PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in May 2012 in the custody of HMP Isle of Wight (Albany)

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This is the report of an investigation into the death of a man. He was 84 years old when he died in May 2012 at HMP Isle of Wight (Albany). He had been unwell for some time with a range of health problems. The post mortem confirmed that he died from the effects of a severe urinary tract infection. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a review of the clinical care the man received in custody. Staff at HMP Isle of Wight cooperated with the investigation.

The man received a long prison sentence in March 2011 when he was 82 and already suffering from ill-health. He transferred to the Isle of Wight in September 2011 and had extensive contact with health services in the prison. He often appeared confused and was investigated for the possibility of Alzheimer's disease, but this was never confirmed. His health gradually declined and in April 2012, during a hospital stay, the prison chaplain arranged for the man's daughter, whom he had not contacted for some time, to visit him. He returned to the prison on 16 April, and remained in the prison's inpatient healthcare unit where he died on 13 May.

When the man went to hospital in April, he was at first restrained by an escort chain. This was reviewed the next day and a sensible decision was made to remove all restraints. However, there is a need for escort risk assessments always to consider the health and mobility of a prisoner.

Overall, I am satisfied that the man received good quality care at HMP Isle of Wight which was equivalent to that which he could have expected in the community. The clinical care he received in his last days was of a particularly high standard and allowed him a peaceful death. I am pleased that the National Offender Management Service has accepted the recommendation in this report.

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 **February 2013**

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SUMMARY

1. On 31 March 2011, the man was sentenced to 25 years imprisonment. After a stay at HMP Dorchester he transferred to HMP Isle of Wight (Albany) in September 2011.

2. At HMP Isle of Wight, as at Dorchester, the man had extensive contact with health services for a range of problems, including possible dementia. He was referred for assessment for Alzheimer's disease but, after several assessments, no firm conclusion was reached. He was often confused and incontinent. He lived on a standard prison wing but was cared for in the prison's inpatient healthcare unit (IHU) when necessary. In the early months of 2012, his health began to fail and on 1 April he was taken to hospital with suspected kidney failure.

3. When he was first imprisoned, the man remained in touch with his daughter but broke off contact in May 2011. This lasted until early April 2012, when the prison chaplain persuaded him, in view of his worsening health, to allow him to contact his daughter on his behalf. The chaplain then arranged for his daughter to visit him in hospital. He subsequently kept her informed of her father's condition.

4. The man returned to prison from hospital on 16 April 2012. He went directly to the healthcare unit and the next day moved into the unit's "end of life suite". His cell door remained unlocked at all times so that healthcare staff had unrestricted access to care for him. His condition deteriorated over the coming days. Healthcare staff did their best to make him comfortable and control his pain. He died in May. The post mortem showed that he died of the effects of a severe urinary tract infection.

5. We make one recommendation about risk assessments for hospital escorts.

THE INVESTIGATION PROCESS

6. The Ombudsman's office was informed of the man's death on Sunday 13 May 2012. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No further information was received.

7. The investigator spoke to the duty governor on 14 May and visited HMP Isle of Wight on 17 May. He met the Governor, as well as senior healthcare staff and a member of the Independent Monitoring Board. He saw the relevant areas of the prison, including the healthcare centre and spoke to staff and prisoners who knew the man.

8. The investigator was provided with copies of the man's prison record and prison medical record. The local Primary Care Trust (PCT) commissioned a clinical reviewer to carry out a clinical review of the man's care and treatment while in custody.

9. The investigator interviewed six members of staff and one prisoner and during the investigation provided written feedback to the Governor.

10. HM Coroner was informed of the investigation and a copy of the post mortem was requested. A copy of this investigation report will be sent to the Coroner to assist with his enquiries.

11. One of our office's Family Liaison Officers contacted the man's daughter to explain our investigation and invite her to ask any questions or raise any concerns about her father's care. His daughter asked if the investigation would consider whether prison staff needed to be present when she and her husband visited her father in hospital, when they would have appreciated some private time with him. The family made no comments in response to the draft report.

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

HMP ISLE OF WIGHT

13. HMP Isle of Wight is an amalgamation of three prison establishments, Parkhurst, Camp Hill and Albany. The man was in the Albany site which houses up to 567 sex offenders and vulnerable prisoners in five cell blocks.

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

Her Majesty's Inspectorate of Prisons (HMIP)

15. The last report published on HMP Isle of Wight by HM Chief Inspector of Prisons followed an unannounced inspection in October 2010. The report noted that the primary care environment was poor at Albany and there was no structured therapeutic activity for inpatients. There were reasonable links with palliative care services, with two dedicated palliative care rooms in the IHU. Clinical care was generally satisfactory and patients in the unit told inspectors that nurses responded to their needs appropriately and sensitively. The report also noted that there was excessive use of handcuffs on escorts and in the grounds of Albany.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Albany noted that the main problem facing healthcare services was the ageing population.

