Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ernest Fisher a prisoner at HMP Isle of Wight on 11 October 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ernest Fisher died on 11 October 2017 of oesophageal cancer while a prisoner at HMP Isle of Wight. He was 77 years old. We offer our condolences to Mr Fisher's family and friends.

We are satisfied that the care Mr Fisher received at Isle of Wight was at least equivalent to that which he could have expected to receive in the community.

Healthcare staff monitored his condition and reviewed him frequently. Staff treated Mr Fisher with respect and agreed an appropriate end of life care plan, which allowed him to die with dignity and in line with his wishes.

However, we are concerned that when Mr Fisher was taken to hospital in April, the use of restraints was not justified by an appropriate risk assessment that took into account his age, health and limited mobility.

This version of our report, published on our website, has been amended to remove the names of staff and prisoners involved in our investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **March 2018**

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Summary

Events

1. Mr Ernest Fisher, who was serving an 11 year sentence for sexual offences, was moved to HMP Isle of Wight on 4 October 2016. He was an elderly, frail man, who suffered from a number of long-term health conditions, including epilepsy and chronic obstructive pulmonary disease (COPD – the term used for a collection of lung diseases including chronic bronchitis and emphysema). He had previously suffered a stroke which affected his speech and ability to swallow.

2. On 29 April 2017, Mr Fisher reported abdominal pain to a prison GP, who suspected constipation and prescribed a laxative. The next day, after Mr Fisher's health deteriorated, a nurse sent him to hospital where he was diagnosed with biliary colic (severe pain caused by a gallstone temporarily blocking the bile duct). On 16 May, a prison GP noted that Mr Fisher continued to have abdominal pain and requested a series of tests, including an ultrasound scan.

3. On 11 June, before the tests could be arranged, Mr Fisher reported severe abdominal pain to a nurse and she sent him by ambulance to hospital. Five days later, a nurse recorded that Mr Fisher had received a diagnosis of oesophageal cancer, which had spread to his spine. Mr Fisher had radiotherapy on 17 June, but further treatment was deemed inappropriate and he was returned to prison the next day. On 19 June, a prison GP saw Mr Fisher to discuss his terminal diagnosis.

4. On 27 June, Mr Fisher told a nurse that he would like to stay on the wing for as long as possible and that he did not want anyone to resuscitate him if his heart or breathing stopped. Healthcare staff continued to support Mr Fisher on the wing, until he agreed to move to the prison's inpatient healthcare unit for palliative care on 1 August. Over the next two months, healthcare staff planned Mr Fisher's care using the Gold Standard Framework for palliative care and kept him under review, as he often refused to accept additional pain relief.

5. On 11 October, at 8.20pm, a nurse noticed that Mr Fisher did not have a pulse and had stopped breathing. At 9.50pm, a prison GP confirmed that Mr Fisher had died. The post-mortem examination found that Mr Fisher died from oesophageal cancer, with COPD being a contributory factor.

Findings

6. We are satisfied that healthcare staff provided appropriate care to Mr Fisher that was in line with his clinical presentation and that there was no delay in his diagnosis. Palliative care was good and staff appropriately involved Mr Fisher in decisions about his end of life care. The clinical reviewer considered that his care was equivalent to that which he could have expected to receive in the community.

7. Mr Fisher was restrained using an escort chain when he was taken to hospital in April. We are concerned that the prison did not take full account of his health and mobility when assessing the risk he presented at the time.

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 the 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 him. No one responded.

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

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

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. The investigator wrote to Mr Fisher's friend, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

13. The investigation has assessed the main issues involved in Mr Fisher'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. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HM Prison Isle of Wight

15. 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

16. 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.

Independent Monitoring Board

17. 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 31 December 2016, the IMB said that it continued to be impressed by the standard of healthcare provided by Care UK. However, they were concerned about prisoners blocking beds in the inpatient healthcare unit, as cell doors in the most suitable house unit were not wide enough for wheelchair users.

Previous deaths at HMP Isle of Wight

18. Mr Fisher was the fourth prisoner to die of natural causes at Isle of Wight since January 2017. There were no similarities between the circumstances of the deaths.

Findings

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

19. On 23 March 2016, Mr Ernest Fisher was sentenced to 11 years imprisonment for sexual offences and sent to HMP Chelmsford. He was moved to HMP Isle of Wight on 4 October.

