Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr Frank Townsend-Oldfield, a prisoner at HMP Isle of Wight, on 2 July 2015

**A report by the Prisons and Probation Ombudsman
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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 Frank Townsend-Oldfield died of lung cancer at HMP Isle of Wight on 2 July 2015. He was 64 years old. I offer my condolences to Mr Townsend-Oldfield's family and friends.

Overall, I am satisfied that Mr Townsend-Oldfield received a good standard of care at the prison. GPs acted promptly in response to his symptoms and arranged timely investigative tests. Healthcare and prison staff offered Mr Townsend-Oldfield a good level of support before and after his diagnosis. However, the investigation found some deficiencies in risk assessments for hospital visits and a compassionate release application was not resubmitted when Mr Townsend-Oldfield's condition deteriorated.

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 **January 2016**

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Summary

Events

1. Mr Frank Townsend-Oldfield had been at HMP Isle of Wight since 18 May 2010, serving an indeterminate prison sentence.

2. On 13 August 2013, Mr Townsend-Oldfield told a prison GP that he had chest pain, was short of breath on exertion and had lost his appetite. The GP referred him for an urgent X-ray, which he had on 19 August. The X-ray results were normal with no evidence of cancer. His symptoms persisted and prison GPs were still concerned about the possibility of cancer and referred him urgently to a specialist. Further tests in September showed a tumour around the main airway of his right lung. Healthcare and prison staff offered him appropriate support and prison GPs prescribed effective pain relief.

3. Mr Townsend-Oldfield had chemotherapy and radiotherapy between February and May 2014, which stopped the growth and spread of the cancer. His condition remained relatively stable until June 2015, when he became increasingly breathless. Staff encouraged him to move to the prison's inpatient unit, but he preferred to remain on his wing.

4. On 2 July, a GP diagnosed Mr Townsend-Oldfield with pneumonia and prescribed antibiotics. He told Mr Townsend-Oldfield that his condition was terminal and he was likely to die in the next few days. That evening, officers persuaded him to move to the inpatient unit for palliative care.

5. At about 9.35pm, nurses found Mr Townsend-Oldfield unresponsive on his bed. At 9.37pm, the control room called an ambulance, which arrived five minutes later. The nurses were unclear about Mr Townsend-Oldfield's wishes about resuscitation and had begun preparations to administer oxygen when paramedics arrived and confirmed that Mr Townsend-Oldfield had died.

Findings

6. We are satisfied that Mr Townsend-Oldfield's clinical care was equivalent to that he could have expected to receive in the community. Prison GPs promptly and appropriately referred him for investigative tests and kept him well informed of the possible diagnosis and future tests. Healthcare and prison staff supported Mr Townsend-Oldfield well. Nurses were unaware of Mr Townsend-Oldfield's resuscitation status when they found him unresponsive but we are satisfied that the prison has made changes to ensure this does not happen again.

7. Prison managers allowed Mr Townsend-Oldfield to attend hospital appointments unrestrained between June 2014 and January 2015, but applied restraints from February to June 2015, even though his condition had significantly deteriorated. We are not satisfied that they based their decisions on a proper and full consideration of Mr Townsend-Oldfield's health and mobility at the time. An application for compassionate release was not resubmitted after a considerable decline in Mr Townsend-Oldfield's condition.

Recommendations

- 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.

- The Governor should ensure that applications for early release on compassionate grounds are submitted without delay, kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

The Investigation Process

8. 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.

9. NHS England commissioned a clinical reviewer to review Mr Townsend-Oldfield's clinical care at the prison.

10. The investigator obtained copies of relevant extracts from Mr Townsend-Oldfield's prison and medical records. She interviewed one member of staff by telephone on 10 August. The clinical reviewer joined her for four interviews with staff at HMP Isle of Wight, on 20 August.

11. We informed HM Coroner for Isle of Wight of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Townsend-Oldfield's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She was concerned that the prison had not contacted her when her father's condition deteriorated and had informed him of his death by telephone, rather than in person. She said that she had received limited contact from the prison. She wanted to know why her father had not been granted compassionate release.

13. The investigation has assessed the main issues involved in Mr Townsend-Oldfield'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.

14. Mr Townsend-Oldfield's daughter received a copy of the initial report. She did not make any comments.

15. The initial 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.

Background Information

HMP Isle of Wight

16. 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.

