Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Locke a prisoner at HMP Isle of Wight on 16 January 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Colin Locke died of a heart attack on 16 January 2019 at HMP Isle of Wight. Mr Locke was 68 years old. I offer my condolences to Mr Locke's family and friends.

I agree with the clinical reviewer that the prison managed Mr Locke's high blood pressure, cirrhosis of the liver and liver cancer appropriately and that the care he received was equivalent to that which he could have expected to receive in the community.

I commend the prison for allowing Mr Locke's wife to stay with him during the day for the last week of his life. I consider this to be an example of good practice.

I am, however, concerned that the prison did not submit a completed application to release Mr Locke on compassionate grounds, despite the Governor, a prison GP and Mr Locke's Probation Officer agreeing that an application should be made.

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 **August 2019**

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Summary

Events

1. On 6 March 2017, Mr Colin Locke was convicted of sexual offences and was sentenced to 14 years imprisonment. Mr Locke was sent to HMP Bristol, before being moved to HMP Isle of Wight on 16 March.

2. Mr Locke had been diagnosed with hypertension (high blood pressure) and cirrhosis of the liver. He required six-monthly ultrasound scans to check for liver cancer.

3. On 27 August, a nurse created a hypertension care plan for Mr Locke. This asked Mr Locke to report certain symptoms to healthcare staff and for them to check him on an annual basis. On 22 February 2018, the nurse changed the care plan so that healthcare staff would check him on a monthly basis.

4. On 19 December, a hospital multidisciplinary team met to review Mr Locke's recent MRI scan. This suggested he had cancer of the liver.

5. On 25 December, a nurse checked on Mr Locke and found that his respiratory rate was high and his blood pressure was low. The nurse sent Mr Locke to hospital. While in hospital, doctors diagnosed Mr Locke with metastatic liver disease (cancer in the liver that has spread from another part of the body), heart disease and stage three kidney failure.

6. On 7 January 2019, the hospital discharged Mr Locke back to prison to receive palliative care. That day, a nurse created a palliative care plan which ensured that healthcare staff monitored Mr Locke's level of pain and social care needs. Healthcare staff saw Mr Locke regularly to check on his condition and to ensure that he was comfortable. The prison allowed his wife to be with him in his cell during the day from 8 January.

7. Mr Locke's condition continued to deteriorate and he died on 16 January. The post-mortem report found that Mr Locke's death was caused by a heart attack, contributed to by cirrhosis of the liver and liver cancer.

Findings

Clinical care

8. We agree with the clinical reviewer that the care Mr Locke received was equivalent, overall, to that which he could have expected to receive in the community.

9. We commend the prison for allowing Mr Locke's wife to be with him in his cell during the day for the last week of his life.

10. We are concerned, however, that care plans for Mr Locke were generic and did not specifically mention him or the processes that were to be followed to maintain his comfort.

Restraints

11. When Mr Locke was admitted to hospital for the final time on 25 December, we are satisfied that the risk assessment took account of his ill health, limited mobility and his low risk, and concluded that restraints were not necessary.

Compassionate release

12. On 11 January 2019, the Governor, a prison GP and Mr Locke's Probation Officer agreed that an application should be made for Mr Locke to be released on compassionate grounds. We are disappointed that the prison did not submit the completed application to the Public Protection Casework Unit promptly before Mr Locke died.

Family liaison

13. We are concerned that when Mr Locke was taken to hospital on 25 December, the prison did not immediately contact his wife despite a clear deterioration in his condition.

Recommendations

- The Head of Healthcare should ensure that all patients with long-term health conditions have clear personalised care plans, with stated aims, planned interventions and monitoring.
- The Governor should ensure that applications for compassionate release are submitted to the Public Protection Casework Section without delay.
- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital.

The Investigation Process

14. 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.

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

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

17. We informed HM Coroner for the Isle of Wight of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Locke's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She wanted to know why she had not been contacted immediately when Mr Locke had been taken to hospital on 25 December, although she said that the prison staff and staff in the healthcare unit had been superb. We have addressed Mr Locke's wife's concern in this report.

19. Mr Locke's wife received a copy of the initial report. She pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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 sex offenders. 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 most recent inspection of HMP Isle of Wight was conducted 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 its latest annual report, for the year to December 2017, the IMB said that, overall, healthcare provided at the prison was at least as good as that provided to the wider population. However, there was an ongoing shortage of nurses, with bank and agency staff covering the shortfall.