20. Mr Fisher was aged 76 and suffered from several long term-health conditions, including epilepsy, high blood pressure and chronic obstructive pulmonary disease (COPD – the term used for a collection of lung diseases such as chronic bronchitis and emphysema.). He had previously suffered a stroke, which affected his speech and caused him to have difficulty swallowing. Healthcare staff reviewed and monitored Mr Fisher's chronic conditions frequently and created multiple care plans.

21. On 28 April 2017, Mr Fisher reported abdominal pain to a prison GP, who suspected constipation and prescribed lactulose (a laxative). The next day, Mr Fisher's condition deteriorated and a nurse sent him by ambulance to St Mary's Hospital, Newport. Hospital staff diagnosed biliary colic (severe pain caused by a gallstone temporarily blocking the bile duct) and Mr Fisher was moved to the prison's healthcare inpatient unit for observation. Staff monitored him frequently and sought advice from hospital specialists when required. On 9 May, a prison GP examined Mr Fisher and agreed that he could return to the wing as his symptoms had improved.

22. A prison GP saw Mr Fisher for a follow-up appointment on 16 May and noted that he was still reporting some abdominal pain. The GP considered the possibility of gall bladder disease and requested a series of blood tests, an X-ray and an ultrasound scan (a procedure that uses high-frequency sound waves to create an image of part of the inside of the body). However, Mr Fisher's health deteriorated before these tests could be arranged as an outpatient.

23. On 11 June, a nurse reviewed Mr Fisher in his cell following a request from prison staff. Mr Fisher reported severe abdominal pain radiating through his back and difficulty breathing. The nurse gave him 15 litres of oxygen through a mask and sent him by ambulance to St Mary's Hospital, where he was admitted for further investigations. Prison healthcare staff kept in daily contact with the hospital for updates on Mr Fisher's condition.

24. On 14 June, while Mr Fisher remained in hospital, a prison GP reviewed ultrasound scan results and noted that they suggested cancer. The GP liaised with hospital staff and Mr Fisher had a series of additional tests to confirm a diagnosis. Two days later, a nurse contacted St Mary's Hospital for an update and recorded that Mr Fisher had received a diagnosis of oesophageal cancer, which had spread to his spine. Mr Fisher was transferred to Southampton General Hospital for radiotherapy on 17 June, but further treatment was not considered appropriate and he returned to the prison's inpatient unit, via St Mary's Hospital, the next day. On 19 June, Dr Fritton saw Mr Fisher for a review and to discuss his terminal diagnosis.

25. The clinical review considered that Mr Fisher received care that focused on his clinical needs at all times. Prison healthcare staff reviewed and monitored his condition frequently, sought advice from hospital specialists and arranged for further investigations into his abdominal pain. When Mr Fisher's health deteriorated, a nurse appropriately sent him to hospital, which resulted in his admission and subsequent cancer diagnosis. We are satisfied that healthcare staff acted in an appropriate and timely manner, and there was no delay in diagnosis.

Mr Fisher's clinical care

26. On 27 June, a nurse saw Mr Fisher for a comprehensive review and he asked to stay on the wing for as long as possible. The nurse noted that he had support from other prisoners and he requested a Zimmer frame to help him mobilise. Mr Fisher informed the nurse that he did not want anyone to resuscitate him if his heart or breathing stopped and an order was signed to that effect, the following day. Mr Fisher's health deteriorated over the next four weeks, but he refused to move to the prison's inpatient unit. Healthcare staff frequently visited him on the wing to monitor and review his condition.

27. On 26 July, a prison GP saw Mr Fisher for a review after prison staff reported that his health had declined. The GP noticed that Mr Fisher had swollen ankles caused by a lack of mobility and spoke to him about moving to the inpatient unit. Although Mr Fisher said he would prefer to stay on the wing, he did acknowledge that he could transfer to the inpatient unit at anytime. On 1 August, Mr Fisher reported struggling to manage on the wing and a prison GP admitted him to the inpatient unit. A nurse saw Mr Fisher for a review and he was moved to a dedicated palliative care cell three days later.

