Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Davis a prisoner at HMP Isle of Wight on 29 September 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.

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 Colin Davis died on 29 September 2017 of multiple organ failure, caused by cancer, while a prisoner at HMP Isle of Wight. He was 75 years old. I offer my condolences to Mr Davis' family and friends.

The clinical care Mr Davis received before his diagnosis was not equivalent to that which he could have expected to receive in the community. A referral delay meant the diagnosis took longer than it needed to, although this did not affect the outcome for Mr Davis.

However, Healthcare staff at Isle of Wight gave Mr Davis a good level of support and clinical care after his diagnosis.

This is the tenth time we make a recommendation to Isle of Wight about the use of restraints, since January 2013. On each occasion, Isle of Wight have accepted our recommendations and committed to act on them. We have already raised our concerns about this with the Executive Director for the Long-Term and High Security Estate, who is satisfied that appropriate actions are being taken to address the area of concern.

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

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

Contents

Summary

Events

1. On 30 March 2017, Mr Davis was remanded into custody and was sent to HMP Winchester. On 7 April, he was sentenced to eighteen years imprisonment for historic sexual offences. Mr Davis had a number of pre-existing conditions, was under review at hospital and had a computerised tomography (CT) scan prior to going into custody at HMP Winchester. The results of the CT scan identified enlarged lymph nodes in his abdomen.

2. Mr Davis' community GP wrote to HMP Winchester explaining that Mr Davis had missed several hospital appointments relating to the enlarged lymph nodes, and had been re-referred him to hospital for tests. The community GP asked Winchester to conduct some blood tests. The results of the blood tests were abnormal but Mr Davis signed a disclaimer refusing all medical treatment, because he was concerned that he knew people at the local hospital and did not want to be seen in restraints.

3. On 10 July, Mr Davis was transferred to HMP Isle of Wight. Two days later, a prison GP referred Mr Davis to the Oncology Department at hospital. The referral should have been made urgently, but it was not sent for another six days.

4. On 26 July, Mr Davis was admitted to hospital with a temperature, low oxygen saturations and low blood pressure. While in hospital, a CT scan confirmed he had enlarged lymph nodes and the hospital referred Mr Davis for a biopsy. Mr Davis was discharged from hospital on 4 August and was transferred back to the Isle of Wight.

5. On 8 August, Mr Davis was vomiting and had a temperature. He was readmitted to hospital and had a biopsy of the enlarged lymph nodes. He was discharged from hospital on 10 August.

6. Mr Davis' condition was deteriorating. He was losing weight and healthcare staff encouraged him to eat and drink. Because the biopsies had been sent for specialist review, the results were not available until 7 September. Mr Davis attended a haematology appointment and the consultant explained to him that he had Hodgkin's Lymphoma. He was eligible for chemotherapy treatment, but Mr Davis decided not to have any active treatment.

7. Mr Davis' condition deteriorated rapidly and he died on 29 September.

Findings

8. When Mr Davis transferred to HMP Isle of Wight, a prison GP appropriately noted the need for him to have investigative tests, but did not make the referral in line with the NHS pathway. Mr Davis had a biopsy in hospital, but had to wait about a month for the results. Due to the delay in the referral being sent, the clinical care Mr Davis received was not equivalent to that which he could have expected to receive in the community. The clinical reviewer found that delay meant the diagnosis took longer than necessary, but that the delay did not affect Mr Davis' chances of survival.

9. Following his diagnosis, healthcare staff at Isle of Wight gave Mr Davis a good level of support and clinical care.

10. We are satisfied that it was appropriate to use an escort chain for earlier hospital appointments, when Mr Davis was fully mobile. However, we are concerned that an escort chain continued to be authorised as his condition deteriorated, even though he was only able to walk short distances and needed a wheelchair. We do not consider that the continued use of an escort chain was adequately justified by his level of assessed risk or that it was proportionate to Mr Davis' circumstances.

11. The prison did not make an application for compassionate release, despite Mr Davis being terminally ill and refusing treatment. There was sufficient time to make an application and Mr Davis should have been given that opportunity.

12. We make the following recommendations.

Recommendations

- The Head of Healthcare should conduct a root cause analysis to establish why the haematology referral was not made in line with NHS pathways and should take appropriate action to ensure it does not happen again.
- 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 risk assessments show clear justification for the use of restraints.
- The Executive Director of the Long-term and High Security Estate, should satisfy himself that the Governor takes effective action to address the inappropriate use of restraints at HMP Isle of Wight.
- The Governor and Head of Healthcare should ensure that all prisoners who are terminally ill are given the opportunity to apply for compassionate release.

The Investigation Process

13. 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.

