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 November 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 the man in November 2013, at HMP Isle of Wight. He died as a result of severe kidney infection, liver disease, Hepatitis C and diabetes. He was 54 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Isle of Wight was conducted. The prison cooperated fully with the investigation.

The man was given an indeterminate prison sentence in 2006 and transferred to what was then HMP Albany in 2007. He had significant health problems before he was sentenced to prison, including liver disease, Hepatitis C, diabetes and kidney problems.

Hospital specialists saw the man frequently as his condition deteriorated. In 2011, he was turned down for a liver transplant and from that time onwards he was nursed palliatively. He spent most of the last two years of his life in the prison's healthcare inpatient unit. The clinical reviewer considered his care was equivalent to that he might have expected to receive in the community, but was concerned that decisions about resuscitation were taken without a record to evidence any discussion with him.

I am satisfied that, overall, the man received a good standard of care at the prison. However, I do not consider the use of restraints when he was taken to hospital was always justified by fully considered risk assessments. This is a matter I have raised a number of times with HMP Isle of Wight and I expect the governor to satisfy himself that lessons are being learned.

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 **June 2014**

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SUMMARY

1. The man received an indeterminate prison sentence for public protection in December 2006. He went to HMP Winchester and then transferred to HMP Albany on the Isle of Wight in March 2007. He had long standing health conditions including diabetes, Hepatitis C and poor liver function. He continued to be prescribed the medication he had received in the community.

2. The man was under the care of specialist medical services at hospital and had frequent admissions due to his liver disease and complications with his diabetes which was poorly controlled.

3. In November 2011, a hospital turned the man down for a liver transplant. He was nursed palliatively from this point on.

4. The man's liver problems worsened and he was also unable to self-regulate his insulin. He also developed a brain disorder caused by his liver disease. Over the next two years he had periods of pain, lethargy and confusion for which he was treated by hospital specialists and healthcare staff. He spent most of the last two years of his life in the prison's inpatient healthcare unit.

5. Gradually the man became more ill and went to hospital on 28 October 2013 for eight days. When he returned to the prison's inpatient unit, staff noticed he was weaker and he complained of pain in his liver area. Healthcare staff continued to monitor him and gave him pain relief. He needed help to monitor his insulin levels, was incontinent and had periods of confusion.

6. One morning in November, the man felt unwell and remained in bed. He died peacefully in the afternoon with nurses present.

7. We found that the overall care the man received was equivalent to that he could have expected to receive in the community. However, he should have been involved in decisions about resuscitation and we are not satisfied that the use of restraints for hospital appointments was always justified by fully considered risk assessments. We make two recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

10. The investigator obtained copies of the man's prison medical records and relevant aspects of his prison records. The investigator and clinical reviewer interviewed six staff at HMP Isle of Wight on 9 January 2014. The investigator gave the Governor initial feedback and followed this up in writing.

11. We informed HM Coroner for Isle of Wight of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's mother to explain the purpose of the investigation. She did not have any concerns for the investigation to consider.

13. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP ISLE OF WIGHT

14. 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.

15. Since 1 June 2013, Care UK has provided healthcare at the prison. There is an inpatient healthcare unit (IHU) 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

16. 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 found that there were good care arrangements for men with palliative care needs.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report for 2012, the IMB commented that the inpatient healthcare unit provided a very high standard of care and were positive about the quality of end of life care.

Previous deaths at HMP Isle of Wight

18. The man was the seventh prisoner to die from apparent natural causes at HMP Isle of Wight since January 2013. In a number of previous reports, we have raised the issue of the inappropriate use of restraints on older and terminally ill prisoners.

KEY EVENTS

19. The man was serving an indeterminate sentence for public protection and had been at HMP Isle of Wight since 2007. At the time of his sentence he had already been diagnosed with liver problems, hepatitis C and type 2 diabetes. He was obese, smoked cigarettes and suffered generally poor health.

20. In addition to his physical illnesses, the man had learning disabilities and schizophrenia. The prison in-reach psychiatric team reviewed him regularly and monitored and adjusted his medication to minimise his symptoms.

21. Records from 2007 to 2011 show that the man had frequent appointments with both liver and diabetic specialists. He had declining liver function and, in 2009, was diagnosed with pancytopaenia (deficiency of all types of blood cells). Records show his diabetes management was poor and he began insulin therapy in 2010.

22. In July 2011, the man attended the transplant clinic at hospital. It was noted that he had advanced liver disease and was suffering with hepatic encephalopathy (disease of the brain caused by advanced liver disease). The transplant team reviewed him again in October 2011 and noted his that he had a history of poor compliance with his medication and treatment, he continued to smoke against advice and he had possible hypertension (high blood pressure).

