PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man at HMP Isle of Wight in October 2012**

## *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 report of an investigation into the death of the man, who died in October 2012, in the inpatient healthcare unit at the Albany site of HMP Isle of Wight. The cause of death was bronchopneumonia due to chronic obstructive pulmonary disease (COPD). I offer my condolences to his family and friends.

One of my investigators carried out the investigation. A clinical reviewer was commissioned to carry out a review of the man's clinical care in custody. HMP Isle of Wight cooperated fully with the investigation.

The man had been in prison for nearly ten years and had been diagnosed with a number of chronic diseases. His health began to deteriorate in 2012. The clinical reviewer concludes that he received good care and support from healthcare staff at HMP Isle of Wight. Although he was sometimes a difficult man to care for, I am satisfied that the man was treated appropriately at the prison. However, I note that he was not offered the anti-pneumonia vaccination recommended by the NHS for people with COPD.

As I have found in another recent investigation at HMP Isle of Wight, restraints were used unnecessarily on the man in hospital, although he needed a wheelchair for mobility and was judged to be a low risk of escape. There is an evident need for the prison to review its risk assessment process for prisoners with poor health and mobility who are receiving hospital treatment. These assessments need to ensure that individual circumstances are taken into account and are informed by the actual risk the prisoner presents.

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.

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**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **February 2013**

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## SUMMARY

1. The man was sentenced to life imprisonment in 2004, and moved to the Albany site at HMP Isle of Wight in January 2005. He had undergone a significant heart operation shortly before being sent to prison and had been diagnosed with a number of chronic diseases, including chronic obstructive pulmonary disease. (COPD, a term that encompasses a number of lung diseases including chronic bronchitis and emphysema).

2. The man had periods when he did not take his medication or attend hospital appointments. After complaining of frequent vomiting in January 2012, he was referred to a specialist at the local hospital with suspected cancer. He refused to go to the first appointment because he said he needed a wheelchair and prison nurses disagreed. A second appointment was made when nurses agreed that he needed a wheelchair, but this was not provided. We recommend that wheelchairs should be provided when necessary.

3. The man attended a third appointment on 13 February. He had a number of scans and tests over the following months, and was a hospital inpatient for over a month, but no cancer was found. However, the man's health continued to deteriorate with worsening kidney function and heart failure. After a second hospital inpatient admission, in June, the man was told that he was terminally ill.

4. The man's health deteriorated significantly in October and he moved to the prison's inpatient healthcare unit. His condition continued to deteriorate and, on 19 October, an end of life pathway was initiated. The man died that night. His cause of death was established as pneumonia due to COPD.

5. The man made two applications for early release which the Governor did not support. We are satisfied these were appropriately considered.

6. The clinical reviewer comments that, because of his poor compliance with medication and treatment plans, the man was not an easy patient to treat. Nevertheless, she concludes that he received good care at HMP Isle of Wight, equivalent to that which he could have expected to receive in the community. However, the man was not offered the pneumococcal vaccination, to protect against certain strains of pneumonia which NHS guidance says should be offered to those over 65 with COPD and other respiratory diseases. We recommend that the vaccination is offered, in line with national guidance.

7. Although the man used a wheelchair and was assessed as a low risk of escape, restraints were mostly used for hospital stays and appointments. We consider that risk assessments need to take into account a prisoner's individual circumstances, particularly their health and mobility. Finally, we recommend that the next of kin of seriously ill prisoners are told when they are admitted to hospital.

## THE INVESTIGATION PROCESS

8. On 22 October 2012, notices about the investigation were issued to staff and prisoners at HMP Isle of Wight, inviting anyone who had relevant information to contact the investigator. No one came forward.

9. The investigator visited the prison on 25 October. He saw G wing, where the man had lived, and spoke to three prisoners who knew him, including a prisoner who was employed as his 'buddy'[1]. He visited the inpatient healthcare unit (IHU) and spoke to a senior nurse who knew the man. He also met the prison's deputy family liaison officer. The investigator obtained the man's prison and medical records.

10. A review of the man's clinical care in custody was carried out by the clinical reviewer, on behalf of the primary care trust cluster.

