

**Investigation into the circumstances surrounding the  
death of man whilst in the custody of HMP Parkhurst**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**May 2009**

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

This is the report of an investigation into the death of a 76 year old prisoner at HMP Parkhurst who died from natural causes in hospital on 26 August 2008. He had been admitted to hospital two days earlier. The man was serving a sentence of 20 years imprisonment (reduced on appeal to 17 years) imposed in August 2004 when he was already aged 72.

I would like to add my personal condolences to those already expressed to the man's family by one of my Family Liaison Officers.

The investigation by my office was undertaken by one of my investigators. In addition a doctor was asked by Isle of Wight Primary Care Trust to undertake a review of the man's clinical care. I am grateful for the assistance they both received from HMP Parkhurst, and would like to thank the Governor and her staff for their cooperation. I must apologise for the delay in issuing this report, which was caused by late receipt of the clinical review.

The man's family has expressed concerns about his care and treatment. However, the clinical reviewer and a clinical review panel conclude that the man's care was of an equivalent standard to that he would have received in the wider community. Nevertheless, the clinical review panel recommend that ways be found to ensure that information is shared more widely. I understand that the Isle of Wight Primary Care Trust, in partnership with HMP Parkhurst, is producing an action plan to address the learning points from the clinical review.

I make one recommendation of my own with regard to Parkhurst's policy on the use of restraints on prisoners who are in hospital. Restraints were not removed from the man until an hour after he had received the last rites. I doubt this is consistent with the Prison Service's 'decency' agenda.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**May 2009**

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## SUMMARY

The man was born in 1932. He was 76 years old when he died in hospital on 26 August 2008. As confirmed at inquest, his death was from natural causes as a consequence of bronchopneumonia, which was caused by chronic obstructive airways disease, leukaemia and heart disease.

The man had been sentenced to 20 years imprisonment in August 2004 and remanded into custody at HMP Woodhill. His sentence was later reduced to 17 years on appeal. It was the man's first time in prison and he had no previous convictions. He transferred to HMP Parkhurst on 14 September 2004.

During his first reception health screening interviews at Woodhill and Parkhurst, it was recorded that the man had arthritis in his knees, chronic obstructive pulmonary disease (COPD), and blocked arteries in his legs. The man was a smoker; assistance to help him stop smoking was offered but he chose not to take up the offer.

The man was admitted to hospital on 15 July 2008. Following tests he was diagnosed with chronic myelomonocytic leukaemia and peripheral vascular disease. The prognosis was that his condition was terminal. Whilst he was in hospital the man's family was able to visit him. He was discharged from hospital on 24 July and returned to Parkhurst.

On 24 August, the man was again admitted to hospital as he was in pain and experiencing breathing problems. Whilst he was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used and two officers needed to be at the man's bedside. The assessment was revised later by the duty governor after the man's condition deteriorated on 26 August, and handcuffs were no longer used. Sadly, the man passed away before his family was able to reach the hospital.

After the man died, the prison activated its death in custody contingency plan. The police were informed and visited the hospital. They found no suspicious circumstances. The man's body was therefore released to the undertakers who removed him to the mortuary for post mortem examination.

The clinical review carried out by the doctor and a panel of his colleagues makes one recommendation for service improvement. In the clinical reviewer's view, the quality of care given to the man was equivalent to that he would have received in the community.

I make one recommendation of my own relating to the use of physical restraints.

## THE INVESTIGATION PROCESS

1. The investigation was opened on 27 August 2008 by my investigator. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. In the event, no one came forward. My investigator also studied all relevant prison records, which included the man's main prison record and his medical records.
2. My investigator visited Parkhurst on 29 August, 6 October, 5 and 26 November and discussed aspects of the man's treatment with staff and prisoners. He interviewed the Governor of Parkhurst, a Senior Officer, an officer the Head of Offender Management. My investigator also interviewed staff from the prison chaplaincy and a prisoner on the wing where the man lived.
3. The Isle of Wight Primary Care Trust commissioned a doctor from the PCT's Public Health Department to lead a panel review of the man's clinical care. I am most grateful to them for undertaking such a thorough review.
4. My investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner.
5. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they wanted explored and addressed. Both my Family Liaison Officer and investigator later met the family to discuss the following matters:
  - The treatment both the man and his family received from the Governor of Parkhurst.
  - Why the man was not re-categorised as a category C prisoner and moved to a prison nearer to his family.
  - That the family had not received a condolence letter from the Governor of Parkhurst.
  - The speed and suddenness of the man's death given it occurred just four weeks after he was first diagnosed with leukaemia.
  - The clinical care provided by Parkhurst, and whether the prison had the facilities to cope with someone with the man's level of disability.
  - The family said they were concerned about the poor communication they encountered when the man was admitted to hospital prior to his death.
  - The family was concerned that the man was discharged from hospital on 24 July 2008 whilst he was still in poor health.
  - The family spoke of an upsetting visit when the man was in hospital and what they view as the excessive security measures taken by Parkhurst
  - The family raised concerns about the communication received from the hospital on the day the man passed away. When they had spoken to the hospital in the morning there had been no indication that his condition was so serious.

- Whether the man had contact with the Independent Monitoring Board whilst in Parkhurst.
- The family was also concerned about the cause of the man's death as it was suggested he had developed an infection after he had been admitted to hospital.

My investigator has attempted to address the issues raised by the family within the report. I hope this helps them better understand the events leading up to the man's death.