Previous deaths at HMP Isle of Wight

24. Mr Locke was the seventeenth prisoner to die at Isle of Wight since January 2017. Of these earlier deaths, 13 were due to natural causes and three were self-inflicted. There have been three subsequent natural cause deaths. We have made previous recommendations about family liaison and compassionate release.

Key Events

25. On 6 March 2017, Mr Colin Locke was convicted of sexual offences and was sentenced to 14 years imprisonment. Mr Locke was sent to HMP Bristol, before being moved to HMP Isle of Wight on 16 March.

26. Before arriving in prison, Mr Locke had been diagnosed with cirrhosis of the liver. He did not receive any active treatment apart from requiring an ultrasound scan every six months to check for liver cancer. Mr Locke had stopped drinking alcohol in 2009.

27. When Mr Locke arrived at Bristol, a nurse performed an initial health screen and Mr Locke said that he took candesartan and propanalol (both used to treat high blood pressure). She checked Mr Locke's blood pressure, which, at 140/65, was high. (A normal blood pressure reading is anything between 90/60 and 120/80.)

28. On arrival at Isle of Wight, a nurse performed an initial health screen and Mr Locke said that he had a history of hypertension (high blood pressure). The nurse asked whether Mr Locke wanted to attend the healthy lifestyle programme but Mr Locke declined. He also checked Mr Locke's blood pressure, which, at 171/80, was high.

29. The same day, a prison GP saw Mr Locke, who reiterated that he had a history of high blood pressure and cirrhosis of the liver. He referred Mr Locke for a blood test, an ultrasound scan and a Q-risk test (a predictive algorithm for cardiovascular disease). On 3 April, he reviewed Mr Locke's blood test results and noted that his cholesterol levels were high.

30. On 12 April, a prison GP saw Mr Locke and completed the Q-risk test. This found that he had a 28% risk of developing a cardiovascular disease over the next ten years. He prescribed Mr Locke atorvastatin (used to prevent heart disease).

31. On 24 May, Mr Locke was given an ultrasound scan. A prison GP reviewed the results and found that Mr Locke's liver was abnormal, which was consistent with cirrhosis. He confirmed that there was no evidence of cancer.

32. On 7 June, a prison GP saw Mr Locke about his cirrhosis diagnosis and said that he would refer Mr Locke to a hepatology (liver) specialist for ongoing care. He also increased Mr Locke's atorvastatin prescription, as his cholesterol level needed to be lowered.

33. On 27 August, a nurse created a hypertension care plan for Mr Locke. It asked Mr Locke to report any headaches, dizziness or swelling in his legs. It also required healthcare staff to record a set of baseline observations and check him on an annual basis.

34. Mr Locke missed two gastroenterology appointments at a hospital (the hospital's gastroenterology department includes hepatology), on 2 November and 6 December. This was because a hospital consultant was unwell on the first occasion and a clinic receptionist mistakenly sent him away on the second occasion. On 24 January 2018, Mr Locke attended a gastroenterology

appointment and a consultant gastroenterologist found no evidence that his cirrhosis had deteriorated to become decompensated cirrhosis (where the liver cannot function properly).

35. On 9 February a prison GP reviewed Mr Locke's blood test results as part of his annual hypertension review. He found that the test results were normal except for Mr Locke's serum alpha-fetoprotein (or AFP) level. (AFP is a molecule found at high levels when a person has certain cancers, including liver cancer.) Mr Locke's AFP level was high at 88 ku/L (A normal level is between 0 and 10 ku/L). He referred Mr Locke to the hospital's hepatology department.

36. On 22 February, a nurse changed Mr Locke's hypertension care plan and planned for healthcare staff to check him on a monthly basis. The nurse also checked Mr Locke's blood pressure, which was high at 141/78.

37. On 1 March and 26 August, Mr Locke declined a gastroenterology appointment and an ultrasound scan, respectively. On both occasions, Mr Locke signed a disclaimer form confirming that he was aware that refusing his appointment might result in him being discharged.

38. On 2 October, a prison GP saw Mr Locke, who said that he had declined his ultrasound scan as he did not like being "chained up" in hospital. He stressed that the scan was needed to discount cancer as the cause of his raised AFP level.

39. Six days later, Mr Locke was given an ultrasound scan and a consultant gastroenterologist confirmed that the result was normal. However, the consultant referred Mr Locke for a CT scan, as his AFP level was very high at 244 ku/L.