11. One of our family liaison officers wrote to the man's brother, his next of kin, on 13 November. She explained the purpose of the investigation. The man's family did not identify any issues for the investigation to address. They were also offered an opportunity to receive and comment on the draft version of the report, however, to date, have chosen not to do so.

12. The report was also sent in draft to the Prison Service. Their response to the recommendations is included on page 18.

[1] Some prisoners, who are assessed as suitable for the role, help those prisoners who require it with everyday activities such as cleaning their cell, collecting meals and hot water, and pushing wheelchairs. Buddies receive formal training and are paid for carrying out the work.

## HMP ISLE OF WIGHT

13. HMP Isle of Wight is an amalgamation of three prisons, Parkhurst, Camp Hill and Albany. The man was at the Albany site, which holds up to 567 sex offenders and vulnerable prisoners in five cell blocks.

14. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). An inpatient healthcare unit (IHU) at the Albany site caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

## HM Inspectorate of Prisons (HMIP)

15. HMIP conducted an announced full follow-up inspection of HMP Isle of Wight in May 2012. They 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.

16. The inspection found that prisoners with chronic (long term) diseases were reviewed regularly and there were suitable nurse-led clinics for prisoners with respiratory diseases.

## Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for HMP Isle of Wight noted that the opening of the inpatient healthcare unit had reduced the number of prisoners staying as inpatients in outside hospital. They also noted that the ageing population at Albany had led to increased waiting lists for some health services.

## Previous deaths at HMP Isle of Wight (Albany)

18. We have investigated a number of previous deaths at Albany, mostly of older prisoners. Many of the men had serious medical conditions. The man was the 11$^{th}$ of 13 men to die at Albany since January 2011. Our investigation into the death of a man who died two days after the man also criticised the use of restraints for a man who was a wheelchair user. Our investigation into the death of a man who died two weeks after the man found that he also died of pneumonia due to COPD and had not been offered the pneumococcal vaccination despite being in one of the recognised risk groups.

## KEY EVENTS

19. The man was remanded into the custody of HMP Exeter on 30 July 2003. He had very recently had a heart bypass operation, from which his consultant reported that he had recovered well. The man had a number of other significant medical conditions, including insulin controlled diabetes, atrial fibrillation (irregular heartbeat) and chronic obstructive pulmonary disease (COPD). He was prescribed various medications for these conditions including warfarin (for atrial fibrillation), ramipril (for high blood pressure) and frusemide (medication to treat the accumulation of fluid in the body because of heart failure).

20. On 4 October 2004, the man was convicted and sentenced to life imprisonment with minimum time of six years and two months before he could be considered for release. He moved to the Albany site at HMP Isle of Wight on 20 January 2005.

21. The man reportedly kept himself to himself for most of his time at Albany. He worked in the prison library and took an Open University course. He stopped taking some of his medications on several occasions, often due to what he regarded as injustices in the prison system. The man declined to attend several hospital appointments, because he did not like having to be searched before leaving the prison. He attended most of his appointments at the prison's chronic disease clinics.

22. In late November 2011, the man collapsed and suffered weakness down his right side. The stroke clinic at St Mary's Hospital, Newport, diagnosed a transient ischaemic attack (TIA, often known as a mini-stroke, caused by a temporary disruption in the blood supply to part of the brain). The next month, a blood test showed that the man had progressively worsening kidney failure and his medication was changed.

23. On 6 January 2012, the man told Dr A, a prison doctor, that he had recently been vomiting several times a day and his mobility had deteriorated. The doctor made an urgent referral under the two week rule for suspected cancer (a national target for patients with possible cancer to be seen by a specialist within two weeks of referral). An appointment was made for 13 January but, that morning, the man said he did not want to go. He explained that he did not want to undergo the usual searches and he was not capable of walking from his cell to the car that would take him to hospital. Staff arranged for the car to collect the man from outside his wing, rather than the reception area from where prisoners are usually collected. A prison nurse said that the man was capable of walking to the car. The man disagreed and did not attend the appointment.

24. A second appointment was made for 16 January, three days later. A nurse now agreed that the man needed a wheelchair, but one was not provided (it is not clear why) and the man said he was unable to walk.

25. In view of the continued concern over his health, a further referral was made and an appointment was scheduled for 13 February.