## **HMP PARKHURST**

6. Parkhurst was a high security prison until the mid 1990s when it was converted to its current role. It now caters for long-term and life sentence category B prisoners and remands from the Isle of Wight courts. It is also the base for the catering and healthcare facilities that serve the three Isle of Wight prisons (Albany and Camp Hill as well as Parkhurst). There are five wings and a healthcare centre. All cells have in cell power and integral sanitation. A and D wings hold vulnerable prisoners. F wing is for prisoners on remand and is the induction wing.
7. Health services at Parkhurst and the other two prisons on the Isle of Wight are commissioned by the Isle of Wight Primary Care Trust (PCT). Healthcare is clustered with both HMP Albany and HMP Camp Hill, and the current healthcare staff are provided by Parkhurst. In total, Parkhurst provides healthcare to 1,500 or so prisoners on the island. The healthcare centre consists of a primary care service and 24 hour inpatient care with 12 beds. There are three nurses on duty from 7.30am to 6.00pm from Monday to Friday. During weekends and evenings, there are two healthcare staff on duty. The inpatient unit has three healthcare staff on duty throughout the day and one qualified nurse overnight. General Practitioners (GPs) from Medina Healthcare, a local community practice, attend Parkhurst for four three-hour sessions each week. Evenings and weekends are covered by on call GPs from the same community practice. Prisoner-patients with more serious conditions or clinical needs are referred to the local hospital.
8. During 2008, there were no other deaths through natural causes at Parkhurst. My investigator reviewed my reports from earlier years but found no common factor between the circumstances surrounding this investigation and those into previous deaths.

### **Independent Monitoring Board**

9. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The report for Parkhurst for the year 2007/08 has a section on healthcare provision in the prison. It highlights the constraints under which healthcare staff worked during this period:

“The Board has a representative on the Prison Health Care Partnership Board representing all three prisons. This has proved to be valuable in informing the PCT of the nature and type of complaints received to help to plan for the future. Clearly the amount of money spent on bed watches will outstrip the budget. We will need to keep a close monitor on this to ensure the PCT meet their obligations. The burden may well ease when the new hospital is opened.”

## **Her Majesty's Chief Inspector of Prisons' report**

10. The most recent inspection by Her Majesty's Chief Inspector of Prisons, Dame Anne Owers, was an unannounced inspection carried out in December 2008. The report of this inspection has not yet been published. In her report from a previous inspection in 2005, the Chief Inspector was "pleased to report that this inspection recorded improvements in a prison that was overall on an upward trajectory".
11. The Chief Inspector wrote that healthcare:

"... had improved, but has a considerable distance to travel. Links with the rest of the prison, particularly in key areas such as suicide prevention and anti-bullying were poor; and the service itself was fragmented and understaffed."
12. The Chief Inspector also noted that Parkhurst:

"... is not a popular location for prisoners, most of whom are from London and who want, and in many cases need, to be nearer home. This is exacerbated by the difficulty of transferring them to category C prisons away from the Isle of Wight."

## KEY EVENTS

13. On 5 August 2004, the man was sentenced to 20 years imprisonment for serious sexual offences. He arrived at HMP Woodhill the same day and transferred to HMP Parkhurst, as a category B prisoner, on 14 September 2004. The man's sentence was later reduced on appeal to 17 years. The man did not accept responsibility for his crimes and refused to participate in programmes to address his offending behaviour. This influenced his security categorisation which was reviewed on a regular basis whilst he was in custody.
14. During the man's first reception health screening interviews at both prisons, it was recorded that he had had arthritis in his knees, chronic obstructive pulmonary disease (COPD), and claudication (this is the name given to pain in the leg caused by "furred up" or blocked arteries) in his legs. He was allowed to keep his medication in his own possession. The man was a smoker but he chose not to accept help to stop smoking.
15. As the man had been identified as a vulnerable prisoner, he was located on D wing when he moved to Parkhurst. Due to his health problems, staff arranged for him to have a cell on the ground floor (known as the 1s) and for his meals to be brought to him. The man worked on the wing doing charity stamp work.
16. In 2005, at an Incentives and Earned Privileged Scheme (IEPS) review, it was agreed that the man was eligible for transfer to another category B prison. (IEPS is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced. Incentives include access to in-cell televisions, more private cash to spend, wearing their own clothes, more time out of the cell and community visits.)
17. When interviewed as part of this investigation, Parkhurst's Governor confirmed that in 2005 a compassionate transfer to HMP Rye Hill, another category B prison, was approved for the man. The Governor said:

"Having checked with our OCA [Observation, Classification and Allocation] clerk, Rye Hill apparently have a very strict criteria where the prisoners have to agree in writing to a series of statements such as they will accept that they have to double-up in the cells, so they will share a cell, they have agree to undergo Sex Offender Treatment Programme and there are a range of other conditions apparently and Rye Hill requires all of these in writing before they will accept the transfer. All of this information was actually sent to the man in 2005 but it was never received back."
18. On 7 January 2008, the man was seen by the prison doctor. He had previously been in regular contact with healthcare staff. He was described as having a persistent cough and being short of breath when he exercised. The man had a Subutamol inhaler but only used it infrequently, and the dosage was increased. The man continued to smoke and was advised to give up. The doctor thought that he might need Atrovent (a medicine which contains Ipratropium Bromide and is used to treat asthma and chronic obstructive pulmonary disease). The

man's mood was described as low and he was tearful, having difficulty sleeping, with increasing pain. He told the doctor that he missed his wife and worried about her as she too was unwell. The doctor judged that the man had been deteriorating since he had known him and they agreed that he needed anti-depressants. A prescription for Fluoxetine 20mg a day was prepared.

