Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Iain Kendall a prisoner at HMP Isle of Wight on 4 January 2016

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*

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 Iain Kendall died on 4 January 2016 of liver failure caused by widespread bladder cancer, at HMP Isle of Wight. He was 55 years old. I offer my condolences to Mr Kendall's family and friends.

I am satisfied that Mr Kendall received a good standard of care at the prison. He was appropriately informed of his illness and his treatment options. Family liaison was generally good but prison staff should have given more priority to considering Mr Kendall's request to move to a prison nearer his family.

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 **July 2016**

Contents

Summary

Events

1. On 30 September 2013, Mr Iain Kendall was sentenced to nearly 12 years in prison. He had been at HMP Isle of Wight since 30 October 2013. Mr Kendall had been treated for bladder cancer in 2011 and the treatment had been regarded as successful.

2. In December 2013, a prison GP referred Mr Kendall urgently to a specialist when he reported blood in his urine. Investigations showed his bladder cancer had returned and had spread to his liver. In September 2014, doctors told Mr Kendall that the cancer could not be cured and Mr Kendall received palliative radiotherapy and chemotherapy. He received appropriate pain relief and his condition was stable for some time.

3. In September 2015, Mr Kendall asked to transfer to a prison nearer to his son. However, there is no record that the prison recorded any consideration of the move until the end of December.

4. An early request for compassionate release was rejected in October 2014. The prison submitted a second application in December 2015, but further required information from his hospital consultant had not been obtained before he died.

5. Initially, Mr Kendall did not want his son informed that he was terminally ill, but agreed that the prison's family liaison should inform him in January 2015. His son visited him at the prison and had spent time with him on 2 and 3 January 2016, just before he died on 4 January.

Findings

6. Mr Kendall's diagnosis was timely and his care was equivalent to that he could have expected in the community. Doctors discussed his care and treatment options with him, and prescribed pain relief medication in line with his wishes.

7. Although a decision had not been made before he died, we are satisfied that the prison properly considered compassionate release. There was appropriate family liaison but we consider that the prison took too long to consider Mr Kendall's application to transfer to a prison closer to his son. Decisions about the use of restraints appear to have been proportionate and no restraints were used when Mr Kendall went to hospital towards the end of his life.

Recommendation

- The Governor and Head of Healthcare should ensure that requests from terminally ill prisoners for transfers to a prison closer to their family are considered promptly.

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. The investigator obtained copies of relevant extracts from Mr Kendall's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Kendall's clinical care at the prison.

11. We informed HM Coroner for Isle of Wight of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Kendall's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had a number of questions, which included:

    - Did Mr Kendall have difficulties with receiving his medication?
    - Was Mr Kendall restrained during hospital appointments after it had been agreed that he would not have to be?
    - Why were officers present when confidential medical information was discussed with Mr Kendall?
    - Were his symptoms taken seriously? Had he made complaints about his treatment?

13. The investigation has assessed the main issues involved in Mr Kendall'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 Kendall's family received a copy of the initial report. They pointed out an omission. This report has been amended accordingly. Mr Kendall's family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

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

HM Inspectorate of Prisons

17. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good, the inpatient unit provided compassionate care to men with complex needs and prisoners with palliative and end of life needs received excellent care. Handcuffing arrangements for men leaving the prison on escort were proportionate and inspectors found many examples of appropriately reduced levels of restraint for prisoners who were physically incapacitated.

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 said it was impressed by the standard of healthcare provided by Care UK and the care given to terminally ill prisoners.

Previous deaths at HMP Isle of Wight

19. Mr Kendall was the tenth prisoner to die of natural causes at Isle of Wight since January 2015. There were no significant similarities between the issues identified in this investigation and those from previous investigations into deaths at the prison.

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Findings

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

20. On 30 September 2013, Mr Iain Kendall was sentenced to almost 12 years in prison for a sexual offence. He had been at HMP Isle of Wight since 30 October 2013. In 2011, he had been treated with radiotherapy and chemotherapy for bladder cancer. The treatment had been regarded as successful. He had ongoing pain in his hips, which made it difficult to walk and affected his sleep. A doctor prescribed tramadol for pain relief.

