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 in July 2013 at hospital, while a prisoner 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 in July 2013, of a man, a prisoner at HMP Isle of Wight. He was 68 years old and died of heart failure at hospital. I offer my condolences to his family and friends.

A clinical review of the medical care the man received at the prison was undertaken.

The man had a history of heart problems and had had a pacemaker fitted before he was sentenced to prison in 2010. He developed a hernia and prostate cancer while he was in prison, although neither condition contributed to his death. His heart condition began to deteriorate significantly from October 2012 and prison healthcare staff monitored his condition and stayed in regular contact with cardiac specialists at the local hospital. The clinical reviewer considers his care was equivalent to that he might have expected to receive in the community.

I am pleased to note that restraints were removed for the last two weeks of the man's life, but I do not believe that their use before that was always justified. Overall, I am satisfied that he was well cared for at the prison and that there was effective liaison between the prison's healthcare staff and hospital specialists about his treatment.

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 **February 2014**

CONTENTS

SUMMARY

1. The man was sentenced to 10 years imprisonment in June 2010. He went to HMP Lewes, and transferred to the Albany site of HMP Isle of Wight a week later. He had a heart condition and pacemaker, which were noted in his reception health screen. He continued to be prescribed the medication he had received in the community.

2. The man was referred to hospital on 11 August 2010. A cardiologist saw him in December 2010 and decided to monitor his condition. Over the next two years, he had frequent appointments with the hospital cardiology department and had his pacemaker adjusted.

3. On 5 October 2012, the man reported suffering from shortness of breath and was tired and dizzy. An X-ray on 11 October showed an enlarged heart but no other obvious evidence of heart failure. On 12 October, he reported further symptoms and was admitted to hospital. He was discharged two weeks later with a diagnosis of decompensated heart failure (his heart could not pump enough blood around the body). Healthcare staff continued to monitor him.

4. The man's symptoms persisted and, in November 2012, the cardiologist reported that his prognosis was poor. An echocardiogram in December 2012 showed that his aortic valve (one of four heart valves) had deteriorated. In April 2013, he was referred to a regional specialist to consider cardiac surgery.

5. The man's heart failure continued to worsen and he was admitted to hospital on 5 July 2013 and then transferred to another hospital for specialists to consider surgical options. He was considered unsuitable for surgery because his heart was in such poor condition and other organs were also starting to fail. He returned to hospital for palliative care on 25 July and died in July 2013.

6. We find that overall the care the man received was equivalent to that he could have expected to receive in the community. However, we are not satisfied that the use of restraints was always justified by his level of risk and make one recommendation about this.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting anyone with any relevant information to contact her. No one responded.

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

9. The investigator obtained copies of the man's prison and prison healthcare records. She liaised with the Head of Healthcare and other staff to obtain further information as the investigation progressed.

10. HM Coroner for the Isle of Wight was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent this report.

11. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation. She said that she felt the prison had done all it could to care for her husband and that she had appreciated the help offered by the prison's family liaison officer.

12. The man's wife received a copy of the Ombudsman's report. She made a number of comments that do not impact on the factual accuracy of this report.

13. The prison considered our draft report and recommendations and has accepted these. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

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, liaison with his family, his location, whether compassionate release was considered and security arrangements for escorts at hospital.

HMP Isle of Wight

15. HMP Isle of Wight is an amalgamation of two prisons: Parkhurst and Albany. The man was at the Albany site of the prison, which holds mostly sex offenders.

16. Since 1 June 2013 Care UK have provided healthcare at the prison. Before this, provision was by the Isle of Wight Primary Care Trust. There is an inpatient healthcare unit (IHU) 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.

Her Majesty's Inspectorate of Prisons

17. In its most recent inspection of HMP Isle of Wight in May 2012, HM Inspectorate of Prisons 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 found that there were good care arrangements for men with palliative care needs. The inspection found that prisoners with chronic (long term diseases) were reviewed regularly.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its annual report for 2012 the IMB noted that a range of treatments and care programmes were delivered to a very high standard. The IMB also noted that the relationship between prison healthcare services and prison service staff was good, and that healthcare staff were engaged in all aspects of the prison community.

Previous deaths at Albany

19. There were 15 deaths from natural causes at the Albany site between 2011 and the man's death. The inappropriate use of restraints has been an issue we have raised a number of times. We make the same recommendation in this report, but welcome the fact that in this case restraints were removed more than two weeks before he died.