19. The man was next seen by a prison doctor on 24 January. The doctor diagnosed restless leg syndrome and changed the man's anti-depressant medication to Amitriptyline 10 mg at night, which was subsequently increased to 25mg at night on 5 March.

20. When interviewed as part of this investigation, Parkhurst's Roman Catholic chaplain described the man as an elderly prisoner who was seen every month by someone from the chaplaincy. Although the chaplain did not think the man appeared to be in ill health, he did complain about pains in his leg. The chaplain said:

"The concerns at the forefront of his mind in general were very immediate 'My wife when am I going to see her next?' I found it always difficult to get him to draw back from the immediate concerns and see that there were other more long term issues that might actually improve his situation."

21. On 26 May, the man attended hospital for a gastroscopy procedure (a gastroscope is an instrument used to examine or view the interior of the stomach). The man was seen two days later by a prison doctor who noted that he could only walk about 50 metres because of osteoarthritis of his knee. It was noted:

"Low mood, poor sleep mainly around pain issues knees & hands. Try Meloxicam [an anti-inflammatory drug] with Omeprazole [a drug used for treating acid-induced inflammation and ulcers] inc [increase] Amitriptyline to 50mg."

22. The man next saw a prison doctor on 16 June. The doctor diagnosed peripheral vascular disease and recorded:

"Ankle swelling, pain calves on walking – getting worse ... pulses not palpable in either feet, feet cold and pale ... Note has been to vascular surgeons before who did not want to do anything."

23. On 26 June, the man was taken to hospital for a colonoscopy (a fibre optic examination of the large intestine). Five days later a referral was made under the two week rule as haematological cancer (cancer of the blood or lymphatic system) was suspected.

24. Whilst the man was in hospital a bedwatch was carried out. The risk assessment was that restraints were to be used and two officers should remain on duty at his bedside. A log of activities was maintained by the officers on

bedwatch duty which was checked on a regular basis by a visiting duty governor. The man family was allowed to visit him whilst he was in hospital.

25. When interviewed as part of this investigation, a Roman Catholic Sister from the prison chaplaincy said that the man:

“ ... struck me from the outset as being a very frail old man, and very concerned about his wife particularly, whose health wasn't too good either, and over the few years I've known him he had often said he wasn't feeling well, that he wasn't sleeping, he was in pain, his leg would keep jerking during the night, and I often suggested to him to write down anything and tell the doctor as soon as he saw him, any things that might not appear to be connected but write everything down and tell his doctor. Eventually I think he was given some medication but it didn't help him very much, he still didn't sleep much and was quite frail. So that was over a period of time.”

26. She was under the impression that the chaplain had investigated whether the man could move closer to his home town. This was because of the difficulties his family faced when they came down to the Isle of Wight for visits, and as the man's wife was quite elderly. The Roman Catholic Sister recalled how she had to reassure the man when he was reluctant to go into hospital. His concerns were that his wife might be worried if he was not in regular contact with her. According to the Roman Catholic Sister, the man rang his wife about three times a day to remind her to take her medication. After the Roman Catholic Sister told him that he could make telephone calls from the hospital, and his wife would not need to know he was there, the man agreed to go into hospital.

27. When the Roman Catholic Sister next spoke to the man at the end of July, he told her that he had been diagnosed with leukaemia. She said that he told her that:

“... his days are numbered, and he didn't want to tell his family but was obviously causing some stress to him ... I suggested it to him that his son's forthcoming visit, to let his son know and then the son would know the best time to break the news to the wife, his son's mother obviously. And within a few weeks he seemed to go downhill very, very quickly, became more frail and one occasion when I came to bring communion he felt too frail altogether, even to have a little service.”

28. The man had an x-ray in hospital on 7 July. Three days later, he attended an appointment with a Consultant Vascular Surgeon. The consultant wrote a prison doctor following the appointment to confirm that he had arranged for the man to attend hospital. This was so that the problems with the claudication in his legs could be investigated and to check whether there were any underlying haematological (blood related) problems. In his letter dated 5 January 2009, the consultant wrote:

“When I saw him [the man] he was still getting pain from his leg but he was not getting nocturnal rest pain and generally the situation

regarding his leg seemed stable. I discussed the situation in some detail with him. He did ask if I could copy my outpatient clinic letter to him as he found all the information quite a lot to take on board and I did this. I also wrote to Dr ..., Consultant Haematologist, to ensure that he was due to be seen and in particular so that he could have an expert haematologist talk to him in detail about his haematological condition.”

29. On 14 July, the man was admitted to hospital for an outpatient follow up appointment with the vascular team. They were going to operate to alleviate problems with the intermittent claudication in the man’s legs. Due to concerns raised after blood tests were carried out, a bone marrow biopsy was performed. Following further tests, the man was diagnosed the following day with chronic myelomonocytic leukaemia (a cancer of the bone marrow affecting the production of healthy white blood cells) and peripheral vascular disease.
30. The man was discharged from hospital ten days later on 24 July and returned to Parkhurst. On his discharge from hospital his pain relief medication was changed to 30 milligrams of Dihydrocodeine four times a day. In her discharge summary dated the same day a house doctor at the hospital, wrote that after a computed tomographic angiography (a medical imaging technique to look at the circulatory system) was performed it was decided that a bone marrow test should be carried out. The test showed the man had chronic myelomonocytic leukaemia. The house doctor confirmed that this result was discussed with the man. It was also decided that it not practical to operate on the man’s leg due to his diagnosis of leukaemia and the risk of bleeding. The house doctor noted that the decision was discussed with the man and his family.
31. In his letter dated 1 August, a Haematology Registrar confirmed that the man had been made aware of his diagnosis and that he had a blood transfusion whilst he was an inpatient. On 6 August, the man was taken to hospital for an x-ray.
32. A week later, on 13 August, the man attended the Outpatients Department and was seen by his consultant. Two days afterwards (15 August 2008), the man was taken to the Accident and Emergency (A&E) Department at the hospital as he had a possible chest infection. He returned to Parkhurst in the same day.
33. A fellow prisoner on D wing who worked as support worker cleaned the man’s cell, helped him move around the prison and delivered his meals. In interview, the prisoner recalled the events during the afternoon of 23 August. He said that after he had been seen by a nurse, the man:

“... slid himself off the bed and I’m standing there and I’m saying ‘hold on, hold on a minute, you’re supposed to rest ..., you’re supposed to take some rest!’ But he said ‘no, no, no I must speak to’ and I can’t remember if he said his wife or he used the word ‘my family’. But that man was adamant that at all costs he had to speak to his family. I helped him to the phone, I got a chair so he can relax in a chair, I dialled the number and he had his conversation.”

34. The prisoner recalled that after he finished his telephone call the man was:
- “... a different man when he came off that phone. When he came off the phone it was like if he had an injection of love. He came off there with a strength of voice and a strength of purpose. Whoever was on the phone and whoever he spoke to, because he always had privacy, so whoever he spoke to I would say that whoever it was really loved ..., he loved them. And they gave him a great deal of energy because he was much better when he came off the phone than when he went on it and that’s not speaking health wise, that’s just an emotional thing when you look at him. But when he came off the phone he was strong of voice and as I said there was always, there was almost like water in his eyes, that’s sadness in his eyes. But there was a strength of character to that man and there was a strong strength in his voice when he came off speaking on the phone to his wife or his son or his family, whoever it was he spoke to. I know that he got a lot of comfort from those people. And the funny thing is after that day, I think it most probably would be the next day, that when I helped him onto his bed and things like this, I asked him ‘are you alright’, he said yes, yes he just needs to lie down, he just needs to rest now.”
35. During the evening of 24 August, the man started to experience difficulties with his breathing. At around 10.20pm, he was escorted man to the A&E Department again as he was suffering with acute pain and breathing problems. He arrived at the hospital at 10.50pm. Whilst the man was an inpatient at the hospital, a bedwatch was carried out by prison staff. The initial risk assessment, carried out by Parkhurst’s Deputy Governor, concluded that restraints should be used and two officers needed to be in attendance at the bedside.
36. On his admission to hospital it was noted that the man had gangrene of his left foot and increasing pain. A blood test showed that he had severe anaemia. A clinical management plan was established which would incorporate pain relief medication and a blood transfusion, as well as a review by the haematology team in the morning and surgical review of his left foot.
37. At 00.36am on 25 August, the man was taken for an x-ray. A hospital doctor confirmed at 1.17am that the man was to be admitted overnight. An electrocardiogram (ECG) was carried out and the man was then moved to the Medical Assessment Unit (MAU). At 2.00pm, the man moved to a bed in a ward. The Deputy Governor visited the man at around 5.20pm and gave permission for him to use the prison mobile telephone to contact his family.
38. When interviewed as part of this investigation, the Roman Catholic Sister said that on:
- “ ... Monday 25 August ... I went to see him there [at St Mary’s Hospital], and again he was very, very frail and he was on oxygen, and they were worrying about what they could do with him, they couldn’t give him a transfusion because his various health problems ... they

were waiting to do some work on him, and trying to decide the best line of action because of his, the complications, they couldn't give him a transfusion. And I went in again on the afternoon of the 26<sup>th</sup>. I accompanied the priest who came to give him the anointing, which is one of the rites of the Catholic church. And I stayed with him quite a while, about two hours, but he, he was I think unconscious at that point."

39. The bedwatch logs during the day on 26 August show that the man was still in restraints and he became more seriously ill as the day progressed. At around 10.55am, after hospital doctors finished their examination of the man, they told the bedwatch staff that if all went well he could be discharged from hospital within the next couple of days.

40. At 2.25pm, however, the man asked to see the nurse as his breathing had worsened. A physiotherapist arrived at 3.00pm to try to help him ease his breathing problems. A doctor visited the man 15 minutes later as his breathing had still not improved and prescribed medication to try to alleviate the problem. The man was taken for another ECG at 3.45pm, and ten minutes later nursing staff informed the officers on bedwatch duties that they intended to contact his next of kin because his condition had worsened. The nurse told the bedwatch staff that she was, "not holding out much hope of him surviving much longer".

41. In the hospital medical notes it was recorded:

"1700 TC [telephone call] – [the man's wife] to inform her that [the man] is very poorly and condition has deteriorated for the past two hours. She will inform her son."

42. When interviewed as part of this investigation, the Roman Catholic chaplain said that he was contacted by someone from the chaplaincy and asked to go into hospital to see the man. He visited the man at 6.25pm and he anointed him with the Sacrament of the Sick. He confirmed that the man was unconscious when he carried out the sacrament. He said that:

"The officers told me something that had indicated that his situation had deteriorated quite a lot over the recent hours ... When I came back from the hospital I had been told that the family were coming to see him the next day or it may be that what I was told gave me the impression that they were making arrangements and it wasn't even as definite as that it was going to be the next day. I think that was actually the impression that I got. It seemed to me that [the man], that his condition was deteriorating rapidly that was just my impression from speaking to the officers and from just taking a look at him and from talking to ... that you know by the hour he was deteriorating rapidly."