26. In the two weeks before this appointment, staff on the man's wing raised concerns with the healthcare department that he was finding it difficult to walk around the wing. A nurse assessed the man, and he told her he was able to walk as far as the wing office. The nurse advised him of the importance of remaining mobile. She encouraged him to continue walking around the wing, as well as using a wheelchair for longer distances. (A wheelchair was now available to the man to use when he needed to leave the wing.)

27. A risk assessment was carried out before the appointment on 13 February to assess what security measures were required, including the use of restraints. In the medical section of the risk assessment, it was recorded that he needed a wheelchair due to poor mobility and this restricted his ability to escape unaided. In the security section, he was assessed as a low risk of escape and medium risk to staff and the general public. The risk assessment was authorised by the security and operations manager, who agreed that two officers should accompany the man and an escort chain[2] should be used to restrain him rather than standard handcuffs as he was a wheelchair user.

28. The specialist who saw the man on 13 February noted his recent symptoms and blood results. She asked that he return for a gastroscopy (examination of the stomach involving the insertion of a long, flexible tube into the mouth or nose and threading it to the stomach) and ultrasound (a scan of the organs using high frequency sound waves).

29. The man's gastroscopy was arranged for 24 February. The security arrangements were the same as for the previous appointment. The escort chain remained on during the man's gastroscopy, which was carried out under a local anaesthetic. A biopsy (a sample of tissue for more detailed examination) was taken during the procedure, the results of which showed nothing significant.

30. The ultrasound took place on 7 March, with the same security arrangements as before. Other than gallstones, the scan showed nothing significant and the man's liver and kidneys appeared normal. However, his blood tests continued to indicate abnormal liver and kidney function. The consultant therefore asked that the man return for a three-day admission on 10 April for further tests.

31. On the morning of 10 April, the escort staff were required for a more urgent hospital admission. Administrators contacted Dr A, who agreed to postpone the man's admission to 24 April.

32. In the two weeks after his postponed admission, the man saw prison nurses and doctors on several occasions. He said he was feeling more unwell and had vomited. The man was offered admission to the prison's inpatient healthcare unit but declined.

33. The man was admitted to St Mary's Hospital on 24 April, as planned. The risk assessment carried out before his admission reached the same conclusions as

[2] An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer.

those previously, and an escort chain was used throughout his time in hospital. The man's symptoms worsened after his admission. At times he was very unwell and remained in hospital much longer than the three days originally envisaged. His risk assessment was reviewed twice in May, by a residential manager. The residential manager concluded that the risk assessment was appropriate and no changes were required.

34. Hospital tests showed that the man had congestive heart failure, an enlarged heart, and congestion of the lungs. He was too unwell to undergo some tests, but no evidence of cancer was found. As his condition improved when his heart medication was changed, hospital doctors thought that his recent symptoms were probably a result of his heart condition. The man returned to the prison on 6 June.

35. The man was unable to pass urine after he returned to the prison so agreed to move to the inmate healthcare unit, but refused other interventions such as catheterisation. On the morning of 9 June, the man complained of chest pain and an ambulance was called to admit him to St Mary's. A risk assessment was completed and, as previously, it was determined that an escort chain should be used. After a review, the escort chain was removed later that evening when the man was so unwell that he had no mobility.

36. On the evening of 9 June, with the man's agreement, doctors at the hospital implemented a 'do not attempt cardiopulmonary resuscitation' (DNAR) order[3]. The doctor who completed the form recorded that resuscitation was unlikely to be successful because of the man's other illnesses.

37. The man was diagnosed with acute kidney failure and had dialysis to improve his kidney function. He was also treated for heart failure, COPD and diabetes. On 12 June, the man moved from the hospital's intensive care unit to a ward. The escort chain was reapplied, but removed again on 14 June, when a review recognised that the man was still immobile.

38. By the time of his return to the prison on 19 June, the man's mobility had improved and he was now able to walk short distances with the help of a walking aid. The heart specialist had told him that his condition meant that he was terminally ill and, while he was comfortable and pain free when he left the hospital, his life expectancy could potentially be very short. The man was initially admitted to the inmate healthcare unit for monitoring.

39. Officer A was appointed as the prison's family liaison officer on 21 June. He introduced himself to the man on the same day to explain the role. Two days later, the man told a prison chaplain that he had told his brother (his nominated next of kin) and sister that he was terminally ill. The officer telephoned the man's brother on 28 June to introduce himself and left contact details should the man's family have any questions.