Her Majesty's Inspectorate of Prisons

17. 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 the death of a prisoner, the prison held a multidisciplinary review, to help identify any lessons to be learned.

Independent Monitoring Board

18. 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

19. Mr Townsend-Oldfield was the eleventh prisoner to die of natural causes at Isle of Wight since January 2014. We have raised the issue of the inadequately justified use of restraints before.

Findings

The diagnosis of Mr Townsend-Oldfield's terminal illness and informing him of his condition

20. In March 2010, Mr Frank Townsend-Oldfield was sentenced to an indeterminate sentence for sexual offences. He had been at HMP Isle of Wight since 18 May 2010.

21. On 13 August 2013, Mr Townsend-Oldfield told a prison GP that he had pain in the left side of his chest, shortness of breath on exertion and had lost his appetite. The GP noted that he smoked, but did not have a cough. He had recently developed clubbing of his fingers, (commonly seen in people with advanced lung or heart disease and evident in some forms of lung cancer). The GP referred Mr Townsend-Oldfield for an urgent chest X-ray, which he had on 19 August.

22. On 2 September, Mr Townsend-Oldfield told a prison GP that he was in a lot of pain. The GP prescribed co-codamol for the pain and chased the X-ray results, which showed no evidence of cancer. On 9 September, a GP noted that she was still concerned about the possibility of cancer and planned to discuss his case at a multidisciplinary meeting.

23. Mr Townsend-Oldfield's chest pain persisted. On 25 September, a GP reviewed him and referred him to a consultant respiratory physician at a hospital under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. He received an appointment for 10 October.

24. The consultant respiratory physician found nothing wrong from initial examinations and investigations, but referred him for a CT scan, which took place on 29 October. On 4 November, a GP told him that the scan indicated a possible tumour in his right lung. They had a long discussion about the results and a nurse went to see Mr Townsend-Oldfield shortly afterwards to discuss support. Mr Townsend-Oldfield did not want to speak to anyone at the time. He said he had accepted his diagnosis and was happy to have pain relief and sleeping tablets, which the doctor had prescribed.

25. The results of a bronchoscopy and biopsy, taken on 12 November, found no evidence of cancer and a hospital multidisciplinary team meeting on 19 November referred Mr Townsend-Oldfield for a more detailed scan and further bronchoscopy. The scan, taken on 4 December, confirmed the presence of a tumour, which was presumed cancerous. On 11 December, Mr Townsend-Oldfield had the further bronchoscopy and another biopsy.

26. On 14 December, a nurse noted that Mr Townsend-Oldfield had a good understanding of his condition. Macmillan nurses and the chaplaincy team had visited him. He was happy with the support offered and had a good support network on his wing.

27. On 27 December, the consultant respiratory physician referred Mr Townsend-Oldfield to a consultant oncologist at another hospital. He noted that the scans and biopsies had confirmed that Mr Townsend-Oldfield had lung cancer and he would benefit from palliative radiotherapy and chemotherapy.

28. On 9 January 2014, the clinical team manager at the prison discussed Mr Townsend-Oldfield’s diagnosis with him. He said Mr Townsend-Oldfield understood his diagnosis and that the cancer was incurable.

29. We are satisfied that the prison GPs appropriately and promptly referred Mr Townsend-Oldfield for investigative tests. Hospital consultants and prison GPs kept him well informed of the outcomes, diagnosis and future tests.

Mr Townsend-Oldfield’s medical treatment

30. Prison GPs regularly reviewed and amended Mr Townsend-Oldfield’s medications. He told healthcare staff that his pain and nausea were well controlled and he attended a cancer support group, weekly. On 20 January, he began to receive a nutritional supplement, as his appetite was poor.

31. On 19 February, Mr Townsend-Oldfield started a six-month course of chemotherapy, with the aim of stopping the cancer from progressing. He stopped after two treatments, as he did not like the side effects (nausea and vomiting). He also had two rounds of radiotherapy treatment to treat rib pain.

32. On 20 March, after a discussion with a GP, Mr Townsend-Oldfield decided that he did not want to be resuscitated if his heart or breathing stopped. He agreed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. A copy of the order was kept on his wing.

