

**Investigation into the circumstances surrounding the
death of a man in September 2009 whilst in the custody of
HMP Isle of Wight – Albany**

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

March 2010

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 from natural causes of a man, who was a prisoner at HMP Isle of Wight - Albany, who died in outside hospital on 21 September 2009. The man was 70 years old. He had been taken to hospital on 9 September 2009 after complaining of pain in his legs. He appeared to be getting better but unfortunately his condition then worsened and he passed away in his sleep. A post mortem carried out after the man's death discovered that he had died from undiagnosed lung cancer. He had entered custody in October 2003 and moved to Albany in September 2005.

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.

The investigation was undertaken on my behalf by one of my investigators. I am grateful for the assistance he received from staff at HMP Isle of Wight - Albany and would ask the Governor to pass on those sentiments. A doctor was asked by Isle of Wight Primary Care Trust to undertake a review of the man's clinical care and I also appreciate his assistance.

The clinical review carried out by the doctor and a panel of his colleagues concludes that the man's clinical care was comparable to that available in the community. I have noted the issues highlighted by the doctor and I endorse the three recommendations in the clinical review.

I have made no separate recommendations of my own.

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2010

SUMMARY

The man was born in 1939 and was 70 years old when he died in outside hospital on 21 September 2009. The man died from natural causes as a consequence of lung cancer.

The man had been sentenced to 15 years imprisonment at Crown Court in October 2003. His sentence was later reduced to 12 years on appeal. After stays in HMP Winchester and HMP Wandsworth, he transferred to HMP Albany on 13 September 2005.

During his first reception health screen interviews, it was recorded that the man had previously been diagnosed with asthma, rheumatism, depression, heart problems and hypertension (high blood pressure). Because of his mobility problems, he used a walking stick. The man was later diagnosed with diabetes. He was also a smoker but the man chose not to accept assistance to help him to stop smoking.

On 9 September 2009, the man was taken to the Medical Assessment Unit at the local hospital after complaining of severe pains in his legs. He moved to a ward on the following day.

Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that restraints were to be used and two officers were to be present at the man's bedside. The restraints were removed after the man's condition deteriorated and were not re-applied.

Around 12.38am on 21 September, the staff on bedwatch duty noticed that the man appeared to have stopped breathing. They immediately informed hospital staff who confirmed that the man had died.

After the man's death, the prison activated its death in custody contingency plan. The police visited the hospital and found no suspicious circumstances. The man's body was therefore released to the undertakers. The coroner's officer told the prison that he had died from natural causes.

The clinical review carried out by a doctor and a panel of his colleagues considered the care provided for the man. In the reviewer's view, the quality of care given to the man was equivalent to that he would have received in the community. The reviewer makes three recommendations. I understand that the prison health partnership is considering the findings from the review and is developing an action plan to address them.

I make no additional recommendations of my own.

THE INVESTIGATION PROCESS

1. The investigation was opened on 22 September 2009 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. In the event no one came forward. My investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.
2. The investigator visited HMP Isle of Wight - Albany on 24 September, 16 November and 4 December and discussed aspects of the man's treatment with staff. He interviewed staff and also interviewed a support worker and fellow prisoner on the man's wing.
3. The Isle of Wight Primary Care Trust commissioned a doctor to lead a panel review of the man's clinical care. I am very grateful to him for undertaking such a thorough review.
4. In line with my normal procedures, the 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 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 raise any concerns or questions that they wanted to be addressed. They chose not to raise any concerns at that time. I hope that my report provides them with a better understanding of the events leading up to the man's death.