23. In November 2011, another hospital, which was responsible for the transplant arrangements, decided that the man was not suitable for a liver transplant. The main reasons were that he was demonstrably poor in complying with his diabetes management and in maintaining healthy living. Doctors prescribed a number of medications for him and from this point he was nursed palliatively. (Palliative care is longer term care that is not curative, but may extend life.)

24. Throughout the man's remaining illness, healthcare staff held regular care planning meetings and discussed and reviewed his needs, treatment and medication. Hospital specialists continued to be involved in the care of his liver disease, encephalopathy and diabetes.

25. On 23 November 2011, the man's psychiatrist discussed with him the decision to turn him down for a transplant. The psychiatrist recorded that there should be a discussion with the man about completing a do not attempt cardiopulmonary resuscitation (DNACPR) order. The next day, a doctor recorded that he did not think it was appropriate to discuss this with him as he had learning difficulties. The doctor made a similar entry in his medical records on 14 May 2012.

26. During 2012, the man was admitted to the prison's inpatient unit on a number of occasions. Records show this was because he was unable to cope on the wing, his poor compliance with medication, incontinence and personal hygiene. Healthcare staff saw him several times each day, both when he was on the wing and in the inpatient unit. Healthcare staff faxed his blood sugar

levels to the diabetic clinic each week and adjusted his insulin levels when necessary.

27. On 23 May 2012, a prison family liaison officer (FLO) was appointed as the man was recognised to be very ill. The next day she contacted his mother, who lived in Germany, and informed her of his deteriorating condition. The FLO remained in frequent contact with both him and his mother.

28. On 24 July 2012, a doctor noted that the man appeared more jaundiced, but was not in pain or discomfort. On 23 August, the doctor saw him again, who said that he was worried about dying. The doctor told him that, although he was chronically ill, he was stable and his condition was not immediately terminal.

29. Over the next few months, healthcare staff saw the man at least daily. Blood tests in December showed he had deteriorating kidney and liver function. His medication was reviewed and adjusted.

30. By the beginning of 2013, the man had periods of being disorientated and was unable to get out of bed. He had problems with his feet, due to his diabetes. Nurses helped him to manage these problems.

31. Throughout 2013, the man continued to receive daily nursing care and attention. He had periods of confusion and difficulty with walking, continence and coordination.

32. On 28 October, the man was admitted to hospital with a deterioration of his brain function (encephalopathy). He was restrained by a single handcuff and escorted by two officers. While in hospital he became unconscious and at that point restraints were removed.

33. The man regained consciousness the next day and an escort chain was applied. On 4 November, the clinical team manager and a prison doctor visited him in hospital. He returned to prison on 5 November. He was again restrained with a single cuff and escorted by two officers.

34. On 12 November 2013, the man's psychiatrist noted there had been a decline in his mental state caused by his ongoing liver failure. The psychiatrist said his periods of incontinence and sometimes challenging behaviour were due to his physical conditions and not his psychosis which was under control.

35. From 15 November, the man was incontinent and said he felt very tired. A nurse assisted him to shower and change his clothing so he could feel comfortable. Nurses checked his blood sugar levels frequently in an effort to control his diabetes.

36. By 18 November, in addition to periods of incontinence, the man said that he had a pain in his upper right abdomen which a nurse noted appeared to be around his liver. A doctor prescribed pain relief.

37. The next day, staff helped the man to eat his meals and take his medication. He was tearful and said that he felt weak. Nurses supported and assisted him. A doctor saw him and noted that he appeared jaundiced and had an enlarged abdomen, due to his liver condition.

38. That night, the man told a nurse he felt confused and was unable to get out of bed and have a drink without assistance. The next morning he stayed in bed as he said he felt drowsy. Nurses remained with him to support him. A doctor began arrangements for his end of life care and contacted the consultant at the hospital for advice about appropriate medication, but he died that afternoon. The clinical reviewer noted that his death was peaceful and painless. Two nurses were with him when he died.

Support for staff and prisoners

39. Prisoners and staff were informed of the man's death by a Governor's notice. We are satisfied that the staff involved in his care were offered appropriate support.

Family liaison

40. The prison's FLO had continued to be in frequent contact with the man's mother in Germany. She had agreed she would telephone his mother in the event of his death, which she did that day. Over the next few days, she remained in contact and offered support and guidance. In line with national guidance, the prison arranged and paid for the funeral. The man's mother told us that she had been grateful for the frequent contact and updates from prison staff who kept her informed throughout her son's illness.

Post-mortem

41. The post-mortem report shows that the man died from acute pyelonephritis (kidney infection); post-hepatic cirrhosis (liver disease); old hepatitis C infection and diabetes mellitus.

