shortness of breath when walking and he was referred for a chest X-ray. This showed nothing abnormal. The next week, he again complained of worsening symptoms and a prison GP examined him and referred him for an ultrasound scan of his liver.

3. On 23 May, the ultrasound showed a mass most likely of cancer cells, a diagnosis which was confirmed by a further scan on 12 June. The man was diagnosed appropriately. He received good support from prison staff at this time and in the following weeks.

4. Specialists determined that the man was too frail to allow any treatment other than palliative care and appropriate referrals were quickly made to community specialists. The man's pain was well controlled and he received a high standard of end of life care, although healthcare staff were unable to obtain the recommended pressure relieving equipment.

5. The Governor did not support the man's application for early release on compassionate grounds and there was a delay submitting the application.

6. The man died on 3 September. We are satisfied that he received a good standard of clinical care at HMP Isle of Wight. However, as we have found in previous investigations at the prison, restraints were used for hospital appointments without proper justification. We repeat a recommendation we have made several times previously.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Isle of Wight of the investigation and asking anyone who had relevant information to contact him. No one responded.

8. The investigator obtained copies of the man's relevant prison and prison medical records. He visited HMP Isle of Wight on 30 October and interviewed two members of staff and one prisoner who knew the man. The investigator provided feedback on the preliminary findings of the investigation and followed this up in writing to the Governor.

9. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.

10. HM Coroner for the Isle of Wight was informed of the investigation and provided the post-mortem report. The Coroner has been sent this report.

11. One of the Ombudsman's family liaison officers wrote to the man's nominated next of kin, a friend, to explain the investigation. The man's friend did not have any issues for the investigation to address. She was later informed the draft report was available, but did not wish to receive a copy or make any comment.

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

HMP ISLE OF WIGHT

13. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man lived on the Albany site.

14. Since 1 June 2013, Care UK has provided healthcare at the prison. There is an inpatient healthcare unit with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Isle of Wight was in May 2012. The Inspectorate 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.

Independent Monitoring Board

16. Each prison has an independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report, for 2011/12, the IMB commented that the inpatient healthcare unit provided a very high standard of care. The IMB highlighted the quality of end of life care staff provided.

Previous deaths at HMP Isle of Wight

17. The man was the 13th prisoner on the Albany site to die of apparent natural causes since January 2012. Several of these men were diagnosed with cancer and, on the whole, we found that they received care equivalent to that which they could have expected in the community. However, in a number of previous reports we have raised the issue of the inappropriate use of restraints on older, terminally ill prisoners and do so again.

ISSUES

The diagnosis of the man's terminal illness

18. The man was remanded into custody in October 2007, for sexual offences committed between 1975 and 1982. He was sentenced to 16 years imprisonment the following month. He transferred to HMP Albany (as it was then known) on 28 December 2007. At that time his medical history included asthma, angina and high blood pressure.

19. On 4 April 2013, the man told a prison doctor that he had felt short of breath when walking. He had experienced this for about four months. The doctor made a referral for a chest X-ray, which took place on 23 April. The X-ray found nothing abnormal.

20. A week later, on 30 April another prison doctor reviewed the man when he said his shortness of breath had worsened and he complained of tightness around his abdomen and chest, a reduced appetite and weight loss. The doctor examined the man and noted his liver felt like it was protruding. She made a referral for an ultrasound scan of his liver.

21. The ultrasound on 23 May showed a mass in the right side of the man's liver which was judged most likely to be a cancerous tumour. The results were received on 28 May and the doctor made an urgent two week referral for cases of suspected cancer. The hospital had already arranged a further scan which took place on 12 June. The results confirmed liver cancer.

22. The clinical reviewer noted that the man's weight fell from 88.9kg shortly after his arrival at HMP Isle of Wight to 74.7kg in July 2012 and 60.05kg on 10 July 2013, a total loss of 28kg (almost four and a half stones). There is no record that the man reported weight loss at any time before diagnosis, and frequent checks of his weight were not made. The clinical reviewer concludes that weight loss as an isolated symptom would lead to earlier detection of a cancer in only a very small percentage of cases.

23. The clinical reviewer considers that appropriate investigations were requested when the man first presented with symptoms in April 2013, and that this was not sufficiently significant to trigger an urgent referral. We agree that a two week urgent referral was appropriately arranged when the results of the man's ultrasound scan were received.

Informing the man about his condition and treatment

24. The results of the man's ultrasound were received at the prison on 28 May. The doctor saw him on 30 May at the first available appointment and told him of the likely diagnosis which he noted the man took well.

25. The results of the follow-up scan on 12 June were received at HMP Isle of Wight on 19 June and the doctor told the man the results the same day.

26. On 4 July, a specialist nurse visited the man to discuss his treatment options before a clinic with the consultant. He was invited to the prison's support group for terminally ill prisoners, but chose not to attend.