40. On 1 November, Mr Locke received the results of his CT scan and a consultant hepatologist reported that the extent of his cirrhosis meant that she could not tell whether he had liver cancer. The consultant referred Mr Locke for an MRI scan.

41. On 13 November, a nurse saw Mr Locke, who said that he felt tired all the time and had occasional shortness of breath. The nurse performed an electrocardiogram (or ECG – a test that measures the electrical activity of the heart) and checked Mr Locke's blood pressure. This was 'pre-high' at 126/74. Later that day, a prison GP reviewed the ECG and noted that Mr Locke needed to be seen by a prison GP as his heartbeat was abnormal.

42. Seven days later, Mr Locke went to hospital for an MRI scan. Two prison officers accompanied him and restrained him with double cuffs. (This is when a prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).

43. On 19 December, a hospital multidisciplinary team meeting reviewed Mr Locke and noted that the MRI scan suggested he had cancer in the right lobe of his liver. They said that prison healthcare should make an urgent referral for Mr Locke to the hepatology department under the NHS pathway. This requires patients with suspected cancer to be seen by a specialist within two weeks. A prison GP made the referral on 20 December.

44. The following day, a prison GP saw Mr Locke and told him that he probably had liver cancer. Mr Locke said that he wanted to be released on compassionate

grounds because he was “low risk”, though the prison GP said that he needed a definitive diagnosis and specialist prognosis to pursue this option.

45. On 22 December, a nurse saw Mr Locke, as he was feeling unwell and felt breathless. She checked Mr Locke’s observations and found his respiratory rate was high at 26 breaths per minute (bpm). (A normal rate is between 12 and 20 bpm.) His blood pressure was normal at 111/67. She offered Mr Locke a move to the prison’s inpatient healthcare unit over the Christmas period.

46. Two days later, Mr Locke moved to the healthcare unit and a prison GP examined him. The prison GP performed an ECG, which showed that Mr Locke had had an anteroseptal infarction (an obstruction to the blood supply to that part of the heart in front of the septum). He asked healthcare staff to check Mr Locke and send him to hospital if he experienced any cardiovascular deterioration.

47. On 25 December, a nurse saw Mr Locke, who felt unwell. He checked Mr Locke’s observations and found that his respiratory rate was high at 24 bpm and his blood pressure was low at 75/45. The nurse Mr Locke to hospital as an emergency case. Hospital doctors admitted him to the intensive care unit. Two prison officers accompanied Mr Locke but they did not use any restraints.

48. The following day, the prison started an application to release Mr Locke on compassionate grounds.

49. On 3 January 2019, a nurse from the prison spoke with a hospital nurse, who said that Mr Locke’s cancer had progressed. The hospital nurse said that Mr Locke had agreed that he did not want to be resuscitated if his heart or breathing stopped.

50. The following day, a nurse from the prison spoke with a hospice nurse, who said that Mr Locke had been diagnosed with stage three kidney failure and heart failure. The hospice nurse said that Mr Locke would be discharged back to the prison to receive palliative care.

51. On 7 January, the hospital discharged Mr Locke back to the prison, where a prison GP saw him. He noted that Mr Locke had been diagnosed with metastatic liver disease (cancer in the liver that has spread from another part of the body) and that he wanted to remain in the prison’s healthcare unit.

52. Later that day, a nurse created a palliative care plan, to ensure that healthcare staff would monitor Mr Locke’s level of pain, food and drink intake, susceptibility to pressure sores, and social care needs. Once completed, healthcare staff checked on Mr Locke multiple times a day and they regularly applied cream and dressed two pressure sores on his buttocks.

53. The following day, the prison decided that Mr Locke’s cell should be opened 24 hours a day and they allowed his wife to be with him during the day. They also gave Mr Locke a pressure relieving mattress to help with his pressure sores.

54. On 11 January, the Governor agreed with the prison GP and Mr Locke’s Probation Officer, that an application should be made for Mr Locke to be released on compassionate grounds as he was likely to die in the next two to three weeks. The prison did not send the completed application to the Public

Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS) before Mr Locke died.

55. The same day, a prison GP saw Mr Locke, who said that he was not experiencing any pain. He prescribed Mr Locke some oramorph (liquid morphine used to treat severe pain) to use if he needed it.

56. Three days later, a prison GP saw Mr Locke and noted that he was restless, unsettled and needed regular doses of pain relief. He arranged for Mr Locke to use a syringe-driver (a device that delivers pain relief steadily over a 24-hour period). A nurse set this up later that day.