43. As his condition was very serious, the chaplain decided to telephone the man's son. Although he could not give any details, the chaplain told the man's son, "I can only tell you that it appears to be very poor and if I were you I could come as soon as you can."

44. At 7.25pm, the duty governor, gave permission for the restraints to be removed from the man. The duty governor had spoken to the ward sister who had told him that the man's prognosis was very poor and that he was unlikely to survive more than four hours. The man's restraints were removed and were not re-applied.
45. The man was reviewed by the medical team who concluded that no treatment was going to reverse his condition and he was likely to die that night. In the hospital medical notes it was recorded:

"19.45 Daughter in law spoke to (son out) regarding the man's deterioration. They are coming to the Island. They are going to speak to the wife."
46. At around 11.00pm, the officers on bedwatch duty noticed that the man had stopped breathing. They immediately informed the nursing staff who confirmed that the man had passed away.
47. One of the bedwatch staff said in his interview for this investigation that he took over the duty at 7.40pm. He confirmed that the restraints had been removed and that the man was unconscious, lying on his bed with an oxygen mask attached to his face. The bedwatch officer said that nurses were constantly in attendance and at 11.00pm it was noticed that the man had stopped breathing.
48. The bedwatch officer said:

"I went straight and told the nurse on duty ... As soon as I told them they came straight through, checked the man and said 'yes, we think he's passed away' ... it seemed, first thing in the morning, it seemed they were saying oh he might be back this afternoon, back to the prison. It seemed as if he would get better during that time, and then all of a sudden he took a big downhill slope."
49. The Night Co-ordinator at the hospital, pronounced the man's death at 11.20pm. Unfortunately, his family did not arrive at the hospital until about 2.20am. They were met by staff from the prison chaplaincy. In her interview, the Roman Catholic Sister said that she and one of the chaplains were there to give support to the family when they arrived at the hospital.
50. The prisoners on D wing were told the following morning about the man's death. Staff on the wing also asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the officers on bedwatch duty returned to Parkhurst they were offered support from the prison's care team.
51. Parkhurst appointed a chaplain as the prison's family liaison officer and Parkhurst gave financial assistance with funeral costs.

52. The post mortem report records the man's death as being due to natural causes, as a consequence of bronchopneumonia caused by chronic obstructive airways disease, chronic myelomonocytic leukaemia and ischaemic heart disease. The verdict of the Coroner's inquest into the man's death, which was held on 16 February 2009, was that he died from natural causes.

## ISSUES CONSIDERED

### The man's prison category

53. The man's family told my investigator and family liaison officer that they were very unhappy with the Governor of Parkhurst. They said they found her uninterested, unapproachable and unhelpful throughout the duration of the man's imprisonment. They felt strongly that her lack of interest and unwillingness to take any action with regard to their father stemmed from the man's refusal to admit to his offence.
54. When interviewed as part of this investigation, Parkhurst's Governor said she regretted that the family were unhappy with her. She wanted:
- “... to reiterate our condolences on behalf of Parkhurst, its staff and other people, the prisoners and the community at Parkhurst for their loss, which I understand is distressing for any family.”
55. The family said they felt that the Governor's apparent disposition towards the man might have prevented him from being re-categorised as a category C prisoner. The family explained that the man was not in good health. He had come into prison with a bad leg and relied on a walking stick to get around. As his general and physical health deteriorated, it was clear to them that he would not have had the strength to escape.
56. In response to this concern, Parkhurst's Governor said in her interview with my investigator:
- “One of the major underlying factors when we consider a re-categorisation has to be a reduction or a visible reduction, a notifiable reduction, in the risk posed by a particular prisoner, for that prisoner to be able to progress onto category C. In the man's case he was sentenced in 2004, had that sentence subsequently reduced from 20 years to 17 years, but he had been convicted and sentenced for very serious offences. As such he posed and was assessed appropriately at that stage as a category B prisoner.
- “We would look towards any prisoner making progress as early as they could do and that would be visible progress through offending behaviour programmes. the man had been in constant denial of his offences and would not undertake any appropriate levels of offending behaviour courses throughout his time whilst he was here, and on that basis there was no visible reduction of risk, hence the decision on an ongoing basis to keep him at the appropriate category of category B.”
57. She confirmed that Parkhurst was one of the few prisons that accept prisoners who are in denial of their offence and who do not agree to undertake the Sex Offender Treatment Programme (SOTP).

58. My investigator has considered the issue of re-categorisation and, from the evidence available, believes that the process was correctly implemented. Regular reviews of the man's categorisation were carried out, and the implications of his refusal to participate in offending behaviour programmes were explained to him. He had been convicted of very serious offences and given a very long sentence, and despite the reduction in sentence length on appeal he still had a significant amount time to serve. The man's refusal to participate in programmes to address his offending behaviour meant that there was no reduction in risk levels and no opportunity for forward movement through the prison system.

