

**Investigation into the circumstances surrounding the
death of a man in outside hospital, whilst in the custody of
HMP Albany, in May 2008**

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

January 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 prisoner at HMP Albany who died from natural causes in outside hospital, in May 2008.

In February 2008, the man had been sentenced to 12 years imprisonment. He moved from HMP Bedford to HMP Albany at the end of that month. He was admitted to hospital on 26 May and died three days later. He was 58 years old.

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

This investigation was undertaken by one of my colleagues. I am grateful for the assistance he received at HMP Albany and would like to thank the Governor and his staff for their cooperation. A doctor was identified by the local Primary Care Trust to undertake a review of the man's clinical care and I also greatly appreciate his assistance.

The clinical review raises a number of learning points which the prison health partnership will need to consider seriously. I note with concern the clinical reviewer's opinion that the man's care was not of an equivalent standard to that he would have received in the wider community. I understand that the local Primary Care Trust, in partnership with HMP Albany, is producing an action plan to address the learning points. I have also made one recommendation that Albany should review its bedwatch instructions.

I have been impressed by the support afforded by the prison to the man's family. In complete contrast, one of the entries in the bedwatch log was unprofessional, disrespectful and wholly inappropriate.

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Prisons and Probation Ombudsman

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SUMMARY

The man was 58 years old when he died in hospital on 28 May 2008. He died from natural causes as a consequence of carcinoma (cancer) of the lung.

He had been sentenced to 12 years imprisonment in February 2008. He was initially received into custody at HMP Bedford and transferred to HMP Albany on 29 February.

During his first reception health screening interviews at Bedford and Albany, it was recorded that the man had previously been diagnosed with emphysema and had arthritis in his knee. It was also noted that he was a smoker.

On 9 May, the man told other prisoners that he had been coughing up blood. He was seen by healthcare staff and an appointment was made with the prison doctor. He was seen by a doctor on 13 May who requested that an x-ray be carried out. On 22 May, he attended the hospital for an x-ray.

During the morning of 26 May, the man was seen by healthcare staff as he was experiencing shortness of breath and appeared to be confused. Around 1:05pm, he collapsed onto the floor of his cell and cut his head. As healthcare staff could not close the cut, he was taken to the Accident and Emergency (A&E) Department of the local hospital. After receipt of the result of the earlier x-ray, which suggested that the man had cancer in his lung, he was admitted to the Medical Assessment Unit (MAU). On the following day, staff at the MAU contacted Albany and informed healthcare staff that the man appeared to have widespread cancer and his prognosis was very poor.

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 his bedside. This was later revised on 28 May and handcuffs were no longer used. The man's family were allowed to visit him whilst he was in hospital. (A bedwatch log was maintained by the staff at the man's bedside. The majority of the entries made in the log were appropriate and respectful. However, my investigator found one entry made during the evening of 27 May which was not appropriate. This entry has been raised separately with the Governor.)

At approximately 9:35pm on 28 May, the officers on bedwatch duty saw that the man was having breathing problems and they informed the nursing staff. At around 9:50pm, he was pronounced dead by a hospital doctor.

The clinical review carried out, the reviewer and a panel of his colleagues identified issues relating to the provision of care for the man. The review panel makes two recommendations for service improvement. In the clinical reviewer's view, the quality of care given to the man was not equivalent to that he would have received in the community. I have made one recommendation of my own suggesting that the Governor reviews his bedwatch instructions.

THE INVESTIGATION PROCESS

1. The investigation was opened on 29 May 2008 when my investigator 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 to my investigator. One prisoner asked to see my investigator. My investigator also studied all relevant prison records relating to the man, which included his main prison record and his medical records.
2. My investigator visited Albany on 17 and 23 June and discussed aspects of the man's treatment with staff and prisoners. He interviewed a prisoner and two officers.
3. The local 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 the doctor for undertaking such a thorough and timely review.
4. My investigator contacted Her Majesty's 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 to assist him in his enquiries into the man's death.
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 would like explored and addressed. His family chose not to raise any concerns at that time. I understand that the family were able to visit Albany after the man's death to visit his cell and speak to other prisoners who lived on his wing. His family spoke very positively about the help and support they received from prison staff. I hope that this report provides the family with a better understanding of the events leading up to his death.