33. On 9 May, a GP told Mr Townsend-Oldfield that the treatment had stopped the cancer from spreading or growing. He needed no further active treatment and would be reviewed in three months. Mr Townsend-Oldfield said he was eating and drinking okay and his nausea was well controlled.

34. The oncology clinic continued to monitor Mr Townsend-Oldfield, who said he felt well and remained stable. Macmillan nurses visited him. The cancer was slow growing and there were no significant entries in his medical record between May 2014 and June 2015.

35. On 29 June 2015, a GP reviewed Mr Townsend-Oldfield, who said his breathing was worse at night and he could hear a gurgling sound. He continued to smoke. He had used an extra pillow, on a nurse’s advice, which had helped. The GP noted he was not in respiratory distress, his chest was clear and there was no evidence of infection. The next day, a GP noted that Mr Townsend-Oldfield was expected to die within three months. A sudden deterioration was highly likely at any time, but this was not predictable.

36. On 2 July, Mr Townsend-Oldfield complained of constipation and discomfort. At about 9.44am, a nurse assessed him and found that he had a fast heartbeat, a raised temperature and a cough. She advised him to move to the inpatient unit to treat the constipation and a possible chest infection, but he refused. A GP prescribed antibiotics and a laxative. At 3.45pm, a nurse reviewed Mr Townsend-Oldfield, who looked grey. He was sweating and his breathing was rapid and shallow. He continued to refuse to be admitted to the inpatient unit.

37. At about 4.23pm, a GP examined Mr Townsend-Oldfield and diagnosed pneumonia. He told him that his condition was terminal and he was likely to die

within a few days. Mr Townsend-Oldfield reluctantly moved to the palliative care suite in the inpatient unit at 5.45pm. The doctor had prescribed a syringe driver (a small pump, which gives pain relief continuously under the skin) and anticipatory end of life medications, in case they were needed, but when he arrived at the inpatient unit his condition had improved and they were not needed.

38. At about 9.35pm, two nurses heard a noise from Mr Townsend-Oldfield's room and found him gasping for breath. He was unresponsive, clammy and his pupils were fixed and dilated. One nurse asked an officer to call an ambulance and bring the resuscitation trolley. The control room called an ambulance at 9.37pm.

39. The nurses were unaware of Mr Townsend-Oldfield's decision about resuscitation and one nurse logged on to the medical record system, which takes over five minutes to load, to check this and then went back to the room. The nurses attached a defibrillator, which found no shockable heart rhythm. They did not begin cardiopulmonary resuscitation as it appeared clinically inappropriate but were preparing to administer oxygen when paramedics arrived at 9.42pm and confirmed that Mr Townsend-Oldfield had died.

40. There was some confusion about Mr Townsend-Oldfield's resuscitation status at the end of his life, but we are satisfied that healthcare staff have recognised this and have introduced changes to prevent this happening again, including that copies of DNACPR forms are kept in hardcopy in the wing healthcare office.

41. We consider that Mr Townsend-Oldfield's clinical care was equivalent to that he could have expected to receive in the community. The cancer support group, nurses and GPs provided a good level of support, and kept him well informed of his prognosis and ongoing care.

Mr Townsend-Oldfield's location

42. Mr Townsend-Oldfield lived on a wing predominantly for prisoners with additional care needs. After his diagnosis, he wanted to stay there and he had a good support network on the wing. A "buddy" (a prisoner volunteer) helped with daily living tasks such as cleaning his cell. He had an adjustable bed with an airflow mattress and a reclining chair. Staff told him he could move to the inpatient unit at any time.

43. Mr Townsend-Oldfield had brief admissions to the inpatient unit to control his nausea and pain, but always insisted on going back to the wing, against the advice of clinical staff. He said that he would move to the unit when he felt the time was right. On 2 July 2015, staff persuaded him to transfer to the inpatient unit, where he died a few hours later.

44. We are satisfied that the prison appropriately took into account Mr Townsend-Oldfield's preferences about his location and he had suitable accommodation to meet his needs.

Restraints, security and escorts

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when 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.

46. From June 2014 to January 2015, Mr Townsend-Oldfield went to his hospital appointments without restraints. However, managers authorised restraints for three hospital appointments between February and June 2015. The medical section of the risk assessments completed before the journeys stated there were no objections to using restraints and his medical condition would not affect his ability to escape unaided. There was little information, apart from his diagnosis of cancer and that he was frail.