### **Transfer to another prison**

59. The family has also asked why the man was situated in a prison so far away from his family, and why he could not have been located in a category B prison nearer to home. The family said that there had been talk about transferring the man to HMP Rye Hill at one point but this had never materialised. They spoke of their frustration at the general lack of information and communication available to them throughout the man's time in prison custody. They felt it was telling that so much help has materialised following the man's death yet no one had wanted to know when he was alive. They appreciated the support received from Parkhurst's family liaison officer, however they felt it was all just "too little, too late".
60. My investigator was able to confirm during his investigation that the option of moving to Rye Hill was discussed with the man. Unfortunately, one of the conditions for transfer would have been agreement to undertake the Sex Offender Treatment Programme. As the man did not complete the compact and agree to the requirement, he would not have been accepted by Rye Hill and this prevented his transfer.
61. In her interview, Parkhurst's Governor explained that the vast majority of prisoners at Parkhurst are a long way from home. She accepted that it was quite difficult and expensive for families to visit regularly. She said that prisoners had the option of asking for a compassionate transfer closer to their home, and she confirmed that in August 2008 a request for a compassionate transfer was received from the man. He had asked to transfer to HMP Bullingdon, HMP Rye Hill or HMP Whatton. The man was told that Whatton was not an option as it is a category C prison. Bullingdon, which is a local category B prison serving Crown Courts in Oxford and Reading, was approached and all of the supporting paperwork (a summary of the man's background, details about his sentence plan and behaviour reports) was forwarded to the prison on 18 August. It is not possible now to say whether his application to Bullingdon would have been successful.

### **Other questions from the family**

62. The family also asked about contact between the man and Parkhurst's Independent Monitoring Board. My investigator was able to confirm that there had been no recent contact between the man and the IMB.

63. The family said that they were deeply offended not to have received a letter of condolence from the Governor at Parkhurst following the man's death. They had been told that one had been written but was subsequently lost. When it was found events had already overtaken it and it had to be changed. However, the family do not recall ever receiving such a letter.
64. In her interview, Parkhurst's Governor confirmed that a condolence letter was sent but that unfortunately it was delayed. She said:

“I would just like to reiterate from my personal point of view and on behalf of Parkhurst and the Service my deep regret if the family had been offended or distressed in any way by any apparent inactivity that they believe has happened, either on behalf of the prison or on behalf of myself as an individual. That's the last thing we would therefore want to happen.”

### **Clinical care**

65. The man's family had a number of concerns relating to his clinical treatment while in custody which I set out in the paragraphs that follow.
66. The man's death came just four weeks after his diagnosis of leukaemia. The family acknowledged that the man was a smoker and suffered inevitable side effects, but felt that he must have been displaying symptoms for some time prior to his diagnosis. They said that the man often spoke about the pain he was in during telephone calls with his family, and sometimes even cried out with the pain. He told them that the doctors would not see him and just repeatedly prescribed him tablets. The family understood he was taking eleven or so tablets a day at one point. The family questioned the appropriateness of the healthcare the man received at Parkhurst.
67. As noted above, a review of the man's medical care was undertaken on behalf of Isle of Wight Primary Care Trust by clinical reviewer who convened a review panel. The panel met on 19 December 2008 and my investigator attended their meeting.
68. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear to the panel that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
69. My investigator asked the panel whether the man's condition could have been diagnosed earlier. The clinical reviewer confirmed that leukaemia was diagnosed as “a side issue” and could not have been diagnosed earlier as the diagnosis was made after a bone marrow biopsy. The man was seen by two different teams – the vascular surgeons and haematology. A multi-disciplinary team meeting on 25 July 2008 decided that, based on his results, it was appropriate to give “supportive treatment” only. His prognosis was not forwarded to the prison's healthcare team.

70. I appreciate that efforts should always be made to ensure that relatives are made aware of serious health concerns. However, this is not always possible. Healthcare staff have to respect patient confidentiality as well as the patient's own wishes. Not everyone wants their loved ones to know about the state of their health. In this case, one factor was the man's reluctance to cause any additional worry for his wife and children. This meant that he did not immediately inform them that he was seriously ill. It would appear that all of these issues conspired to delay notification to the family of the seriousness of the man's condition.
71. At the review meeting, a prison doctor said that on 23 June 2008 she had been informed that the man's blood results had shown he had low platelets. The problem was discussed with the man but he was reluctant to go to hospital. The man attended hospital for a gastroscopy three days later on 26 June which showed no evidence of bleeding. As there were still concerns about his abnormal blood results, the man was referred to the Haematology Department and was seen on 10 July. He also had an appointment on the same day to see the vascular surgeons to investigate claudication in his legs. The haematologists arranged for a bone biopsy to be carried out whilst the man was an inpatient.
72. The Roman Catholic Sister was also able to confirm that, when she spoke to the man after he returned from hospital, he told her of his diagnosis of leukaemia. He had said that he "may not have much time left" and did not want to worry his family. She presented the option that the man might wish to discuss this with his son who could then find the best time to relay the news to his mother.
73. A meeting was held on 22 January 2009, attended by the clinical reviewer, the Head of Healthcare and a Consultant Haematologist. At the meeting it was recorded that, although the man had been told that he had leukaemia, he had not been informed that his prognosis was very poor. The healthcare team at Parkhurst were unaware that the man was only to receive palliative care. Consequently, no application was made for his early release on compassionate grounds. The recommendation from the meeting was to improve communication links between healthcare professionals both inside the prison and in the outside community. The minutes recorded the following: "All consultants in ... and Lead Nurses for cancer should be reminded of the importance of informing the prison healthcare team where a prisoner with cancer has a poor prognosis."