HMP ISLE OF WIGHT - ALBANY

6. HMP Isle of Wight was inaugurated on 1 April 2009. It is the amalgamation of the former Albany, Camp Hill and Parkhurst prisons. HMP Isle of Wight holds approximately 1,700 prisoners on the three sites. The prison is governed by Mr Barry Greenberry, who took up post following the amalgamation. Each site has its own Director who reports to Governor Greenberry.
7. Albany is a category B training prison. It opened in 1967 on the site of a former military barracks. Albany offers a varied regime with education and several offending behaviour programmes. At the time of the man's death, the prison could hold up to 567 adult male prisoners. The average age of Albany's population is high compared to most jails.
8. There are five wings (A – E) that are almost identical and hold between 94 and 96 prisoners in single cells with in-cell power and access to electronic night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small 'spurs' on each landing, with communal recesses containing showers, toilets and wash basins. There are also two 40-bed units (F and G) which comprise single cell accommodation with en-suite facilities.
9. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). A new Inpatient Healthcare Unit (IHU) was opened in October 2009 and is situated at Albany. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, surgical, rehabilitative and health-related respite needs, requiring hospital type inpatient care within a prison setting. In general, these include:
 - Acute care and treatment of prisoners where admission to the local hospital is not appropriate.
 - Recovery post-discharge from emergency treatment, or elective secondary care and treatment at the local hospital or elsewhere.
10. General Practitioners (GPs) from a local community practice attend Albany for four three-hour sessions each week. Evenings and weekends are covered by on-call GPs from the same community practice. Prisoners with more serious conditions or clinical needs are referred to the local hospital.
11. A risk assessment must be completed when prisoners attend hospital inpatient and outpatient appointments. This is to determine the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff will carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch will be carried out by a duty governor. Visits from family may be allowed but these will be closely monitored to ensure that they do not impinge on the security of the bedwatch.

12. The risk assessment will consider the following:
 - i. The prisoner's medical condition. When there is doubt the prison's medical officer will be asked to advise on any medical objections to the use of restraints.
 - ii. Behaviour in prison.
 - iii. Home circumstances.
 - iv. The nature of the offence (criminal history), the risk to the public and hospital staff, including the risk of hostage taking.
 - v. The prisoner's motivation to escape, likelihood of outside assistance and their conduct whilst in custody.
 - vi. The physical security of the hospital.
 - vii. Assessment of visits restrictions.

13. According to the policy for performing hospital bedwatches adopted by Albany at the time that the man was in hospital in September 2009, 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 prisoners should be kept under review to take into account their medical condition, the physical surroundings in which they are located, and any new information.

14. My investigator reviewed the reports into earlier deaths from natural causes at Albany. He found that the issue of poor record keeping had been raised on several occasions previously. It was noted in an investigation into a death at another prison on the island that the introduction of the new electronic medical system (SystmOne) might help to improve this.

Performance rating

15. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS uses a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being "serious concerns" and four "exceptional performance"). For the last two quarters, HMP Isle of Wight has been given a rating of two (or "requiring development"). For the last quarter before the creation of HMP Isle

of Wight, however, Albany was given a rating of three, which was an improvement on previous ratings.

Independent Monitoring Board report

16. 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 latest report for Albany, for the year 2007/08, drew attention to limitations in the healthcare services at Albany. The report said:

“The existing services within the prison are stretched to capacity, largely due to the age of the prison population. This can, at times lead to missed hospital appointments, and delays in issuing medication, from the pharmacy in Parkhurst, which, in itself is a time consuming problem. Unlike patients in the community, who can usually obtain a months supply of medication, many inmate patients are not suitable for a similar policy, resulting in medication being issued daily, or more frequently. This is also a security requirement, as it is not unknown for a prisoner to sell his medication to another.”

Her Majesty’s Chief Inspector of Prisons’ report

17. The most recent report on Albany by HM Chief Inspector of Prisons, Dame Anne Owers, followed a full announced inspection in November 2007. The Chief Inspector’s report noted that public protection and the range of activities provided were good. Offending behaviour programmes were also of a very high standard. However, the Chief Inspector noted that relationships between staff and prisoners were distant and mistrustful. There were insufficient work places and systems to protect prisoners against bullying and self-harm were not sufficiently robust.