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

40. On 26 June, the man returned to his wing from the IHU. His buddy told the investigator that the man seemed much worse than before he was admitted to hospital. He said that the man now needed help with getting out of bed and dressing. A wing officer noted that the man appeared very unwell and rarely came out of his cell. A referral was made for an occupational therapy assessment to see if he could get an aid to help him get out of bed. It is not clear whether this assessment took place.

41. The man's solicitor requested that early release on compassionate grounds[4] should be considered. Dr B, a prison doctor, completed the medical section of the application on 6 July. He said that the man's prognosis was unknown and that his condition did not render him incapable of re-offending. The offender supervisor's section of the application was completed on 9 July. It highlighted the high levels of risk presented by the man and concluded that it did not support the application. The Governor considered the application on 16 July but did not approve it, as the man did not meet several of the required criteria, including his risk to the public, and that his life expectancy was unknown.

42. The man signed a disclaimer on 23 July, to say that he did not wish to attend an appointment for an ultrasound examination at St Mary's Hospital that day. (The appointment had been arranged three weeks earlier after the man reported a swollen testicle.) No reason for his refusal was recorded.

43. In late July and early August, prison nurses visited the man in his cell several times, when he reported no problems. The man's buddy confirmed that nurses came to see him frequently, but said that he thought the man did not tell them how unwell he was because he did not want to move to the inpatient unit.

44. The man's solicitors made a second request for early release on compassionate grounds in early August. They wrote to Dr A to ask for an updated medical report and prognosis. In his reply, dated 8 August, the doctor wrote that it was very difficult to provide an accurate assessment of the man's prognosis. He explained that the man could die very quickly, in the next few days, but could also live for longer than three months.

45. On 21 August, the man told a nurse that he had vomited a number of times recently. He did not attend a doctor's appointment arranged for the next day. A nurse visited him in his cell on 25 August, and noted that he appeared comfortable. Dr A saw the man on 28 August, when he said he was vomiting every day. The doctor prescribed a course of prochlorazepine (to control nausea and vomiting). The man also told the doctor he had recently experienced a sharp throbbing pain in his foot. The doctor diagnosed diabetic neuropathy (nerve damage due to high blood sugar from diabetes).

46. On 5 September, the man signed a disclaimer to say he did not wish to attend an upcoming hospital urology appointment as he said there was "no point" in going.

[4] Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. Prisoners are usually expected to have less than three months to live, and various other criteria must be met for an application to be successful, including a minimal risk of re-offending and adequate arrangements for the prisoner's care and treatment outside prison.

He declined an appointment at the prison's diabetes clinic later in the month and did not attend several appointments with prison doctors in September.

47. The Governor considered the second application for early release on 6 September. In the light of Dr A's comments on the uncertainty of the man's prognosis, he again decided not to support the application.

48. Dr A examined the man on 18 September and concluded that he was "clearly deteriorating". He continued to experience sickness and vomiting, and blood tests showed his kidney function was worsening. They discussed his decision not to be resuscitated, which he said he wanted to continue. The doctor offered to admit the man to the inpatient unit but he preferred to stay on his wing.

49. On 21 September, the man passed urine that appeared to contain traces of faeces. Dr A suspected that he might have a fistula (an abnormal connection between two organs or vessels that do not normally connect) and discussed this with a specialist at St Mary's, who suggested admission for further investigation.

50. The man remained in hospital for six nights for tests but nothing abnormal was found. He was again restrained by an escort chain and accompanied by two officers. The man was prescribed antibiotics and returned to G wing on 27 September, once he had stabilised. On 28 September, Dr A reviewed the man and noted that his urine was now clear. Two days later, the man complained of kidney pain and Dr C, a prison doctor, prescribed co-codamol to treat the pain.

51. In the first week of October, prison nurses visited the man frequently. He told them he felt comfortable, but was not eating or drinking as he vomited anything that he swallowed. The man continued to decline a place in the inpatient unit, but, on 11 October, he agreed to move after nurses persuaded him that he would have better access to nursing care and his nausea and vomiting would be better monitored and managed. It was agreed that the man's room in the inpatient unit would remain unlocked to allow nurses 24 hour access.