Previous deaths at HMP Isle of Wight

17. This office has investigated 36 previous deaths at what was HMP Albany, now part of HMP Isle of Wight. Twenty eight of these deaths were as a result of natural causes, reflecting Albany's relatively elderly population. There have been a further two deaths since the man's. In a recent report we made a recommendation about the use restraints for prisoners in hospital which the prison would have been aware of at the time of his death.

ISSUES

The man's diagnosis

18. The man was born in 1928 and had suffered from poor health for some time. He had had to retire through ill-health at the age of 50. Many medical problems were listed in his pre-sentence reports, including deterioration of his eyesight, visual hallucinations, hearing problems, heart disease, high blood pressure, high cholesterol, a possible mini-stroke, problems with his prostate gland, osteoarthritis (joint pain), chronic kidney disease, gout, angina, and a hernia. He had had a knee replacement and a coronary stent fitted.

19. The man was sentenced to 25 years on 31 March 2011. This was his first time in prison. He had extensive contact with healthcare services in prison.

20. During the early months of 2012 the man's health worsened. On 13 March, a prison doctor noted that he was obviously deteriorating but that his condition, both physical and mental, was not able to withstand intrusive investigations. On 16 March, the doctor saw him again and noted that there was no obvious diagnosis other than generalised deterioration. The doctor discussed him with an elderly care physician. She suggested that he might be suffering from malabsorption syndrome (an inability of the stomach to absorb nutrients). On 20 March, a prison doctor contacted a gastroenterologist at the local hospital, and arranged for him to have an abdominal ultrasound scan on 11 April.

21. Before that could happen, the man was taken to hospital on 1 April, with suspected kidney failure. On admission, he was diagnosed with a pulmonary embolus (a blood clot on the lung). Hospital staff also found a mass in his lung. It did not appear to be cancerous but further investigation was not possible at the time as he was not well enough. He was scheduled to return to hospital as an outpatient for further tests. No treatable cause was found for the overall deterioration in his health.

22. On 26 April, the man was sick. An ECG (an electro-cardiogram, which gives a reading of the heart) gave an abnormal reading. The tips of his fingers were blue and nurses were unable to obtain blood samples. A doctor noted that tests in November had shown no evidence of suspected cancer. He made a note on the file that there were no indications that further tests should be made and that all that could be done for him at this stage was to make him comfortable.

23. The man's health had been recognised to be failing for some time but there was never any one clear diagnosis of the cause which was a result of his multiple health problems and advancing age. The first explicit mention on his medical record that he was terminally ill was on

3 May 2012, when one of the prison doctors diagnosed his condition as terminal, noting multi-system failure and old age. The doctor entered in the record that he was in no state for further investigation at this time. The plan from this point was just to maintain his comfort.

24. The clinical reviewer writes that, when there were concerns over the man's health at the beginning of April, the symptoms were immediately and appropriately addressed. On his return to prison, he was given full nursing care and support. His health deteriorated over time, in large part due to his age.

Informing the man about his condition and treatment

25. From arrival into prison, there were concerns that the man was suffering from a degree of dementia. He was referred to the memory service for further investigation. On 13 March 2012, his medical record contains a note from a doctor that he should be given nursing care (made comfortable and given pain relief) and that staff should not attempt to resuscitate him should such a situation arise. The investigator asked the doctor if he discussed this with him, and the doctor said that he did not. His dementia was significant by this point, and the doctor said that he would have been incapable of understanding the point at issue.

26. When the man was taken to hospital in April, he was drowsy on admission and notes show that through his stay his mental state fluctuated. The clinical reviewer notes that it would not have been possible to fully discuss with him the reason for his admission. He was acutely unwell it would not have been in his best interests to try to discuss this with him. In hospital he was often confused, and it is not clear how much he understood the condition of his health.

27. The man's dementia seemed to worsen towards the end of his life along with his physical health and it is difficult to gauge how much he understood or would have been capable of understanding about his own health. The clinical reviewer notes that he was increasingly lethargic and confused. We are satisfied that he was treated in his own best interests and there was no suitable point when it would have been appropriate to inform him that his condition was terminal.

The man's medical appointments and treatment

28. Because of his history of ill-health throughout his imprisonment, the man was in frequent contact with healthcare services. He was referred to hospital on several occasions, either for routine tests or when there were more immediate concerns about his health. He was referred to the memory service over concerns about the possibility of dementia. Prison staff ensured that appointments were made and kept.

