



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Isle of
Wight in February 2014**

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 of lung cancer on 19 February 2014, while a prisoner at HMP Isle of Wight. He was 61 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 10 years imprisonment on 1 October 2010 and sent to HMP Exeter. He transferred to HMP Isle of Wight shortly afterwards. .

The man had no health issues when he arrived in prison. He had very little interaction with healthcare staff until November 2013 when he complained of shoulder pain. In January 2014, he fell over and lost consciousness briefly and was admitted to the inpatient healthcare unit for observations.

A doctor requested blood tests which showed abnormal results. On 31 January, after further tests, the man was diagnosed with lung cancer which had spread to other parts of his body. Due to the advanced stage of his condition, active treatment was not possible.

I agree with the clinical reviewer that the man received good care, equivalent to that he could have expected in the community. However, I am concerned that the use of restraints for some of the man's hospital visits was not justified by fully considered risk assessments. This is an issue I have raised frequently with the prison and, while I am pleased that recent efforts have been made to ensure restraints are used appropriately on the terminally ill, in the man's case there was a lack of healthcare input to the risk assessments which meant that his condition and immobility were not adequately considered.

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 arrived at HMP Isle of Wight on 27 October 2010. When he arrived it was noted he was fit and well with no health concerns. The man had very little contact with healthcare staff until 5 November 2013, when he reported shoulder pain. A nurse examined him and found nothing abnormal.
2. On 5 December, a prison GP examined the man who said that his shoulder pain had spread to the front of his chest. The doctor diagnosed muscle strain.
3. On 10 December, a nurse took the man to the inpatient healthcare unit when she noted that his pain had got worse. A prison GP examined him and considered his pain was musculoskeletal pain (affecting the nerves, tendons, muscles and supporting structures of the body). The GP prescribed pain relief.
4. The man had a blood test on 18 December. On 30 December, the results showed slightly raised C reactive protein (CRP) levels. (CRP tests the level of protein in the blood and is an indicator of infection or long term disease.) The man was due to see the GP on 15 January 2014 to discuss his results.
5. On 11 January, a nurse found the man on the floor of his cell. He had passed out briefly and was admitted to the inpatient healthcare unit for observation. A prison GP examined the man after he fell again two days later. The doctor was concerned that the man had symptoms of cancer and arranged a chest X-ray for 15 January 2014.
6. The X-ray results received on 17 January, showed a suspected tumour in his right lung. Later that day, the GP told him that it was possible he had cancer. He was discharged from the inpatient unit and went back to live on his own wing, at his request.
7. The man began to suffer with increased memory loss and his mobility deteriorated. He returned to the inpatient healthcare unit four days later. On 31 January, a CT scan confirmed that he had cancer which had spread to other areas of his body. On 3 February, a prison GP told the man that his life expectancy was around 3 months.
8. On 12 February, an application for early release on compassionate grounds was rejected and did not contain all the required supporting documents. The man's health continued to deteriorate and he died seven days later, on 19 February. The clinical reviewer commented that the man's diagnosis of lung cancer was prompt and that he received good care. However, we are concerned about the unjustified use of restraints for some of the man's hospital appointments and the process of handling the application for compassionate release. We make two recommendations about these matters.

THE INVESTIGATION PROCESS

9. 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.
10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed five members of staff at HMP Isle of Wight on 27 March and informed the prison of the preliminary findings of the investigation.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. We informed HM Coroner for Isle of Wight of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.
13. One of the Ombudsman's family liaison officers informed the man's partner about the investigation. We did not receive a response.
14. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
15. The man's partner received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP ISLE OF WIGHT

16. 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.
17. Care UK has provided healthcare services at the prison since 1 June 2013. Before this, provision was by the Isle of Wight Primary Care Trust. There is an inpatient healthcare unit providing 24 hour care. The unit has 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

18. The most recent inspection of HMP Isle of Wight was in May 2012. The Inspectorate noted that, waiting times for routine GP appointments were sometimes too long. However, management of long-term conditions was good with good care arrangements for men with palliative care needs.

Independent Monitoring Board

19. 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 report for the year to December 2012, the IMB noted that the ageing population, particularly at the Albany site, had placed a considerable demand on healthcare services and staff. The IMB commented that, the older population had resulted in a number of deaths in custody, which the prison had handled with care and compassion.
20. The IMB also commented that the on-site inpatient healthcare unit provided an increasing range of care and treatments at a very high standard reducing the need for transfers to hospital.

Previous deaths at HMP Isle of Wight

21. The man was the twelfth prisoner to die from natural causes at HMP Isle of Wight since January 2013. We have raised the issue of the inappropriate use of restraints on a number of occasions.