27. We are satisfied that the man was appropriately informed of his diagnosis and treatment options.

The man's medical appointments and treatment

28. When his diagnosis was confirmed, the man's case was referred by the consultant at St Mary's Hospital, Isle of Wight, to liver specialists in Southampton for advice. A multi-disciplinary team (MDT) meeting was arranged in Southampton on 26 June, but due to an apparent computer failure, the man's results were not discussed. The MDT reconvened on 3 July, and determined that the cancerous tumour could potentially be removed by surgery but this would depend on how fit the man was. As noted, the specialist nurse visited the man in prison the next day to explain this to him

29. On 10 July, the man had an outpatient appointment at St Mary's Hospital to discuss possible treatment. The consultant explained to the man that, given his age and frailty, surgery was a very dangerous option. The man decided he did not want to have surgery. The consultant told the man that palliative care was therefore the most appropriate treatment and wrote to the prison to ask that they make a referral to local services.

30. We are satisfied that the man received appropriate treatment after his diagnosis, his wishes were respected and he attended all appointments. He was able to discuss his treatment options and there was good communication between the hospitals and prison healthcare staff. The clinical reviewer concluded that the man received a high level of clinical care.

Palliative care plans

31. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place. 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 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.

32. When it was agreed that surgical removal of the man's tumour was not viable, a referral was made to local palliative care services in line with the consultant's advice. On 1 August, a Macmillan nurse and a nurse from the local Earl Mountbatten Hospice assessed the man and advised on nursing care, pain relief and diet. The doctor contacted the hospice team later in the month when he required advice on symptom control and medication.

33. On 2 August, the man agreed to move from his wing into a high dependency room in the prison's inpatient healthcare unit. He had lost a lot of weight but was still able to walk independently using a walking stick and could get in and out of bed without assistance. On the day of his move, nursing care plans were created to assist healthcare staff monitor and support him in areas such as pain control, personal care, and food and fluid intake.

34. On 7 August, with the agreement of the man, the doctor completed a 'do not attempt cardiopulmonary resuscitation' order (DNAR), as he believed that resuscitation in the event of a cardiac or respiratory arrest was unlikely to be successful because of the man's advanced and untreatable cancer.

35. The man's health deteriorated over the remainder of the month. Ensuring he had enough food and fluid was difficult and he was given nutritional supplements. The man began to have difficulty swallowing and, on 24 August, intravenous fluids were initiated as he was becoming dehydrated. Prison healthcare staff attempted unsuccessfully to obtain pressure relieving equipment from the community which the Macmillan nurse had recommended. St Mary's Hospital did not have any available to loan and the community nursing service said that as the prison healthcare service was provided privately, they were unable access their supply. The clinical reviewer comments that the lack of this equipment was likely to have contributed to greater discomfort for the man and a greater challenge for prison nurses. There appears to be a need for appropriate agreements with local services. We make the following recommendation:

The Head of Healthcare should ensure that necessary equipment is available when required for terminally ill prisoners.

36. On 31 August, the man was admitted to St Mary's Hospital as he was very short of breath and had low oxygen saturation levels. Hospital doctors and the nursing team at the prison then agreed that the best place to care for the man at the time was the high dependency room at the prison. The man then returned to the prison a few hours after admission. That afternoon a prison nurse telephoned the hospice for advice on the use of an end of life pathway. They recommended that prison healthcare staff should work to control the man's symptoms and develop care plans if necessary.

37. Over the following days, healthcare staff regularly monitored the man's symptoms and nursed him appropriately. At around 11.30pm on 2 September, the night nurse checked the man and saw no signs of life. She telephoned the on-call doctor, who visited the prison and confirmed death at 12.30am on 3 September. A post-mortem report later confirmed the cause of death as hepatocellular carcinoma (liver cancer).

38. The clinical reviewer concludes that prison healthcare staff, with the support of external specialists, provided a consistently high standard of end of life care, including the use of a comprehensive care plan in the final month of the man's life. We agree with his conclusion that the man received a very high standard of clinical and personal care.

The man's pain relief and medication

39. On 30 May, the man told the doctor that he had some abdominal discomfort and muscle pain. The doctor prescribed a buprenorphine patch (an opiod painkiller which provides continuous relief over a period of several days). In June, the strength of the patch was increased twice. Later in the month the man was prescribed dexamethasone, a steroid used to reduce sickness and boost appetite in cancer patients.

40. Throughout July, the man said that his pain was manageable and the strength of the patch remained the same. On 18 July, the doctor asked that the patch be changed every six days rather than seven as the man said it was not so effective towards the end of the week.

