



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 from skin cancer of a man on 14 November 2013, at HMP Isle of Wight. He was 63 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at HMP Isle of Wight. The prison cooperated fully with the investigation.

The man was sentenced to 14 years in prison in 2009 and transferred to the Isle of Wight the same year. In May 2013, the man complained of a sore left ear. The prison doctor promptly referred him for tests which subsequently indicated skin cancer. In October, the man was told the cancer had spread and was too advanced to treat. His prognosis was very poor. The man moved to the prison's inpatient healthcare unit where palliative care specialists ensured his care and pain relief were well managed.

Overall, I consider that the man received a good standard of care at the prison and his end of life care was exemplary. He was also well supported by the prison's commendable nurse-led cancer support group. However, while the man was fully informed about his condition, given his learning disability, he would have benefited from additional support at hospital appointments. I am also disappointed that restraints were sometimes used unnecessarily on the man who was an older, terminally ill prisoner. This is an issue I have raised with HMP Isle of Wight a number of times before and I am not satisfied that sufficient has been done to ensure staff understand the legal requirement to ensure dying prisoners are treated with appropriate dignity.

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

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SUMMARY

1. The man was sentenced to 14 years in prison on 3 February 2009 and sent to HMP Wandsworth. He transferred to HMP Isle of Wight on 2 April 2009. During his initial health screen, the man said that he had hearing loss caused by brain surgery when he was in his twenties. He wore hearing aids in each ear.
2. On 21 May 2013, the prison doctor examined the man who had complained of a sore ear with a discharge. The doctor found a concerning lesion on his ear and referred the man urgently to a specialist as he suspected cancer. Tests confirmed that it was a malignant melanoma for which the man had surgery in July.
3. In October, doctors found that the melanoma had recurred in the man's ear. The cancer was aggressive and had spread to his glands and liver. Specialists at the Queen Alexandra Hospital in Portsmouth reviewed him but found that curative treatment was unlikely to be possible and that the cancer was terminal.
4. Initially, the man returned to his previous wing at the prison. On 19 October, he vomited blood and was admitted to the prison's inpatient healthcare unit. The next day, his condition deteriorated and he was taken to St Mary's Hospital, Newport. When his condition stabilised, he returned to the prison's inpatient unit.
5. The man was admitted to hospital again on 30 October with a deep vein thrombosis (DVT). Further tests confirmed that his cancer was aggressive, and had spread widely. No further treatment was possible. On 7 November, The man was discharged back to the prison's inpatient unit for palliative care.
6. The man's condition continued to deteriorate to a point where he was unable to take any pain relief by mouth. Medication was administered by syringe driver from 13 November. His wife visited him that day. Nurses remained with the man and he died peacefully on the morning of 14 November.
7. We are satisfied that the man received care at the prison which was equivalent to that he could have expected to receive in the community. We agree with the clinical reviewer that the nurse-led cancer support group provided commendable help for the man. However, we also agree with the clinical reviewer that, because of his learning disability, the man would have benefited from additional support to help his understanding at hospital appointments. We are not satisfied that the use of restraints for some hospital visits was 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 review 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 four staff at HMP Isle of Wight on 16 December 2013 and visited the healthcare inpatient unit where the man had lived. The investigator gave the Governor initial feedback on the investigation, and followed this up in writing.
11. We informed HM Coroner for Isle of Wight of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
12. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation. The man's wife asked why the prison had failed to respond to, or acknowledge, a letter she wrote to the Governor asking for an update on the man's condition. We drew this to the attention of the Governor, who has since written to her and apologised for this omission.
13. 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 family, his location, whether compassionate release was considered; and security arrangements for escorts.
14. The man's family received a copy of the draft report. They welcomed the findings of the investigation. 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

15. 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.
16. Since 1 June 2013, Care UK have 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