21. On 5 November 2013, a doctor prescribed Mr Kendall anti-inflammatory medication and medication to treat an over active bladder. On 2 December, Mr Kendall told a prison GP that he had blood in his urine. The GP made an urgent urology referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

22. On 12 December, a urology consultant examined Mr Kendall, suspected a return of bladder cancer and referred him for an urgent cystoscopy (camera examination of the bladder), biopsy and CT scan. On 27 December, a scan confirmed that bladder cancer had returned and had possibly spread to Mr Kendall's liver. Hospital staff informed him of the diagnosis.

23. We consider that that the prison GP appropriately referred Mr Kendall to a specialist as soon as he suspected cancer and he received a prompt diagnosis as a result.

Mr Kendall's clinical care

24. On 16 January 2014, Mr Kendall asked a prison GP for more information about his ongoing treatment and care. The GP explained that the cystoscopy had been delayed because Mr Kendall had asked for a spinal anaesthetic which the hospital needed to arrange. This was later organised for 21 January, but Mr Kendall decided not to attend because he wanted to discuss it with the urology team first. On 10 February, he discussed the cystoscopy with the hospital urologist. On 18 March, Mr Kendall was admitted to hospital for the cystoscopy and biopsy. He returned to the prison on 22 March.

25. On 24 March, the prison's clinical team manager discussed with Mr Kendall the future plan for his care. Mr Kendall was anxious about his treatment and care because he said his previous experience had been poor. He wanted to speak to a Macmillan nurse (who specialise in cancer care) and staff referred him. (A Macmillan nurse did not see Mr Kendall until October, but the delay was with the Macmillan service, which is outside the remit of this investigation.)

26. Over the next months, hospital doctors and prison healthcare staff monitored Mr Kendall. Nurses saw him daily to give him medication. He was prescribed tramadol for pain relief but his pain was difficult to manage. Doctors tried different methods of pain relief and discussed each change of medication with Mr Kendall.

27. On 11 September, Mr Kendall had another CT scan. The next day a prison GP discussed the results with Mr Kendall and told him the cancer had spread to his liver and spine. Mr Kendall received ongoing support from nurses and the prison doctors. Officers also told Mr Kendall that he could get emotional support through Listeners (prisoners trained by the Samaritans to support other prisoners in distress).

28. Hospital consultants discussed treatment options with Mr Kendall, but explained that the cancer was incurable and any treatment would be palliative. Mr Kendall agreed to have palliative radiotherapy and chemotherapy. On 1 October, he had his first radiotherapy session. On 10 October, he told a prison GP that he did not want to change his pain relief medication, although the GP believed an alternative would be more effective. On 12 October, Mr Kendall was given a new mattress and chair to make him more comfortable. He continued to have chemotherapy in hospital, and went back to the prison's inpatient unit for care afterwards.

29. Mr Kendall sometimes complained that there were delays getting his pain relief medication. He wanted to have this medication in his possession to administer when he wished, but in the inpatient unit it is a requirement that nurses administer medication. They did this on request and at specific times. We are satisfied from the records that Mr Kendall always received his medication as prescribed.

30. Mr Kendall often suffered infections, as a side effect of the chemotherapy. Each time, he was appropriately admitted to hospital for treatment.

31. Hospital and prison healthcare staff monitored Mr Kendall over the following months. On 13 August 2015, a CT scan showed that the extent of the liver cancer had decreased, and the remaining cancer was stable. Prison and hospital doctors continued to monitor Mr Kendall. On 10 December, a prison GP sent Mr Kendall to hospital when he appeared unwell and jaundiced. A CT scan in hospital showed that the cancer had spread. Hospital doctors told Mr Kendall that he had approximately three months to live. On 17 December, the hospital discharged him back to the prison.

32. On 24 December, Mr Kendall decided he did not want anyone to try to resuscitate him if his heart or breathing stopped. On 26 December, he was admitted to the prison's specialist facility for end of life care when his health deteriorated. On 31 December, healthcare staff began an end of life care plan to monitor his pain relief and ensure his comfort. Mr Kendall did not want to be left alone for long and healthcare staff monitored him every five to ten minutes. On 4 January 2016, a nurse was with Mr Kendall as he neared the end of his life. She noted that he had stopped breathing and did not attempt resuscitation in line with his wishes. The out of hours doctor could not attend the prison immediately, so the nurse called paramedics. At 2.31am, a paramedic recorded that Mr Kendall had died.