ISSUES

Clinical Care

42. The clinical reviewer notes that when the man arrived at HMP Isle of Wight he had schizophrenia, obesity, type 2 diabetes, hepatitis C infection and serious liver disease/failure. She is satisfied that his care was equivalent to that which he could have expected in the community. He attended regular outpatient appointments for his liver disease and diabetes and his mental health was well managed. She says that he survived longer than expected and died gently and without pain.

43. She also noted that the man had a brain disorder (hepatic encephalitis) caused by his liver damage and often manifested itself as confusion and behavioural changes. She said he had received appropriate care and was referred to local and regional specialist centres for his brain disorder.

44. The clinical reviewer noted that HMP Isle of Wight has a high number of foreseeable deaths and has developed end of life facilities in the inpatient unit and had a team experienced in end of life care. The staff meet monthly to ensure good planning and liaison. However, she considered that decisions about resuscitation should be made in discussion with the patient wherever possible.

Do not attempt cardiopulmonary resuscitation (DNACPR)

45. A DNACPR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

46. A DNACPR order was in place for the man and had been so for some time, but it had never been discussed with him. It is not clear from the records when the order was initiated, but there are various entries in his medical records in November 2011 and May 2012 about resuscitation.

47. A doctor recorded that it was not in the man's interests to discuss the DNACPR with him due to his learning difficulties and general state of mind. However, his psychiatrist, who had worked with him for several years, had said that it was appropriate to have a discussion about the resuscitation options and that he was capable of such a discussion.

48. The clinical team manager said that he and the man had had many discussions about resuscitation. He said that, after he had been turned down for a liver transplant, they had conversations about death and dying during which he agreed that he would not want to be resuscitated. There is no record of these discussions.

49. We accept that discussions about resuscitation can be difficult and that there are circumstances when it would not be appropriate. However, good palliative care should include discussion about resuscitation with the patient and/or their

relatives wherever possible. HMP Isle of Wight is working towards adopting the Macmillan Adopted Prison Standards for palliative care. Standard 16 says that palliative care patients should be offered the opportunity to have advance care planning discussion which should provide an opportunity for resuscitation to be discussed. We make the following recommendation:

The Head of Healthcare should ensure that palliative care patients have the opportunity to discuss advance care planning and that views about resuscitation are discussed when appropriate. All decisions should be recorded.

Restraints, security and escorts

50. The Prison Service has a duty to protect the public when escorting prisoners 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 about 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.

51. On 28 October, the man was admitted to hospital. At the time, he was semi-conscious and was restrained by a single handcuff and escorted by two officers. The medical part of the risk assessment noted that there were no medical objections to restraints being used, which is not the test that the court judgement requires. Later that day, an operational manager authorised the removal of the restraints as he was unconscious at the time and the medical opinion was that he could not escape unaided and he was unlikely to regain consciousness in the near future. The manager said that if he regained consciousness the restraints should be reapplied.

52. On 29 October, at 10.50 am, the man regained consciousness and was considered mobile. The manager decided that an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) should be applied. We do not consider that consciousness is the appropriate test to apply and there was no healthcare input at the time to indicate how his condition impacted on his risk of escape.

53. The Prison Service's has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that the risk

assessments we examined were fully considered and took into account the man's risk and condition at the time and that the tests required by the 2007 High Court judgement were applied. It is not sufficient for healthcare staff simply to say that there are no medical objections to the use of restraints. There needs to be active consideration of how a prisoner's health and mobility impacts on his risk of escape. This is a matter we have raised with the prison before. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

RECOMMENDATIONS

1. The Head of Healthcare should ensure that palliative care patients have the opportunity to discuss advance care planning and that views about resuscitation are discussed when appropriate. All decisions should be recorded.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

1	The Head of Healthcare should ensure that palliative care patients have the opportunity to discuss advance care planning and that views about resuscitation are discussed when appropriate. All decisions should be recorded.	Accepted	A multi-disciplinary palliative care team meeting is now held on a monthly basis, at which the treatment for any prisoners who may be considered for palliative care is discussed. Systems are now in place to ensure that where appropriate a healthcare professional discusses resuscitation and advance care planning arrangements with palliative care patients. All decisions relating to this are now recorded.	Head of Healthcare Completed and ongoing	
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time	Accepted	The decision making process with regards to the appropriateness of restraints has now significantly improved with different departments now working closer together when decisions are made and questions in risk assessments now accurately recording clinical information regarding a patient's mobility. Operational managers now inform senior managers when a risk assessment has been completed. They then reassess this within 24 hours of any prisoner being admitted to hospital or immediately following any serious decline in their medical condition. Escorting staff now make dynamic assessments of a prisoner's mobility and behaviour during an escort and record this on Prison-NOMIS upon their return to the prison. The Head of Operations has briefed senior staff at operational briefings, and sent an email to all operational managers, to remind them of	Head of Operations Completed and ongoing	

			the need to consider the use of restraints on an individual basis and to take medical assessments of mobility into consideration.		