41. A Macmillan nurse visited the man on 1 August and suggested changing to a fentanyl patch for more effective pain relief. The Macmillan nurse also advised that oramorph (a morphine-based painkiller used to treat severe pain) be provided for the man to use if he experienced a sudden increase in pain. The doctor wrote prescriptions for these medications the same day.

42. After the man moved to the inpatient healthcare unit on 2 August, his care plan required nurses to monitor his pain and offer oramorph when required. In August the man's pain was relatively well controlled and he rarely asked for oramorph, although the strength of his fentanyl patch was increased on 13 August when he complained of increasing pain.

43. A syringe driver (to give a continuous dose of painkillers) was hired from the local hospice on 9 August and a 'just in case' box containing medication that might be needed for end of life care was established that day. The man's pain control was reviewed frequently in the final days of his life and his symptoms were adequately controlled without the need for the syringe driver.

44. We agree with the clinical reviewer's conclusion that the man received effective pain management throughout his terminal illness.

Liaison with the man's next of kin

45. Prison Service guidance states that prisons must engage with the families of seriously or terminally ill prisoners and encourage a terminally ill prisoner to do likewise. The man had been estranged from his family for some time and had nominated a friend as his next of kin. A trained family liaison officer was appointed in August, together with an assistant for when she was unavailable. The family liaison officer introduced herself to the man on 6 August, when they discussed various matters including contacting his friends and his wishes for his funeral.

46. The family liaison officer telephoned the man's friend, his nominated next of kin, the same day and arranged for her to visit. Over the course of the month,

the family liaison officer and the assistant liaison officer arranged visits in the inpatient healthcare unit for several of the man's friends.

47. When he was admitted to hospital on 31 August, the duty governor telephoned the man's friend to inform her. The family liaison officer telephoned the next day to update her. Visits were arranged for 1 and 2 September, but these were cancelled at the man's request as he did not feel well enough.

48. An operational manager telephoned the man's friend within an hour of his death being confirmed. This arrangement had been agreed in advance. The family liaison officer telephoned the man's friend later that morning, and several times in the coming weeks, to discuss funeral arrangements and returning his property. She also telephoned several of the man's friends to tell them about his death.

49. The man's funeral was held on 25 September. The man had told the family liaison officer that he wanted to pay for his own funeral out of his savings and this was recorded at the time. We are satisfied that this was appropriate.

50. While it would have been best practice to appoint a member of staff to liaise with the man's next of kin when he was first diagnosed with a terminal illness, we are satisfied that once a family liaison officer was appointed good efforts were made to support the man's desired contact with his friends.

The man's location

51. The man lived on D wing at the time of his diagnosis. Due to a previous wrist injury, he was already assigned a buddy (a prisoner who provides help with everyday tasks for those with restricted mobility) to help with collecting his meals and cleaning his cell. The man's buddy said he thought all was done that could have been when the man was on the wing, and that the wing officers were good and aware of the needs of older prisoners.

52. The man was offered admission to the prison's inpatient healthcare unit on 21 July, but preferred to stay on D wing. He agreed to move to the unit on 2 August and his friends from the wing were able to visit him there. He remained in the unit apart from a brief admission to hospital on 31 August, when it was agreed that the prison's inpatient unit was the most appropriate location for his care at the time. We are satisfied that the man's location in the prison was appropriately managed and met his needs.

Compassionate release

53. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is

expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

54. An application for early release on compassionate grounds was initiated at HMP Isle of Wight in mid August. The doctor completed the medical assessment on 21 August and indicated that the man would die "within a few weeks". A letter from the consultant outlining his view of the prognosis, which would usually be required, was not obtained.

55. A prison probation officer completed her assessment on 22 August. She highlighted that the man was still considered a high risk to the public. She acknowledged that the man's deteriorating health reduced this risk, but concluded that some risk remained and any licence conditions would be difficult to enforce in a hospice. The man wished to move to a hospice in his home area, but this was not supported by the local probation service due to his notoriety in the area and the related risks.

56. The Governor completed his assessment on 23 August. In the light of the probation officer's concern about the risks surrounding a hospice placement, he did not support release. PPCS told us that the application was submitted to them on 2 September, the day before the man's death and was not considered before he died.

57. We note that the prison probation officer seems to have taken an extremely cautious approach when assessing the man's risk to the public as high, at the same time as acknowledging his deteriorating health reduced this risk. It is not apparent how far the circumstances of the offences, which were over thirty years previously, were taken into account in assessing his current risk or how much weight was given to his health condition at the time. A lot of weight seems to have been given to the fact that he had denied his offences and had friends who supported him in this view. Against this background it is unlikely that an application for early release would have succeeded. There is no clear explanation why it took ten days for the prison to submit the application and, even if it appears it was unlikely to succeed, it is a concern that any application for release on compassionate grounds should have been delayed for so long when the prisoner was assessed as having just weeks to live. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds for terminally ill prisoners fully reflect the actual risk at the time and are considered and submitted as a matter of priority.

