

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Investigation into the death of Mr Raymond Smith, a prisoner at HMP Isle of Wight, on 22 March 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Raymond Smith died of bronchopneumonia and chronic obstructive pulmonary disease at HMP Isle of Wight on 22 March 2015. He was 77 years old. I offer my condolences to Mr Smith's family and friends.

I am satisfied that Mr Smith received a commendably high standard of well-coordinated and compassionate care at the prison, which allowed him to die peacefully and with dignity.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

**February 2016**

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# Summary

## Events

1. Mr Raymond Smith was sentenced to 12 years and six months in prison, for sexual offences, on 12 April 2013. On 4 February 2014, he moved to HMP Isle of Wight from HMP High Down. Mr Smith had been diagnosed with chronic obstructive pulmonary disease (COPD) in 2003.
2. Healthcare staff at the prison continued to treat Mr Smith's COPD with medication. They reviewed him frequently and adjusted his medication as necessary. When his condition worsened, he spent periods in hospital and the prison's inpatient unit.
3. In February 2015, Mr Smith's condition deteriorated and became terminal. On 4 March, he moved to the inpatient unit, where healthcare staff treated him palliatively, focusing on his symptoms and pain management. Mr Smith died on 22 March 2015.

## Findings

4. We are satisfied that Mr Smith received a very good standard of care at HMP Isle of Wight, at least equivalent to that he could have expected in the community. The prison's healthcare team gave him commendable, well-coordinated and compassionate care. We make no recommendations.

## The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
7. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.
8. We informed HM Coroner for Isle of Wight of the investigation. We did not receive the post-mortem report and the investigation was suspended until then. We regret the consequent delay in issuing our report. We have sent the coroner a copy of this report.
9. One of the Ombudsman's family liaison officers and the investigator visited a friend of Mr Smith's, who he had named as his next of kin, to explain the investigation. Mr Smith's friend asked when his health had started to decline, if his medication was appropriate and if he could have remained living on his wing for longer.
10. The investigation has assessed the main issues involved in Mr Smith'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.
11. Mr Smith's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
12. The prison considered our initial report and did not identify any factual inaccuracies.

# Background Information

## HMP Isle of Wight

13. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs.

## HM Inspectorate of Prisons

14. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good and long-term medical conditions were managed well. There were good palliative care facilities. Inspectors noted that the prison had introduced a form, which was included in the Person Escort Record, which specifically asks healthcare staff to comment on mobility and physical health, to help make better-informed decisions about the use of restraints. After the death of a prisoner, the prison held a multidisciplinary review, to help identify any lessons to be learned.

## Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2014, the IMB reported that the prison provided an effective standard of healthcare and very good care for terminally ill prisoners.

## Previous deaths at HMP Isle of Wight

16. Mr Smith was the eighth prisoner to die from natural causes, at HMP Isle of Wight, since 2014.

## Findings

### The diagnosis of Mr Smith's terminal illness and informing him of his condition

17. On 12 April 2013, Mr Raymond Smith was sentenced to 12 years 6 months imprisonment for sexual offences and was sent to HMP High Down. On 4 February 2014, he was transferred to HMP Isle of Wight. At an initial health screen, a nurse noted that he had been diagnosed with chronic obstructive pulmonary disease (COPD) in 2003. (COPD is the name for a collection of progressive lung diseases, including chronic bronchitis and emphysema.) He had other medical conditions and used a walking stick and a wheelchair.
18. On 5 February, Mr Smith told a prison GP that he had constant shortness of breath. Despite his condition, Mr Smith did not want to stop smoking. The GP told him that his COPD had worsened and prescribed steroids and antibiotics.
19. Over the next year, healthcare staff reviewed Mr Smith's COPD at least 15 times. They continued to prescribe steroids and antibiotics, which they adjusted as necessary. Between 4 and 28 April, he was admitted to the inpatient unit for monitoring and treatment when his condition worsened. He stopped smoking only briefly, in August 2014.
20. On 7 October 2014, Mr Smith was admitted to the inpatient again. His appetite was poor and he had shortness of breath and chest pain. Healthcare staff were unable to stabilise his condition and he was admitted to hospital until 3 November.
21. On 7 January 2015, a multidisciplinary team discussed Mr Smith's condition and decided he should have a nebuliser (a machine that changes liquid medicine into a fine mist for inhalation through a mask or mouthpiece).
22. On 25 February, a nurse noticed that Mr Smith had slurred speech, a stooped posture and fell asleep while talking. A prison GP reviewed him immediately and considered that his symptoms indicated end stage respiratory failure. He was admitted to hospital for a day for assessment and returned to the prison's inpatient unit. A nurse noted that his breathing was still poor and he needed a wheelchair. On 27 February, a GP told Mr Smith that he had heart failure and end stage COPD.
23. Mr Smith had COPD for several years before he went into prison. We are satisfied that when he arrived at the Isle of Wight, a nurse quickly identified his condition and referred him to the GP, who prescribed appropriate medication. A prison GP told him promptly when his condition became terminal.

