Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Fisher, a prisoner at HMP Isle of Wight, on 1 April 2019

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 Thomas Fisher died on 1 April 2019 of stomach cancer at HMP Isle of Wight. He was 71 years old. I offer my condolences to Mr Fisher's family and friends.

The investigation found that Mr Fisher received a standard of care at Isle of Wight equivalent to that he could have expected to receive in the community.

We have made no recommendations.

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 **January 2020**

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Summary

Events

1. On 30 September 2005, Mr Thomas Fisher was sentenced to ten years imprisonment for sexual offences. On 22 December 2011, he was released on licence but recalled to prison on 19 May 2016. He was moved to HMP Isle of Wight on 21 February 2017.

2. In November 2018, Mr Fisher told a prison GP that his stomach was bloated and causing him discomfort. The GP treated him for constipation and requested blood tests, the results of which were normal.

3. In December, Mr Fisher told a prison GP that he was still experiencing abdominal problems and had developed a lump on his neck. The GP referred Mr Fisher to a hospital specialist. Mr Fisher underwent investigations in January 2019, and in February, a specialist told him he had cancer in multiple sites.

4. Healthcare staff looked after Mr Fisher in the prison's inpatient unit until his death. He died at midnight on 1 April.

Findings

5. The clinical reviewer was satisfied that the standard of care Mr Fisher received at HMP Isle of Wight was equivalent to that which he could have expected to receive in the community.

6. We make no recommendations.

The Investigation Process

7. 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.

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

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

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

11. One of the Ombudsman's family liaison officers wrote to Mr Fisher's named next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Isle of Wight

13. 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

14. The most recent inspection of HMP Isle of Wight was in April and May 2019. Inspectors reported that health services were very good. Physical health care was effective across both sites, with nurse triage and emergency GP appointments available on weekdays, and access to long-term condition clinics, routine GP consultations and visiting specialists equivalent to the community. The inpatient unit provided safe and effective care, delivered by suitably trained and supported clinical staff.

Independent Monitoring Board

15. 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 2018, the IMB reported that the prison's healthcare unit was a well-run and well-led organisation which provided a standard of care at least equal to that provided for the general public. The IMB noted that the manager had changed mid-year and the new manager had continued to maintain the same high standard, ensuring that staff remained positive and well-motivated.

Previous deaths at HMP Isle of Wight

16. Mr Fisher was the 18th prisoner to die at HMP Isle of Wight since April 2017. Of the previous deaths, 14 were from natural causes and three were self-inflicted. There are no similarities between our investigation findings in Mr Fisher's case and those in previous deaths.

Findings

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

17. On 30 September 2005, Mr Thomas Fisher was sentenced to ten years imprisonment (with a five-year extension) for sexual offences. He was released on licence on 22 December 2011 but recalled to prison on 19 May 2016. He was moved to HMP Isle of Wight on 21 February 2017.

18. On 9 November 2018, Mr Fisher told a prison GP he had had a bloated stomach for three weeks and was in discomfort. He said he had experienced no rectal bleeding, vomiting or weight loss. The prison GP diagnosed constipation and prescribed macrogol (a gentle laxative). He requested various tests and made an appointment to review Mr Fisher on 13 November, but Mr Fisher did not attend.

19. On 14 November, a nurse took a blood sample from Mr Fisher, but the results were recorded as needing 'no further action'.

20. On 3 December, a prison GP recorded that Mr Fisher's constipation had resolved but he still had some bloating and discomfort. He prescribed mebeverine (a treatment for a range of abdominal problems).

21. On 27 December, a prison GP saw Mr Fisher. He said he was in a lot of pain in his abdomen, back and legs and paracetamol was not helping. He also said he was constipated again, and laxatives were not effective. The prison GP noted that Mr Fisher had a tender supraclavicular lump (near the neck's lymph nodes). He initially intended to make a referral to a colorectal surgeon under the two-week rule (the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks). However, the referral form requires certain criteria to be fulfilled. At least two, of a list of symptoms must be present and in Mr Fisher's case they were not. Instead, the prison GP made a normal referral.

22. On 4 January 2019, Mr Fisher had a chest X-ray in hospital. He was not restrained. There was no record of the appointment or its outcome in Mr Fisher's medical record.

23. On 8 January, a prison GP saw Mr Fisher who told him that his abdominal pain had improved, but he was still constipated. The prison GP recorded that Mr Fisher had lost 5kgs in weight since November 2018 and requested further blood tests. (They were done the next day and the results were normal.) Mr Fisher refused a rectal examination.

24. On 10 January, a prison GP saw Mr Fisher who said he was passing liquid stools. He recorded that Mr Fisher's colorectal surgical clinic appointment was pending. Mr Fisher continued to decline a rectal examination and the prison GP recorded that they could not provide him with further relief without doing an examination. He told Mr Fisher to let healthcare staff know if his abdomen distended or if absolute constipation developed.