KEY EVENTS

18. The man was born in 1939. He was one of five children and had been married twice. After leaving school with no qualifications, the man had a variety of manual jobs including working at a brewery, at a factory making doors, and as a farm worker. He gave up work to become his wife's carer after she became ill with heart disease.
19. On 22 October 2003, the man was sentenced to 15 years imprisonment for serious sexual offences. He arrived at HMP Winchester on the same day and transferred to HMP Wandsworth on 30 October. It was the man's first time in custody as he had no previous convictions. He transferred to Albany on 13 September 2005. The man's sentence was later reduced on appeal to 12 years.
20. At the man's first reception health screen interviews, it was recorded that he had previously been diagnosed with asthma, congestive heart failure, depression, hypertension (high blood pressure) and rheumatism. He was a smoker but chose not to accept help to stop smoking. Because of his mobility problems, the man used a walking stick and had access to a wheelchair when he had travel long distances. He was located on the ground floor of B wing at Albany in a single cell.
21. On 8 June 2007, the man was diagnosed with Type 2 diabetes (also known as non-insulin dependent diabetes mellitus). He was prescribed gliclazide (to stimulate the pancreas gland to produce more insulin hormone) and lisinopril (this is used to treat hypertension, congestive heart failure and to improve survival after a heart attack).
22. Just over two months later, on 24 August, the man was also prescribed simvastatin (a medication that helps to reduce cholesterol and prevent heart disease in people at high risk and those who have already had a heart attacks or stroke). According to the man's prison medical record, regular blood pressure monitoring and blood tests were carried out whilst he was at Albany.
23. The man was seen in the healthcare centre on 1 July 2009 as he had a dental infection. He was prescribed antibiotics.
24. On 19 July, the man's personal officer (each prisoner is allocated a personal officer, who is the first point of contact for them), made the following entry in his prison record:

"He is still awaiting [the] outcome of the parole process, he hopes it is positive. I have warned him that it can go either way. He is getting out of his cell a bit more, only once or twice around the landing but it is good for him. No other issues."

25. The Parole Board rejected the man's application for release on licence on 26 August. In their letter the Board wrote:

"Given that no sexual offending behaviour work has been undertaken, the panel looked elsewhere for evidence of reduction of risk. None was available. Furthermore, it appears that the man still shows a lack of insight into the offences, and a lack of appreciation of future difficulties. He has not planned for release, has no strategies in place to reduce the risk of future offending, and has no apparent support network. In the circumstances, the panel considered that the risk had not reduced to a level which was manageable in the community. Parole was therefore refused."

26. When interviewed as part of this investigation, the personal officer said that the man:

"... was quite a jovial chap. He was an old fellow who took things as they came, spent most of his day in his cell and didn't ask for much. Didn't come and see me with many problems. And as I said he took each day as it came. The only issue he personally raised with me was, because he couldn't walk very far, he had problems getting across to the healthcare centre, [and] sometimes they were late in delivering his tablets. So I had to contact them in healthcare and ask them in effect to get a move on. He was on daily medication and 99 times out of a 100 it was brought to him."

27. The personal officer also said that the man attended a weekly event at Albany:

"Usually I think it was Wednesday afternoon or Friday afternoon there was a function run by the Disability Liaison Officer. She used to run things like bingo or watch a video ... Really just to get together with some other old chaps and have a natter."

28. A prisoner on B wing was a support worker for the man. He cleaned the man's cell, assisted him in moving around the prison and collected his laundry and meals. He also used to play games with the man on his television. When interviewed as part of this investigation, the support worker said: "I found him to be easy going. He used to take the mickey, tell a few jokes and play games on the TV with his game machine".
29. Around 7.00pm on 9 September 2009, the man complained of severe pain in his legs which were red and swollen. After he was seen by a prison doctor, healthcare staff arranged for the man's immediate admission to the Medical Assessment Unit (MAU) of the local hospital. He was escorted by two officers.
30. On admission, as well as having cellulitis - a bacterial infection of the deep layer of skin (dermis) and the layer of fat and soft tissues (the subcutaneous tissues) that lie underneath the skin - and eczema of his legs, the man was found to have very long toe nails. He moved to a ward on the following day.

