Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Hindes a prisoner at HMP Isle of Wight on 29 June 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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 Arthur Hindes died of bladder cancer on 29 June 2018 at HMP Isle of Wight. He also had chronic obstructive pulmonary disease (a lung disease which causes obstruction of lung airflow) which contributed to but did not cause his death. He was 73 years old. I offer my condolences to his family and friends.

The investigation found that the clinical care that Mr Hindes received at Isle of Wight was equivalent to that which he could have expected to receive in the community. Healthcare staff referred him to specialists when appropriate, monitored him regularly, managed his condition appropriately and offered a high level of nursing care, including providing emotional support.

However, I am concerned that Mr Hindes was double-cuffed on his last admission to hospital on 1 May contrary to medical advice. I do not consider that the risk assessment took proper account of the impact Mr Hindes' very poor health had on his risk to others and his ability to escape.

We have made recommendations to Isle of Wight about the inappropriate use of restraints on ten previous occasions since January 2013. On each occasion, Isle of Wight have accepted our recommendations and committed to act on them. Effective action must now be taken to implement our recommendations and I draw this unsatisfactory state of affairs to the attention of the Prison Group Director once again.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. On 2 May 2017, Mr Arthur Hindes was sentenced to 11 years in prison for historic sexual offences and sent to HMP Exeter.

2. When he arrived, Mr Hindes told a nurse that he had Type 2 diabetes, chronic obstructive pulmonary disease (COPD, a group of lung diseases that cause breathing difficulties) and arthritis.

3. On 10 May, he was transferred to HMP Parc, where he first showed symptoms of bleeding when urinating. He was referred to specialists in the urology department, but was admitted to hospital before his appointment with them due to continued bleeding.

4. While an inpatient in hospital, he was diagnosed with an infection, and was booked for a follow-up appointment with the urology team. Mr Hindes refused to attend this appointment.

5. He continued to bleed when urinating. On 27 September, Mr Hindes was transferred to HMP Isle of Wight. It was not until he was transferred to Isle of Wight that he agreed to go to hospital. He was referred to a urologist under the two-week suspected cancer pathway.

6. On 22 November, Mr Hindes underwent a procedure which confirmed that he had a tumour in his bladder.

7. By 2 March 2018, the tumour had spread and was confirmed as inoperable by 27 April. Mr Hindes was offered chemotherapy to slow down the growth of the cancer, but his health declined so rapidly that he was not well enough to undergo treatment.

8. Mr Hindes received palliative care in the healthcare department at Isle of Wight. On 28 June, a nurse noted that Mr Hindes had deteriorated overnight. Mr Hindes was closely monitored, and on 29 June, he died of bladder cancer, with nursing staff by his side.

Findings

9. We are satisfied that Mr Hindes' care at Isle of Wight was equivalent to that which he could have expected to receive in the community. Mr Hindes first had symptoms of cancer at Parc, and the healthcare department acted appropriately in referring him to specialists. However, Mr Hindes refused to attend appointments for diagnosis, which allowed the cancer to spread rapidly.

10. Staff provided Mr Hindes with considerate and well-managed care, and spent time spent addressing his emotional needs.

11. When Mr Hindes' health declined, Isle of Wight appropriately appointed a family liaison officer who contacted Mr Hindes' son who was his next of kin.

12. We are concerned that Mr Hindes' escort risk assessments did not always evidence a clear decision-making process, and on his last admission to hospital, he was double-cuffed against the advice of a nurse.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments are proportionate, fully take into account a prisoner's health, and are based on the actual risk a prisoner presents at the time.
- The Governor should provide the PPO with the last two quarterly reviews of the use of restraints during hospital escorts, by 15 January 2019, together with an account of any action he has taken in response.
- The Governor should revise the prison's escort risk assessment form to ensure that it requires:
    - healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and
    - prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.

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 Hindes' prison and medical records.

