Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Smith a prisoner at HMP Isle of Wight on 6 October 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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 Darren Smith died of lung cancer on 6 October 2015, at HMP Isle of Wight. He was 42 years old. I offer my condolences to Mr Smith's family and friends.

I consider that Mr Smith received a good overall standard of care at the prison, at least equivalent to that he could have expected to receive in the community. Although an earlier referral for suspected cancer might have been appropriate, I understand that this would not have changed the outcome for Mr Smith. However, I am not satisfied that all decisions to use restraints, when Mr Smith, was taken to hospital towards the end of his life, were properly justified.

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 **May 2016**

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Summary

Events

1. In July 2012, Mr Darren Smith received an indeterminate sentence for public protection. He had been at HMP Isle of Wight since 16 September 2014.

2. In April 2015, Mr Smith began to report a cough and chest pain. Prison GPs examined him several times and initially considered his pain was musculoskeletal, caused by excess stomach acid or a chest infection. On 8 June, a doctor referred him for a chest X-ray, which identified lesions (damage or shadow) on Mr Smith's right lung. Hospital doctors referred him for further investigations.

3. Initial results suggested that Mr Smith might have tuberculosis, but tests were negative. On 22 July, hospital doctors confirmed that Mr Smith had terminal lung cancer and arranged chemotherapy to help control its spread.

4. Mr Smith often went to hospital for chemotherapy. On 29 August, the hospital admitted Mr Smith, as he had reacted badly to the chemotherapy. The hospital discharged him on 8 September.

5. Mr Smith was cared for in the prison's inpatient unit. He attended further hospital appointments for chemotherapy, but, by 22 September, he was too ill to continue. His condition continued to deteriorate and he died on 6 October.

Findings

6. As Mr Smith smoked, we consider that GPs should have referred him for an initial chest X-ray a little earlier, in line with NICE (National Institute for Health and Care Excellence) guidelines. However, this would not have prevented Mr Smith's death. We consider that Mr Smith received a good standard of care at the prison, at least equivalent to that he could have expected to receive in the community. There was a good holistic approach to his care, and good management of his pain and symptoms.

7. Mr Smith, was, taken to hospital a number of times. We recognise that restraints might have been justified for earlier appointments but when Mr Smith attended hospital for the last time, he was very frail and needed a wheelchair, yet a manager decided he should be restrained by an escort chain. We do not consider that this was justified.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understands 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 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 Smith's prison and medical records. She interviewed four members of staff by telephone on 11 December 2015.

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

11. We informed HM Coroner for the 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 Smith's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked us to consider the following:

    - She said she would like to have spoken to someone with the clinical experience and knowledge to explain Mr Smith's illness more fully.
    - Whether the prison had progressed Mr Smith's compassionate release application early enough.
    - She was positive about the support she had received from the prison's family liaison officer and a nurse who was with Mr Smith when he died, but was upset that a letter of condolence from the Governor contained incorrect names for her and Mr Smith.

13. Mr Smith's sister received a copy of the initial report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

14. 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.

15. The investigation has assessed the main issues involved in Mr Smith'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.

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 sex offenders.

17. Care UK provides healthcare at the prison. There is an inpatient healthcare 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

18. The last inspection of Isle of Wight was in June 2015. The inspectorate found that health services had improved since the previous inspection. Clinical records were very good for those with complex needs. The inpatient unit had a good environment, excellent palliative care facilities and good management. Older prisoners received good care, but a strategic approach was required in response to the increasing number of older prisoners.

19. Inspectors noted that the prison had introduced a form, which was included in the Person Escort Record, which 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

20. 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

21. Mr Smith was the thirteenth prisoner to die of natural causes since January 2014. We have made recommendations before about inadequately justified use of restraints.

Findings

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

22. In July 2012, Mr Darren Smith received an indeterminate sentence for public protection for sexual offences. He had to serve a minimum of ten years, before he could be considered for release. He had been at HMP Isle of Wight since 16 September 2014. Mr Smith smoked but, on 1 March 2015, he started nicotine replacement therapy to help him give up.

23. On 8 April 2015 a prison GP, Dr A, examined Mr Smith and recorded that he had a cough with white sputum. The GP noted that he had started smoking again and that he had an ache in his chest that was worse when he inhaled deeply. The doctor diagnosed musculoskeletal chest pain, and prescribed pain relief and medication to reduce stomach acid.

24. On 28 April another prison GP, Dr B, examined Mr Smith, who had a cough and pain in the right side of his chest. The GP noted that his chest was clear and prescribed paracetamol. Mr Smith said he was still smoking and the doctor advised him against this and of the risk of serious lung disease.

25. On 6 May, Mr Smith told a nurse that he had been having right sided chest pain and not sleeping well for six weeks. He asked for stronger pain relief. The nurse took a sputum sample, which was normal, and referred him to the GP.

26. On 13 May, a third GP, Dr C, examined Mr Smith. He noted that Mr Smith's right rib was tender and diagnosed musculoskeletal pain disorder. He prescribed a pain relief gel and paracetamol.