31. The following entry was made in the man's medical record on 10 September:

"Telephone conversation with ward. The man is doing well, has been on IV [intravenous] antibiotics but is now going onto oral antibiotics for the next 36-40 hours. The staff nurse I spoke with was unhappy with the state of his feet and toenails. Apparently his slippers were too small and he had been waiting for new ones for three months, also his toe nails desperately needed cutting which have now been done in the hospital. I have explained that it is the man's responsibility to make appointments for his feet and we do have a podiatrist. We were unaware that he was having foot trouble or he was having problems with his slippers but I will chase up getting him some new slippers. I have since spoke to the Disability Liaison Officer at Albany about the man and she will look into this case and get some slippers sorted out."

32. My investigator asked Albany to comment on this issue. In response the Head of Residence at Albany wrote:

"The Disability Liaison Officer said that she saw the man usually about once a week and he had never asked for slippers, however she did supply the man with slippers when she was asked for them."

(The state of the man's toe nails is discussed later in this report.)

33. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment completed by the duty governor concluded that restraints were to be used and two officers needed to be at the man's bedside. The assessment was revised on 11 September by another duty governor who concluded that restraints were not to be used. The following entry was made in the risk assessment: "Due to existing medical conditions and physical locations cuffs can be removed. Cuffs to be re-applied when medical condition improves."
34. A log of activities was maintained by the officers on bedwatch duty and checked regularly by a visiting duty governor.
35. The man's health appeared to be improving and a discharge date was set for 19 September. However, on 16 September, the man's oxygen saturation (the percentage of haemoglobin in the blood that is taken up by oxygen molecules) dropped and he had to be given oxygen. On the following day, he was seen by a doctor who suspected that the man had a mild respiratory infection and asked for tests to be carried out. He was started on intravenous antibiotics on 18 September. Blood tests were also carried out as the man was complaining of feeling unwell.
36. At approximately 6.30pm on 20 September, two officers took over the bedwatch duty. Around 15 minutes later, they were informed by nursing staff that the man was going to be assessed by a doctor because of his worsening

condition. The hospital staff then considered whether to move the man to the Intensive Care Unit but ultimately decided not to move him from the ward.

37. The bedwatch staff told the duty governor that the man's condition was very poor and that nursing staff were in attendance as he had respiratory problems and his condition was in rapid decline.
38. At around 11.30pm, nursing staff informed the two officers that the man was very likely to die at some point during the night. They also said that it had been decided that, if the man stopped breathing, no effort would be made to resuscitate him. Just over an hour later, at 12.38am, the bedwatch staff noticed that the man appeared to have stopped breathing. Officer A told nursing staff and they confirmed soon after that the man had died.
39. When interviewed as part of this investigation, one of the bedwatch officers said:

“After the intensive guys left, the nurses did say that he probably would die. They left his oxygen mask on but took off the machine [that] was monitoring him. His breathing slowed and I said to the nurse, ‘Do you want me to press the bell if he stops breathing?’ They said no, that we should come and get them. It slowed, it seemed to stop and I said to my colleague that I thought I should get the nurses. I then went to get the nurses and when we returned his breathing was quite shallow. They took his oxygen mask off and laid him back. He then stopped breathing ...”

40. The following entry was made in the hospital nursing records after the man's death:

“Patient became progressively unwell with reduced urine output, increased shortness of breath, confusion few days prior to his death. ICU doctor came to review patient on 20/09/09 at 23:50 and decided that in view of his pre morbid condition, his prognosis was very poor. Has advised to continue medical treatment and keep him comfortable. With further deterioration, he was not for resus [resuscitation].”

41. Prisoners on B wing were informed of the death after they were unlocked on 21 September. They were also asked 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.) All prisoners who were on an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime were reviewed. (ACCT is the Prison Service's procedure for supporting and monitoring prisoners believed to be at risk of suicide or self-harm.) When the officers on bedwatch duty returned to Albany, they were offered support from the prison's care team.
42. A Senior Officer was appointed as the prison's Family Liaison Officer. He maintained contact with the family and assisted with the funeral arrangements. Albany also offered financial assistance with the costs of the funeral. The

man's funeral took place in October 2009. The service was conducted by a member of the prison chaplaincy.

