



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 from leukaemia in September 2013 at HMP Isle of Wight. He was 66 years old. I offer my condolences to the man's family and friends.

The man was first diagnosed with leukaemia in 2002, while in prison for a previous offence. He was treated and went into remission for a long period. He received a further 13 year sentence in 2009 and was sent to HMP Isle of Wight. The man's leukaemia returned in 2011, but he went back into remission after chemotherapy. He became unwell again in February 2012 and was eventually found to have relapsed again in October 2012. His prognosis was poor, but he had chemotherapy to slow down progression of the disease. In September 2013, the man was admitted to hospital and his treatment became palliative. He returned to the prison's healthcare centre where he was cared for until he died.

I agree with the clinical reviewer that the man was diagnosed appropriately in October 2012 and received appropriate care and support from staff at HMP Isle of Wight. However, I do not consider that the use of restraints when the man attended hospital was always justified by appropriate risk assessments which fully took into account his state of health. This repeats a finding that has been made in a number of previous investigations at the prison and I expect the governor to satisfy himself that lessons are being learned.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2014

CONTENTS

Summary	5
The investigation process	6
HMP Isle of Wight	7
Issues	8
Recommendations	14

SUMMARY

1. The man was first diagnosed with acute myeloid leukaemia (cancer that starts in the bone marrow) in 2002, while in prison for a previous offence. He received treatment and went into a long period of remission. In 2009, he was convicted of drug offences and sentenced to 13 years in prison. He arrived at HMP Isle of Wight in September that year.
2. The man was referred for blood tests on 30 March 2011, because he was short of breath and felt tired. On 4 April 2011, the tests confirmed that the man's leukaemia had returned. The man received good support from prison staff at this time and in the following weeks. He underwent chemotherapy which appeared to be successful.
3. The man's blood count was regularly tested throughout 2012. In February 2012 the results showed a decline in red blood cells, which continued to be monitored. On 5 October 2012, blood tests revealed that the man's leukaemia had returned. He was told that he possibly only had three months to live. The man was treated with chemotherapy and attended a support group for prisoners with terminal illness.
4. The man went into a brief remission in May 2013, but his condition worsened again over the summer. On 6 September, a prison doctor discussed with the man his poor prognosis and quality of life. The man agreed he did not want resuscitation to be attempted if he had a cardiac or respiratory arrest. The man died on 14 September.
5. The prison made two applications for compassionate release, but neither were successful, because of concern about ongoing risk and the lack of suitable accommodation.
6. We are satisfied that the man received a high level of clinical care at HMP Isle of Wight. However, as in previous investigations at this prison, we are concerned that a terminally ill prisoner was unnecessarily restrained at hospital appointments. We repeat a recommendation we have made several times previously.

THE INVESTIGATION PROCESS

1. 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 her. A member of the Independent Monitoring Board (IMB) contacted her in response,
2. The investigator obtained copies of the man's relevant prison and prison medical records. She visited HMP Isle of Wight on 23 September and spoke to a prison officer who knew the man well, the clinical care manager and the Head of Healthcare. The investigator gave preliminary feedback to the Governor and followed this up in writing.
3. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
4. The investigator informed HM Coroner for the Isle of Wight of the investigation and the Coroner provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
5. One of the Ombudsman's family liaison officers contacted the man's daughter to explain the investigation. The man's daughter had the following questions about her father's treatment at the Isle of Wight which she wanted the investigation to consider:
 - Was there a breakdown in communication between the prison staff and hospital staff that adversely affected her father's care?
 - Did he miss hospital appointments?
 - Was there a failure to dispense prescribed medication?
6. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, whether palliative care was provided, liaison with his family, his location and security arrangements and whether compassionate release was considered.
7. The man's family received a copy of the draft report. They pointed out a factual inaccuracy and this report has been amended accordingly. The man's family also raised a question that did not impact on the factual accuracy of this report and has been addressed through separate correspondence. The prison considered our draft report and recommendation, which it has accepted. The prison has also submitted an action plan detailing what they have done to address the issue we raised and this is included at the end of the report.

HMP ISLE OF WIGHT

8. 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.
9. Since 1 June 2013, Care UK has provided healthcare at the prison. Before this, provision was by the Isle of Wight Primary Care Trust. 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

10. In their most recent inspection of HMP Isle of Wight 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

11. 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

12. The man was the fourteenth prisoner on the Albany site to die of apparent natural causes since January 2012. In a number of previous reports, we have raised the issue of the inappropriate use of restraints on older, terminally ill prisoners.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