ISSUES

The diagnosis of the man's terminal condition

20. The man was born with heart problems and had had major heart surgery and a pacemaker fitted before he came to prison. Shortly after arriving at HMP Albany, the prison received a letter from his wife informing them that there had been plans to operate on his heart.

21. On 11 August 2010, the prison referred the man to the hospital's cardiology service, which took on the specialist care required to manage his heart condition and maintain his pacemaker. He also saw experts based in Portsmouth and Southampton.

22. Between December 2010 and October 2012, the man had a number of cardiology appointments at hospital. His pacemaker was also adjusted during this time as he was suffering from recurrent bouts of tachycardia (rapid heartbeat). He was also diagnosed with a hernia in September 2012.

23. On 5 October 2012, the man told the prison GP that he was suffering from shortness of breath, dizziness and tiredness. The GP referred him for an X-ray which took place on 11 October. The results showed that his heart was enlarged but there was no overt evidence of cardiac failure. On 12 October, he reported a number of symptoms including shortness of breath, feeling hot and then cold and back pain. His pulse rate was low. The GP arranged for him to be admitted to the medical assessment unit at hospital.

24. The man was discharged on 25 October 2012, diagnosed with decompensated left ventricular failure. His medication had been adjusted. The hospital asked the prison healthcare staff to monitor his blood, weight, fluid status and diuretic regime (to reduce water retention). On 29 October and 6 November, he was admitted to the prison healthcare unit for monitoring when his symptoms caused particular concern.

25. On 7 November, the cardiologist from the hospital told the GP that the man's prognosis was poor and his condition might be terminal. He said that he might not be suitable for a heart transplant because he had prostate cancer (which was being monitored).

26. On 14 December, the man had an ECG and his cardiologist recorded that his aortic valve had deteriorated very rapidly over two years. He arranged for a cardiac catheterisation (inserting a tube into a heart vessel for diagnostic purposes) at another hospital and this took place on16 April 2013. Another doctor from took over as the man's cardiologist in May 2013. When he received the results of the catheterisation, he referred him to a regional specialist to consider whether he could benefit from surgery.

27. Over the next two months, the man's condition worsened and on 5 July he was admitted to hospital once again. Another echocardiogram showed severe aortic stenosis (narrowing of the artery), severe mitral incompetence

(leaking heart valve), severely reduced left ventricular function (one side of the heart not working efficiently) and moderate to severely reduced right ventricular function. His heart and his kidneys were failing and his liver had also started to show signs of failing. Clinicians agreed that he was unlikely to recover.

28. On 22 July, the man was transferred to another hospital. In view of the valve problems and his multiple organ failure, surgery was discounted as an option. His condition was considered terminal, and he moved back to the first hospital for palliative care.

29. The man died several days later. The post-mortem report shows he died from congestive cardiac failure, aortic stenosis and mitral incompetence.

Informing the man about his condition and treatment

30. On 8 November 2012, the prison GP told the man that the prognosis for his heart condition was poor. She told him that he would discuss the prospect of a heart transplant with the cardiologist but that might not be possible because of his prostate cancer.

31. On 13 November, the GP received a letter from the cardiologist detailing possible procedures which suggested that the prognosis might not be as poor as originally believed. She passed on his views to the man, but was less optimistic about the prognosis.

32. On 14 December, the cardiologist wrote to the GP explaining the results of an echocardiogram carried out that day and recommended that the man continue with medication and cardiac catheterisation with a view to a possible valve replacement. The GP understood that the cardiologist would have discussed his condition with him, but made an appointment to see him on 11 January. He did not attend, but the GP saw him on 18 January, and they discussed the cardiologist's letter.

33. The man was in hospital when his condition became critical, in July, and an end of life care pathway was initiated. Hospital staff were then responsible for keeping him informed about his condition and treatment.

34. The prison GP and other prison healthcare staff saw the man frequently before his final hospital admission. We are satisfied that he was fully informed about his condition and treatment options and that he was well supported by healthcare staff at the prison.

The man's medical appointments and treatment

35. The man had a number of appointments at the local hospital and at another hospital. We are satisfied that he was able to attend all hospital appointments without any hindrance.

The man's pain relief and medication

36. When the man was sentenced to prison he had a pre-existing heart condition for which he was taking a number of medications. One of the prison doctors assessed him on 23 June 2010, shortly after he arrived at Albany, and ensured that his medication continued.