HMP ALBANY

6. Albany is a category B training prison situated near Newport on the Isle of Wight. The prison occupies the site of a former military barracks, and was opened in 1967. Albany has a varied regime with education and various offending behaviour programmes. At the time of the man's death the prison could hold up to 566 adult male prisoners.
7. There are five wings (A – E) which are almost identical and hold between 94 and 96 prisoners in single cells with in cell power and access to electronic night sanitation. There are three small 'spurs' on each landing, with communal recesses that house showers, toilets and wash basins. There are also two 40 bed units (F and G) which are comprised of single cells with en-suite facilities.
8. Health services at Albany and at the other two prisons on the Isle of Wight are commissioned by the local Primary Care Trust (PCT). The prison's healthcare is clustered with HMP Camp Hill and is provided by HMP Parkhurst. Parkhurst provides healthcare to the 1,500 or so prisoners on the island and has a 12 bed in-patient facility (mainly for psychiatric patients). Prisoners' medical needs are catered for by way of out-patient clinics and core day primary nursing cover. There are three nurses on duty from 7:30am to 5.30pm on Monday to Friday. During weekends and evenings, one member of healthcare staff is on duty. General Practitioners (GPs) from Medina Healthcare, a local community practice, attend Albany for four sessions of three hours each week. Evenings and weekends are covered by on call GPs from the local PCT. There is no nursing or healthcare cover based at Albany during the night.
9. The most recent report of a full announced inspection by Her Majesty's Chief Inspector of Prisons was in November 2007. The inspection report noted that public protection and the range of activities were good and that offending programmes were of a very high standard. However, the Chief Inspector noted that relationships between staff and prisoners were distant and mistrustful. There were also insufficient work places, and systems to protect prisoners against bullying and self-harm were not sufficiently robust.
10. The Independent Monitoring Board (IMB) in its most recent report for Albany (2006-2007) drew attention to the difficulties faced by prisoners with mobility problems. The IMB noted that the management team at Albany was aware of this and every effort was being made to accommodate prisoners with mobility difficulties in appropriate locations. The report also referred to the limited availability of staff for escorts to accompany prisoners to the local hospital. The report said, "we still feel that this problem will not go away due to the age of our prisoners".
11. During 2008, my office has investigated five deaths through natural causes at Albany. There was no link between the circumstances surrounding this investigation and the previous deaths.

KEY EVENTS

12. On 7 February 2008, the man was sentenced to 12 years imprisonment. He arrived at HMP Bedford the same day and transferred to HMP Albany on 29 February.
13. During his first reception health screen interviews at both prisons (on 7 and 29 February), it was recorded that the man had previously been diagnosed with emphysema and arthritis. He was a smoker who continued to smoke and refused assistance to help him stop. He was allowed to keep his medication in possession. At Albany, he was located on A wing. Due to his breathing problems, an officer arranged for him to move from a cell on the first landing (the 2s) to a cell on the ground floor (the 1s).
14. During the morning of 31 March, the man was seen by a nurse in the healthcare centre because he needed to complete a fitness form as he wanted to play bowls.
15. On 9 May, the officer who arranged the cell move contacted healthcare after the man told other prisoners that he was coughing up blood. A second nurse saw the man on the wing and noted that his breathing and colour were good. He said that he had a persistent cough which had blood stained sputum, and that he was coughing so much that it was now a strain. An appointment was made with the prison doctor to seek further advice.
16. A doctor saw the man four days later on 13 May. The doctor noted that the man had lost three stone in the past few months. He decided to make an urgent referral for him to have a chest x-ray at the local hospital. On 16 May, a member of staff from the prison's healthcare centre arranged an appointment for him at the local hospital.
17. On 22 May, the man went to the hospital for an x-ray. (The result of the x-ray was received by Albany on 28 May - two days after his admission to hospital). The result of the x-ray was:

“There is a significant loss of volume of the right lung with a large mass arising from the right hilum and measuring 10 X 8.3cm. There are also infiltrative changes surrounding the mass. There is no evidence of any pleural effusion. The right lung [(sic). I assume this is in error.] is clear. The changes primarily are in keeping with a malignant tumour of the right lung with ipsilateral metastatic disease. For further investigation I would like to suggest bronchoscopy and CT of the lungs.”
18. Around 9:00am on 26 May, a second officer noticed that the man's speech was slurred and he was acting differently. When interviewed as part of this investigation, the officer said he became concerned about the man's well being and thought that he might have suffered a stroke. The second officer informed Healthcare about his concerns and kept him under observation. A third nurse attended his cell on two occasions during the morning at the second officer's

request. On his first visit just after 9:00am, the third nurse noted that the man was able to answer simple questions. Because he was concerned about the man's condition, the second officer made regular checks throughout the morning. At around 11:00am, the second officer made a further check on him. He observed that the man was incoherent and short of breath. The second officer again requested medical assistance. When the third nurse saw him for a second time he found him talking to other prisoners in his cell. He complained of feeling short of breath when he lay down and the nurse suggested that he sit propped up. The second officer asked the nurse whether the man would be referred to hospital. The nurse replied that he would not make a referral but had arranged an appointment for him to see the prison doctor at 2:00pm. The nurse noted on the medical record that Albany was still awaiting the result of the man's earlier x-ray.

19. At approximately 1:05pm, the second officer checked the man and found him sitting on his bed. The man spoke to him and appeared to be okay. As the second officer walked away from the cell he heard a noise. The officer re-checked the cell and discovered that the man had collapsed onto the floor in front of his cell door. He immediately used his radio to summon medical assistance. The officer told the man that he needed to move away from his cell door so that it could be opened. With his colleague he then opened and entered the cell. They discovered that the man had a deep cut to his left eyebrow. The second officer asked his colleague to fetch the first aid kit. When his colleague returned to the cell, they helped the man to sit on his bed. The third nurse arrived at the cell shortly afterwards at approximately 1:11pm. Whilst medical treatment was being carried out it was apparent that the man's head injury was serious and arrangements were made to take him to the local hospital. At 1:56pm, the man arrived at the Accident and Emergency (A&E) Department at the local hospital for treatment of his wound. He was later admitted to the Medical Assessment Unit (MAU) at the hospital after the results of his earlier x-ray (on 22 May) were received.
20. Whilst the man was an in-patient at the hospital, a bedwatch was carried out by prison staff. The initial security risk assessment carried out on 26 May by the Head of Security and Operations concluded that an escort chain should be used and two officers needed to be in attendance at his bedside. During his stay in hospital, the man was visited by his family.
21. On 27 May, the bedwatch logs show that the man was seriously ill. During the day, he was noted to be confused following an episode of brachycardia (slow heart rate). The doctors spoke with his family and explained that lung cancer was suspected. The Duty Governor informed the Family Liaison Officer at Albany that doctors at the hospital were talking about life expectancy of hours rather than days. The third nurse contacted staff at the MAU and was told that the man appeared to have widespread cancer in his lung, brain and abdomen. The nurse was also informed that his prognosis was very poor. Later that same day an officer, who was on bedwatch duty, made an inappropriate entry in the bedwatch log to which I refer later in this report (paragraphs 35 - 37).