27. On 1 June, Dr A examined Mr Smith. He was still tender on his right rib and had scattered crackles (sounds while breathing) on his chest. The doctor diagnosed a chest infection and prescribed antibiotics. On 8 June, as Mr Smith's symptoms had not improved, the doctor referred him for a chest X-ray, which he had on 11 June.

28. On 15 June, Mr Smith's X-ray result identified lesions on Mr Smith's right lung. The hospital doctors recommended an urgent referral to the chest clinic for a CT scan. Dr A referred Mr Smith the same day.

29. Shortly before midnight on 17 June, a nurse saw Mr Smith in his cell, as he had complained his chest was tight. The nurse noted that Mr Smith was smoking very heavily and arranged a GP appointment for the next morning. On 18 June, Dr A saw Mr Smith and told him that his chest X-ray had identified lesions, he might have pneumonia, and that he had referred him for a CT scan.

30. On 25 June, Mr Smith went to the chest clinic at St Mary's Hospital, Newport. During the consultation, the doctor told Mr Smith that he might have lung cancer. The doctor wrote to Dr A and said Mr Smith's case would be discussed at a hospital multidisciplinary team meeting.

31. On 26 June, Mr Smith had a CT scan and the hospital recommended that Dr A should test Mr Smith for tuberculosis. On 1 July, the doctor admitted Mr Smith to

the prison's inpatient unit for isolation and monitoring. The test for tuberculosis was negative.

32. On 2 July, after a multidisciplinary team meeting at the hospital, a specialist nurse told Dr A that Mr Smith had been referred for a CT guided lung biopsy on 16 July and for further detailed scans. On 22 July, Dr B received the result of the lung biopsy, which showed that Mr Smith had primary lung adenocarcinoma (lung cancer). The doctor explained the diagnosis to Mr Smith.

33. On 23 July, Nurse A and Nurse B discussed Mr Smith's diagnosis with him. They noted that Mr Smith was calm. He said he felt safe in the inpatient unit where he could talk to staff and have immediate pain relief if he needed it. Nurse B told him about a support group for cancer patients, which he used toward the end of his illness.

34. An internal multidisciplinary review, the day after Mr Smith died, identified that there had been missed opportunities to suspect lung cancer, before Mr Smith was referred to hospital for an X-ray in June. The Head of Healthcare noted that clinicians should follow more closely the National Institute for Health and Care Excellence (NICE) guidelines for suspected cancer when patients who smoke have a persistent cough and chest pain. Subsequently, the Head of Healthcare introduced a clear process to ensure that healthcare staff have easy access to current NICE guidelines and circulated this to all GPs. (New NICE guidelines for suspected cancer were issued in June 2015.)

35. Although an earlier referral for an X-ray at the end of April or during May might have led to an earlier diagnosis, the clinical reviewer considered that this was unlikely to have affected the outcome for Mr Smith, as the spread of the cancer was very rapid. We are satisfied that the Head of Healthcare has taken appropriate action and therefore do not make a recommendation.

Mr Smith's clinical care

36. On 23 July, a respiratory consultant told Mr Smith that he had advanced lung cancer and that he would have an appointment with an oncologist about palliative chemotherapy. The consultant told Mr Smith that the chemotherapy would help control the cancer, but would not be able to cure it.

37. On 29 July, an oncology consultant at Southampton University Hospital told Mr Smith that he would receive palliative care and that he had a possible life expectancy of up to five years. Mr Smith began a course of chemotherapy at St Mary's Hospital on 3 August.

38. On 29 August, a nurse found Mr Smith sitting on the floor of his cell. He had a temperature and a fast heart rate. Mr Smith was taken to St Mary's Hospital and hospital doctors diagnosed neutropaenic sepsis (a reaction to chemotherapy). He was admitted to hospital and treated with antibiotics.

39. On 3 September, while Mr Smith was still in hospital, he decided that he did not want to be resuscitated if his heart or breathing stopped. This decision was formally recorded in his medical record.

40. On 8 September, the hospital discharged Mr Smith. Dr B recorded that Mr Smith's life expectancy was now around four months. He continued with chemotherapy, but his condition continued to deteriorate very quickly. By 22 September, he was too weak to continue the treatment.

41. Healthcare staff saw Mr Smith every day to manage his pain and other symptoms. His condition continued to deteriorate and he died at approximately 12.30am on 6 October.

42. The coroner gave the cause of death as lung cancer with widespread metastases. (This means the cancer had spread from his lungs to other parts of his body).

43. We consider that the care Mr Smith received in prison was equivalent to that he could have expected to receive in the community. Prison healthcare had a holistic approach to his care and managed his pain and other symptoms effectively.

Mr Smith's location

44. Until he became seriously ill, Mr Smith lived in single cell on a standard prison wing. On 1 July 2015, Dr A admitted Mr Smith to the prison's inpatient unit for closer observation. Mr Smith continued to live in the inpatient unit for the rest his time at the prison, apart from his hospital stay between 29 August and 8 September. We are satisfied that Mr Smith was appropriately located throughout his illness.