37. On 8 November 2011, a GP reviewed the man, who had been experiencing tachycardia. He told the doctor he had been better on a higher dose of carvedilol (a beta blocker, which helps slow the heart's rhythm). She consulted his cardiologist and increased his beta blocker prescription.

38. On 3 January, the GP saw the man again and noted that the carvedilol dose seemed to have settled his tachycardia. His medication chart indicates that, on 20 January 2012, his medication was reviewed and increased again.

39. The clinical reviewer considers that the man's medication was regularly checked and monitored by prison healthcare staff. His blood pressure was taken, clinical condition checked and blood and urine tests done to monitor the effects of his illnesses and drugs. The reasons for any alterations were clearly recorded and advice from specialists was frequently sought to try to establish the best regime for his heart condition.

40. Toward the end of his life, the man's medication and, ultimately, his pain relief was taken care of by hospital staff. He was given powerful drugs to improve heart muscle action and antibiotics, but these were gradually withdrawn as it became clear that they were not going to help. We agree with the clinical reviewer that his pain relief and medication was managed appropriately by healthcare staff at the prison.

Liaison with the man's family

41. An officer was appointed as the prison family liaison officer (FLO) on 19 November 2012, shortly after the man was given the original poor prognosis about his heart condition. He did not contact his family at this time but he spoke to his wife frequently and told healthcare staff that he had shared the recent news about his condition with her.

42. On 19 July, the FLO telephoned the man's wife to introduce himself to her and to make sure that she had the hospital's telephone number so that she could find out directly from the hospital how her husband was. There was fairly frequent contact between the FLO and the man's wife during his final admission to hospital, as they updated each other on his condition and arranged visits.

43. On the day the man died the FLO went to the hospital to speak to his family, who had been with him when he died. Over the next few days, he explained to them what would happen in terms of the post-mortem examination, inquest and funeral arrangements. In line with national guidance, the prison offered a contribution towards the funeral. The FLO and an operational manager from the prison attended the funeral on 13 August.

44. We are satisfied that there was appropriate family liaison, albeit at the latter stage of the man's life. However, up until that time he had been able to keep in contact with his family himself. His wife told us that she was grateful for the support offered by the prison family liaison officer.

The man's location

45. After November 2012, the man spent time both in the healthcare unit and on his residential wing at the prison. He also spent time in hospital.

46. On 6 November 2012, after two weeks in hospital, the man was admitted to the prison's healthcare unit for almost a month. This was to monitor and stabilise the rapid deterioration of his heart's function. In early December, he returned to his wing. The clinical reviewer notes that he preferred to be on the wing and it is likely that at times he underplayed his symptoms so that he could stay there. When on the wing, he was able to manage his own medication and symptoms fairly well. We are satisfied that the prison accommodated his wishes as far as possible.

47. When the man's condition deteriorated on 5 July, he was admitted to hospital. He was then sent to the Coronary Care Unit at another hospital on 22 July to review his suitability for valve surgery. This was not considered possible and he returned to the other hospital on 25 July for palliative care.

48. The clinical team manager at the prison visited the man on 26 July and discussed the possibility of a transfer back to the prison's healthcare centre. It was decided that the stress of such a move would be too much for him and would make family visits more difficult.

49. We do not have any concerns about the man's location after his diagnosis.

Compassionate Release

50. 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. 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). Where the Governor does not support the application, it is expected to be rejected at local level.

51. The possibility of compassionate release was considered on two occasions. The first was started on 27 December 2012 when the man's offender supervisor at the prison completed his section of the application and did not support early release because he had not addressed his offending behaviour. He therefore considered his risks remained the same as when he was convicted. The man's offender manager completed his section on 11 January 2013. He was concerned about victim issues and noted that he had not completed any offence-based work.

52. A doctor completed his medical report on 18 January 2013. He considered that the man was incapable of repeating his offences because of his physical condition. However, he noted that although he might not live for a year, there was a possibility that his life expectancy could be increased with surgery and that there was a referral for surgery pending. The Governor did not support this application as it did not appear that he was in the last three months of his life. He noted that a reapplication should be made if his circumstances changed.

53. On 22 July 2013, the man's offender supervisor started a new application for compassionate release. He noted that he had threatened to kill one of his victims when he was convicted and still had not completed any offence-based work. However, he understood that he was now effectively bed-ridden. He had not been able to contact the offender manager, but noted that in January he had not supported release.