58. The prison's action plan (see page 17) identified the process by which they prepare applications for early release on compassionate grounds, but did not

highlight how a prisoner's actual risk at the time of the application will be addressed. This is a key aspect of the application process and it is vital that an up to date and accurate assessment, that does not rely solely on historic factors, is produced.

Restraints

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

60. The man attended various planned hospital outpatient appointments before and after his diagnosis was confirmed. An escort risk assessment was completed for each one. Each time, the man was assessed as a high risk to the public (on a scale of low, medium, high) and a medium risk of escape. The head of security said that these assessments are based, respectively, on the prisoners' offence and sentence length, plus any other relevant security information. We have not been made aware that there was any such "other" information in relation to the man. As the man's offence and sentence length would never change, we consider this is too inflexible an approach to risk assessment and not consistent with the court judgement.

61. The medical assessment section in the man's risk assessments varied in quality. Sometimes his use of a walking stick was highlighted, other times not. The nature of the appointment and of the man's diagnosis was often vague. They did not make it clear how his medical condition impacted on his risk of escape as the court judgement requires. On each occasion, except for the admission to hospital on 31 August, at the very end of his life, it was concluded that the escort should consist of two officers using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

62. The man was 78 years old, had reduced mobility and had been diagnosed with a terminal illness. While his offences were of a serious nature, the circumstances would not suggest that he was any current risk to the general public and his convictions were for offences committed over 30 years previously. Our view is that an objective assessment, taking into account his

age, health and mobility would have concluded that restraints were unnecessary to prevent escape. An escort of two officers should have been sufficient.

63. This is an issue we have raised several times previously with HMP Isle of Wight. Although our previous recommendations have been accepted, and action plans submitted, it is difficult to see that these responses have been reflected in operational practice when elderly dying men, such as the man, continue to be restrained. We make the following recommendation:

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 at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that necessary equipment is available when required for terminally ill prisoners.

2. The Governor should ensure that applications for early release on compassionate grounds for terminally ill prisoners fully reflect the actual risk at the time and are considered and submitted as a matter of priority.

3. 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 at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that necessary equipment is available when required for terminally ill prisoners.	Accepted	A contract is in place between Care UK and the Isle of Wight NHS Trust for the leasing of a range of equipment items required for the care of patients on an ad hoc/temporary basis. As appropriate equipment is not always immediately available from the local Healthcare Trust, where such issues arise Care UK now purchases the equipment directly. A number of items of equipment have been purchased recently to ensure that such equipment can be provided immediately pending agreement over longer term supply.	Completed Head of Healthcare	
2	The Governor should ensure that applications for early release on compassionate grounds for terminally ill prisoners fully reflect the actual risk at the time and are considered and submitted as a matter of priority	Accepted	The safer custody team in consultation with Care UK meet fortnightly to discuss medical needs and identify any terminally or very ill prisoners. As appropriate the safer custody team then allocates an Initial Incident Liaison Officer (IILO) and family liaison officer to the case. At the same time the safer custody team informs the offender supervisor in offender management unit (OMU) who starts the compassionate release process. This is then tracked and reviewed at each stage by the safer custody team. As well as reports from the prison doctor and consultant, the home probation officer will consider where the person is to live and be	Completed and ongoing Safer Custody	

			treated, and also home circumstances and victim issues. Often this will necessitate the probation officer to check with the Police and MAPPA. The offender supervisor collates all reports and submits them to the governor for consideration of the management of risk which will be informed by and reliant on external agencies. At all stages the offender supervisor in OMU will pursue this matter with Safer Custody checking on progress at key stages. In order to speed up the process documents are now scanned and sent electronically to Public Protection Casework Section (PPCS) rather than by recorded delivery. The offender's risk takes into account all current relevant factors which include the medical condition and the ability to re-offend, if released. It will also take into account any previous offending behaviour work already completed. There are systems in place for the application to be reviewed if the offenders condition changes.		
3	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 at the	Accepted	There were several of the six risk assessments that contained no medical information regarding the mobility or condition of the man to inform the operational manager in deciding the level of restraint required. A change in the type of questions asked has now led to a better clinical response regarding	Completed Head of Operations	

	time.		mobility of the prisoners being escorted to outside hospital appointments. As a result there is now a better risk assessment process in place. HMP Isle of Wight is assessing each prisoner on an individual basis with a greater knowledge of pertinent medical issues when making decisions regarding restraints. The governor and deputy governor are being consulted when the assessment indicates that no restraints should be used. Prisoners have recently attended routine medical appointments without restraints being required and this practice will continue. The head of operations has briefed senior staff at operational briefings and has sent an email to all operational managers as a reminder of the need to consider the use of restraints on an individual basis taking into consideration their medical assessment of mobility.		