ISSUES

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

22. The man arrived at HMP Isle of Wight on 27 October 2010. The next day, a nurse carried out a reception health screen and noted the man had no health concerns. He smoked cigarettes and was offered advice on giving up, but turned this down.
23. The man had little contact with healthcare staff between October 2010 and April 2011. On 12 April 2011, a prison GP examined the man who said he had a pain in his left arm. The doctor noted his chest was wheezy and arranged for a lung function test which was normal. He had no further significant contact with healthcare until 5 November 2013, when the nurse saw him as he had complained of shoulder pain. She noted he had full range of movement and she could find nothing abnormal. She gave the man ibuprofen and advised him to come back if his pain continued.
24. On 2 December, the man reported pain in his right upper groin area. A nurse examined him and noted that the area was tender but found no abnormality. A urine test showed no irregularities.
25. The nurse saw the man three days later, he said the groin pain had settled but he had right sided shoulder pain spreading to the front of his chest. She made an appointment for him to see the prison doctor the next day.
26. On 6 December, the GP examined the man and diagnosed his shoulder pain as muscle strain. Four days later, the man told the nurse that he had experienced a very sudden and increased pain in his shoulder after coughing. The GP examined him and noted his blood pressure, pulse, oxygen levels and temperature as normal. The doctor diagnosed musculoskeletal pain.
27. On 18 December, a locum GP examined the man who had left sided back pain. His lower rib was tender and he suffered increased pain on coughing. A blood test was taken.
28. The GP reviewed the blood test results on 31 December, the day after they were received, and noted high cholesterol levels and a slightly raised CRP. The clinical reviewer commented that C-reactive protein (CRP) could be slightly raised in the presence of a mild viral illness and is common.
29. The man had an appointment to see the GP on 15 January to discuss his blood results. However, on 11 January, a nurse found him on the floor of his cell. He had fallen and passed out briefly. The man told the nurse that he had a pain in the centre of his neck which radiated up into the centre of his head. The GP examined the man and admitted him to the inpatient healthcare unit for observation over the weekend.

30. The man fell again two days later and complained of a noise in his right ear which increased in volume when he spoke. A nurse examined the man but found no injuries.
31. On 14 January 2014, the man saw the GP and said he had been unsteady over the last few days and had a headache and cough that had continued for weeks. The GP was concerned that the man had a cancer malignancy which affected his brain and contacted a consultant radiologist at St Mary's Hospital, Newport for advice. The radiologist recommended that the man had a chest X-ray as the most common form of malignancy affecting the brain in men of the man's age is from lung cancer. An urgent chest X-ray was arranged at St Mary's Hospital the next day.
32. The GP received the X-ray result on 17 January, which showed a suspected tumour in the man's right lung. The GP arranged a CT scan of the man's abdomen and brain and made an urgent referral to the respiratory clinic at St Mary's Hospital under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.
33. The GP spoke to the man later that day and informed him of his suspected cancer diagnosis. He explained that he needed further tests and to see a respiratory specialist. The man said he was not in pain and did not need pain relief. He asked to return to his normal wing and was discharged from the inpatient unit the same day.
34. A nurse went to see the man that day and spoke to him about his diagnosis. He was shocked and asked to attend a weekly support group she ran for prisoners with life limiting conditions. On 21 January, the man fell while using a walking frame. He had increasing memory problems and could not walk unaided. He agreed to go back to the inpatient unit.
35. On 23 January, the man attended the respiratory clinic at St Mary's Hospital. A consultant respiratory physician prescribed dexamethasone (a strong steroid used to reduce brain swelling from cancer deposits).
36. On 29 January, the man told a prison GP that he could not remember being told of his suspected diagnosis. The GP believed that this could have been due to his brain condition, or a form of denial to cope with the bad news.
37. On 31 January, the man had a CT scan of his abdomen, chest, pelvis and head. The results, received three days later, confirmed that he had cancer of the right lung, which had spread to brain, ribs and adrenal glands (a gland located at the top of both kidneys). The GP spoke to the man the same day to confirm the diagnosis and told him that, because the cancer was so advanced, his life expectancy was about three months.
38. The clinical reviewer commented that the man's initial symptoms were non-specific and not immediately suggestive of cancer, which is common in lung cancer. After the man complained of pain in his shoulder in November 2013 he was seen promptly and offered advice and treatment. The clinical reviewer

noted that when the GP suspected malignancy in the brain he immediately discussed his concerns with the consultant radiologist at St Mary's Hospital who suggested an urgent chest X-ray.

39. We are satisfied that the man's diagnosis of lung cancer was prompt and the clinical reviewer considers that his cancer could not have been diagnosed any earlier. Doctors informed the man of his diagnosis without delay but as a result of his brain malignancy he suffered increased confusion and sometimes appeared to forget his diagnosis. Nurses spoke to him frequently and gave him the information he needed.

