A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in February 2014 while in the custody of HMP Isle of Wight

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 in February 2014, while a prisoner at HMP Isle of Wight. He died from pneumonia in hospital where he had been taken because of a leaking aortic aneurysm. He was 69 years old. I offer my condolences to his family and friends.

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

The man was sentenced to 13 years in prison in 2009 and shortly after was sent to what was then HMP Albany. He had a number of pre-existing medical conditions, including ischaemic heart disease, high blood pressure, diabetes, epilepsy and asthma.

In November 2011, the man fell over in his cell and went to hospital where he was diagnosed with an abdominal aortic aneurysm. In July 2013, tests revealed that his aneurysm had grown and surgical intervention was considered. However, a second aneurysm was found close to his heart. His consultant decided an operation would be too risky and that his overall health was too poor for any active intervention.

On 5 February 2014, the man complained of pains in his chest and abdomen. He was taken to hospital where his condition deteriorated and he died several days later.

I agree with the clinical reviewer that the man received a good standard of care at HMP Isle of Wight. I am pleased to note that staff took a balanced and proportionate approach to the use of restraints on hospital visits after his terminal diagnosis and these were appropriately deemed unnecessary given his poor state of health.

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 **October 2014**

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SUMMARY

1. The man was sentenced to 13 years in prison for sexual offences on 18 September 2009 and sent to HMP Wandsworth. He transferred to HMP Albany in December that year.

2. The man had a number of pre-existing medical conditions when he arrived at the prison. He was prescribed 11 different medications to treat ischaemic heart disease, type two diabetes, epilepsy, asthma, high blood pressure, indigestion and chronic back pain. He was also a lifelong smoker and clinically obese. Healthcare staff reviewed him frequently. He was offered help to give up smoking on more than one occasion, which he refused.

3. On 22 November 2011, a prison GP referred him for an X-ray after he fell in his cell. The results showed degenerative changes to his spine, for which he was already receiving treatment. It also revealed an aortic aneurysm.

4. The man was referred to specialists at hospital, who examined him on 24 May 2012 and noted that he had an aneurysm which measured approximately 4.5 centimetres. This did not require surgery at the time but needed to be kept under review.

5. In July 2013, monitoring indicated that the man's aneurysm had grown to 6.2 centimetres and required surgical intervention. As part of the pre-operative process, he had an angiogram which indicated that he had developed a second aneurysm close to his heart. He was referred to a consultant vascular surgeon.

6. In December 2013, the consultant concluded that the only course of action to deal with the aneurysm would be for the man to have major surgery, but due to his poor physical condition it was unlikely that he would survive such a procedure. Because of the risks, the consultant decided not to intervene and that he would not benefit from any further monitoring of his aneurysms.

7. On 5 February 2014, the man was taken to hospital with chest and abdominal pains. Hospital staff believed that the aneurysm in his chest had started to leak. He was stabilised and transferred to hospital. His physical condition precluded any chance of a surgical intervention and he remained in hospital. His condition continued to deteriorate and he died several days later.

8. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Isle of Wight was equivalent to that he could have expected to receive in the community. We make no recommendations, but the head of healthcare will need to address recommendations made in the clinical review.
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THE INVESTIGATION PROCESS

1. 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 him. No one responded.

2. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. He visited HMP Isle of Wight on 27 March 2014 and interviewed five members of staff. He provided initial feedback on the preliminary findings of the investigation to the prison's Head of Operations.

3. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

4. We informed HM Coroner for the Hampshire, New Forest and Southampton district of the investigation, who confirmed the cause of death. We have sent the Coroner a copy of this investigation report.

5. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. His family received a copy of the draft report. They did not make any comments.

6. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, his location, security arrangements for escort and bedwatch, liaison with his family and whether compassionate release was considered.

HMP ISLE OF WIGHT

9. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders. The man spent time on both the Albany and Parkhurst sites.

10. Care UK provides healthcare services at the prison. There is an inpatient healthcare unit (IHU) with 18 beds on the Albany site which provides 24 hour care. The unit caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

11. The most recent inspection of HMP Isle of Wight was in May 2012. The Inspectorate noted that although healthcare services had improved considerably there were still some difficulties for prisoners accessing primary care services promptly, especially at the Albany site. However, provision for older prisoners and those with disabilities was generally found to be good and prisoners with chronic conditions were regularly reviewed. It was also noted that the management of prisoners with long term conditions was good.

