A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in September 2014 at 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 of lung cancer in September 2014 at HMP Isle of Wight. He was 66 years old. I offer my condolences to the man's family and friends.

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

The man was sentenced to 19 years in prison in November 2013 and moved to HMP Isle of Wight in February 2014. He had high blood pressure and smoked heavily, but did not want to stop. Nurses monitored the man's blood pressure and doctors reviewed his medication regularly. The man did not report any significant health issues until August, when he said he had chest pains and tightness in his upper abdomen. A doctor referred him urgently to a specialist who diagnosed terminal lung cancer which had spread to his liver.

I am satisfied that there was no delay in the man's diagnosis and that healthcare staff at the prison kept well informed about his condition. He had a high standard of end of life care and staff managed the man's pain relief well. I consider that the man received very good medical care at Isle of Wight and that he received commendable and compassionate support from all the staff involved. There was an inconsistent approach to the use of restraints for hospital visits in early September, with inadequate healthcare input into the risk assessment. However, I recognise that this was rectified the next day and the man was not restrained after that.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2015**

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SUMMARY

1. The man was sentenced to 19 years in prison on 25 November 2013. In February 2014, he moved to HMP Isle of Wight from HMP Exeter.

2. The man had high blood pressure for which he took medication. He smoked heavily, but refused help to stop smoking. Healthcare staff monitored his blood pressure regularly.

3. On 26 August, the man told a prison GP he had pains in his chest and tightness in his upper abdomen. The GP referred him to a gastrointestinal specialist at St Mary's Hospital, Newport. On 2 September, a scan showed that he had advanced lung cancer, which had spread to his liver. A prison GP informed the man of the diagnosis the next day.

4. The man's condition was not suitable for active treatment and healthcare staff implemented an end of life care plan to ensure he received appropriate pain relief and support. After his diagnosis, staff moved him to a designated end of life care room in the prison's healthcare centre to allow appropriate nursing care. The man's condition deteriorated quickly and he died on 23 September.

5. The clinical reviewer concluded that the man received a high standard of care at Isle of Wight. We agree and commend the caring approach of staff at the prison. However, we are concerned that there was insufficient healthcare input into the risk assessment in September, when the man was restrained with an escort chain when he went to hospital. We make one recommendation.

THE INVESTIGATION PROCESS

6. 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.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She gave the Governor written feedback about the preliminary findings of the investigation.

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

9. 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.

10. One of the Ombudsman's family liaison officers contacted the man's daughter, his nominated next of kin, to explain the investigation. She did not raise any concerns about the man's care at the prison.

11. 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 visits, liaison with his family, and whether compassionate release was considered.

12. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

13. The man's family received a copy of the draft report. They did not make any comments.

HMP ISLE OF WIGHT

14. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany. The prison holds mostly sex offenders.

15. Care UK provides healthcare at the prison. There is an inpatient healthcare unit with 18 beds on the Albany site, catering for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

16. 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

17. 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 the year to December 2013, the IMB commented very favourably on the healthcare provision at the prison and care for prisoners with terminal illnesses.

Previous deaths at HMP Isle of Wight

18. The man was the fifteenth prisoner to die of natural causes at the prison since January 2013. A number of these men were also diagnosed with cancer and we have generally found a good standard of care, equivalent to that which they could have expected in the community. We have made recommendations about the need for appropriate risk assessments to justify the use of restraints a number of times before.

ISSUES

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

19. The man had high blood pressure for which he took medication. He was a heavy smoker and had declined help to give up smoking several times. After he arrived at the prison in February 2014, nurses monitored the man's blood pressure and doctors reviewed his medication regularly. He did not report any significant symptoms and he did not have a cough.

20. On 22 August, the man told a prison GP, that he felt nauseous, had a loss of appetite and a sore throat. The doctor prescribed medication to relieve excess stomach acid.

21. On 26 August, the man told another prison GP that he had chest pains and tightness in his upper abdomen. The GP noted a palpable mass in the man's abdominal area and asked for blood and liver function tests, the results of which were abnormal. The GP admitted the man to the prison's healthcare inpatient unit for observation and prescribed dihydrocodeine and co-codamol for pain relief. He told the man it was possible he had cancer and he would refer him to a specialist.

22. On 27 August, the GP referred the man to a gastrointestinal specialist under the NHS pathway which requires patients with suspected cancer to be seen within two weeks.

23. On 1 September, the man had an ultrasound scan at St Mary's Hospital, Newport. The results showed an advanced malignancy in his abdomen. The next day, a CT scan showed he had advanced lung cancer which had spread to his liver. On 3 September, the GP explained the diagnosis to the man.

24. On 11 September, a consultant gastroenterologist at the hospital saw the man and suggested a bronchoscopy to provide a more detailed diagnosis. The man discussed this with the GP but decided not to proceed because he did not want any more information about his condition.