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

16. We informed HM Coroner for the Isle of Wight of the investigation. Although there was no post-mortem examination, she told us Mr Hindes' cause of death. We have sent the coroner a copy of this report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

18. We have assessed the main issues involved in Mr Hindes' 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

19. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds up to 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 specialist facilities for end-of-life care.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that healthcare services were good, the inpatient unit provided compassionate care to prisoners with complex needs, and those with palliative and end-of-life needs received excellent care.

Independent Monitoring Board

21. 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 31 December 2017, the IMB said that it continued to be impressed by the standard of healthcare provided by Care UK.

Previous deaths at HMP Isle of Wight

22. Mr Hindes was the twenty first prisoner to die at Isle of Wight since January 2015, which is not remarkable, given the prison's population. Nineteen of these deaths were from natural causes and two took their own lives. There have been two deaths from natural causes since Mr Hindes died.

23. Since 2013, we have made 10 previous recommendations to address the inappropriate use of restraints, which Isle of Wight agreed to implement, and we have also raised our concerns about this with the Executive Director for the Long-Term and High Security Estate on two occasions in 2018.

Findings

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

24. On 2 May 2017, Mr Arthur Hindes was sentenced to 11 years in prison for historic sexual offences and was sent to HMP Exeter.

25. When he arrived, Mr Hindes told a nurse that he had Type 2 diabetes, COPD and arthritis in his legs and feet. She noted that Mr Hindes was a heavy smoker and he was offered a smoking cessation programme, which he accepted.

26. A prison GP saw him later that day as part of his secondary health screen. He prescribed him medication to manage his conditions, and noted that staff would monitor his COPD.

27. On 10 May, Mr Hindes was transferred to HMP Parc.

28. On 24 May, a nurse saw Mr Hindes as he was complaining of passing blood in his urine. She recorded that he had a potential urine infection. She sent his urine for testing and booked an appointment for him to see a prison GP.

29. On 30 May, two nurses separately saw Mr Hindes because his bleeding had increased when passing urine. She added him to the clinic list to see a prison GP that day. A prison GP saw Mr Hindes that afternoon. He noted that he had passed blood for the last six days, and referred him to the urology department at hospital.

30. Mr Hindes continued to produce blood in his urine. On 5 June, before the date of his urology appointment, he was sent to hospital, where he was diagnosed with an infection, prescribed antibiotics and given a follow-up appointment in the urology department for 5 July.

31. On 5 July, a major incident occurred in Parc and all movements in and out of the prison were cancelled. The urology team were informed of this and Mr Hindes' appointment was rescheduled for 26 July.

32. On 26 July, Mr Hindes refused to attend his urology appointment. He said that he was innocent and did not want to be restrained for the transfer and appointment. A nurse told him that it was policy for him to be restrained, and advised him that he should attend his appointment. Mr Hindes still refused, and signed a disclaimer to confirm his decision.

33. On 14 August, Mr Hindes saw a prison GP, and again complained of blood when passing urine and pain in his penis. She advised him that he would need to see a specialist in the urology department, but Mr Hindes declined.

34. On 27 September, Mr Hindes was transferred to HMP Isle of Wight. Two prison GPs completed an initial healthcare screen. A prison GP prescribed his COPD and diabetic medications and noted that he had been bleeding when urinating for the past three months. Mr Hindes explained that he had not wanted to go to hospital as he had not wanted to be restrained, but he was now willing to go. The prison GP arranged for blood and urine tests and referred him urgently to the

urology specialist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

35. On 14 October, Mr Hindes attended an appointment in the urology department at hospital. He was offered a cystoscopy (a test where a telescope is passed through the penis into the bladder) under local anaesthetic, but he refused and was scheduled to have the procedure under general anaesthetic.

36. On 22 November, Mr Hindes had a cystoscopy at hospital. Surgeons found a large tumour in his bladder, which they partially removed.