52. On his first full day in the inpatient unit, the unit manager discussed with the man his preferences for end of life care. The unit manager explained the principles of palliative care and the benefits of the King's Fund high dependency rooms in the unit for end of life care. Over the next days, the man vomited and was incontinent of urine and faeces a number of times. A care plan was written, records were kept of his food and fluid intake and he was given a liquid diet.

53. On 16 October, Dr A discussed different ways of administering medication with the aim of better controlling the man's nausea, but the man refused all the suggestions. The doctor noted that the man was obviously deteriorating, but he denied being in pain. The next day, the man moved into the King's Fund room and he now agreed to a syringe driver[5] to administer his anti-sickness medication. It was agreed that diamorphine (a strong painkiller) should be added to the medication as he said he had pain in his legs and abdomen. Due to an

[5] A syringe driver provides continuous infusion of medication through a needle inserted under the skin. They are often used for seriously ill patients who are suffering from vomiting and unable to keep tablet medication down.

apparent communication error, the man did not receive the painkiller until the next morning.

54. On the morning of 19 October, the man was placed on the Liverpool Care Pathway. This is a process intended to provide the best quality of care possible for dying patients in the last hours or days of life, tailored to an individual's needs and in line with their wishes. The aims of the pathway were explained to the man. The syringe driver appeared to control the man's nausea and he said he was pain-free once the diamorphine was added. During the night of 19-20 October, while making a routine check, the night nurses discovered that the man had stopped breathing. The doctor was called and formally confirmed death at 12.24am.

55. Around an hour later, Officer A telephoned the man's brother to break the news of the death. The man's brother had previously said that he did not want prison staff to visit him at home and would prefer to be contacted by telephone. A prison officer told the man's buddy in person about his death. A memorial service was held at the prison.

56. At the request of the man's brother, the funeral was organised by staff at HMP Isle of Wight. A prison chaplain led the service.

## ISSUES

### Clinical care

57. The clinical reviewer comments that the man had multiple chronic diseases and, at times, did not comply with his medication and recommended treatment plans. She comments that this made the man's care very difficult for healthcare staff, although she concludes that they managed his treatment well and were able to provide good care during his time in prison, particularly at times when he was more unwell.

58. The clinical reviewer goes on to say that, while the man received care equivalent to that he could expect to receive in the community, there were some areas for improvement to help achieve a 'gold standard' of care. For example, she comments that the man's blood pressure and cholesterol were not in the target range, which is particularly important for patients with a history of heart disease, yet there was little evidence of action plans to improve these results. Additional thought could have been given to alternative medications to manage the man's diabetes and deteriorating kidney function.

59. The clinical reviewer said that the man's nausea and vomiting symptoms were difficult to treat. She concludes that he was treated with suitable medication and, as he deteriorated, the Liverpool Care Pathway was appropriately used.

### Provision of pneumococcal vaccination

60. NHS guidance recommends that persons aged 65 or over or those who fall into certain risk groups should receive the pneumococcal vaccination. This is a vaccination that protects against 23 strains of a bacterium that can cause several conditions, including pneumonia. The at-risk groups who should be offered the vaccination include persons with long-term respiratory conditions, such as COPD. The vaccination is given just once and, for most adults, offers protection for life. However, it does not protect against all pneumonia causing bacteria.

61. The cause of the man's death, established following post-mortem examination, was bronchopneumonia due to COPD. Although he fell into several of the risk groups, there is no indication in his records that the man was offered or received the pneumococcal vaccination.

    **The Head of Healthcare should ensure that patients with respiratory conditions who meet the NHS criteria are offered the pneumococcal vaccination.**

### Attendance at hospital appointments

62. The man had a hospital appointment on 13 January 2012, under the two week rule for suspected cancer. He said he was not able to walk from his cell to the car that would take him to hospital and, despite a nurse saying he could manage this distance, he refused to go. The appointment was rebooked three days later when a nurse acknowledged that he did need a wheelchair. However, a

wheelchair was not provided and the man missed a second appointment. On both occasions it was agreed that the car would collect the man from outside his wing, rather than the reception area from where prisoners are normally collected for external visits, so the man's lack of mobility was acknowledged.