28. Mr Fisher's condition continued to deteriorate over the next two months and healthcare staff monitored and reviewed him frequently. Staff attended multidisciplinary meetings, created appropriate care plans, monitored his food intake and discussed his wishes for end of life care. Prison GPs reviewed Mr Fisher's medication regularly and offered to prescribe stronger pain relief medication as his health declined and he appeared more uncomfortable. However, Mr Fisher often denied any pain and did not always accept additional pain relief.

29. On 4 October, a prison GP recorded that Mr Fisher was receiving care under the Gold Standards Framework (used to optimise care for those approaching end of life) and that he was occasionally accepting additional pain relief. Six days later, the GP saw Mr Fisher for a review and noted that he appeared a lot weaker and that he had difficulty speaking. The GP advised Mr Fisher that he was approaching the end of his life and assured him that healthcare staff would issue medication to keep him calm and pain-free.

30. On 11 October, at 7.15pm, a nurse helped Mr Fisher across his cell to the toilet, where he became incontinent of faeces. At 8pm, having given Mr Fisher a wash, the nurse noticed that he appeared weak and asked another nurse for assistance transferring him back to bed. Shortly afterwards, Mr Fisher became unresponsive. The nurses moved him onto his right side and notified the on call

GP. At 8.20pm, a nurse noticed that Mr Fisher did not have a pulse and that he had stopped breathing. At 9.50pm, the GP confirmed that Mr Fisher had died.

31. The clinical reviewer considered that Mr Fisher received effective, appropriate and compassionate care in prison. Healthcare staff managed his terminal illness well and kept his pain under regular review. Staff planned his care effectively, prescribed appropriate medication and involved Mr Fisher in decisions about his end of life care. We are satisfied that the care Mr Fisher received in prison was equivalent to that which he could have expected to receive in the community.

Mr Fisher's location

32. Mr Fisher chose to remain on the wing following his terminal diagnosis. In line with his wishes, staff monitored and reviewed Mr Fisher frequently and provided him with suitable support, until he accepted a transfer to the prison's inpatient unit. On 4 August, healthcare staff moved Mr Fisher to one of the palliative care cells, which was appropriate for his needs.

33. We are satisfied that the prison took account of Mr Fisher's preferences about his location and that a prison GP appropriately admitted him to the inpatient unit for end of life care.

Restraints, security and escorts

34. 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.

35. When Mr Fisher went to hospital on 29 April, a prison manager reviewed his risk assessment and authorised two officers to escort him using an escort chain. (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.) The assessment identified Mr Fisher's overall risk as low and the medical section did not object to the use of restraints or consider that his health condition impacted upon his risk of escape. Although he was a category B prisoner, Mr Fisher was 77 years old, frail, and had limited mobility due to severe pain. The risk assessment was based on the prison's view of his offence with little consideration of how his health and mobility affected the risk he presented at the time, as is required by the 2007 High Court judgement.

36. When Mr Fisher went to hospital on 11 June, a prison manager reviewed his risk assessment and authorised two officers to escort him without using any restraints due to the seriousness of his condition and lack of mobility. Restraints were not used again.

37. We agree that restraints were not appropriate when Mr Fisher went to hospital in June but can see no justification for the use of an escort chain in April. 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 the prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Fisher's family

38. On 8 August, the prison appointed two officers as family liaison officers. Three days later, one of them visited Mr Fisher and confirmed that he wanted his friend, with whom he had regular contact, as his nominated next of kin. On 31 August, the family liaison officer contacted Mr Fisher's friend to introduce himself and explain his role. He confirmed that Mr Fisher's friend would like to be informed of his death by telephone and that he would arrange to visit her afterwards.

39. On 11 October, at 10.15pm, the family liaison officer arranged for Essex police to visit Mr Fisher's friend to break the news of his death, as he could not contact her by telephone. The next afternoon, he visited Mr Fisher's friend and continued to provide ongoing support.

40. The prison arranged Mr Fisher's funeral, which took place on 7 November, and paid for it in line with national policy.

Compassionate release

41. Prisoners can be released from custody 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.

42. On 20 June, following Mr Fisher's terminal diagnosis and return to prison from hospital, a prison GP completed the medical part of the compassionate release application. Mr Fisher told him that he would like compassionate release to be considered, but did not feel that his nominated next of kin would be able to care for him. The GP identified a hospice or nursing home as a possible option, but at that time, Mr Fisher was given a life expectancy of more than three months.

43. We are satisfied that the prison appropriately considered compassionate release.

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