

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Allan Pickett a prisoner at HMP Isle of Wight on 21 July 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 Allan Pickett died of lung cancer, which had spread to his liver and spine, at HMP Isle of Wight, on 21 July 2015. He was 79 years old. I offer my condolences to Mr Pickett's family and friends.

Mr Pickett was diagnosed with lung cancer on 6 July and he died just over two weeks later. While there was a delay in arranging an X-ray, requested two weeks before Mr Pickett's diagnosis, this did not affect the outcome, as the cancer was already too advanced for treatment. Overall, I consider that Mr Pickett received a very high standard of care at the prison. The healthcare team adopted a holistic approach to his palliative care and communicated well with Mr Pickett, his family and the hospital. His care was at least equivalent to that he could have expected to receive in the community

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2016

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Summary

Events

1. Mr Allan Pickett had been at HMP Isle of Wight since December 2012. He had a progressive lung disease but would not give up smoking. In January 2015, he reported a persistent cough but a chest X-ray was clear.
2. In May 2015, Mr Pickett complained he felt exhausted. Over the next four weeks, his symptoms continued and he lost weight. On 18 June, a doctor ordered an urgent X-ray. However, healthcare staff made a standard referral to the hospital and the appointment was arranged for 10 July. No one queried this. On 2 July, Mr Pickett reported acute chest pain and staff sent him to hospital as an emergency.
3. In hospital, scans revealed lung cancer, which had spread to Mr Pickett's liver and spine. No active treatment was possible. On 7 July, the hospital discharged him to the prison for palliative care and he was admitted to the prison's inpatient unit. Mr Pickett died there on 21 July. His family were with him at the time.

Findings

4. The clinical reviewer commended the high standard of Mr Pickett's care at the Isle of Wight. The healthcare team took a holistic approach and ensured good communication and continuity of care. The clinical reviewer concluded that Mr Pickett's care was at least equivalent to that he could have expected to receive in the community.
5. Security risk assessments for transfer to hospital were well considered and no restraints were used.
6. Although it would not have made a difference to the outcome for Mr Pickett, a request for an urgent chest X-ray in June was not given sufficient priority.

Recommendation

- The Head of Healthcare should ensure that prisoners have urgent X-rays as soon as possible after the request.

The Investigation Process

7. 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.
8. The investigator obtained copies of relevant extracts from Mr Pickett's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Pickett's clinical care at the prison.
10. We informed HM Coroner for Isle of Wight of the investigation who gave the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Pickett's daughter, to explain the investigation. She said that her family was very happy with the standard of care her father had received and the support they had received from the prison. She had no specific matter for the investigation to take into account.
12. The investigation has assessed the main issues involved in Mr Pickett'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.
13. Mr Pickett's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
14. The prison has submitted an action plan detailing what they have done to address the issues we raised. They raised no factual inaccuracies.

Background Information

HM Prison Isle of Wight

15. 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. The inpatient unit includes special facilities for end of life care.

HM Inspectorate of Prisons

16. 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 that specifically asks healthcare staff to comment on mobility and physical health, to help make better-informed decisions about the use of restraints. After deaths at the prison, the prison held multidisciplinary reviews to help identify any lessons to be learned.

Independent Monitoring Board

17. 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

18. Mr Pickett was the twelfth prisoner to die at HMP Isle of Wight since January 2014. We have previously made a number of recommendations about the use of restraints for elderly and infirm prisoners and welcome the fact that in this case there was a properly considered risk assessment when Mr Pickett was taken to hospital and he was not restrained.

Findings

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

19. Mr Allan Pickett was serving a ten-year prison sentence and had been in prison since March 2012. He had been at HMP Isle of Wight since 14 December 2012. Mr Pickett had several medical conditions, including asthma, chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis and emphysema), angina, gout, and kidney problems. Doctors prescribed medication, including inhalers for asthma. Prison healthcare staff frequently reviewed him and offered him help and encouragement to stop smoking, but he did not give up. The clinical reviewer found that Mr Pickett's treatment for his health conditions was fully in line with national guidelines.
20. On 20 January 2015, Mr Pickett reported that he had had a cough for six weeks. Dr A diagnosed a chest infection and prescribed antibiotics. He ordered an urgent chest X-ray, which took place at St Mary's Hospital, Newport, on 30 January. The results were normal.
21. On 18 May, Mr Pickett told Nurse A that he felt exhausted all the time. On 26 May, Dr B examined him and noted that his memory was poor and he had lost weight. His X-ray in January had been clear. Dr B thought Mr Pickett's symptoms were due to worsening of his COPD. He prescribed antibiotics and planned to review him if he did not improve.
22. Healthcare staff continued to monitor Mr Pickett. On 18 June, he told nurses that he felt generally unwell and weak. He said that he found it difficult to eat and was losing weight. The pain from coughing kept him awake. Dr C referred him for an urgent chest X-ray and blood tests. The next day, Mr Pickett agreed to move to the inpatient unit, which does not allow smoking. Dr B prescribed pain relief and nicotine replacement treatment.
23. Healthcare staff made the referral for the X-ray on 18 June but did not indicate that it was urgent. When the appointment was received for 10 July, three weeks after the doctor had requested one, no one queried this. We understand the hospital can perform urgent X-rays on the same day or next day. On 2 July, Mr Pickett complained of sharp central chest pain and Dr C suspected a worsening of his COPD, or a malignancy. He discussed Mr Pickett with the medical registrar at the hospital who agreed to admit him as an emergency. After tests, hospital doctors informed Mr Pickett that he had terminal lung cancer, which had spread to his liver and spine. No active treatment was possible.
24. Although this would not have changed the outcome for Mr Pickett, as his cancer was very advanced when diagnosed at the beginning of July, we are concerned about the delay with the urgent X-ray requested on 18 June. We make the following recommendation:

The Head of Healthcare should ensure that prisoners have urgent X-rays as soon as possible after the request.

Mr Pickett's medical treatment

25. On 7 July when Mr Pickett returned to the prison, he had a palliative care plan prepared by the hospital. He had decided in hospital that he did not want to be resuscitated if his heart or breathing stopped. Prison healthcare staff liaised with the hospital palliative care team for advice and doctors prescribed increased doses of morphine as his pain became worse.
26. Nurses assessed Mr Pickett several times a day, including nutritional assessments. He had frequent palliative care reviews, with a good focus on holistic care. The clinical reviewer noted that a review on 11 July made good efforts to discover what activities were important for Mr Pickett to try to continue, including playing the guitar and being able to go outside. The prison GPs reviewed his care frequently.
27. On 14 July, Mr Pickett went to hospital for a bronchoscopy (examination of the inside of the throat and lungs, with a camera). However, after examining him, hospital doctors cancelled the procedure, as he was too frail.
28. Dr B discussed Mr Pickett's condition with him, and told him that he might have weeks to live, but his condition could deteriorate very quickly. By 20 July, Mr Pickett was finding it difficult to swallow. He could not take the pain relief medication orally and was therefore in pain. Healthcare staff used a syringe driver (a small pump, which gives pain relief continuously under the skin) and he settled.
29. On 21 July, Mr Pickett became unresponsive. At 12.50pm, Dr B certified his death. A post-mortem examination found that he had died of widespread lung cancer and chronic obstructive pulmonary disease.
30. The clinical reviewer concluded that Mr Pickett received high quality, holistic care that was at least equivalent to what he could have expected to receive in the community. The prison's inpatient unit appropriately managed Mr Pickett and he often saw the same doctor, which allowed good continuity of care. While Mr Pickett was in hospital, there was good communication between the prison and hospital staff.

Mr Pickett's location

31. From the time Mr Pickett arrived at the Isle of Wight, he was unable to use the stairs. He lived on a wing for elderly and disabled prisoners. Staff consulted Mr Pickett about where he wanted to be and he remained on the wing with his friends for as long as possible, with periods in the inpatient unit when his COPD worsened.
32. When the hospital discharged Mr Pickett on 7 July, it was medically necessary to admit him to the inpatient unit for palliative care. On 9 July, the prison agreed that his door could be left open at all times to facilitate his care. Staff encouraged his friends to visit him and ensured that he had suitable activities to occupy him. We are satisfied that Mr Pickett's location was appropriate throughout his time at the prison and met his needs.

Restraints, security and escorts

33. When prisoners have to travel outside prison, such as to a hospital, a risk assessment determines the nature and level of any security arrangements, including any 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.
34. Mr Pickett attended hospital twice in July. Each time, there was relevant medical opinion on the risk assessment forms, stating that he found it hard to move around, and was frail. Prison managers decided that two officers should accompany him and should not use restraints. We consider that this was an appropriate and humane decision, which properly took into account Mr Pickett's poor health and mobility and how it affected his risk of escape.

Liaison with Mr Pickett's family

35. On 6 July, the prison appointed a family liaison officer. The family liaison officer arranged for Mr Pickett's daughter and son-in-law to visit him in the prison. Dr B met them and explained Mr Pickett's condition to them, so they were aware of the extent of his illness. His daughter and son-in-law were with him in the inpatient unit when he died on 21 July. Mr Pickett's funeral was held on 14 August and the prison contributed towards funeral costs, in line with national guidance. We are satisfied that there was good communication with Mr Pickett's family who were appropriately supported.

Compassionate release

36. Release on compassionate grounds is a means by which seriously ill prisoners, usually with a life expectancy of less than three months, can be permanently released before their sentence has expired. A clear medical opinion of life expectancy is required. 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).
37. The prison started an application for release on compassionate grounds on 9 July. Dr B noted on the form that Mr Pickett's life expectancy was significantly less than three months. We would usually have expected such an application to be progressed quickly but the clinical reviewer noted that Mr Pickett's clinical decline was very rapid after that and would have made compassionate release impracticable. We therefore make no recommendation.

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