22. On 28 May, two further officers were on bedwatch duty during the day. They noted in the log that the man slept most of the morning and that, when he was awake, he was not very coherent. The man had a CT (Computed Tomography) scan around noon. He was found to have a lesion in the left frontal lobe of his brain and a large tumour in his right lung. A hospital consultant met the man's family. He explained that he was very ill and that he was being kept comfortable because a cure for his condition was not possible.
23. The Head of Security and Operations revised the security risk assessment at 3:20pm on 28 May. The man's restraints were removed and were not re-applied. At 6:45pm, another two officers reported for bedwatch duty. They relieved the day bedwatch officers. At approximately 9:35pm, the relief bedwatch officers saw that the man was having breathing problems. Nursing staff were summoned and the officers left the room to allow the family some privacy. The man's family remained in the room with him. At around 9:50pm, death was pronounced by a hospital doctor. One of the relief bedwatch officers immediately informed the prison. The Head of Security and Operations met with the man's family and offered condolences on behalf of HMP Albany.
24. At 9:00am on 29 May, the Diversity Manager and an officer from Safer Custody called all the prisoners on A wing together in the association area to inform them of the man's death. They also asked the 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.) Three prisoners were upset and were spoken to individually following the group meeting.
25. A principal officer was appointed as the prison's Family Liaison Officer. He met the family when they went to see the man in hospital during the morning of 28 May. The principal officer maintained contact with the family and assisted with the funeral arrangements. The prison offered financial assistance with the costs of the funeral.
26. The post mortem report records the man's death as being due to natural causes, as a consequence of a carcinoma (cancer) of the lung with cerebral metastases (cancer in the brain).

ISSUES CONSIDERED

Clinical care

27. A review of the man's medical care was undertaken on behalf of the local Primary Care Trust by a doctor who convened a review panel. The panel comprised of a Chair, the clinical reviewer, a member of the Independent Monitoring Board, a General Practitioner for the Isle of Wight prisons and a Risk Incident and Claims Manager.
28. My investigator asked the panel whether the man's condition could have been diagnosed earlier. The clinical reviewer says that the man did not tell staff of any health concerns at his first health screen interviews at either Albany or Bedford. The clinical reviewer also says that a routine chest x-ray was not part of the reception process but a tuberculosis (TB) risk form was used during the health screening process. The man only reported that he suffered from emphysema and arthritis.
29. The panel has expressed concerns about the delays arranging the man's x-ray. It was requested on 13 May and carried out on 22 May but it is unclear what caused this delay. The result of the x-ray was not received by Albany until 28 May. However, the x-ray result was known to hospital staff soon after he was admitted to hospital, on 26 May. During the panel's discussion, the GP for Isle of Wight prisons said that x-rays results in primary care are sent electronically via a system called Pathlinks. The result is received the day after the x-ray has been performed. The panel agreed that there should be a review of the Pathlinks system and how it might be used by Healthcare at Albany. It also agreed that the Chair and Risk Incident and Claims Manager should discuss with the hospital the communication problems encountered in this case.

During the proposed new healthcare building programme at HMP Albany there should be an assessment of the benefits of adopting the Pathlinks system.

There should be a review to improve communication between Albany and the hospital with regard to urgent x-ray and pathology reports.

30. The GP for Isle of Wight prisons advised that another referral route for the man could have been the two week cancer referral under the cancer care guidelines. The GP said that the man would have qualified, although this would not have altered his prognosis.
31. The panel agreed that, had the man reported his symptoms earlier, tests could have been performed more quickly. He and his family might then have known about his prognosis earlier. However, it is very unlikely that an earlier diagnosis would have altered the outcome. The GP said that a lesion on the frontal lobe of the man's brain might have affected his personality and he might have acted out of character. This may explain why he did not bring his symptoms to the attention of healthcare staff or his family.

32. Following tests on 28 May, the man was diagnosed with terminal cancer and his family were informed that there was no active treatment for his condition. He was kept comfortable and passed away later that day.
33. The clinical reviewer concludes that the man's care was not equivalent to that he would have received in the community. He says this was due to the delay in obtaining a chest x-ray, and the result of that x-ray, although this did not alter the eventual outcome.

Restraints

34. I am pleased to report that the man was properly assessed whilst he was in hospital and, as a result, the level of restraints was reduced and the escort chain removed. This was entirely appropriate and enabled the nursing staff to have easy access when they carried out their duties. The bedwatch officers remained on duty but withdrew when his condition deteriorated, allowing his family to be alone with him when he died.