25. We agree with the clinical reviewer that doctors referred the man quickly to hospital for assessment when he presented with symptoms. Hospital staff and healthcare staff at the prison kept him fully informed about his condition.

The man's clinical treatment

26. Hospital consultants considered that no active treatment was possible and the man's condition was terminal. Healthcare staff implemented an end of life care plan to manage the man's pain relief and palliative care.

27. On 4 September, the man discussed his symptoms and prognosis with the GP. They discussed his views about resuscitation if he had a cardiac or respiratory arrest. The man said he did not want to be resuscitated and signed an order to that effect.

28. Nurses saw the man every day and talked to him frequently about how he was feeling. Doctors prescribed morphine tablets and oramorph (liquid morphine) for pain relief. On 19 September, the man's condition deteriorated suddenly. Healthcare staff gave him oxygen to help with his breathing and diazepam (to treat anxiety) because he was unsettled and agitated. On 22 September, the man began to have difficulty taking medication orally and healthcare staff fitted a syringe driver to administer medication continuously.

29. During the night of 22/23 September, nurses checked the man every half hour and noted that he was in the last hours of his life. A nurse was with the man when he died at 8.04am on 23 September.

30. The post-mortem report showed the cause of death as disseminated bronchogenic carcinoma of right lung (widely spread cancer which originated in the lung).

31. We agree with the clinical reviewer that the man received a high standard of end of life care. The prison's healthcare team gave him commendable, well coordinated and compassionate care, which was at least equivalent to that he could have expected to receive in the community.

The man's location

32. Until he became ill, the man lived on the Parkhurst site of the prison. On 26 August, he moved to the inpatient unit at the Albany site for observation. He wanted to return to his wing and went back briefly on 28 August, but was admitted to the healthcare inpatient unit the same day, when his health deteriorated.

33. On 3 September, the man moved to a designated end of life care room in the inpatient unit, which allowed more effective nursing care. On 8 September, The man told a prison nurse he was comfortable in his room and did not want to move elsewhere. We are satisfied that the man's location was appropriate throughout his illness.

Restraints, security and escorts

34. 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 a prisoner's risk of escape (and the risk to the public in the event of an escape) when fit and the risk when the same prisoner is 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 and kept under review as circumstances change.

35. On 1 September, the man had an ultrasound scan at St Mary's Hospital. The escort risk assessment, authorised by a senior manager regarded the man as a high risk to children and a low risk of escape. The healthcare input simply indicated that there was no objection to the use of restraints and entered the word 'mobile'. It did not say whether his condition affected his risk of escape, as the High Court judgement requires, or comment on the extent of his mobility. Two officers escorted him to hospital and used an escort chain (a long chain with a handcuff at each end, one attached to the prisoner, the other to an officer).

36. The next day, 2 September, the man went to hospital again and a different senior manager. The senior manager authorised the risk assessment. The healthcare input was exactly the same as the day before, but the senior manager noted that the man was very frail, had a serious medical condition and used a wheelchair to attend medical appointments. He decided that restraints were not necessary. Staff did not use restraints for any subsequent visits to hospital.

37. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. We note that the man had been an inpatient at the prison from 26 August, as he was too frail to live on the wing. There is no evidence from his medical record of any significant change in his condition between 1and 2 September and the inadequate healthcare input into the risk assessment makes it impossible to be satisfied that the use of restraints was justified on 1 September. We are pleased to note, that even with similarly limited healthcare input, the next day, the senior manager concluded that restraints were not needed and that the man was not restrained again. We have made a number of recommendations to the prison before about the use of restraints for elderly and frail prisoners and welcome the progress that has been made, but there needs to be a consistent approach. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

38. On 1 September, the prison appointed two family liaison officers. The man told one officer that he did not want the prison to contact his family. He continued to maintain this position and, on 18 September, told the officer that he did not want anyone to contact his family until after his death. After the man died on 23 September, the prison contacted the man's daughter and offered advice and support.

39. The man’s funeral was held on 15 October and representatives from the prison attended. The prison organised and paid for the funeral in line with national guidance.

40. The prison appropriately appointed family liaison officers when the man became seriously ill and staff respected his wish that they should not contact his family until after he died. We are satisfied that contact with his daughter after his death was appropriate.

Compassionate release

41. Prisoners can be released on compassionate grounds for medical reasons before their sentence has expired. This is usually when they are suffering from a terminal illness, have a life expectancy of less than three months and meet a range of other criteria.

42. On 18 September, the man told the family liaison officer that he did not want to apply for release on compassionate grounds and preferred to spend the end of his life in the prison’s palliative care room where he felt comfortable and supported.

RECOMMENDATION

The Governor and Head of Healthcare 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
1	The Governor and Head of Healthcare 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	Briefings with 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. Further to this action, the Head of Operations has held discussions with Healthcare Managers regarding planned training for healthcare staff in the risk assessment process, and a database is maintained by the Head of Operations to monitor the use of restraints.	June 2015 Head of Operations