

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Acres a prisoner at HMP Isle of Wight on 1 April 2019

A report by the Prisons and Probation Ombudsman

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*



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Summary

1. 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.
2. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr David Acres, who was 68 years old, died of cancer on 1 April 2019 at HMP Isle of Wight. We offer our condolences to Mr Acres' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Acres received was equivalent to that which he could have expected to receive in the community. He has made three recommendations relating to Mr Acres' clinical care. These can be found below.
5. We are concerned that Mr Acres was restrained during an escort to hospital shortly before he died, despite being very unwell and having limited mobility. We have made a recommendation about this.

Recommendations

Clinical

- The Head of Healthcare should ensure that protocols are in place for prompt follow up of raised blood pressure and abnormal blood tests.
- The Head of Healthcare should ensure that hypertension management follows NICE guidelines (Clinical guideline [CG127]).
- The Head of Healthcare should review the systems for follow up of appointments, requested for GP follow up, which are not attended.

Non-clinical

- The Governor should:
 - review the decision-making process used on 16 February 2019 when it was concluded that Mr Acres should be restrained; and
 - write personally to the Ombudsman setting out the lessons that have been learned and the changes that have been made as a result.
- The Executive Director for the Long-Term and High Security Estate should write personally to the Ombudsman setting out what he proposes to do to ensure that all staff undertaking risk assessments for prisoners taken to hospital at Isle of Wight understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Acres' clinical care at HMP Isle of Wight. The clinical review is annexed to this report.
7. The PPO has investigated non-clinical issues, including Mr Acres' location, the security arrangements for his hospital escorts, liaison with his family, and whether compassionate release was considered.
8. We wrote to Mr Acres' wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Isle of Wight

10. There have been 19 deaths from natural causes at HMP Isle of Wight over the last three years.
11. Since 2013, we have made 11 previous recommendations to address the inappropriate use of restraints – all of 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.

Key events

12. Mr Acres was serving a term of 16 years imprisonment for sexual offences. He arrived at HMP Isle of Wight in October 2016.
13. In September 2017, Mr Acres was diagnosed with incurable lung cancer. He successfully underwent a course of chemotherapy to shrink the tumour. In October, Mr Acres signed a form to state that he did not wish to be resuscitated in the event of cardiac or respiratory arrest. In December, Mr Acres was moved to the prison's healthcare unit and provided with palliative care.
14. By December 2018, investigations revealed that Mr Acres' cancer had spread, and chemotherapy was deemed to no longer be effective. He was provided with end of life care at the prison. In 2019, his condition progressively deteriorated.
15. In January 2019, the prison supported his application for release on compassionate grounds but this was declined by the Secretary of State.
16. On 1 April 2019, Mr Acres died in his cell. The post-mortem concluded that he died from carcinomatosis (the widespread dissemination of cancer throughout his body) caused by carcinoma of the lung (lung cancer).

Non-clinical findings

Restraints, security and escorts

17. When prisoners have to travel outside a 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.
18. In September 2018, the prison decided not to restrain Mr Acres when he was taken to hospital. On 21 January 2019, his escort risk assessment concluded that he should be restrained. On 31 January, his risk assessment initially concluded that he should be restrained but a subsequent note recorded that restraints were not required because he was subject to palliative care.
19. We are concerned, however, that on 16 February, Mr Acres' escort risk assessment concluded that restraints should again be used, despite noting that he was frail and had limited mobility. The medical assessment on the risk assessment recorded that Mr Acres was in the advanced stages of cancer, and was confused and agitated. It noted that he could walk short distances with a wheeled Zimmer frame. We consider that the prison should have considered the actual risk which Mr Acres posed at that time and that the use of restraints was not justified given his very weak state and the fact that he was accompanied by two prison officers.
20. In our report on a death at Isle of Wight in June 2018, we similarly found that restraints had been used inappropriately and we made three recommendations on the subject: that the Governor and Head of Healthcare should remind staff of their responsibilities; that the Governor should send the Ombudsman a copy of

the prison's last two quarterly reviews of restraints decisions; and that the Governor should revise the risk assessment form to make it clearer to staff that they should take the prisoner's health into account. The prison accepted all three recommendations in February 2019.

21. It is, therefore, extremely disappointing to find the same issue arising again in Mr Acres' case, particularly in February 2019 when we would have expected our recommendations to be fresh in the minds of staff.
22. We do not doubt that the Governor and the Executive Director are acting in good faith, but it is clear that the actions they have taken so far have not been effective in ensuring that the staff who make escort risk assessments understand their legal responsibilities.
23. We therefore recommend:

The Governor should:

- review the decision-making process used on 16 February when it was concluded that Mr Acres should be restrained; and
- should write personally to the Ombudsman setting out the lessons that have been learned and the changes that have been made as a result.

The Executive Director for the Long-Term and High Security Estate should write personally to the Ombudsman setting out what he proposes to do to ensure that all staff undertaking risk assessments for prisoners taken to hospital at Isle of Wight understand the legal position on the use of restraints and that risk assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

**Simon Stanley
Assistant Ombudsman**

November 2019