**The communication of clinical information between prison, prison healthcare and the local hospital should be improved and the information sharing protocols should be reviewed.**

### **Support for the man's personal care needs.**

74. The man's family was pleased to know that he received some assistance, although they felt he should not have been in Parkhurst if they did not have the facilities to cope with someone with his level of disability. My investigator was able to confirm that support was made available to accommodate the man's disability and mobility needs. He had been located on the ground floor of the wing on which he was housed. Both his meals and medication were brought to him in his cell. He was provided with a wheelchair, and support was also given by prisoner carers. When interviewed as part of this investigation the prisoner who assisted the man described him as:

"... an elderly gentleman, quite old actually. He was like most prisoners, in as much that we all have our off days and I suppose if there was something that he wanted and he didn't get it that time or straightaway then he'd be a little peeved. But other than that I thought that he was polite, he was quiet and justifiably grumpy because of his age. I think he had the right to be a grumpy old man when he so chose ...

"I think that ... his health kind of deteriorated and when I say 'his health' I mean in him being able to be actively mobile in comparison to what he used to be. Because I have no medical experience so I can't say other than that, but ... there was a point where he was able to go and get his dinner himself and do a lot of movements himself and these things became restricted due to some kind of illness, something to do with his feet.

"So I was appointed to assist him, along with three other inmates. My role in assisting ... was to clean his cell daily, which would entail emptying his ashtrays, because he smoked, emptying his ashtrays; and cleaning up his utensils which would be the knife and the fork and the spoon and the cup, the things which he used for dinner. Tidying his bed when required, sweeping the small room that he was in, commonly known as the cell but he was in there on his own, he had single occupation. So I would sweep that and mop it. I also had the right to see if ... man wanted to escort him where he can have a bath, if he wanted me, where I could take him for a bath, change his kit. In as much as taking him for a bath would just mean preparing the bath that the man was on, he was well enough to bath himself and take care of himself in that department. Making sure that he was okay, making sure that whatever he needed within the permit of the prison laws I got for him. If he needed more bread or he needed cereal, he never had to walk for anything; it was just delivered to him. And there were times when he was in need of the telephone. I would wheel his chair and put it by the phone, put him in his chair and put him by the telephone so he can speak to his family."

75. The family consider that the man should not have been in Parkhurst if there were no facilities to cope with someone with his level of disability. In response to their concerns, the Governor said in her interview:

“ ... there was nothing during the man’s time that Parkhurst could not cope with. If there had been concerns from a disability point of view or from a medical point of view, we have a disability liaison officer who regularly assesses prisoners and gets an assessment on reception and is available to all prisoners on an individual basis for their individual assessments and ... also if healthcare at any stage whether it will be the doctors, whether it be the healthcare staff that are employed by us at the moment, [if] the nursing staff had ever indicated that we hadn’t got suitable arrangements or we could not manage his condition at Parkhurst, he would have either have been admitted to the outside hospital and they would have liaised accordingly, or we would have had to make alternative arrangements to transfer him to another establishment that could have done.

“But there was never at any stage indication that we could not manage, and indeed the decision of the hospital to return him to us would have indicated that and there would have been liaison between ourselves and the Primary Care Trust (PCT) at that stage. Because anybody coming back from the Primary Care Trust, there is an immediate assessment done and contact made with our clinical staff and our head of healthcare to make sure we can appropriately manage the prisoner and the PCT are very aware of our arrangement and our facilities. So if there were any concerns at all he would not have been discharged; there were obviously no concerns that were ever raised and I sit monthly on the partnership board with the PCT and have done since I have arrived. There were never any concerns that were either raised with me or anybody that I am aware of to say we could not manage[the man] and his condition.”

76. The family were very concerned about the poor and confused communication they encountered when the man was admitted to hospital prior to his death. They questioned why the man was not given a blood transfusion when he was initially admitted on 15 July when he was in better health and potentially more able to fight off infection. They queried whether his white blood cell count would also have been low at this time, as it seemed unlikely that this could have dropped so significantly in such a short time. The family have said they are also deeply concerned that the man was discharged back to Parkhurst on 24 July when it was clear he remained in such poor health. They had been told this was because the hospital was unable to operate on him for at least a week or so and required the bed.

77. In his letter sent in response to the concerns raised by the family a Consultant Vascular Surgeon at the hospital, wrote:

“The options of the treatment left were then to continue with his leg as it was with pain relief or to undertake amputation. We felt that even amputation with his current haematological condition would be high risk although it would probably have been possible to cover this with platelet transfusions. However, on balance it seemed that his leg was relatively stable and as the prognosis from his haematological condition was poor it would have better to continue a conservative approach to managing his leg ischaemia ... the plan was for [the man] to return to prison but be reviewed in two weeks time on the Isle of Wight and a Haematology outpatient appointment was also made for him.”

78. The man was re-admitted to hospital on 24 August. His family was told the following day that he required a blood transfusion and they were advised to contact the hospital again the following day. They called again on the morning of 26 August and were told that he was experiencing some breathing difficulties, and had developed an infection, but was otherwise comfortable. The family received a telephone call from the Roman Catholic chaplain during the early evening telling them that the man's condition had worsened, and that it would be wise to make arrangements to come to the hospital. The family began making arrangements to travel the following morning.
79. At 7.15pm, another member of the family received a telephone call from the hospital informing her that they should come to the hospital now. Given the distance, 'now' was never a possibility. The family left home at around 9.00pm, arriving at the hospital at around 2.20am. Sadly, the man had already passed away by this time.
80. The family said it was a real shock to be met by numerous police and prison officers informing them of the man's father's death, given they had received no indication that his condition was in any way serious when they had spoken with hospital staff only that morning. The family was told that the hospital had tried to contact them following the man's death but they have not found any evidence of missed calls around this time. They questioned how the chaplain was able to inform them of the man's worsening condition at around 5.30pm when the hospital, whose responsibility it was to notify them of any change, did not call until 7.15pm.
81. The family was also concerned about the cause of the man's death as it was suggested by hospital staff that he had developed an infection (bronchopneumonia) after being admitted to the hospital.

