

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Maurice Lennox a prisoner at HMP Isle of Wight on 16 November 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 Maurice Lennox died on 16 November 2015, of heart failure, while a prisoner at HMP Isle of Wight. He was 79 years old. I offer my condolences to Mr Lennox's family and friends.

Mr Lennox had been in poor health for some years. On 9 November 2015, he was admitted to hospital with pneumonia and died a week later. I consider that his family should have been informed of his hospital admission at the time, but I am satisfied that overall, Mr Lennox received a good standard of care in prison.

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

June 2016

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Summary

Events

1. On 4 April 1993, Mr Maurice Lennox was sentenced to life imprisonment for sexual offences. He spent most of his sentence at HMP Wakefield.
2. In November 1995, Mr Lennox suffered a heart attack and began to take medication to manage his heart condition. He was a heavy cigarette smoker from a very young age, but consistently refused all offers of help to stop smoking.
3. In June 1996, Mr Lennox suffered a second heart attack. In February 1997, he had heart bypass surgery. Hospital and healthcare staff gave him ongoing care.
4. On 20 February 2014, Mr Lennox was moved to HMP Isle of Wight. On 7 March, a prison GP reviewed Mr Lennox. He noted symptoms of chronic obstructive pulmonary disease (COPD) and referred him to the cardiology department of the local hospital and to the prison's respiratory clinic. In September, he was diagnosed with COPD but continued to refuse help to stop smoking.
5. Mr Lennox's health deteriorated over the next fourteen months. On 9 November 2015, he was admitted to hospital with pneumonia. Mr Lennox's health continued to decline in hospital and on 16 November, he collapsed and died. The hospital informed his daughter of his death. She had been unaware that he was ill in hospital.

Findings

6. Prison healthcare staff reviewed Mr Lennox's medical conditions frequently and he received appropriate treatment and care. Healthcare staff offered advice to help him give up smoking throughout his time in prison, but Mr Lennox always refused. We are satisfied that Mr Lennox received an appropriate standard of care at the prison, equivalent to that he could have expected to receive in the community. However, we are concerned that the prison did not inform his family when he was admitted to hospital with pneumonia on 9 November.

Recommendation

- The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

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 him. No one responded.
8. NHS England commissioned a clinical reviewer to review Mr Lennox's clinical care at the prison.
9. The investigator obtained copies of relevant extracts from Mr Lennox's prison and medical records. He and the clinical reviewer interviewed four members of staff at HMP Isle of Wight on 15 December 2015.
10. We informed HM Coroner for the Isle of Wight of the investigation who gave us the post-mortem report. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers wrote to Mr Lennox's daughter to explain the investigation.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.
13. Mr Lennox's daughter received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Isle of Wight

14. 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

15. 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 asked 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

16. 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 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

17. Mr Lennox was the fifteenth 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. Although Mr Lennox was restrained when he was taken to hospital in November, we understand that this was an error and they removed very shortly after he arrived at the hospital.

Key Events

18. On 4 April 1993, Mr Maurice Lennox was sentenced to life imprisonment for sexual offences. He spent most of his sentence at HMP Wakefield.
19. On 26 November 1995, Mr Lennox had a heart attack. He was admitted to hospital and doctors prescribed medication. Mr Lennox was a heavy cigarette smoker from a very young age, but refused all help to give up smoking. On 28 June 1996, Mr Lennox had another heart attack. In February 1997, he had a cardiac bypass procedure. Hospital staff and prison healthcare staff reviewed him regularly after the operation.
20. On 22 January 2004, a cardiologist reviewed Mr Lennox, when he reported experiencing dizziness and some intermittent chest pains. Tests indicated moderate disease in the aortic valve and doctors prescribed medication. Hospital and prison healthcare staff continued to review and monitor Mr Lennox regularly over the following years. .
21. On 20 April 2009, the hospital cardiology team reviewed Mr Lennox who said he still had intermittent chest pains. Tests showed that the cardiac bypass was working, but the left side of his heart was working ineffectively and doctors adjusted his medication. His condition continued to be monitored.
22. On 20 February 2014, Mr Lennox transferred to HMP Isle of Wight. At an initial reception health screen, a nurse noted his heart conditions and that he had asthma and rheumatoid arthritis, which affected his mobility. The nurse offered Mr Lennox advice to give up smoking, but again he refused. The next day, Dr A, a prison GP, saw Mr Lennox, discussed his medication, and reviewed his extensive medical history.
23. On 7 March, Dr B, another prison GP, reviewed Mr Lennox and noted that he had symptoms indicating chronic obstructive pulmonary disease (COPD - the name for a collection of long-term progressive lung diseases, including chronic bronchitis and emphysema). He referred him to the prison's respiratory clinic and the cardiology department at St Mary's Hospital, Newport, Isle of Wight.
24. On 9 April, Nurse A, a respiratory nurse at the prison, carried out a spirometry test, which measures the volume of air expelled from the lungs. This indicated that Mr Lennox's breathlessness might have been related to his heart problems. Mr Lennox continued to refuse help to give up smoking. The nurse referred Mr Lennox for a chest X-ray, which did not reveal any serious issues.
25. On 11 June, a consultant cardiologist at St Mary's Hospital examined Mr Lennox and did not consider any further surgical intervention was necessary. However, he noted that Mr Lennox's chest sounded terrible, which was not unexpected for someone who had smoked for 70 years.
26. After another spirometry test on 16 September, Nurse A confirmed Mr Lennox had COPD. She referred him to Dr A who prescribed inhalers (used to open the airways and ease breathing). The nurse and prison GPs monitored Mr Lennox in the prison's respiratory clinic. He received an annual influenza vaccination in line with National Institute for Health and Care Excellence (NICE) guidelines.