29. When a doctor saw the man on 1 April 2012, he was concerned that he may be suffering from problems with his kidney function. He was taken to hospital. He remained there until 16 April, with healthcare staff from the prison maintaining frequent contact with the hospital. Thereafter he was in the prison's healthcare centre where he was under frequent observation. On 8 May, the prison received a hospital appointment for him for 31 May, but they informed the hospital that he was not well enough to attend.

30. As the man's health deteriorated his treatment consisted of nursing care in the IHU. He was issued with incontinence pads which were changed frequently. There were no plans for intrusive investigations. However, when he became acutely unwell in April, and it appeared that he might benefit from treatment, he was taken straight to hospital.

31. The clinical reviewer notes that the man had a full assessment of the concerns over dementia and no treatment was felt appropriate. His heart condition was thoroughly investigated and his treatment was updated. When he was hospitalised in April 2012, hospital staff found signs that might possibly have indicated lung cancer. Although he was not well enough for investigation at that time, plans were set in place if his condition improved.

32. The man was put onto the Liverpool Care Pathway for the dying on 4 May. Nurses agreed that there had been a noticeable deterioration in his physical state. A doctor assessed him and made a note on the medical file that he was "slipping downhill". His medication was reduced, and nurses and the on-call doctor system were notified that he was likely to die within the next two weeks. The clinical reviewer notes that he was cared for very well in the healthcare centre, which can be seen from well-kept documentation. He died peacefully with a nurse sitting with him to ensure he was comfortable.

The man's pain relief and medication

33. Because of his frequent contact with medical staff, the man's medication was under ongoing monitoring. His medication was altered on 15 March after a consultation with a doctor.

34. The man was in the IHU so his medication was readily accessible. His memory problems meant that it would not have been appropriate to allow him to retain his own medication. As he became more ill, he was given appropriate pain relief, and made as comfortable as possible using the necessary equipment. When he began to have trouble swallowing his medication, he was given patches. When necessary, he was put onto a syringe driver with appropriate medication.

35. The clinical reviewer writes that the man's pain was well controlled and pressure areas were treated with cream regularly. He was given pain relief through a syringe driver when this became appropriate.

Liaison with the man's family

36. After his imprisonment, the only outside contact the man retained was with his daughter. In May 2011, he broke off this contact. Apart from one telephone call in December, he remained estranged from his family. On 14 March 2012, a doctor was concerned about his failing health and asked staff in the IHU to contact the prison's family liaison service so he could talk to the family about his health and the likely prognosis. The family liaison service advised that he would have to give his consent for them to contact his family. The doctor discussed this with him, but he declined.

37. At the end of March, a prison chaplain asked the man if, in view of his deteriorating health, he wanted him to arrange a visit from his daughter. Again, he declined. However, when he was hospitalised in early April, the chaplain raised the issue again and he agreed he should contact his daughter. The chaplain spoke to the man's daughter on the telephone on 3 April. He informed her that her father was in hospital and from that point on he acted as the prison's family liaison officer. He made arrangements for her and her husband to visit him in hospital on 6 April.

38. The man's daughter asked this investigation to consider the appropriateness of prison staff being present during her visit to her father in hospital. While it is unfortunate that she did not feel she was given appropriate privacy, and in the circumstances there was perhaps some room for a little more discretion to have been used, the officers were following standard instructions. When escorting prisoners during a stay in hospital, officers are required to remain with the prisoner. They can move aside and be as unobtrusive as possible, but they must be able to see and hear the prisoner at all times. They are also required to be aware of the need to ensure the safety of both the prisoner and visitors.

39. On 12 April, the man told the chaplain that he did not want any further visits from his daughter. The chaplain passed this message on. On 18 April, he telephoned the man's daughter to tell her that her father was back at the prison, though he still did not want any visits. He agreed to update her over the telephone each week and kept her informed of his deteriorating health. On 4 May, he told her that her father was now bedridden, his pain relief had been increased and his death might be expected relatively soon.

40. The chaplain agreed that he would inform the man's daughter by telephone when her father died, which he did. At her request, he agreed to visit her that afternoon. In line with his family's wishes, the chaplain arranged and officiated at the funeral, which was held on 28 May. The prison contributed to the costs. A memorial service was held in the prison chapel on 1 June, to which the family was invited.

41. We are satisfied that the chaplain maintained good contact with the man's family throughout the later stages of his life and gave very good support to them at the time of his death and afterwards.

The man's location

42. Specialist units had been considered for the man when he was first imprisoned but in September 2011, before his transfer from Dorchester, the prison doctor's opinion was that he would benefit from a structured regime on a normal wing, where he would be able to engage in activities. He transferred to Isle of Wight later that month. At Albany, he moved between the healthcare centre and his wing depending on his state of health.