57. Healthcare staff continued to check on Mr Locke regularly and made sure that he was comfortable. Mr Locke's condition continued to deteriorate. On 16 January, at 6.44am, a prison GP confirmed that he had died.

Contact with Mr Locke's family

58. Although Mr Locke was admitted to a hospital's intensive care unit on 25 December 2018, his wife was not informed and was only given details of his condition after she telephoned the prison on 26 December.

59. On 28 December, the prison appointed an officer and an operational support grade officer (OSG) as family liaison officers. The OSG visited Mr Locke in the hospital and offered him support.

60. On 7 January 2019, the OSG visited Mr Locke and his wife in the hospital. She explained that the prison had arranged for her to visit Mr Locke in the prison's healthcare unit from 8 January. Mr Locke told the OSG that he wanted a simple cremation. Mr Locke's wife asked to be kept informed of any changes in his condition.

61. Following Mr Locke's death, the OSG telephoned Mr Locke's wife to offer her condolences and support. The OSG continued to support Mr Locke's wife until his cremation, which was held on 11 February 2019. The prison paid for the costs of the cremation in line with national instructions.

Support for prisoners and staff

62. After Mr Locke's death. the Head of Operations debriefed the staff who were working when Mr Locke died to ensure they had the opportunity to discuss any issues arising, and to offer support.

63. The prison posted notices informing other prisoners of Mr Locke's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Locke's death.

Post-mortem report

64. The post-mortem report found that Mr Locke's death was caused by myocardial infarction (a heart attack). His death was contributed to, but not directly caused by, his cirrhosis of the liver and disseminated adenocarcinoma (cancer that forms in the body's glands and spreads throughout the body).

Findings

Clinical care

65. The clinical reviewer found that, for the most part, Mr Locke received person-centred care and that this was good, particularly towards the end of his life. We are pleased that the prison allowed Mr Locke's wife to be with him in the final week of his life. We agree with the clinical reviewer that, overall, the care Mr Locke received was of a good standard and was equivalent to that which he could have expected to receive in the community.

66. We are concerned, however, that while the care plans that healthcare staff created for Mr Locke were functional, they appeared to be standardised and did not specifically mention him or the processes that would be followed to maintain his comfort. We note that the Head of Healthcare told the clinical reviewer on 1 February, that discussions were in place to develop the care planning process. In the absence of any clear improvements, we make the following recommendation:

The Head of Healthcare should ensure that all patients with long-term health conditions have clear personalised care plans, with stated aims, planned interventions and monitoring.

Restraints

67. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

68. Mr Locke had several visits to hospital. He was initially mobile and relatively well and we cannot say that it was obviously inappropriate that he was restrained with double cuffs for some of these visits. When he was admitted to hospital for the final time on 25 December, however, we note that the risk assessment took account of Mr Locke's poor health, limited mobility and low risk, and concluded that restraints were not necessary. We are satisfied that the prison kept Mr Locke's level of restraint under review.

Compassionate release

69. 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.

70. 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 the PPCS. The PSO makes it clear that early release will be granted "in only the most exceptional of cases".

71. The prison began an application to release Mr Locke on compassionate grounds on 26 December 2018. By 11 January 2019, The Governor, a prison GP and Mr Locke's Probation Officer, had completed the application and supported Mr Locke's release on compassionate grounds. We are concerned that the prison did not send the completed and supported application to the PPCS before he died, despite the prison GP noting that Mr Locke was likely to die within the next two to three weeks.

72. There is no guarantee that the application would have been approved, but the application was not even considered because the prison failed to send it promptly. We make the following recommendation:

The Governor should ensure that applications for compassionate release are submitted to the Public Protection Casework Section without delay.

Family liaison

73. Prison Rule 22 requires that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that should be followed when a prisoner has a terminal illness or suffers an unpredicted or rapid deterioration in their physical health. This includes that prisons must have procedures in place for supporting the prisoner and engaging with their next of kin.

74. On 25 December, Mr Locke was taken to hospital and was admitted to the hospital's intensive care unit. However, no one from the prison contacted Mr Locke's wife to tell him about his emergency admission and she only found out what had happened after she telephoned the prison herself. We are concerned that the prison failed to comply with Prison Rule 22 or PSI 64/2011 as they did not engage immediately with Mr Locke's wife despite a clear deterioration in his condition. We recognise that this may have been because the admission took place on Christmas Day when staffing levels would have been lower than normal. However, we make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that prison staff inform the next of kin of seriously ill prisoners immediately when they are admitted to hospital.

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