82. My investigator was unable to clarify why the Roman Catholic chaplain was able to call the family to update them about the man's condition whereas staff at the hospital did not. I also cannot comment on whether the man developed an infection after he was admitted to hospital although bronchopneumonia was given as the cause of death.

### **Use of restraints**

83. The man's family told my investigator about a visit when he was admitted to hospital on 15 July 2008, having just been diagnosed with leukaemia. They said the visit had been upsetting. They described how the man had been wheeled to see his family in a 'tiny room' with two prison officers chained to him. The family felt it was impossible to talk and offer comfort to someone under such unsuitable conditions.

84. In her interview, Parkhurst's Governor said:

"We will always take an individual decision on the level of restraints required with any prisoner escort and that would be looked at ... in the man's case, yes he was elderly and yes he was not the best of health and was slowly deteriorating. However, we go back to the fact that he was a category B prisoner convicted of very serious offences and therefore posed a high risk as far as we were concerned ...

"We have to ensure that we maintain our duty of protection of the public as well and that the staff would have received briefings. They would have been detailed in terms of what levels of restraints would have been required. They are individually assessed and if the condition had deteriorated or there'd been a dramatic change those would have been reassessed on a regular basis. And I think the other thing to say is that there was never a healthcare objection, if there had had been it would have been changed. But there was never a healthcare objection to restraints as well which would always been one that was taken into consideration."

85. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law (Judgment by Mr Justice Mitting on 23 November 2007 in case of (1) Graham (2) Allen v Secretary of State for Justice). The Prison Service is currently drawing up new guidance in relation to the matter.

86. According to the policy for performing hospital bedwatches adopted by Parkhurst at the time that the man was in hospital, the following options were available to the Governor:

- i. Escort and bedwatch with two officers or more, with restraints.
- ii. Escort and bedwatch with two officers or more, without restraints.
- iii. Escort and bedwatch with one officer, without restraints.
- iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).

- v. ... exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all cases should be kept under review to take into account the prisoner's developing medical condition, the physical surroundings in which the prisoner is located, and any emerging intelligence.

- 87. When the man was taken to hospital, the security risk assessment was that an escort chain should be used and two officers needed to be in attendance. I believe that this was entirely appropriate at that time and enabled the nursing staff to have easy access when they carried out their duties.
- 88. On 24 August 2008, when the man returned to hospital it was in line with standard procedures that he was to be handcuffed in the first instance. At the time the handcuffs were first applied, the man was conscious and could reasonably have been judged to have posed a security risk. Whilst the man was in hospital two officers always remained on bedwatch duty. The risk assessment for the man was revised on 26 August when his condition deteriorated. The restraints were then removed although this was an hour after the man had been anointed with the last rites.
- 89. The over-use of physical restraints on elderly offenders in hospital is a recurrent theme in my reports. I understand why decision-making has become so risk-averse, but I believe there are many occasions when earlier decisions to remove restraints would be more consistent with the Prison Service's own 'decency' agenda. I consider that this is one such case. It was clear from the action taken by both medical and chaplaincy staff that the man's prognosis was very poor. He had two officers at his bedside and action to review the use of restraints could and should have been taken more quickly. In other cases I have investigated, restraints have been removed following a telephone call to the duty governor. Here I think that the duty governor should have attended the hospital earlier, or the bedwatch officers should have asked for permission to remove the restraints. I recommend that there is a review of the bedwatch and escort instructions to ensure that this situation does not arise in the future.

**HMP Parkhurst should conduct a review of bedwatch and escort instructions. This should include improved guidance and training for staff on the action to be taken when a prisoner is seriously ill.**

- 90. As I have indicated, policy and practice in the Prison Service in respect of the use of restraints on prisoner-patients in hospital is extremely cautious. That caution may be entirely proper. However, I cannot believe that an elderly man in serious ill health and who has been anointed with the last rites constitutes a likely escapee. All the more so given that he was attended by two members of prison staff. I think that Parkhurst should have reviewed the risk assessment at a much earlier juncture especially when the man's health deteriorated to the extent that his family was advised to attend urgently and a priest anointed him with the Sacrament of the Sick as his prognosis was so poor.

91. On a happier note, I am pleased to report that my investigator found that the bedwatch notes were concise, legible and appropriate. At interview, bedwatch officers spoke perceptively and compassionately about their relationship with the man.

## **CONCLUSION**

92. The man moved to Parkhurst in September 2004 and died of natural causes in hospital on 26 August 2008.
93. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were in line with current policy and expectations, although my strong view is that a revised risk assessment should have been carried out at an earlier juncture.
94. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was equivalent to that he would have received in the community.

## RECOMMENDATIONS

1. The communication of clinical information between prison, prison healthcare and the local hospital should be improved and the information sharing protocols should be reviewed.

Accepted - To be raised at the Primary Care Trust partnership board April 2009. To review info sharing protocols by end June 2009.

2. HMP Parkhurst should conduct a review of bedwatch and escort instructions. This should include improved guidance and training for staff on the action to be taken when a prisoner is seriously ill.

Accepted - Parkhurst is now part of HMP Isle of Wight. All bed watches have a single duty governor management check. Review of bed watch and escort procedures to be carried out by head of security HMP Isle of Wight by end May 2009. Training committee to add specific training for escort staff on training plan by end June 2009.