37. On 23 November, he had a CT scan to determine whether the cancer had spread beyond the bladder wall. The scan confirmed a Grade 3 bladder tumour. (Grade 3 means that the tumour had penetrated the bladder muscle, that its growth rate could be rapid, and that it was more likely to come back after treatment or spread into the deeper muscle layer of the bladder.)

38. Before he was discharged from hospital, Mr Hindes was catheterised and a urologist discussed his diagnosis with him in detail. On 25 November, he returned to Isle of Wight's inpatient unit, where a prison GP discussed his diagnosis with him.

39. The clinical reviewer concluded that Parc and Isle of Wight had both acted appropriately and referred Mr Hindes when he first experienced bleeding when urinating. Mr Hindes' unwillingness to attend further appointments for diagnoses allowed the cancer to progress. By the time it was diagnosed, the cancer was large and Mr Hindes' treatment options were limited.

40. There is evidence in Mr Hindes' medical records that healthcare staff consistently worked with him, kept him informed at all times and involved him in decisions about his care.

Mr Hindes' clinical care

COPD

41. Mr Hindes arrived at HMP Exeter, with a diagnosis of COPD. Staff did not seek information from his community GP, which caused a delay in prescribing Mr Hindes with the correct medication. The clinical reviewer does not consider that this delay would have caused any harm to Mr Hindes.

42. Mr Hindes' medical records indicate that his COPD was regularly monitored, and when it got worse, he was appropriately managed and referred to specialists.

Bladder cancer

43. On 7 December, a multidisciplinary meeting took place at hospital to discuss treatment options for Mr Hindes. It was agreed that due to the grading and stage of his cancer, removing the prostate and bladder might cure the cancer.

44. On 15 January 2018, a urology consultant at hospital wrote to the prison healthcare department. They received the letter on 30 January. The consultant was concerned that they had offered two future appointments for Mr Hindes to attend for treatment, and had been told that the prison could not accommodate

them. The consultant stated that Mr Hindes needed treatment, and a delay of a few weeks could impact on his long-term outcome.

45. On 5 February, Mr Hindes saw the consultant who told him that he had an invasive form of muscle cancer which needed extensive treatment in the form of a cystoprostatectomy (a procedure in which the bladder and prostate gland are removed).

    A follow-up scan was booked for 26 February but Mr Hindes refused to attend as he said was frightened of the noise that the machine made. He signed a disclaimer to say that he would not attend the appointment. A nurse met him that day, and advised him that he needed to attend the rescheduled scan appointment on 2 March.

46. The results of the scan showed that the tumour was no longer contained in the bladder and prostate, but had spread to the muscles of the abdomen and to a lymph node. This meant that extensive surgery would not cure the cancer, and treatment was aimed at preventing the cancer from spreading further.

47. On 9 March, Mr Hindes saw a prison GP as Mr Hindes had increased pain when passing urine. He prescribed him pain relief (tramadol and paracetamol) and discussed that this would probably need to change as the cancer progressed.

48. Mr Hindes still had pain and on 22 March, he saw a prison GP, who prescribed a slow-release morphine tablet. Later that month, the prison GP prescribed him nutritional supplement drinks as he was losing weight and his overall condition was deteriorating.

49. The prison GP was concerned about Mr Hindes' appearance and on 13 April, he asked for his admission to hospital for treatment to be brought forward. The urology consultant wanted a further CT scan before Mr Hindes could have an operation. His medical records do not explain why.

50. On 27 April, a CT scan was completed at hospital which indicated that the bladder cancer had spread further and was no longer operable. On 1 May, the urology consultant at hospital discussed with Mr Hindes the option of chemotherapy to slow down the cancer. Mr Hindes agreed to have chemotherapy.

51. On 3 May, a prison GP spent some time talking to Mr Hindes about his condition. Mr Hindes was aware that his condition was not curable and that the treatment options would be physically gruelling. He was advised that having chemotherapy with advanced cancer placed him at significant risk of cardiac arrest. Mr Hindes signed an order not to be resuscitated if his breathing or heart stopped.