33. The clinical reviewer concluded that the care Mr Kendall received in prison was equivalent to that he could have expected to receive in the community. Doctors frequently reviewed his medication, which was administered appropriately. Mr Kendall sometimes complained he was not told enough about his care and

treatment, but this was mainly directed towards hospital staff. (Hospital care is outside our remit.) Despite Mr Kendall's complaints, records show that communication between prison healthcare staff and the hospital was good. Prison doctors discussed Mr Kendall's care with him frequently and in detail. We are satisfied that prison healthcare staff communicated with him well.

Mr Kendall's location

34. Mr Kendall stayed in the inpatient unit of the prison after each round of chemotherapy treatment, but otherwise preferred to remain on his wing. On 17 December 2015, when he was discharged from hospital he refused to stay in the inpatient unit but was admitted on 26 December, when his condition deteriorated. Throughout his illness, he was admitted to hospital appropriately when he needed specialist treatment.

35. In September 2015, Mr Kendall said he wanted to move to HMP Ashfield, so that his son could visit him more easily. It was not until 29 December, that records show that Ashfield indicated that they could not accept Mr Kendall as the prison had no palliative care facilities. The possibility of HMP Exeter was considered but no move was decided before Mr Kendall died and there is no evidence that anyone discussed a potential move to Exeter with him.

36. There are no records to show what the prison did to try to organise a transfer in the three months after Mr Kendall requested a move or why it took so long to get a response from Ashfield. No one at the prison could give any reason to explain the delay and we do not consider that this request was appropriately considered. While a move might not have been possible before Mr Kendall died, this request should have been dealt with more quickly. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that requests from terminally ill prisoners for transfers to a prison closer to their family are considered promptly.

Restraints, security and escorts

37. 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 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 and based on a risk assessment which takes into account factors such as the prisoner's health and mobility.

38. Earlier in his illness, Mr Kendall was restrained for hospital appointments. On 11 December 2014, when Mr Kendall went to hospital, two officers escorted him and used handcuffs or an escort chain during treatment. (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.) His risk assessment indicated he was medium risk, although a prison GP recorded that Mr Kendall was weak and had poor mobility.

39. Mr Kendall asked to see the doctor alone at this appointment but officers would not allow this, as they had been instructed to stay in the room with him. We do not consider that this was unreasonable. A concordat between the National

Offender Management Service (NOMS) and the NHS recognises that NOMS has a responsibility to ensure the secure custody, dignity and confidentiality of prisoners and that the prisoner receives the appropriate NHS care to which they remain entitled. It is unavoidable that officers will be present when restraints are used but the concordat recognised that escorting staff should be mindful of the need, at all times, to maintain confidentiality of information and refrain from disclosing any confidential information without the proper and specific authority.

40. Healthcare staff had input into each risk assessment when Mr Kendall went to hospital. Initially they had no objections to the use of restraints. At the time, he was mobile although slow. When Mr Kendall received chemotherapy, no restraints were used. When Mr Kendall was admitted to hospital on 10 December 2015, no restraints were used as healthcare staff had objected to their use and noted that he was now in a wheelchair because of his deteriorating health.

41. We consider that the risk assessments for when Mr Kendall went to hospital appointments were mostly properly considered and included input from healthcare staff. Although it appears that some judgements were a little risk averse as Mr Kendall's health declined during 2015, we do not consider that the decisions were wholly unreasonable and managers took into account the advice from healthcare staff.

Liaison with Mr Kendall's family

42. On 20 September 2014, the prison appointed an officer as its family liaison officer and he offered Mr Kendall support. Initially Mr Kendall did not want his son informed of his illness but the officer informed him in January 2015, with Mr Kendall's agreement.

43. On 2 November 2015, two other officers took over as the family liaison officer. One discussed with Mr Kendall his preferences for his end of his life care and for his funeral arrangements. She arranged for his son to visit him in the inpatient unit on 2 and 3 January 2016 and they agreed that she would telephone him to let him know when his father died. On 4 January, she telephoned Mr Kendall's son as agreed, and his son visited the prison later that day.

44. Mr Kendall's funeral was held on 4 February. The prison contributed towards the costs, in line with national policy.

Compassionate release

45. Prisoners can be released 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.

46. The prison first applied for compassionate release for Mr Kendall in October 2014, but this was turned down as he had no clear prognosis at the time. On 30 December 2015, the prison submitted another application to the National Offender Management Service but staff were asked to obtain additional information from Mr Kendall's hospital consultant. Mr Kendall died before this was received.

47. We are satisfied that the prison properly considered the possibility of compassionate release.

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