47. The risk assessments seem to have been based on his offence rather than his condition at the time and concluded that he was a high risk to the public, a medium risk to hospital staff, and of escape, and a low risk of hostage taking. The level of restraint for each appointment varied between no handcuffs, an escort chain and double handcuffs. 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. Double handcuffs mean that the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. They are usually used for high-risk prisoners in good health.

48. The information in the risk assessments for Mr Townsend-Oldfield's numerous hospital appointments and the justification for use of restraints were inconsistent. It is difficult to see how managers concluded that it was appropriate for him to be escorted unrestrained throughout 2014, yet decided that he needed to be restrained on subsequent escorts, when his health had deteriorated further.

49. Public protection is fundamental, but 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. This is a matter we have raised with the prison a number of times before. We do not consider that staff appropriately assessed Mr Townsend-Oldfield's risk, or took fully into account his condition at the time. 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 Mr Townsend-Oldfield's family

50. On 2 January 2014, the prison appointed an officer as Mr Townsend-Oldfield's family liaison officer. The officer tried to contact Mr Townsend-Oldfield's daughter, his nominated next of kin, several times but could not get through. He then telephoned Mr Townsend-Oldfield's probation officer to check the telephone number and ask for an alternative contact. She contacted Mr Townsend-Oldfield's ex-wife, who agreed that she could give her telephone number to the officer, and she passed this to him on 7 January.

51. On 8 January, the officer informed Mr Townsend-Oldfield's ex-wife of Mr Townsend-Oldfield's condition. He asked to speak to Mr Townsend-Oldfield's daughter, but his ex-wife said that she was unwell and offered to pass on the information. He also spoke to Mr Townsend-Oldfield's son that day during a visit at the prison. He continued as the family liaison officer, but had little contact with Mr Townsend-Oldfield's family in the next few months, as his condition was stable and Mr Townsend-Oldfield kept in touch with his family directly. They had agreed that, when Mr Townsend-Oldfield died, the officer would telephone the family to break the news.

52. At 11.00pm on 2 July 2015, the officer telephoned Mr Townsend-Oldfield's daughter to tell her that he had died but was unable to get through. He rang Mr Townsend-Oldfield's ex-wife, who said she would pass on the message. At 9.45am the next morning, he spoke to Mr Townsend-Oldfield's daughter to offer condolences and she told him that her mother had passed on his message. Mr Townsend-Oldfield's daughter said she did not need anyone to visit her and was happy to maintain contact by telephone. They later spoke about the post-mortem and funeral arrangements.

53. In line with national policy, the prison contributed to the costs of Mr Townsend-Oldfield's funeral, held on 24 July. Another family liaison officer and a prison manager attended the funeral.

54. We are satisfied that the prison appointed a family liaison officer, at an early stage, shortly after Mr Townsend-Oldfield's diagnosis and that it was reasonable for the prison's family liaison officer to contact his ex-wife when it was difficult to get hold of his daughter.

Compassionate release

55. 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. A clear medical opinion of life expectancy is required. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. 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 of the National Offender Management Service (NOMS).

56. On 6 March, the deputy governor submitted an application for compassionate release. A GP noted on the application form that Mr Townsend-Oldfield was likely to die in three to six months. The prison did not support the application on grounds of risk. On 24 March, the Public Protection Casework Section informed Mr Townsend-Oldfield that his application had been refused.

57. On 25 June 2015, a week before Mr Townsend-Oldfield's death, a GP emailed the Safer Custody Business Administrator about compassionate release. He said that Mr Townsend-Oldfield was frail, his condition was deteriorating and he wanted to be released to his family home. She contacted a GP, who said he did not expect him to live longer than three months, but could not be exact. He also said that he was at high risk of sudden death at any time from events, such as strokes.

58. There is no record that anyone considered resubmitting the compassionate release application. When a prisoner has a terminal illness and wants to be considered for release, this should be considered, as his position changes. In exceptional circumstances, applications can be dealt with urgently to reach a decision before the applicant dies. We make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds are submitted without delay, kept under review and reconsidered quickly when a terminally ill prisoner's condition deteriorates.

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