52. Over the following weeks, while in the prison's inpatient unit, Mr Hindes met a nurse, who specialised in providing end-of-life care. She regularly offered him emotional and physical support. Doctors reviewed his medication when his pain was not controlled and amended his prescription accordingly.

53. On 23 May a prison GP noted that Mr Hindes' first chemotherapy appointment was not until late July and asked a member of the support team to contact the

hospital. An administrator, rang the urology department and asked for this appointment to be brought forward.

54. On 11 June, Mr Hindes was seen in the prison's inpatient unit by a palliative care consultant. He noted that although Mr Hindes was aware of the treatment plan, he assessed that he was too weak for chemotherapy. He warned Mr Hindes that the oncologist was likely to agree with his assessment, which Mr Hindes accepted. He explained that as his sickness progressed, he would probably get weaker and die in his sleep. Mr Hindes was relieved about this as he was concerned that his pain would worsen.

55. On 14 June, Mr Hindes attended hospital for a further appointment with his oncologist, who noted that his condition had not changed much. Over the following weeks, Mr Hindes' symptoms suggested that the cancer was now affecting the nerves of his genital area, rectum and leg. Although he was trying to remain mobile and independent in carrying out his daily activities, his pain became more difficult to manage. On 21 June, a prison GP amended Mr Hindes' prescription to give him morphine for pain relief on an hourly basis. He recorded that Mr Hindes was starting to find it difficult to walk.

56. Mr Hindes still had high levels of pain despite the changes made. On 27 June, a doctor contacted a prison GP to discuss how they should progress. The prison GP recommended that Mr Hindes should be given methadone (an opioid analgesic) using a syringe driver (a pump used to administer small amounts of fluid gradually) as this was compatible with his other pain-relief medication. He told the doctor that if this did not work, he would visit Mr Hindes to discuss alternative options.

57. On 28 June, a nurse recorded that Mr Hindes had deteriorated overnight and now needed help with his personal care. Mr Hindes' health continued to deteriorate rapidly. Healthcare staff saw Mr Hindes at regular intervals, checked his syringe driver was still in place and although he was mostly sleeping, they noted that he did not appear to be in pain.

58. At 7.14pm on 29 June, a nurse recorded that Mr Hindes' breathing was steady, but approximately 20 minutes later, another nurse described it as 'see-saw' breathing and suggested that there was an obstruction of his airways.

59. A nurse monitored Mr Hindes closely and at 7.40pm, she recorded that his pulse was weak and that he was declining rapidly. She sat with him and at 7.45pm, she noted that he had died. A prison GP confirmed Mr Hindes' death at 8.50pm. Although there was no post-mortem examination, the Coroner's office confirmed that Mr Hindes had died of bladder cancer. His COPD contributed to but did not cause his death.

60. We agree with the clinical reviewer that Mr Hindes' condition was well managed at Isle of Wight, and was equivalent to the clinical care that he could have expected to receive in the community.

61. His response to pain relief was closely monitored, and as his condition deteriorated, interventions were made to support him with personal hygiene, bladder and catheter care.

62. In his final days, there is evidence in Mr Hindes' medical records that he received good nursing care and that a nurse remained with him so that he did not die alone.

Mr Hindes' location

63. On 27 April, when Mr Hindes returned from hospital, he was admitted to Isle of Wight's inpatient unit. A nurse described him as looking anxious, but reassured him of the unit's routine and that he would receive 24-hour care. Mr Hindes remained in the inpatient unit for the remainder of his time at Isle of Wight.

64. The clinical reviewer noted that Isle of Wight has developed expertise in end-of-life care over recent years, and that they have special cells and facilities for these patients. She concluded that all the decisions made about Mr Hindes' location were timely and appropriate.