43. On 26 February 2012, the man collapsed. An ambulance was called, and he was treated by paramedics. It was agreed that he did not need to be hospitalised, but he moved to the IHU. He remained there until 2 March, when he was discharged back to E wing. However, he was confused and his health was deteriorating. On 6 March, a doctor admitted him back to the IHU.

44. On 31 March, the man was moved to the Kings Suite in the IHU, which contains the end-of-life cells, which provide more comfort. The next day he was taken to hospital where he stayed until he returned to the IHU on 16 April.

45. On 18 April, he moved into the end-of-life suite, a healthcare cell designed to allow terminally ill prisoners to be as comfortable as possible. These rooms are appropriate for end of life care but we were a little surprised that the cells were referred to, in front of prisoners, as "end-of-life" cells. It had been agreed that his cell should be left open at all time and with round-the-clock access to him, nursing staff provided a high level of care, equivalent to that which might be provided in a hospice.

46. We are satisfied that the man's location was given regular consideration during his time in prison. He was moved to the IHU, as his health problems became more serious and then to more appropriate accommodation in the unit to allow him more suitable and comfortable surroundings at the end of his life.

Compassionate release

47. In certain circumstances, prisoners who are dying may be granted release on compassionate grounds. This will depend on a number of factors, including the availability of somewhere appropriate for them to live.

48. On 14 March 2012, a doctor noted in the man's medical record that there might be a case to consider compassionate release. He asked staff in the IHU to contact the prison's family liaison service so he could talk to the man's family about the prognosis. A note on his case history file dated 29 March 2012 shows that a compassionate release request was in progress, but he would not give his consent to allow the doctor to discuss his medical information with his family. When he accepted the chaplain's offer to contact his daughter, he received one visit but then declined any further contact.

49. We are satisfied that compassionate release was appropriately considered, but the man did not have an address to be released to and would not give permission for this to be discussed with his family. A hospice place would have been difficult to find as, right until the end of his life, there was no clear prognosis. The clinical reviewer notes that as his health worsened, his medical needs were adequately met in the prison's IHU and he did not require the care of a hospice.

Restraints, security and bed watch

50. When prisoners are taken outside prison, they are assessed as to the level of security that is required. When the man was taken to hospital on 1 April, the assessment was that he should be accompanied by two prison officers and handcuffed to one of them by an escort chain (a set of handcuffs with a chain approximately six feet in length). He was admitted to hospital and, the following day, his security was reassessed. The escort officers spoke to hospital staff and the duty governor subsequently judged that he did not require any physical restraint. This would be reviewed each day, but restraints would only be reapplied if there was a significant improvement in his health.

51. We are pleased to see that the man's security assessment was reviewed the day after he was admitted into hospital and that it was judged that he did not require any physical restraints. Nevertheless, we are concerned that he was restrained when being escorted to the hospital. He was likely to have presented a very low risk of escape and his age and his state of health would have made it difficult for him to evade two members of staff. Copies of the initial risk assessment could not be found, but we are not satisfied that the decision that he should be handcuffed to a prison officer using an escort chain fully took into account his individual circumstances and the risk of escape he actually presented at the time.

The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

Palliative care plans

52. The man's health deteriorated over a period of time and on 3 May, a doctor noted that his condition was terminal, which he attributed to multi-system failure and old age. He noted that he was "in no state for further investigation at this time", and the plan was to maintain his comfort.

53. The man's prison records do not indicate that there was any contact with specialist palliative care services, either during his time in prison or whilst he was in hospital. The clinical reviewer notes that specialist advice was available, but his health was well looked after in the prison's IHU and additional help was not required.

54. The clinical reviewer concludes that the man had treatment plans in place, including being put onto the Liverpool Care Pathway (this is a plan of care used in the last days or hours of life and promotes good communication, care planning including psychological and spiritual, symptoms and pain control and care after death) when it became necessary and that he received excellent nursing care. It is not clear how actively he was able to be involved in decisions about his treatment, but we accept that his mental and physical health made this difficult.

CONCLUSION

55. The man was an elderly man who came into prison with a history of poor health. His health steadily deteriorated, and it was recognised that his life was coming to a close through old age and the breakdown of many of his bodily systems. He died at Isle of Wight prison in May 2012. The investigation found that he received appropriate treatment at the prison and was treated with care and compassion at the end of his life. We conclude that he received a standard of healthcare equivalent to that he could have expected in the community.

RECOMMENDATIONS

1. The Governor should ensure that a prisoner's health, mobility and actual risk at the time are considered and taken fully into account in deciding the level of escort and whether restraints are needed.

   The National Offender Management Service accepted this recommendation, with the comment:

   "As far as is practically possible a prisoner who attends outside hospital will have his health, risk and mobility taken into consideration when deciding the strength of the escort and the use of restraints."