Independent Monitoring Board

12. 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 ageing prison population, a third of all prisoners at the Albany site are over the age of 50, placed considerable demands on healthcare staff. However, the IMB noted that overall prisoners were satisfied with their treatment and access to healthcare services and that the inpatient healthcare unit provided a very high standard of care.

Previous deaths at HMP Isle of Wight

13. The man was the eleventh prisoner to die from natural causes at HMP Isle of Wight since January 2013.

ISSUES

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

14. The man was sentenced to 13 years in prison for sexual offences on 18 September 2009 and sent to HMP Wandsworth. He transferred to HMP Albany in December 2009 and a prison GP examined him.

15. The GP noted that the man was not in good health and suffered from a number of pre-existing medical conditions. He was prescribed 11 different medications to treat his ischaemic heart disease (he had suffered two previous heart attacks) type two diabetes, epilepsy, asthma, high blood pressure, indigestion and chronic back pain. He also recorded that the man was a lifelong smoker and clinically obese.

16. Healthcare staff frequently reviewed the man for all of his conditions. He was also offered help to give up smoking, which he refused.

17. On 22 November 2011, a nurse referred the man to a GP after he fell in his cell. The GP was concerned that the fall had exacerbated his existing back pain, and referred him for an X-ray of his spine. On 19 January 2012, an X-ray indicated a degenerative change in his spine, for which he received treatment. The results also revealed that he had an aortic aneurysm (a ballooning of the aorta, which is the main blood vessel from the heart).

18. The man was referred to the cardiovascular and thoracic care group at hospital. A consultant vascular surgeon examined him on 24 May 2012 and noted that he had an infrarenal (below the line of the kidneys) aneurysm which measured approximately 4.5 centimetres. He concluded that he did not need surgical intervention at this time, but should be monitored and arranged a follow up ultrasound scan for 6 November. This appointment was cancelled by the hospital and rebooked for 3 December.

19. On 17 January 2013, the man attended an outpatient's appointment at hospital where a specialist vascular nurse told him that his aneurysm had grown to 5.3 centimetres, but did not require surgical intervention. He had a further ultrasound scan review on 11 July.

20. On 17 July, the specialist vascular nurse discussed the results of the scan with the man and told him that his aneurysm had increased to 6.2cms and he would need an operation. On 7 August, he had an angiogram to assess his physical condition for an operation. (An angiogram is an injection of a substance into the blood stream to show accurate measurement of the aneurysm and the involvement of other vessels leading off from the aorta.)

21. A multidisciplinary team at the hospital reviewed the results on 16 August and noted that the man had developed a second aneurysm close to his heart and that his entire aorta was in very poor condition. (The aorta is the largest artery in the body, extending from the heart to the abdomen.) The team agreed that his prognosis was extremely poor and his condition was difficult to

manage surgically. He was referred to the vascular outpatient's clinic for further review and discussion of how to proceed with his care.

22. On 17 October, the specialist vascular nurse examined the man at hospital to assess his suitability for surgery and decided to carry out a further series of tests. She noted that she had had a frank conversation with him about his condition and the possibility that the risks of a surgical procedure would outweigh the risk posed by the aneurysm itself. She noted that he was fully aware that she considered surgery was not an appropriate or viable option for him.

23. On 17 December, a consultant vascular surgeon at hospital reviewed the results of the man's tests. He noted that the vascular anaesthetist considered he was "very frail and at significant risk for open surgery". A CT scan had shown that he had disease of the aorta and there had been an increase in the diameter of the aorta. The CT scan showed that his thoracic and abdominal aneurysms were equal in size, approximately 6 centimetres in diameter, and there was a restriction on the flow of blood through his arteries caused by calcium salts.

24. The consultant vascular surgeon said that the man needed a complete aortic replacement but due to his poor physical condition it was unlikely he would survive a surgical procedure so decided not to proceed. He concluded that the man would not benefit from further monitoring or intervention related to his aneurysms. Records show that hospital staff informed him that his condition was considered inoperable.

25. We agree with the clinical reviewer that the man's diagnosis was timely and appropriate. He was fully informed and understood his condition and that no active treatment was possible.