14. The investigator obtained copies of relevant extracts from Mr Davis' prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Davis' clinical care at the prison.

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

17. One of the Ombudsman's family liaison officers contacted Mr Davis' cousin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said she was happy with the care Mr Davis received and would like a copy of the investigation report.

18. The investigation has assessed the main issues involved in Mr Davis' 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.

19. Mr Davis' cousin received a copy of the initial report. She pointed out some factual inaccuracies. This report has been amended accordingly.

20. 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.

Background Information

HMP Isle of Wight

21. 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

22. The last 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

23. 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 their latest annual report, for the year to December 2016, the IMB said that Care UK provide a well-led, dedicated and professional team. The inpatient healthcare unit on the Albany site provided a high standard of 24-hour care. There was an issue with the local council providing personal social care due to a high staff turnover. The IMB had concerns that the social care budget was not sufficient to provide the level of care needed by the prison's increasingly aged and infirm prisoners.

Previous deaths at HMP Isle of Wight

24. Mr Davis was the sixth prisoner to die of natural causes at Isle of Wight since January 2016. This is the tenth time we have made a recommendation about inappropriate use of restraints since January 2013. This is also the third time we have made a recommendation about compassionate release since 2014.

Findings

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

25. On 30 March 2017, Mr Davis was remanded into custody and was sent to HMP Winchester. On 7 April, he was sentenced to eighteen years for historic sexual offences.

26. Mr Davis had suffered poor health before going to prison. He had pre-existing high blood pressure, ischaemic heart disease, hypothyroidism, type 2 diabetes and a hernia. Due to a restriction of blood flow to his foot, he was under review at hospital and had had a computerised tomography (CT) scan prior to being remanded into custody. The results of the CT scan identified enlarged lymph nodes in his abdomen.

27. On 21 June, Mr Davis' community GP wrote to HMP Winchester. They noted that he had missed several hospital appointments to investigate the enlarged lymph nodes and recommended that he should have further blood tests. The community GP had re-referred Mr Davis to hospital and the prison would receive an appointment in due course. Later that day, a prison GP saw Mr Davis and explained he needed to go to hospital for tests. Mr Davis refused to go because he said he knew people at the hospital and did not want them to see him in restraints. There is no documented evidence that the GP tried to persuade Mr Davis to attend hospital, or that he explained the importance of the tests.

28. Mr Davis had the blood test on 23 June, the results of which were abnormal. A prison GP noted that Mr Davis did not want to attend a haematology oncology appointment. Again, there is no documented evidence that the GP tried to encourage Mr Davis to attend.

29. On 5 July, Mr Davis signed a disclaimer stating that he was refusing medical treatment.

30. Mr Davis asked to move to HMP Isle of Wight and he was transferred there on 10 July.

31. On 12 July, Mr Davis saw a prison GP and agreed to be referred to the hospital's Haematology Department. The GP should have made an urgent referral under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks, but the referral was not sent for another six days.

32. On 26 July, Mr Davis became acutely unwell with a temperature, low oxygen saturations and low blood pressure and he was admitted to hospital. While in hospital he had a CT scan which confirmed he had enlarged lymph nodes. The doctor said he would be referred to a specialist for a biopsy. Mr Davis was discharged from hospital and was transferred back to the Isle of Wight inpatient healthcare unit (IHU) on 4 August.

33. On 8 August, Mr Davis had a hospital appointment for a biopsy. That morning, he appeared unwell with a temperature and was vomiting. A prison GP sent Mr Davis to hospital, via the accident and emergency department, where he was admitted. While in hospital, Mr Davis had a guided biopsy of the enlarged lymph

nodes. He was discharged from hospital and returned to the IHU at Isle of Wight on 10 August.

34. Healthcare staff regularly chased the results of the biopsy and kept Mr Davis informed. During this time, healthcare staff reviewed Mr Davis several times a day. He was losing weight and healthcare staff encouraged him to eat and drink.

35. On 22 August, Mr Davis told a nurse that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made). All other appropriate treatment and care would continue to be provided. Mr Davis had become frail and IHU staff provided a wheelchair for him.

36. On 23 August, healthcare staff held a Gold Standard Framework (GSF) meeting where they discussed Mr Davis. They said it was likely he had lymphoma (cancer of the lymphatic system). However due to the biopsies being sent for specialist review, the results were not available until 7 September. Mr Davis attended a haematology appointment that day and the consultant told him he had Hodgkin Lymphoma. Prison healthcare staff appropriately offered Mr Davis support.