Bedwatch log

35. My investigator carefully studied the bedwatch logs completed by prison staff during the time that the man spent in hospital. My investigator was shown a copy of the guidance made available to staff undertaking escorts outside the prison. The guidance gives no advice about what the log should or should not contain or about the language and tone of the entries. The majority of the log entries were appropriate and suitable, but my investigator found one that was wholly lacking in respect and decency.

HMP Albany should conduct a review of bedwatch instructions. This should include improved guidance and training for staff on what to write on bedwatch logs and how to write it. The review should reflect whether additions are required to the Visiting Manager's Bedwatch Checklist.

36. During his bedwatch duty on 27 May, the officer on the initial bedwatch duty wrote the following inappropriate entry in the bedwatch log:

"Prisoner was asleep on our arrival. Had to be told on numerous occasions not to swear with the nurses present. Also warned about trying to touch up the nurses. Noisy through the night P.I.T.A. Likes to expose himself."

37. When asked by his line manager, this officer said he was not sure exactly what he meant by the "P.I.T.A." abbreviation. I have to say that it is difficult to accept the officer's claim. If he was not sure, why did he take the trouble to record the letters? In fact, it is manifest that P.I.T.A. is an abbreviation for pain in the arse.

38. The officer on the initial bedwatch duty was in the hospital to monitor a terminally ill man, although I accept he was not to know that the man would die the following day. I am sorry to say that his entry is not consistent with the Prison Service's decency agenda, and was both unprofessional and wholly inappropriate. I have chosen not to make a separate recommendation but have written to the Governor of Albany personally. I am confident that this will be sufficient to ensure that appropriate action will be taken.
39. The NOMS Safer Custody and Offender Policy Group confirmed that the officer concerned accepts that the comment he made were not appropriate. He has apologised and given assurances that it will not happen again.

CONCLUSION

40. The man moved to Albany in February 2008 and died of natural causes in the Medical Assessment Unit at the local hospital on 28 May 2008.
41. He entered custody with a very serious undiagnosed physical health problem. It was only after his condition deteriorated and the prison referred him for further investigation at the hospital that it was established that he had terminal cancer. The disease was extensive and the prognosis poor. He died within two days of the diagnosis.
42. I was pleased to note that the family were treated respectfully and compassionately when they visited Albany after the man's death. Albany's treatment of his family reflected well upon individuals, their place of work, and the Service they represent.
43. In contrast, one of the entries in the bedwatch log was unprofessional, disrespectful and wholly inappropriate. The Governor will wish to review and strengthen existing procedures at Albany for management checks and the monitoring and support of staff on bedwatch duty.
44. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was not equivalent to that he would have received in the community. The review panel made two recommendations which I endorse. They will need to be addressed by the local Primary Care Trust in partnership with the Governor of Albany.

RECOMMENDATIONS

HMP Albany

1. HMP Albany should conduct a review of bedwatch instructions. This should include improved guidance and training for staff on what to write on bedwatch logs and how to write it. The review should reflect whether additions are required to the Visiting Manager's Bedwatch Checklist.

Accepted - A full re-assessment of current bedwatch instructions will be carried out and a training session for guidance to staff and managers will be produced. The Visiting Manager Checklist will be included in this review. Personal views and/or assessments are actively discouraged.

Clinical

2. During the proposed new healthcare building programme at HMP Albany there should be an assessment of the benefits of adopting the Pathlinks system.

Accepted - The new build steering group is considering the best options for all electronic patient reports and records. It is not clear at this stage whether Pathlinks will be part of that. This will be reviewed on an ongoing basis at least until commissioning of the new build.

3. There should be a review to improve communication between Albany and the local hospital with regard to urgent x-ray and pathology reports.

Accepted - This has been reviewed and a clear protocol is in place for urgent reports. All prison healthcare staff, GPs and appropriate hospital staff have been updated.