13. The man was diagnosed and treated for acute myeloid leukaemia, in prison, in 2002. He was then in remission for a long period. On 24 August 2009, the man was convicted of drug offences and sentenced to 13 years in prison. He arrived at HMP Isle of Wight in September 2009.
14. On 30 March 2011, the man told a prison doctor that he felt short of breath and tired. She arranged blood tests to determine the cause. On the 4 April 2011, the doctor informed the man that blood tests had shown that his leukaemia had returned. The doctor noted that the man was reasonably well in himself and agreed to chemotherapy immediately.
15. The man's treatment was regarded as successful and his condition improved. He continued to have regular blood tests and, in February 2012, the tests revealed that he was not producing enough red blood cells. He was to be monitored closely over the next few months.
16. On 5 October 2012, a consultant haematologist at St Mary's Hospital, Isle of Wight, saw the man and told him that his most recent blood test had shown that the leukaemia had returned and his prognosis was poor. He was told that he possibly had only three months to live.
17. The man requested a second opinion about his terminal diagnosis. In response to this request, another prison doctor, discussed the man's condition with the haematologist further and arranged tests which established that a further course of palliative chemotherapy (cytarabine) would be appropriate but active curative treatment was not possible.
18. The man responded well to this course of chemotherapy. As a result, he often felt positive about his prognosis and then appeared to be shocked when he received bad news about his condition. The clinical reviewer is satisfied that there was evidence that both hospital and prison staff had conversations with him about his prognosis and that there was no breakdown of communication.
19. The clinical reviewer considers that appropriate investigations were requested when the man presented with symptoms in March 2011 and we agree. The clinical reviewer found that the man received a lot of information about his clinical treatments from the hospital. We are satisfied that the man was appropriately informed of his diagnosis and treatment.

The man's medical treatment

20. When the man's relapse in April 2011 was confirmed, he immediately began an intensive course of chemotherapy at Southampton General Hospital. He received two subsequent cycles of chemotherapy and returned to the prison's inpatient healthcare unit on 27 August 2011. The man's condition improved and he went back to his wing on 12 September 2011.
21. The man remained generally well until a blood test in October 2012 revealed that his leukaemia had returned. The haematologist wrote to the prison on 5 November 2012 and explained that the man was not suitable to continue chemotherapy at Southampton Hospital but agreed to a trial of palliative chemotherapy, which started on 12 November 2012.
22. Although acute myeloid leukaemia is not usually a painful condition, the man began to experience anal pain as he had developed an abscess on his anus. The clinical reviewer notes that this is a difficult condition to manage in healthy adults and particularly difficult to manage in a patient with leukaemia as his poor immunity meant the abscess would not heal properly. This infection was also a risk to his health.
23. The man suffered greatly with rectal pain often needing to lie down to be comfortable. Healthcare staff tried a range of medications to try and reduce the man's obvious discomfort. On 20 February 2013, the man had a surgical procedure to manage this condition. The clinical reviewer found that healthcare staff were responsive to his pain and increased the pain relief to morphine when necessary.
24. The man's illness required numerous hospital appointments. There were only three occasions documented in the records that a hospital appointment was missed. Once the man's consultant was not available, towards the end of his life the man missed a blood transfusion because he was too ill to attend and, on 2 July 2013, he missed an appointment with his consultant the haematologist as prison transport 'failed'. Despite numerous requests, the prison has not been able to provide a reason for this. However, the clinical reviewer notes that the appointment was rescheduled for the next week and the man's care was not compromised.
25. 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.

26. On 6 September 2013, the prison doctor discussed a Do Not Attempt Resuscitation (DNAR) order with the man, who was in agreement. (A DNAR order means that in the event of a cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided). The man contacted his daughter to discuss this with her and the DNAR was agreed.
27. The clinical reviewer states that appropriate palliative care plans were in place for the man and notes that prison healthcare staff at HMP Isle of Wight are trained in end of life care. Healthcare staff regularly monitored the man's symptoms and provided nursing care when appropriate. On 10 September, an airwave mattress was provided to help make him more comfortable. The doctor took advice from the local palliative care team on medication for the man, although he decided that this medication would be too risky for a patient in the man's condition. On 13 September, a prescription was made for "just in case" medication (this is to ensure appropriate medication, such as for pain or to alleviate sickness, is available without delay) for someone near the end of their life. During that night, nurses sat with the man. His breathing became shallow and, when he was checked at 6.50am on 14 September, there were no signs of life. A doctor attended and confirmed that he had died.
28. A post-mortem examination showed that the man died from end stage acute myeloid leukaemia.
29. We are satisfied that the man received appropriate treatment after his diagnosis and his wishes were respected. We agree with the clinical review that he received good care at the end of his life and his pain was effectively managed. He was able to discuss his treatment with staff of different disciplines and there was good communication between the hospitals and prison healthcare. We agree with the clinical reviewer that the man's illness required a high level of resources and that this was managed well at the prison.