Restraints, security and escorts

65. 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 he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

66. Although prison staff completed a risk assessment each time that Mr Hindes was transferred to hospital, not all the assessments included clear medical input about Mr Hindes' health and mobility. For every transfer between 27 December 2017 and April 2018, Mr Hindes was assessed as posing a high risk to staff and the general public, but a standard risk of hostage taking, of potential escape and external assistance. He was restrained with a double cuff on each occasion. (Double-cuffing 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.)

67. On 1 May 2018, Mr Hindes was taken to hospital to discuss treatment options with an oncologist. A nurse completed a medical assessment for his transfer. She concluded that he was very frail, in a lot of pain, was unsuitable to be double-cuffed and may benefit from using a wheelchair for his appointment. An escort risk assessment was completed and a manager assessed him as posing a high risk to staff and the public, and he was restrained by a double cuff. The Head of Operations, authorised the decision to double-cuff Mr Hindes because he was a Category B prisoner. She stated that the cuffs could be removed for examination.

68. We are concerned that the escort risk assessments completed for Mr Hindes did not always evidence clear decision making, medical input was not consistently

sought and the records did not say whether his restraints could be removed for treatment.

69. We are particularly concerned that when Mr Hindes was taken to hospital on 1 May, a nurse noted that he was very frail and explicitly said he should not be double-cuffed. There is no evidence that staff considered how Mr Hindes' health impacted on his risk and it is difficult to understand why staff considered that Mr Hindes posed a high risk and how double cuffs could be justified in addition to the two escorting officers.

70. We have previously brought our concerns about the inappropriate use of restraints at Isle of Wight to the attention of the Governor's manager who told us that from 31 May 2018, the Governor would review restraints used for outside hospital visits and bed watches at least once a quarter.

71. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments are proportionate, fully take into account a prisoner's health, and are based on the actual risk a prisoner presents at the time.

The Governor should provide the PPO with the last two quarterly reviews of the use of restraints during hospital escorts, by 15 January 2019, together with an account of any action he has taken in response.

The Governor should revise the prison's escort risk assessment form to ensure that it requires:

- **healthcare staff to say whether the prisoner's current state of health has an impact on his mobility; and**
- **prison staff to show that they have taken this information into account in assessing the prisoner's current level of risk.**

Liaison with Mr Hindes' family

72. On 14 June, a family liaison officer (FLO) was appointed, and met Mr Hindes in the inpatient unit to discuss contacting a family member to let them know of his diagnosis. Mr Hindes asked that she try to contact his son, though he did not know his number.

73. The FLO found a contact number for Mr Hindes' son and telephoned him that day. As Mr Hindes did not want any contact from his son at that stage, she agreed to contact him in a couple of weeks.

74. On 27 June, the FLO and a nurse met Mr Hindes to discuss his funeral preferences. He said that he did not have any, but that he had already paid for a burial plot.

75. The FLO contacted Mr Hindes' son on 28 June to tell him that his father's health had deteriorated. They agreed that she would call him when his father died.

76. On 29 June, after Mr Hindes' death, the FLO contacted his son and informed him of his father's death. They agreed that she would visit him at his home with an offender supervisor, on 2 July. The FLO offered both emotional and practical support to Mr Hindes' son and agreed to organise the funeral. The prison paid for Mr Hindes' funeral which took place on 16 August 2018. No family attended.

Early compassionate release

77. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they have a terminal illness and a life expectancy of less than three months.

78. Although Mr Hindes was never given a formal prognosis of three months or less, the prison GP first discussed the possibility of applying for early compassionate release with Mr Hindes on 13 June. Mr Hindes said that he was interested, but that he had no contact with his family and had no friends. He also said that he did not want to return to his home town. The prison GP recorded that he was not convinced that early release on compassionate grounds would benefit Mr Hindes.

79. Mr Hindes' health declined rapidly, and there was no time to consider whether to apply for compassionate release before his death. However, with his personal circumstances, it is unlikely that Mr Hindes would have been approved for early release on compassionate grounds.

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Third Floor, 10 South Colonnade
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