17. 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

18. 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

19. The man was the sixth prisoners 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, terminally ill prisoners.

ISSUES

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

20. The man was sentenced to 14 years imprisonment on 3 February 2009 and transferred to Isle of Wight on 2 April 2009. He had a degree of learning disability and had difficulty reading and writing. During his initial health screen, the man reported that he had undergone surgery for a brain tumour when he was in his twenties, which resulted in hearing loss. The man wore hearing aids and his hearing was checked regularly.
21. On 21 May 2013, a prison GP, examined the man who believed he had an ear infection. The GP noticed a lesion on the man's left ear and referred him urgently to a consultant dermatologist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. On 5 June, a consultant dermatologist examined the man and arranged surgery at St Mary's Hospital, Newport to remove the lesion.
22. On 24 June, the lesion was removed and confirmed as a malignant melanoma (skin cancer). The man had subsequent reconstructive surgery on 25 July. He was discharged to be followed up in three months.
23. HMP Isle of Wight has a weekly nurse led cancer support group. The man first attended a group meeting on 3 July and said that he had had difficulties understanding and remembering everything that was explained to him during hospital appointments. At the man's request, a nurse accompanied him when his wife visited to answer any questions she had about his condition. There is no evidence at that time that nurses or any other support attended his outpatient appointments to assist his understanding.
24. On 3 September, the GP examined the man and noted what appeared to be early signs of a recurrence of the melanoma. He referred him for a review by the ear, nose and throat (ENT) surgeon. On 16 September, another prison GP saw the man, who said he had increasing pain in his ear. The GP also noted there appeared to be a recurrence of the melanoma and again contacted the ENT surgeon to arrange an earlier review than originally planned.
25. On 24 September, The GP noted that the lesion had grown substantially and appeared to be spreading. He noted that the hospital had still not responded to his referral which the other GP had also followed up. The other GP examined him again on 26 September and noted that the lesion had grown rapidly and that the man was in pain. She again asked the hospital for an urgent review which the man attended on 1 October.
26. Diagnostic tests showed the cancer had recurred. After further tests on 11 October, a surgeon, informed the man that the cancer had spread to his liver.
27. On 14 October, the prison GP discussed the man's diagnosis with him. She noted that the hospital had asked for a nurse to attend any further outpatients

appointments with the man due to his difficulty in understanding and retaining information about his condition.

28. The clinical reviewer is satisfied that when the man first presented with symptoms the doctor referred him promptly to a specialist. She did not consider that the delays in getting a further hospital appointment in September affected the eventual outcome. When his cancer recurred it was likely to have already been widespread, with a poor prognosis.
29. We consider that the man was appropriately informed of his condition and well supported by prison staff after his diagnosis. It was commendable that a nurse helped him explain his condition to his wife but we agree with the clinical reviewer that he should have had support when he attended significant hospital appointments. The man had a degree of learning disability and had difficulty understanding and recalling the information he was given at appointments. Although this was overcome to some extent with the support of healthcare staff when he returned to prison, help at the time of the appointment would have been better. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with learning disabilities have a trained supporter to attend hospital appointments and help with communication and understanding.

The man's medical treatment

30. After his diagnosis, the man's care was supervised and managed by the multidisciplinary cancer team (head and neck) at Queen Alexandra Hospital, Portsmouth. There was frequent contact between the prison and hospital team.
31. The man's cancer progressed rapidly. He was monitored in the prison's inpatient unit on 19 October after he began to suffer abdominal pain and vomiting. The nurse noted that the man's skin felt clammy, he was grey, his urine was very dark and he was not eating. The next day, after continuing to suffer abdominal pain and was vomiting blood, he was taken as an emergency to St Mary's Hospital, Newport.
32. Tests confirmed the cancer had spread. The ENT surgeon, told the man that he was terminally ill with a poor prognosis and his remaining treatment option was for palliative care only (care that is not curative but may extend life). The man was discharged back to the prison's inpatient unit on 21 October. After he returned, there was good liaison between healthcare staff and hospital staff, including a skin cancer nurse specialist.
33. Records show that the man regularly attended the cancer support group where he received support, advice and guidance. We agree with the clinical reviewer that the group is a commendable initiative to help prisoners with a diagnosis of cancer and other life limiting conditions.