### Mr Smith's medical treatment

24. On 27 February 2015, after discussion with a prison GP, Mr Smith decided that he did not want to be resuscitated if his heart or breathing stopped. After a fall the next day, he was again admitted to hospital. The GP and the hospital registrar agreed that Mr Smith was entering the end of his life and should be managed palliatively.

25. A prison clinical team manager visited Mr Smith on 3 March and discussed his medical needs with hospital staff. Mr Smith was discharged the next day and returned to the inpatient unit.
26. On 20 March, a prison GP noted that Mr Smith was deteriorating; he was breathless and confused. The next day, another prison GP noted he was agitated and unable to take oral medication. He arranged for a syringe driver (a small pump, which gives pain relief continuously under the skin). Nurses checked Mr Smith frequently. At 2.18am on 22 March, a nurse noticed that Mr Smith had stopped breathing. At 2.53am, a GP certified Mr Smith's death. A post-mortem examination found that Mr Smith had died from bronchopneumonia and COPD.
27. We are satisfied that Mr Smith received appropriate medical treatment at the prison before and after his condition was diagnosed as terminal. The clinical reviewer noted that he received suitable medication for his conditions. After his terminal diagnosis, his treatment was palliative, focusing on relieving his symptoms and pain management. Nurse assessed him frequently and, towards the end of his life, GPs reviewed him almost daily. The clinical reviewer concluded that the management of his condition was at least equivalent to that he could have expected in the community. We consider that the prison's healthcare team gave him commendable, well-coordinated and compassionate care.

### **Mr Smith's location**

28. A prison GP offered to admit Mr Smith to the prison's inpatient unit when he first arrived, but Mr Smith declined as he preferred to live on a standard residential wing. He had a prisoner disability carer, who helped to collect his meals and clean his cell. As his condition deteriorated, he spent some periods in the prison's inpatient unit and in hospital.
29. During a hospital admission at the end of February, doctors diagnosed that his condition had become terminal. When he went back to the prison, nurses looked after him in a dedicated room in the inpatient unit, designed for end of life care. On 4 March, Mr Smith told a prison GP he was happy to be in the inpatient unit and did not want to move elsewhere. We are satisfied that Mr Smith was appropriately located throughout his illness and that staff took into account his preferences.

### **Restraints, security and escorts**

30. 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 restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. 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.

31. There was one occasion in March 2014 when Mr Smith was restrained by an escort chain when he went for an X-ray at hospital, apparently on the basis of an inaccurate healthcare contribution to the risk assessment about his mobility. However, after this, we are satisfied that the prison appropriately took into account his health and mobility and restraints were not used for further hospital admissions.

### **Liaison with Mr Smith's family**

32. On 25 February 2015, the prison appointed an officer as Mr Smith's family liaison officer. When Mr Smith went into hospital, the officer notified the friend he had named as his next of kin that he was seriously ill in hospital and arranged for her to visit him.
33. In March 2015, after Mr Smith was discharged from hospital and admitted to the inpatient unit, the family liaison officer telephoned his friend to update her about his condition. His friend visited him at the prison every two or three days. On 18 March, a prison GP met Mr Smith's friend to explain that Mr Smith was in the final stages of COPD. The family liaison officer agreed to telephone Mr Smith's friend to let her know when he died.
34. Mr Smith's friend, her daughter and stepdaughter visited him on 21 March, the day before he died. Although he was unconscious, they spent some time with him. When Mr Smith died, the family liaison officer telephoned his friend to inform her, and offer condolences and support. In line with Prison Service guidance, the prison contributed to the costs of the funeral, which was held on 15 April 2015.

### **Compassionate release**

35. 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.
36. On 2 March 2015, the prison started an application for compassionate release. Prison staff made several requests to the hospital for information about Mr Smith's life expectancy. On 9 March, a hospital doctor informed the prison that a prognosis would not be available until a review of his condition two weeks later. This meant that the prison was unable to complete the application before he died.