25. On 29 January, Mr Fisher went to hospital for a computerised tomography (CT) scan (uses X-rays and a computer to create detailed images of the inside of the body) of his abdomen, chest and pelvis. He was not restrained. The consultant radiologist concluded that the results indicated lymphoma. (Lymphoma is a type of cancer that starts in the lymphocytes (infection fighting white blood cells).)

26. On 31 January, Mr Fisher attended hospital and was told that his scan results indicated cancer but that further investigations were needed to confirm it.

27. On 11 Feb, Mr Fisher had a pre-assessment hospital appointment for his upcoming investigations. Restraints were not applied. There was no record of this appointment or its outcome in the medical record.

28. On 20 February, Mr Fisher was admitted to the inpatient healthcare unit. His condition had deteriorated, and he was very frail. The plan was to administer regular enemas and pain relief.

29. On 28 February, Mr Fisher attended hospital for a gastroscopy and a sigmoidoscopy (a test which examines a particular part of the colon lining called the sigmoid). Restraints were not applied. He was told he did not have lymphoma but did have a tumour in his stomach area, and that the cancer had spread all over his body. A nurse spoke to him about his diagnosis when he returned from hospital.

30. The clinical reviewer concluded that the care Mr Fisher received at Isle of Wight up to his diagnosis, was equivalent to that he could have expected to receive in the community. His symptoms were appropriately monitored, and he was referred to a specialist when necessary.

Mr Fisher's clinical care

31. On 28 February, Mr Fisher was prescribed night sedation and Oramorph. He was still located on the healthcare unit although he asked to move back to the wing so he could see his friends.

32. On 1 March, a nurse discussed Mr Fisher's diagnosis with him again and the fact that the hospital had informed healthcare staff that his condition was not treatable. A liquid diet and fortisips (nutritional drinks) were arranged for Mr Fisher and, on 4 March, he was moved to The Kings Fund room (an enhanced cell with a private garden).

33. On 4 March, a prison GP noted Mr Fisher's medical record that he was waiting for the oncologist to confirm their plan for Mr Fisher before instigating a palliative care referral. A prison GP signed a Do Not Attempt Resuscitation Order the same day, which noted that Mr Fisher had capacity to make decisions about his treatment.

34. Staff continued to monitor Mr Fisher and frequently made comprehensive entries on his medical record. A dietician had oversight of his nutritional intake.

35. On 5 March, a member of the multidisciplinary team at the hospital contacted a prison GP to say that Mr Fisher was not considered fit for any treatment. A nurse formulated care plans to cover diet, pain control and general comfort.

36. On 11 March, a nurse completed a falls assessment after Mr Fisher had apparently rolled out of bed. His bed was moved to minimise the risk of this happening again.

37. On 13 March, a nurse created a pressure area care plan.

38. On 19 March, a palliative care doctor met Mr Fisher. She suggested a syringe driver be put in place to manage his increasing pain. One was put in place the same day. Mr Fisher did not tolerate it well and pulled it out on 20 March. His pain relief was then delivered orally and via fentanyl patches and staff closely monitored their effectiveness.

39. On 24 March, Mr Fisher was nursed on permanent unlock as his condition deteriorated and he became increasingly confused. He gradually deteriorated, and a prison GP declared Mr Fisher's death at midnight on 1 April.

40. The clinical reviewer concluded that the care Mr Fisher received at HMP Isle of Wight after his diagnosis was also equivalent to that he could have expected to receive in the community.

41. However, the reviewer has noted omissions by healthcare staff with regard to recording appointments in January and February. As we are content that the appointments went ahead and failing to record them had no impact on Mr Fisher's death, we make no recommendation.

Mr Fisher's location

42. Mr Fisher was located in the prison's inpatients unit. He was placed in an enhanced cell on 4 March and from 24 March, he was nursed on permanent unlock. We are satisfied that his location was appropriate.

Restraints, security and escorts

43. When prisoners have to travel outside 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.

44. We are satisfied that staff took Mr Fisher's frailty and health into account and he was not restrained when he was taken to hospital for investigations into his symptoms.

Liaison with Mr Fisher's family

45. On 8 March, the prison appointed a Senior Officer as Mr Fisher's family liaison officer (FLO). On 12 March, Mr Fisher asked the FLO to contact his son and he did so by letter the next day. The FLO helped arrange visits from Mr Fisher's family and established that his son wished to be informed of Mr Fisher's eventual death by telephone.

46. In the early hours of 2 April, the FLO contacted Mr Fisher's son and informed him that Mr Fisher had died. Mr Fisher's funeral took place on 2 May. The FLO and

another FLO, who was a prison chaplain attended. In line with national policy, the prison contributed to the cost of the funeral.

Compassionate release

47. 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.

48. On 11 December, a prison GP recorded that compassionate release had been discussed with Mr Fisher but that he had declined to apply, preferring instead to be cared for at the prison. We are content that the prison took appropriate steps to discuss compassionate release with Mr Fisher.

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