37. Mr Davis initially refused to go to hospital for investigative tests through fear of being recognised by people who knew him. There is no evidence to suggest that the prison GPs encouraged him to go, or highlighted the importance of the tests. When Mr Davis was transferred to Isle of Wight, a prison GP appropriately noted the need for Mr Davis to go to hospital. It was appropriate for the GP to make a referral, but he did not make the referral in line with the NHS pathway. Mr Davis had a biopsy in hospital but had to wait about a month for the results.

38. The clinical reviewer found that the clinical care Mr Davis received was not equivalent to that which he could have expected to receive in the community. Diagnosing Mr Davis took longer that it needed to, although the clinical reviewer concluded that the delay did not affect Mr Davis' chances of survival. We make the following recommendation:

The Head of Healthcare should conduct a root cause analysis to establish why the haematology referral was not made in line with NHS pathways and should take appropriate action to ensure it does not happen again.

Mr Davis' clinical care

39. Following Mr Davis' diagnosis, the hospital consultant said he would be eligible for chemotherapy treatment but advised it might not be successful. On 12 September, Mr Davis told a prison GP that he did not want to have any active treatment.

40. On 14 September, Mr Davis attended a follow-up appointment with the oncology consultant. He said he did not want any treatment and the consultant arranged palliative care services. However, Mr Davis died before any meaningful engagement was made.

41. Mr Davis' condition deteriorated rapidly and he died on 29 September.

42. Healthcare staff gave Mr Davis a good level of support and clinical care following his diagnosis. Although his condition deteriorated quickly, he remained comfortable and healthcare staff acted appropriately to meet his changing needs.

Mr Davis' location

43. Mr Davis was located on a residential wing when he first entered prison. After being discharged from hospital on 4 August, he was transferred to the IHU at HMP Isle of Wight. On 17 September, Mr Davis was moved to the palliative care cell.

44. We are satisfied that Mr Davis' location was appropriate at all times, enabling his care needs to be met efficiently.

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. The risk assessments for Mr Davis' earlier hospital escorts in July and August considered he was a normal level of risk of escape, hostage taking, and high risk to the public and staff. For these appointments, an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was applied but removed for tests and treatment. As Mr Davis was fully mobile and did not yet have a definitive diagnosis, we consider that this was appropriate.

47. However, after Mr Davis' diagnosis and as his condition deteriorated, the quality of the risk assessments for escorts varied. Not all the risk assessments recorded his condition and frailty, or that he could only walk short distances. Regardless of the information contained in the risk assessments, the level of risk remained the same (a normal level of risk of escape and hostage taking and a high level of risk to staff and the public). Prison managers authorised an escort chain for all external hospital appointments.

48. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. The High Court judgement set out very clearly the conditions, which need to be met to justify the use of restraints and it is hard to see that they were appropriately considered.

49. It is the Governor's responsibility to ensure that the risk assessment process is managed properly, that there is meaningful input from healthcare staff and that

there is a clear justification for any use of restraints. We are not satisfied that this happened and consider the continuing use of restraints was inappropriate.

50. We are concerned that this is the tenth time since 2013 that we have expressed concern about the inappropriate use of restraints on prisoners at Isle of Wight. We have previously brought this matter to the attention of the Governor's manager, who has assured as of the 31 May 2018, the Governor will direct periodic testing of restraints applied for outside hospital visits and bed watches with immediate effect. This will be done at least quarterly, carrying out full reviews of PERs and supporting documentation, including Risk Assessments. The Executive Director is satisfied that appropriate actions are being taken to address the areas of concern.

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 risk assessments show clear justification for the use of restraints.

The Executive Director of the Long-term and High Security Estate, should satisfy himself that the Governor takes effective action to address the inappropriate use of restraints at HMP Isle of Wight.

Liaison with Mr Davis' family

51. On 19 September, the prison appointed two family liaison officers (FLO). They provided support to Mr Davis and his cousin, who was his listed next of kin. One FLO arranged for Mr Davis' cousin to visit him on 29 September and provided support during the visit. Both FLOs provided on-going support to Mr Davis' cousin after his death.

52. Mr Davis' funeral was held on 31 October. The prison contributed to the cost of the funeral in line with national policy.

53. We are satisfied that the prison gave a good level of support to Mr Davis and his cousin.

Compassionate release

54. 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 determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. 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 Her Majesty's Prisons and Probation Service (HMPPS).

55. Despite Mr Davis being terminally ill and refusing treatment, the prison did not make an application for compassionate release. Although Mr Davis died about three weeks after being diagnosed, the prison was aware that his condition was

deteriorating. Mr Davis' needs were being met in the prison's IHU, but he should have been given the opportunity to apply for compassionate release. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners who are terminally ill are given the opportunity to apply for compassionate release.

Prisons & Probation Ombudsman
Independent Investigations

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