63. These were important appointments and the prison should have made reasonable efforts to encourage the man to attend. There was a clear inconsistency between the assessments of the man's mobility before the two appointments, even though they were only three days apart. We consider it would have been appropriate to provide a wheelchair for the first appointment and it was unacceptable that one was not provided on the second occasion when a nurse assessed that one was needed.

    **The Governor should ensure that prisoners are encouraged and assisted to attend hospital appointments and that wheelchairs are provided when a healthcare assessment concludes that one is needed.**

**Restraints**

64. 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 deemed that handcuffing 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.

65. After the problem with the January appointments, the man was able to use a wheelchair for all future outpatient appointments, as it was then evident that he could only walk for short distances without assistance. He also had three inpatient stays in hospital, one of which was particularly lengthy. For each of these visits the risk assessments were consistent. The man was assessed as a low risk of escape and a medium risk to staff and the public. An escort chain was used on each occasion, other than during his inpatient stay at St Mary's from 9 June to 19 June 2012, when restraints were not applied for most of the stay, when it was recognised he had extremely limited mobility.

66. Prison Service guidance is that restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. As the man needed a wheelchair to get about, this would apply in these circumstances. There is no evidence to suggest that the man presented a risk of escape or to the public that could not be managed by a two officer escort. In the light of the severity of his

condition and his lack of mobility, we do not think the use of an escort chain was necessary or justified.

67. In addition, the man underwent two particularly instrusive procedures: a gastroscopy on 24 February 2012 and a sigmoidoscopy during his inpatient stay from 21 September to 27 September 2012. These procedures involve inserting a long, flexible tube into the mouth and rectum respectively, and were carried out under local anaesthetic. An escort chain was used during both procedures.

68. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The man had been assessed as a low risk of escape and a medium risk should he do so. We do not consider the risk the man presented warranted the use of an escort chain during these invasive procedures, or during any of his hospital visits once he became a wheelchair user.

**The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.**

**Compassionate release**

69. Early release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include 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).

70. The man's solicitors twice applied for early release on compassionate grounds. On both occasions the Governor decided not to support the application. Although the man had been told he was terminally ill and could die very soon, his prognosis could not be measured with any certainty and it could not be said that he had less than three months to live. There were also doubts that his risk had reduced sufficiently to allow his release and that there was suitable accommodation for his future care. We therefore agree that these were appropriate decisions. It was not until the very late stages of his life that his prognosis became clear. It would have been difficult to organise suitable care in the community at that stage and we consider that the prison acted appropriately.

**Family liaison**

71. A family liaison officer, Officer A, was appointed on 21 June 2012, shortly after the man's return from a ten-day inpatient admission to hospital, when he was told he was terminally ill.

72. The man had previously had a long stay in St Mary's Hospital, from 24 April to 6 June, as well as his ten-day admission from 9 June to 19 June. The man's family were not contacted during these admissions, although he was very unwell.

73. Prison Rule 22 requires that a prisoner's family is informed if they become seriously ill. We believe it is right that a family liaison officer was appointed when the man was told that he was terminally ill. However, we also consider that it would have been appropriate to tell his family that the man was in hospital during his long inpatient admissions.

    **The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.**

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with respiratory conditions who meet the NHS criteria are offered the pneumococcal vaccination.

   *Accepted – All primary healthcare centres within HMP Isle of Wight have been instructed to administer the appropriate course of pneumococcal vaccination to all prisoners meeting the criteria and who agree to receiving it. Stocks of vaccine are available in all centres and Patient Group Directive (PGD) is in place.*

2. The Governor should ensure that prisoners are encouraged and assisted to attend hospital appointments and that wheelchairs are provided when a healthcare assessment concludes that one is needed.

   *Accepted – All escort risk assessments now have section two completed by the healthcare team prior to the remaining elements of the risk assessment being completed. This will indicate if a wheelchair is required and if so it will be arranged with an appropriate vehicle supplied to transport the wheelchair.*

3. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

   *Accepted – Placed in Local Security Strategy and checks in place to ensure compliance.*

4. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

   *Accepted – Operational managers have been made aware. Advice to be issued to operational and custodial managers to ensure that they are aware of their responsibility to inform next of kin. This has been added to the Local Security Strategy and a question has been added to the risk assessment. Checks are in place by in-charge governor at operational briefings.*