43. The post mortem report records the man's death as being due to natural causes, as a consequence of a lung cancer. The report says:

“The death of the man was clearly the result of natural disease. The man had been suffering for a long period of time from undiagnosed lung cancer (pulmonary squamous carcinoma) which has spread widely throughout the tissues of the lungs and on to their surfaces. It had also become more widely disseminated, involving one of the adrenal glands. There were no features to suggest that the man had been the victim of attack or restraint by any other person. Toxicology analysis is being undertaken upon a blood sample obtained on the deceased man's admission to hospital, but the results of this examination will be the subject of a supplementary report only if they modify significantly the cause of death, which is highly unlikely, or if requested.”

(It should be noted that the diagnosis of lung cancer was not made until the man's tissue samples were examined under the microscope.)

ISSUES CONSIDERED

Clinical care

44. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Isle of Wight Primary Care Trust. The doctor convened a review panel. The panel met on 26 November 2009.
45. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
46. However, the panel found that the standard of record keeping needed to be improved. This has been raised as an area of concern in previous investigations into deaths at Albany.

The Head of Prison Healthcare and the Governor of HMP Isle of Wight should ensure all staff record details of all cell visits.

The Head of Prison Healthcare should ensure that visiting specialists record details of all appointments attended and/or not attended.

47. After his admission to hospital in September 2009, the man was found to have long toe nails and his slippers did not fit. It was not clear how this situation had arisen. The man had not complained about his toe nails to staff at Albany and, according to the Disability Liaison Officer at Albany, he had not told her that his slippers did not fit. The panel decided that, where a prisoner has personal social care/mobility issues, a Social Services representative and/or the Disability Liaison Officer will in future be invited to the clinical review.

The Isle of Wight Primary Care Trust in partnership with HMP Isle of Wight should ensure that future death in custody clinical reviews extend an invitation to Social Services and the Disability Liaison Officer as appropriate.

48. My investigator asked the panel whether the man's condition could have been diagnosed earlier and whether his admission to hospital was timely. In response, the clinical reviewer said that at post mortem the cause of death was not immediately clear. Only a microscopic examination of tissue samples had showed that the man had lung cancer. This is unusual but the diagnosis could not reasonably have been made earlier by prison healthcare staff. The clinical reviewer also felt that the man's admission to hospital was timely.

Use of restraints

49. I am pleased to report that the risk assessment for the man was regularly reviewed and revised during his time in hospital. The investigator found that restraints were removed when the man's condition deteriorated and he was

then simply accompanied by two officers. The investigator found that the bedwatch notes were concise with legible and appropriate entries.

50. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Albany. The Governor may wish to share that assessment with both managers and staff.

CONCLUSION

51. The man moved to Albany on 13 September 2005 and died from natural causes in outside hospital on 21 September 2009.
52. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. The review panel has made three recommendations that I endorse. They will need to be addressed by the Isle of Wight Primary Care Trust in partnership with the Governor of HMP Isle of Wight.

RECOMMENDATIONS

1. The Head of Prison Healthcare and the Governor of HMP Isle of Wight should ensure all staff record details of all cell visits.

Accepted - The professional responsibility for recording healthcare staff visits and interventions in cells lies with the individual healthcare professional. Since the implementation of the SystmOne Prison Healthcare IT system, these records are now entered on SystmOne by the involved healthcare professional. Overall Directorate accountability lies with Head of Prison Healthcare and through this role to the PCT Chief Nurse.

2. The Head of Prison Healthcare should ensure that visiting specialists record details of all appointments attended and/or not attended.

Accepted - The professional responsibility for recording healthcare specialist visits and interventions in cells lies with the individual healthcare professional. Non PCT Prison Healthcare employed clinical staff will keep their own contemporaneous notes and liaise with Prison Healthcare staff who will ensure an appropriate entry is made on SystmOne. Overall Directorate accountability lies with Head of Prison Healthcare and through this role to the PCT Chief Nurse.

3. The Isle of Wight Primary Care Trust in partnership with HMP Isle of Wight should ensure that future death in custody clinical reviews extend an invitation to Social Services and the Disability Liaison Officer as appropriate.

Accepted - The Offender Health Commissioner of the Primary Care Trust now routinely Chairs Death in Custody clinical reviews. Involved stakeholders from a range of inter-professional groups and agencies are invited to participate and contribute to these reviews.