The man's location

30. From the point of receiving a terminal diagnosis in October 2012, the man stayed on his wing when he was well and was admitted to the healthcare unit when his health deteriorated. The man preferred to stay on the wing, because he knew the officers and prisoners. He was accommodated there as long as possible, in a single cell on the ground floor.
31. On 30 August 2013, the man was admitted to the healthcare unit after returning from hospital. The man stayed in a single cell and was offered a room in the palliative care suite. The suite has two enhanced care rooms for patients with palliative needs. The rooms are purpose built, furnished with soft chairs and adjustable beds and look out onto gardens. At first the man did not want to move to one of these rooms,

but on 6 September he changed his mind and moved. He subsequently had a number of falls going to the toilet, so his room was permanently unlocked from 11 September, which allowed healthcare staff easy access to care for him.

32. We are satisfied that the man's wishes to be accommodated on the wing were respected for as long as possible. He was then appropriately accommodated in the healthcare unit when necessary.

Restraints, security and escorts

33. 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 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.
34. The man attended numerous planned and unplanned hospital appointments throughout his time in prison. An escort risk assessment was completed before each planned escort. Each time the man was assessed as a medium risk to the public (on a scale of low, medium, high) and a medium risk of escape. The information in the risk assessments remained largely static, including that in the medical assessment, even when the man's health had severely deteriorated.
35. On each occasion, it was concluded that the man should be accompanied by two officers. For the most part single hand cuffs were used, but on occasions he was double cuffed. (This is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).
36. The man attended hospital appointments for treatment up until the end of his illness, by which time he was very unwell. The significant deterioration in his health was not reflected in the escort risk assessments to indicate how this impacted on his risk of escape as the High Court judgement requires. We cannot therefore be satisfied that the risk assessments reflected the actual risk that the man presented at the time.
37. 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 apparent that there has been little change in practice and that prisoners such as the man continue to be restrained without a satisfactory risk assessment which fully indicates how their health impacts on the level of risk. 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.

Liaison with the man's family

38. 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. A trained family liaison officer was appointed on 11 October 2012 and remained in contact with the man's family throughout.
39. On 3 November, a prison chaplain arranged for the man's daughter to visit him. During this visit the family liaison officer explained her role to the man's daughter.
40. When the man was admitted to hospital on 13 February 2013, the family liaison officer contacted his daughter to update her and discuss arrangements with her should her father's health deteriorate. On 22 February 2013, the man's daughter contacted the family liaison officer as she was concerned that she had not heard from her father. The family liaison officer spoke to the man, then telephoned his daughter to update her.
41. As the man's health deteriorated at the beginning of September 2013, the family liaison officer arranged for the man's daughter to visit him in the healthcare unit. The family liaison officer arranged another visit on 14 September 2013, the day that he died. Unfortunately, the man's daughter was on her way to see him at the time he died. Although national Prison Service policy requires that where possible the news of a death should usually be broken in person, the family liaison officer telephoned the man's daughter at 7.03am to inform her that her father had died. While it might have been preferable to have waited till his daughter arrived and to have informed her in person, we are satisfied that this was an understandable decision in the circumstances. The prison offered a contribution to the man's funeral costs, in line with national guidance. The funeral took place on 1 October.
42. We are satisfied that when the man became seriously ill his next of kin was informed, and that family liaison was appropriate.

Compassionate release

43. 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).

44. The prison started an application for release on compassionate grounds in October 2012. On 11 October 2012, the man's daughter wrote to the prison to confirm that she would be willing to have the man stay with her. However, it was assessed that the man's care needs could not be accommodated at his daughter's home. At the time he was assessed as a medium risk of serious harm, even though his likelihood of reoffending was low. The application was eventually rejected because of a lack of suitable release address in January 2013.
45. The prison started another application for compassionate release in June 2013. A prison doctor, commented that the man was severely debilitated by his illness and he was confident that he would not reoffend. However, a different offender manager assessed the man's risk of serious harm as high and that the previous assessment had not fully considered the circumstances of his offending. This application for compassionate release was also declined.
46. We are satisfied that the prison appropriately applied for compassionate release on the man's behalf on two occasions. Unfortunately, due to the lack of a suitable release address and the man's perceived risk the applications were both turned down.

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.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>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.</p>	Accepted	<p>Since the beginning of December 2013 the decision making process surrounding the use of restraints has significantly improved with closer working with medical staff whenever possible prior to the escort leaving the establishment. The questions in the risk assessment are now structured to enable accurate clinical information regarding mobility to be made available to operational managers when completing documentation.</p> <p>Senior managers will continue to consult with healthcare staff and/or attending medial professionals in assessing risk taking account of the mobility/medical condition of the person being escorted. Operational managers inform senior managers when a risk assessment has been completed, who then re-assess the initial risk assessment within 24 hours of any prisoner being admitted to hospital or immediately following any serious decline in health/medical condition of the prisoner admitted to hospital.</p> <p>The Governor and Deputy Governor are briefed about those going out daily without restraints and escorting staff briefed to make their dynamic assessment of a prisoner's mobility and behaviour during escort and to report it via PNOMIS upon their return.</p>	<p>Completed and ongoing.</p> <p>All band managers 5 and above, and Head of Operations</p>	