34. 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.
35. It is clear from the records that there were good, clear care plans in place for the man. These were well communicated to healthcare staff and discussed with the man and his wife.
36. The man had a number of hospital appointments at both St Mary's Hospital and Queen Alexandra Hospital, all of which he attended. On 18 October there was a multidisciplinary team review at Portsmouth, and it was noted the man's cancer could be a challenge to manage, but that his pain was under control and was regularly reviewed. The prison GP did not attend this meeting but did receive a letter from the hospital.
37. The GP completed a do not attempt cardiopulmonary resuscitation (DNACPR) form on 29 October. This meant that in the event of a cardiac or respiratory arrest resuscitation would not be attempted, but all other appropriate treatment and care would continue to be provided. The GP recorded he did not discuss the order with the man as he did not think it was in his best interests. Usually we would expect such decisions to be discussed with the patient, however the clinical reviewer considered that the decision not to discuss this with the man at that time was appropriate. The issue of DNACPR discussions is a matter we have covered in another recent report into a death at HMP Isle of Wight.
38. The man's cancer progressed rapidly. He was admitted to St Mary's Hospital on 30 October with a deep vein thrombosis (DVT) and discharged back to the prison's inpatient unit on 7 November. The man's cell was left permanently unlocked to allow full nursing care and easy access for staff.
39. Over the following days, the man received pain relief and other palliative medication. Records show he was nursed well, with frequent repositioning, skin and mouth care as his condition deteriorated. He received fluids and some soft foods such as jelly and yoghurt. On 13 November, he could no longer take medicines by mouth and a syringe driver was set up to administer pain relief and palliative medication. Nurses remained with the man to support him until he died at 9.25 am on 14 November.
40. A post-mortem examination found the cause of death to be disseminated malignant melanoma.
41. We agree with the clinical reviewer that the man's end of life care was exemplary. Healthcare staff took good care to liaise effectively with the hospital. Good efforts were made to look after the man and to maintain his

dignity throughout his decline, and nurses stayed with him to ensure he was not alone when he died. .

The man's location

42. When the man was first diagnosed with cancer he lived on C wing on the Albany site of HMP Isle of Wight. He moved permanently to the prison's healthcare inpatient unit when he returned from hospital on 21 October.
43. On 22 October, the GP discussed the man's location with him. The man said he wanted to be closer to his wife and the doctor said he would recommend a move to a prison nearer to his home. The next day, the clinical team manager, discussed a possible transfer with the Governor, but the man's condition deteriorated significantly before this could be arranged. He was admitted to hospital on 31 October.
44. After he returned from hospital on 7 November, the man told healthcare staff he no longer wanted a move, but preferred to stay at the Isle of Wight. We are satisfied that the man's location was appropriate to meet his needs.

Restraints, security and escorts

45. 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.
46. On 11 October, the man's condition deteriorated and he went to hospital for further tests. The prison was unable to provide a copy of the escort risk assessment for this visit, but the person escort record (PER – a record which accompanies prisoners on all journeys) noted that restraints were applied when the man left the prison. There is no record of the level of restraint used or whether these were removed during treatment.
47. On 20 October, the man became very sick and was taken to St Mary's Hospital by emergency ambulance. The PER noted he was restrained 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). The man returned to the

prison in a wheelchair. The escort risk assessment for this visit was mostly incomplete and there was no healthcare input as the court judgment requires.