54. A doctor completed medical reports on 23 and 25 July. In the first he said that the man was severely debilitated, bed and chair bound and that even if he had valve surgery, his physical strength would be very poor. However, the actual prognosis depended on whether surgery took place. He thought that his condition rendered him incapable of committing further offences. On 25 July, the doctor completed a further report stating that he had been declared unfit for heart valve surgery and that he would certainly die within the next few days or weeks.

55. On 25 July, a senior offender supervisor indicated that, although there were risk issues, the man's current situation meant that his risk could be managed safely in the community with a robust management plan. The Governor noted on 26 July that he did not consider that the criteria for compassionate release were fully met. He acknowledged that his life expectancy was short and that his condition mitigated the risk of reoffending but thought that his continuing imprisonment would not reduce his life expectancy and release would not bring significant benefit. He also noted that there were victim issues. However, the application was forwarded to Public Protection Casework Section on 30 July. Sadly, he died before the application was considered.

56. We are satisfied that the man's application for early release on compassionate grounds was appropriately revisited when his condition

changed in July. Unfortunately, a decision had not been made by the time of his death.

Palliative care plans and end of life care pathway

57. On 23 July, the specialist hospital reviewed the man's case and decided that because he had multiple heart valve problems and organ failure, surgery was not an option. The cardiothoracic surgical team told him the news and he decided that he would not want to be resuscitated if he stopped breathing or his heart stopped. He was transferred back to the local hospital on 25 July and the hospital was responsible for his palliative care.

58. The man's care did not become palliative until the late stages of his illness, when he was in hospital. The clinical reviewer is satisfied that his palliative care was managed appropriately.

Restraints, security and bedwatch

59. 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.

60. The man had a number of appointments and an admission to hospital after November 2012, after doctors had confirmed that he was in a poor medical condition. On 14 December 2012, he attended an appointment at the hospital's cardiology clinic. The medical part of the risk assessment noted that his condition made him unsuitable for double cuffing, that his ability to escape unassisted was restricted as he got so short of breath and he needed a wheelchair. (Double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) The security part of the risk assessment concluded that his overall risk was medium. The senior manager concluded that two officers should escort him and use an escort chain to restrain him. (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.)

61. On 26 February 2013, the man attended an appointment at the hospital's pacemaker clinic and later had one at the urology clinic. The medical part of the risk assessment noted that he was a wheelchair user and that his medical condition restricted his ability to escape unaided. The security risk assessment was the same as before. The senior manager concluded that

officers should use an escort chain or double cuffs if he became mobile. Records show that double cuffs were not used.

62. On 16 April 2013, the man had an appointment at a hospital in Portsmouth for a surgical procedure. The medical and security risk assessments were the same as before and the same senior manager agreed the same level of escorts and restraints. Escort officers contacted the prison at 11.50am and asked for permission to remove his escort chain for the surgical procedure and permission was granted. He was conscious throughout the procedure and officers stayed with him in the theatre.

63. On 5 July, the man was admitted to hospital with severe and deteriorating heart failure. The medical assessment said that as he was in a wheelchair it was considered that his medical condition restricted his ability to escape unaided. The security risk assessment was the same as before and the senior manager's decision was that an escort chain should be used and two officers should accompany him.

64. On 16 July, the duty governor visited the man at the hospital and decided that restraints should be removed as his condition had deteriorated. Officers remained with him but restraints were not used again.

65. Security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We welcome the fact that the man's risk was reviewed and that restraints were removed two weeks before he died. However, an objective assessment of his risk would have concluded that his poor physical health and limited mobility, which required him to rely on a wheelchair, meant his risk of escape was very low at an earlier stage. Despite this, he was restrained when attending appointments and continued to be restrained during his final admission. We make the following recommendation:

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.

RECOMMENDATION

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 at the time.

ACTION PLAN: The Man – HMP Isle of Wight

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	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 at the time.	Accepted	There have been significant shifts in the decision making process surrounding the use of restraints in recent months, involving much more consultation with medical staff/medical professionals whenever possible prior to the escort leaving the establishment. Senior managers will continue to consult with health care staff and or attending medical professionals in assessing risk taking account of the mobility/medical condition of the person being escorted. Band 5 operational managers or above inform Band 7 or above regarding risk assessment completion. Senior managers (band 7 or above) will re-assess the initial risk assessment within 24 hours of any prisoners being admitted to hospital or immediately following any serious decline in health/medical condition of the prisoners admitted to hospital.	Completed and ongoing All band managers 5 and above Primarily Head of Operations Primarily Head of Operations	