The man's medical treatment

40. After his diagnosis, the man remained in the inpatient unit for monitoring and symptom control. On 4 February, the GP and the man discussed his end of life care.
41. The clinical team manager met the man on 10 February and they talked about his prognosis. The manager told him that it would be weeks or months rather than years. The man had not made any decision about resuscitation, but was reassured that he would still receive symptom and pain control regardless of his decision.
42. On 11 February, the manager accompanied the man to hospital for a bronchoscopy (this is an examination of the major air passages of the lungs). The man suffered a fit in the back of the escort van while waiting at the endoscopy department. The manager alerted hospital staff and the man was taken straight to the resuscitation area of the Accident and Emergency department.
43. Blood tests confirmed that the man's brain condition had caused the fit and doctors prescribed anticonvulsant medication. Once the man had recovered, he had the bronchoscopy and returned to prison later that day.
44. On 12 February, the man discussed and agreed with the GP that he did not want to be resuscitated in the event of cardiac or respiratory arrest. On 13 February, he was given a special mattress and reclining bed to help make him more comfortable.
45. On 17 February, the GP told healthcare staff that due to the man's deterioration there would be no further intensive or invasive investigations, as he was in his terminal phase of end of life care.
46. The GP saw the man the next day, 18 February, and noted he was incontinent of urine and bedbound, but otherwise appeared comfortable and in no pain. The man found it difficult to swallow and a syringe driver was fitted to administer pain relief medication if required. This was never needed and he showed no signs of pain or distress. On 19 February at 9.45am, the man was unresponsive to voices. He died later that day at 4.40pm, a nurse and a friend were at his bedside at the time.

47. The post-mortem report shows the cause of death as disseminated bronchogenic carcinoma of right lung (widely spread cancer which originated in the lung).
48. The man had a number of care plans in place which addressed his risk of falling, his nutrition, skincare and his choice of location within the prison. We agree with the clinical reviewer that the man received good care, equivalent to that he could have expected in the community.

The man's location

49. When he first arrived at HMP Isle of Wight the man had no health or mobility issues and lived on a standard wing. After he fell on 11 January 2014, he was admitted to the inpatient unit for observation over the weekend. He stayed there until 17 January when he went back to his wing which he wanted to do.
50. The man had a ground floor cell on the wing and was given a walking frame to help him get about. The Albany site does not have in-cell sanitation and wing staff were concerned that the man might fall while going out of his cell to use the toilet at night. They arranged that the prison control room would let the man's wing officer know when the man had used the electronic system to come out of his cell at night so that the officer could check he was safe. His medical records indicated that the man had a good support network from both staff and prisoners on the wing.
51. On 21 January, the man had another fall and went back to the inpatient unit. An operational manager agreed that the man's cell should be left unlocked to allow healthcare staff access at all times. The man wanted to remain independent and continued to try to get out of bed to use the toilet. However, his balance was severely impaired and he continued to fall. Staff were concerned about his safety, and the fire hazard, as he continued to smoke. It was agreed that the man would be observed 24 hours a day and an officer remained with him at all times.
52. We are satisfied that the man was appropriately located in the prison. When he became more ill he moved to the inpatient healthcare unit where all of his care needs were met and his friends were able to visit him. The clinical reviewer was satisfied that he did not need to be admitted to hospital or a hospice.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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.

54. On 15 January, the man attended St Mary's Hospital for a chest X-ray. He needed a wheelchair. The escort risk assessment showed that the man was considered a risk to children and a medium risk of escape. The medical assessment showed no objections for the use of restraints, but did not consider his condition or how it impacted on his risk of escape, as required by the 2007 High Court judgement. The man was escorted to hospital by two prison officers and a single handcuff was used.
55. The man returned to St Mary's Hospital on 23 January to attend a respiratory clinic appointment. His risk assessment remained the same but this time no restraints were used.
56. When the man attended the hospital eight days later, on 31 January, he was escorted by two prison officers and restrained by 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.) The man's last escort to hospital was on 11 February when no restraints were used.
57. The man was escorted to hospital on four occasions. The risk assessment paperwork shows that his level of risk was assessed as the same throughout, although the risk assessment for 11 February was not available. However, on all four occasions the level of restraints used differed.
58. The investigator spoke to the head of operations. The head of operations explained that HMP Isle of Wight had reviewed its escorting procedures in November 2013 to ensure that risk assessments took into account factors such as health and mobility. From March 2014, they have kept a record (spreadsheet) when decisions were made not to restrain a prisoner.
59. The head of operations was unable to explain why the man was restrained during two of his hospital visits and why there was no healthcare assessment of his mobility and risk. It is important that there is appropriate healthcare input to risk assessment and that the requirements of the 2007 High Court judgement are followed. We recognise that the prison appears to be beginning to look more closely at the need to use restraints for elderly or infirm prisoners but it is important that the appropriate tests are applied. In this case they were not. We make the following recommendation:

The Governor and the Head of Healthcare should ensure 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

60. On 21 January, when it was clear the man's health had deteriorated, the prison family liaison officer visited him in the inpatient unit and asked if he could contact his (the man's) family on his behalf. The man agreed and the family liaison officer telephoned his partner (his nominated next of kin) the same day.
61. The family liaison officer called the man's partner again on 4 February after the man received his CT scan results. The man's partner lived some distance away from the prison and the family liaison officer gave her details of financial help available for visits if she needed it.
62. On 17 February, the man's partner visited him at the prison. The GP and the clinical team manager discussed the man's care with her. She visited him again the next day. She then had to go home and asked the family liaison officer to telephone her if the man's condition got worse.
63. The man's health deteriorated quickly overnight and the family liaison officer remained in contact with his partner. The man died at 4.40pm on 19 February and the family liaison officer telephoned his partner, as they had previously agreed, to inform her of his death.
64. The man's funeral was held on 17 March at the Isle of Wight Crematorium. Family liaison officers and the prison chaplain attended. In line with national policy, the prison contributed towards funeral costs.

Compassionate release

65. 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).
66. The GP completed the healthcare section of a compassionate release application on 4 February 2014. He detailed that the man was unable to stand unaided and had terminal lung cancer with brain metastasis. The GP provided a letter from the consultant respiratory physician dated 24 January

which showed a diagnosis of “probable cerebellar metastases with possible right hilar lung mass”. The man’s offender manager and the Governor did not support the man’s application for compassionate release as they considered his risk of harm to others was not sufficiently low to warrant early release. It is not clear how they reached that conclusion given his physical condition at the time. The application was submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service on 7 February.

67. On 12 February 2014, the application was rejected. Concerns were raised about the man’s current level of risk, provision of healthcare in the community and lack of information about his diagnosis. The PPCS explained that the letter provided from the consultant respiratory physician did not give a prognosis and was slightly vague as to the current diagnosis. The prison was asked to monitor the man’s health and re-submit his application if his condition deteriorated.
68. On 18 February, the GP noted that the man was bedbound, confused and barely conscious and that he expected him to die within the week. Later that afternoon, the Governor asked that the man’s application for compassionate release should be sent to the public protection casework section again.
69. The PPCS contacted the prison the next day, to explain that they required something from the man’s consultant to be able to reconsider the application. The PPCS suggested the hospital CT scan results of 31 January confirming the cancer diagnosis. These hospital scan results had been received by the prison on 3 February, the day before the GP completed his section of the ERCG paperwork, and four days before the ERCG application was submitted for the first time. It was not clear why these scan results confirming the cancer diagnosis were not submitted then. The man died at 4.40pm that day before his application was reconsidered.
70. It is possible that the man’s application would have been refused for a number of reasons, but it is important that all required information is submitted with applications and that risk assessments are based on current, up to date information, reflecting the prisoner’s condition at the time. We make the following recommendation:

The Governor should ensure that all compassionate release applications are complete and supported by all necessary information, including up to date risk assessments, before they are submitted.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure 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
2. The Governor should ensure that all compassionate release applications are complete and supported by all necessary information, including up to date risk assessments, before they are submitted.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor and the Head of Healthcare should ensure 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>Briefings to senior staff have taken place, and an e-mail has been sent to all operational managers, to remind them of the need to consider the use of restraints on an individual basis and to take medical assessments of mobility into consideration when assessing each prisoner's risk of escape and/or risk of causing harm to others.</p> <p>The South Central DDC has discussed this issue with the Governor and is content that appropriate action has been taken to remind staff of their responsibilities in line with the senior leaders' bulletin from the Director of Public Sector Prisons and the Deputy Director of Contracted Prisons issued in January 2014.</p>	<p>Complete</p> <p>Head of Operations / Head of Health / South Central DDC</p>
2	The Governor should ensure that all compassionate release applications are complete and supported by all necessary information, including up to date risk assessments, before they are submitted.	Accepted	A record of all terminally ill prisoners is kept by the safer custody team and regularly updated in consultation with Care UK. On the request of safer custody staff, offender supervisors will initiate compassionate release applications and ensure these are completed and supported by all	<p>Complete</p> <p>Safer Custody / Offender Management Unit</p>

			<p>necessary information, including up to date risk assessments, before they are submitted.</p> <p>Safer custody staff will be provided with updates about applications and the custodial manager in the Offender Management Unit will carry out monthly management checks to ensure compliance.</p>	
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