48. When the man was taken to hospital on 30 October, the risk assessment had been completed the previous day. The healthcare section noted that the man was a “very poorly prisoner”, but did not comment on how this affected his risk of escape. The security assessment assessed the man as a medium risk of escape and risk to hospital staff, and a high risk to prison staff and the general public. His overall risk was considered to be medium. An operational manager authorised that he should be restrained by an escort chain with two officers escorting.
49. The man was admitted to hospital and the use of restraints was reviewed by another manager on 1 November. The manager noted that the man had very poor mobility and was in a secure room. He decided that the restraints should be removed. The man was not restrained again.
50. We are concerned that the man was restrained by an escort chain on 11 October, when he was very sick at the time. He was restrained again on 20 October without any information on the risk assessment about how his medical condition impacted on his risk. The risk assessment for his hospital stay beginning 30 October noted that he was very ill but did not comment on his risk of escape.
51. On 24 October, the GP had provided a medical assessment as part of the compassionate release process which said that the man was deteriorating, largely wheelchair bound and was highly unlikely to be able to reoffend. This does not appear to have been reflected in decisions about the use of restraints. We are not satisfied that the decisions were justified by a fully considered risk assessments that took into account the man’s medical condition at the time, as required by the 2007 High Court judgement. This is a matter we have raised with HMP Isle of Wight a number of times 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

Liaison with the man’s family

52. On 22 October, an officer was appointed as the prison family liaison officer. He introduced himself to the man and explained his role. He also telephoned the man’s wife. There was frequent contact between the family liaison officer, the man and his family, and he facilitated visits for family members.
53. The family liaison officer telephoned the man’s wife to inform her of his death on the morning of 14 November, in line with arrangements they had previously agreed. The family liaison officer offered appropriate advice and

guidance. The prison contributed to the funeral costs as required by national guidance.

54. While it might have been better to have appointed someone earlier, we note that a nurse had earlier informed the man's wife of his condition and that the family liaison officer was appointed quickly after the man returned from hospital with a definite terminal diagnosis. We are satisfied there was good family liaison at the latter stage of the man's life. It is also commendable that healthcare staff ensured that the man's wife understood his condition.

Compassionate release

55. 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. The prison's Governor makes the final decision. A supported application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS). If the Governor does not support the application for release, the application is not usually forwarded to NOMS.
56. An application for early release was initiated on 22 October 2013, shortly after the man's terminal diagnosis. The probation service did not support early release as the man was assessed as still posing a risk of serious harm if he were to reoffend. The GP completed a medical report on 24 October, and considered the man was incapable of reoffending because of his physical condition, the speed of his deterioration and because he was wheelchair bound. The GP said that the man had a prognosis of less than two months.
57. On 1 November, the Governor noted that although the man's life expectancy was short he did not consider the risk of further offending was past. Because of specific victim issues there was insufficient time for alternative arrangements for care and treatment and the criteria for compassionate release had not been fully met. The Governor did not support the application and it was not progressed further.
58. While we are satisfied that the application for the man's compassionate release was considered in a timely manner, it is difficult to see how the conclusion was reached that he remained a risk of re-offending on 1 November when his condition was extremely poor. However, we acknowledge that arrangements for appropriate care and treatment had not been satisfactorily resolved which made release unlikely. The man's health declined very quickly after this and he died two weeks later before any concerns about his potential release arrangements could be resolved.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with learning disabilities have a trained supporter to attend hospital appointments and help with communication and understanding.
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

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 prisoners with learning disabilities have a trained supporter to attend hospital appointments and help with communication and understanding. | Accepted | <p>Healthcare staff now attend planned escorts to hospital for prisoners with Learning Disabilities.</p> <p>Disability Awareness forms part of the Mental Health Awareness training package, which is provided monthly to prison and healthcare staff. The aim is that all frontline staff will eventually receive this training. A training pack will also be circulated to all healthcare staff.</p> | <p>Head of Healthcare</p> <p>April 2014</p> | |
| 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 | <p>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.</p> <p>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.</p> <p>All operational managers have been reminded of the need to consider the use of restraints on an individual basis based on the risk each prisoner presents at the time of assessment.</p> | <p>Head of Operations</p> <p>Completed</p> | |