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 judgment 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 11 June to 10 September, Mr Smith went to hospital fifteen times. Thirteen were for routine appointments (including chemotherapy treatment), and two for urgent treatment. He was always assessed as low risk of escape but a high risk to the public (based on his offence). The medical section of all the risk assessments indicated no objections to restraints and that Mr Smith's condition would not affect his risk of escape. From June to early August, officers used double handcuffs to restrain Mr Smith. (This is when 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.) From 3 August, the manager decided single handcuffs should be used and for his last three visits to hospital for chemotherapy, an escort chain was used and removed 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.) When Mr Smith was admitted to hospital, handcuffs were removed after he arrived. (The clinical reviewer noted that escort officers appeared to have rushed one of Mr Smith's appointments on 28 July, but we are satisfied after speaking to the officers that this was not the case.)

47. On 10 September, (the last time Mr Smith attended hospital for chemotherapy), Nurse C, completed the medical section of an escort risk assessment. She noted that Mr Smith needed a wheelchair because he tired easily, but said it would not prevent the use of restraints or impact on his risk of escape. Senior prison manager, A, decided an escort chain should be used to restrain him.

48. It is likely that the use of restraints was justified for Mr Smith's earlier appointments, when he was fully mobile. For his later appointments, although managers reduced the level of restraint, the healthcare input into the risk assessment remained the same as earlier and simply said 'no' in response to questions about whether there was an objection to the use of restraints and whether his condition impacted on his risk of escape. Although Mr Smith's health had deteriorated considerably there was no further information about his health until 10 September, when Nurse C noted he was frail, tired and needed a wheelchair. However, she still indicated that his condition would not affect his risk of escape.

49. Although risk assessment forms at the prison include space for healthcare staff to comment, there was little information about his condition until 10 September when Nurse C noted his frailty. The risk assessment for 10 September still indicated that Mr Smith was a high risk to the public. However, the same day, Dr A recorded in an application for compassionate release that Mr Smith's level of weakness and illness would prevent him from reoffending. We therefore consider that the decision to restrain Mr Smith was not based on up to date information and risk was assessed based on his offence and not his condition at the time, as the High Court judgment requires. 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 Smith's family

50. On 27 August 2015, an officer was, appointed as the prison's family liaison officer. He introduced himself to Mr Smith that day and remained in contact with him throughout the last weeks of his life.

51. Mr Smith kept in frequent contact with his sister, who he named as his next of kin, and his mother. The prison's family liaison officer also kept Mr Smith's sister informed about his condition. From 3 September, he arranged for her to speak directly with nurses in the prison's inpatient unit.

52. The prison's family liaison officer informed Mr Smith's sister when he was taken to hospital on 29 August. On 2 October, he telephoned her on 2 October when Mr Smith's health deteriorated and they agreed the prison would inform Mr Smith's sister by telephone when he died.

53. When Mr Smith died on 6 October, Nurse A, who was with him when he died, telephoned Mr Smith's sister. The prison's family liaison officer spoke to her later that day and offered his condolences and support.

54. Mr Smith's funeral was on 30 October. The prison contributed towards the costs, in line with national policy.

55. Mr Smith's sister told us she was happy with the contact from the prison's family liaison officer but she would have liked to speak to someone with clinical knowledge to explain Mr Smith's illness more fully. We are satisfied that the prison's family liaison officer arranged for Mr Smith's sister to speak directly with nurses in the inpatient unit and that they would have been in a position to explain Mr Smith's illness to her.

56. Mr Smith's sister was upset that the letter of condolence she received from the Governor had incorrect names for her and Mr Smith. While more care should have been taken to ensure that the personal details were correct, we recognise that the Governor wrote to apologise for this mistake.

Compassionate release

57. 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. 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).

58. On 29 July, hospital doctors gave Mr Smith a prognosis of about five years. However, the cancer progressed much more rapidly than expected and, when Mr Smith was discharged from hospital on 8 September, Dr B recorded that his prognosis was four months. The doctor recommended the possibility of compassionate release should be considered and a senior prison manager, B, started an application. On 10 September, Dr A completed the medical section and noted that Mr Smith's level of weakness and illness would prevent him from reoffending. Mr Smith's probation officer did not support the application and said that Mr Smith had made no effort to address his offending behaviour and reduce his risk.

59. On 2 October, senior prison manager, B, reviewed the application and consulted Dr B about Mr Smith's condition. Dr B said Mr Smith was now confined to bed, required full nursing care and he anticipated that he would die within seven days. The doctor did not consider compassionate release was appropriate at this late

stage for Mr Smith. Based on this information, the senior prison manager decided not to progress the application. While it is not clear that the probation officer's earlier assessment was based on Mr Smith's actual risk at the time, we recognise that there were no other alternative agreed arrangements for Mr Smith's care and the senior prison manager's decision not to progress the application was pragmatic and reasonable.

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