The man's medical treatment

26. After the hospital decided that nothing could be done to treat the man's aortic aneurysm, healthcare staff continued to monitor his general health. Records show that although frail, his condition was stable with no significant deterioration.

27. At 9.40am on 5 February 2014, a nurse saw the man in his cell after he complained of pains in his chest and lower abdomen. Although it was not an emergency call, she had taken emergency equipment with her including a defibrillator. She noted that he was initially alert, aware of his surroundings and interacted with her but his condition deteriorated and he became unresponsive. She gave him oxygen. At about 9.45am, she contacted the control room and requested a doctor and ambulance.

28. A prison GP arrived at the man's cell and noted he was extremely pale and drifting in and out of consciousness. The defibrillator was attached to monitor his heart. At 10.00am, paramedics arrived and took him to hospital. Hospital

staff examined him and noted that his aortic aneurysm was dissecting (an abnormal widening of the aorta).

29. The man was transferred to the vascular surgery department at hospital later that day, where it was again concluded he was unsuitable for surgical intervention due to his poor physical condition. The hospital planned to move him back to another hospital for palliative care, when he was considered well enough to travel. However, his condition continued to deteriorate and it was not possible to move him. He died several days later.

30. The specialist team in charge of the man's care concluded that he died of hospital acquired pneumonia, a leaking aortic aneurysm, gross aortopathy and multiple co- morbidities (multiple medical conditions).

31. The clinical reviewer considers that the care the man received at the prison after his diagnosis was of a good standard and that healthcare staff reviewed him frequently. We agree. It is clear that hospital staff told him his condition was inoperable however there is no evidence that healthcare staff at the prison discussed this or his prognosis with him or offered him support. The clinical reviewer points out that since his death healthcare staff at HMP Isle of Wight have started to identify prisoners with a prognosis of a year or less, to discuss expectations, end of life planning and decisions regarding resuscitation. We therefore do not make a recommendation

The man's location

32. The man lived in a single cell on the ground floor of his houseblock. He had limited mobility and occasionally used a wheelchair. He had assistance from other prisoners who helped him with daily tasks.

33. On occasions, the man was admitted to the inpatient healthcare unit for observations after falls in his cell, or when input was required from healthcare staff for one of his medical conditions.

34. It is apparent from entries in the man's prison record that he was content to live on the houseblock among his friends. He remained there until he was taken to hospital shortly before his death. We are satisfied that he was appropriately located throughout his illness

Restraints, security and escorts

35. When prisoners have to travel outside prison such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints.

36. The National Offender Management Service (NOMS) has a fundamental duty to protect the public, but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk

assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

37. After his diagnosis, the man attended hospital on a number of occasions, as both an outpatient and inpatient. The risk assessments show that two officers accompanied him but no restraints were used due to his physical condition. We are pleased to note that appropriate account was taken of his health and mobility in reaching this decision.

Liaison with the man's family

54. On 5 February 2014, the prison appointed a family liaison officer (FLO) for the man and his family. She contacted the family to inform them he had been admitted to hospital and was very poorly. She also informed them that he would be moved to another hospital later that day.

55. The FLO remained in contact with the family throughout his stay in hospital and arranged their visits.

56. At 9.31am on 13 February, one of the escorting officers contacted the Head of Offender Management at the prison to inform him that the man's condition had deteriorated and hospital staff had asked for his next of kin to be contacted.

57. Prison family liaison officers travelled to the man's sister's home to let her know. However, before they arrived, his niece had contacted the hospital for an update on his condition and was informed he had died. She then rang the man's sisters and informed them of the news. The FLOs were able to offer advice and support.

58. The funeral was held on 28 February 2014. The prison offered financial assistance in line with national guidance.

59. We are pleased to note that the prison appointed a family liaison officer when the man became seriously ill on 5 February. This ensured both he and his family were supported. We are also satisfied that his family received appropriate support after his death.

Compassionate release

38. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. There is no evidence that the man was given a life expectancy. Although his condition was considered to be inoperable, it was not clear that his death was considered imminent at the time.

39. On 12 February, as it became apparent that the man's condition was worsening, his offender supervisor started a compassionate release

application on his behalf. However, his condition continued to deteriorate rapidly and he died before it could be completed.

40. We are satisfied that the compassionate release application process was started as soon as relevant information was available to staff at the prison.