27. On 13 February 2015, Mr Lennox complained of pains in his chest and down his left side. Nurse B encouraged Mr Lennox to use his GTN spray (glyceryl trinitrate used to treat angina and heart disease) which eased the pain. The nurse telephoned wing staff 20 minutes later to check on Mr Lennox and officers said his pain had eased. He advised them to call an ambulance if Mr Lennox experienced any more chest pain.
28. The next morning, Dr A carried out an ECG test (electrocardiogram used to detect abnormal heart rhythms) and sent Mr Lennox to hospital by emergency ambulance, as he was concerned about the results. Mr Lennox was admitted to hospital. Doctors diagnosed a heart attack and prescribed medication. The hospital discharged Mr Lennox on 19 February and prison healthcare staff continued to monitor him.
29. On 15 September, Nurse C saw Mr Lennox for an annual coronary disease review. He told her he often experienced twinges, but recovered quickly when he used his GTN spray. Again, he refused help to give up smoking.
30. On 4 November, Mr Lennox felt short of breath and said his inhalers had had little effect. A nurse took his temperature, pulse, oxygen saturation (a measure of how much oxygen is in the blood stream) and blood pressure. The results were not concerning, but the nurse asked Dr B to review him, as he appeared generally unwell. The doctor diagnosed a chest infection and prescribed antibiotics. Mr Lennox did not appear to get better.
31. On 9 November, Dr C, another prison GP, noted Mr Lennox was very short of breath and experienced pain in his right side when he breathed. The doctor suspected he had developed pneumonia and he was admitted to hospital. On 11 November, hospital staff confirmed that Mr Lennox had right lower lobe pneumonia. He remained in hospital for treatment.
32. At 9.40am on 16 November, Mr Lennox collapsed backwards on his bed and one of the escorting officers shouted for help and supported Mr Lennox's head. Hospital staff arrived and began cardiopulmonary resuscitation but Mr Lennox did not respond. At 9.59am, he was pronounced dead.

Contact with Mr Lennox's family

33. Later that morning, the prison appointed Officer A as their family liaison officer. At 11.25am, Officer A and Officer B, another of the prison's family liaison team, were about to leave the prison to visit Mr Lennox's daughter to break the news of her father's death. Before they left, his daughter rang the prison and said that hospital staff had contacted her and informed her that her father had died.
34. Officer B rang her immediately, offered her condolences and explained they had been about to leave the prison to inform her in person. She arranged to meet her on 19 November. Officer A and Officer B remained in contact with Mr Lennox's daughter to offer support.
35. Mr Lennox's funeral was on 2 December. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

36. At 10.28am, shortly after Mr Lennox's death, Officer C, a member of the prison's care team, went to the hospital to support the escort staff. A prison manager, arrived shortly afterwards and offered his support.
37. The prison posted notices informing staff and prisoners of Mr Lennox's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Lennox's death.

Post-mortem report

38. A post-mortem examination found that the cause of death was acute and chronic congestive heart failure, thrombosis of a coronary bypass (a blood clot in one of the veins inserted during heart bypass surgery) with a background of ischaemic heart disease with stenosing coronary atheroma (fatty deposits to the network of blood vessels on the surface of the heart). There was also evidence of myocardial scar (scarring to the heart caused by disease) and previous coronary bypass surgery.

Findings

Clinical care

39. The clinical reviewer noted Mr Lennox had a significant medical history with a number of chronic health issues including ischaemic heart disease and COPD. He noted that Mr Lennox was at a very high risk of a heart attack, because of his medical history and his repeated refusal to stop smoking. He noted that Mr Lennox had regular, well-documented reviews throughout his time in prison.
40. After Mr Lennox transferred to HMP Isle of Wight in 2014, healthcare staff recorded his past medical history, and made appropriate referrals to secondary care providers. Healthcare staff made all reasonable efforts to assist Mr Lennox to cope with the progressive nature of his illnesses.
41. The clinical reviewer noted that on 12 February 2015, Mr Lennox had reported chest pains during the night but a GP did not examine him until the next morning and sent him to hospital. Although there were no adverse effects for Mr Lennox at the time, for someone with his medical history the outcome could have been different. We are pleased to note that after that incident, the prison held a team-learning event and introduced new systems to help avoid such situations in future.
42. The clinical reviewer considered that the standard of care Mr Lennox received at HMP Isle of Wight was equivalent to that he could have expected to receive in the community and we are satisfied he received appropriate care.

Restraints, security, and escorts

43. When prisoners have to travel outside prison 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 should be necessary in the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and factors such as the prisoner's health and mobility.
44. When Mr Lennox went to hospital as an emergency on 13 February, two prison officers accompanied him but restraints were not used. He remained unrestrained throughout his stay in hospital.
45. On his final admission to hospital on 6 November, two prison officers accompanied him and initially use an escort chain (a long length of chain with a handcuff at each end) to restrain him. A manager reviewed this very shortly after Mr Lennox arrived at hospital and directed officers to remove them. After this, Mr Lennox was not restrained again.
46. We are satisfied that, although Mr Lennox was restrained when he was taken to hospital, officers removed these very quickly and did not reapply them. This was appropriate and humane.

Family liaison

47. Prison Rule 22 says that the prison should inform the next of kin of a prisoner if they are seriously ill. Mr Lennox went to hospital on 9 November and was diagnosed with pneumonia but no one informed his daughter, his next of kin. She had not been aware her father was in hospital until hospital staff told her that he had died. Officer A told us that Mr Lennox was not expected to die and this was probably why no one had informed his daughter. Although Mr Lennox's death was sudden and unexpected, we consider Mr Lennox was seriously ill when admitted to hospital and the prison should have informed his daughter straight away in line Prison Rules. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

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