

**Investigation into the circumstances surrounding the
death of a man, he died in hospital whilst in the custody of
HMP Albany, in October 2008**

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

April 2009

This is the report of an investigation into the death from natural causes of a prisoner at HMP Albany, who died in hospital, in October 2008. He was 61 years old. He entered custody in 2000 and moved to HMP Albany in May 2002. 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.

I would like to extend my condolences to all those touched by the man's passing.

The investigation was undertaken by my colleague. I am grateful for the assistance he received from staff at HMP Albany and would ask the Governor to pass on those sentiments. A doctor was appointed by the local 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 good and comparable to that available in the community. I have noted the issues and I endorse both the recommendations in the clinical review.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2009

SUMMARY

The man was 61 years old when he died in hospital on 4 October 2008. He died from natural causes as a consequence of pulmonary embolism (a blockage affecting blood flow into the heart) caused by blood clots which had travelled around his body.

He had been sentenced to 14 years imprisonment at Crown Court in September 2001. He was received into custody (on remand) at HMP Parc in December 2000 and transferred to HMP Albany in May 2002.

During his first reception health screen interviews at Parc and Albany, it was recorded that the man was a smoker. He was offered assistance to help him to stop smoking but he was unable to complete the course.

On 10 August 2006, the man was diagnosed with lung cancer. After surgery, he was discharged from hospital on 29 August and returned to Albany. He saw his consultant on 14 June 2007 for a surgery follow up appointment. It was noted that he was doing very well and would next need to be seen for review after a further 12 months.

Unfortunately, in April 2008 it was discovered that the man's cancer had returned. He started a course of palliative chemotherapy and radiotherapy the following month.

On 8 September 2008, papers for compassionate release were sent to the Parole Board. The panel was due to sit on 15 October to consider the matter.

On 4 October at 9.45am, the man pressed his cell bell. As he was found to be having trouble with his breathing, officers immediately requested medical assistance. Healthcare staff arrived at his cell within five minutes and his condition was assessed. An ambulance was called at 10.50am and arrived five minutes later. The ambulance left Albany at 11.20am and he arrived in the Accident and Emergency (A&E) Department at the local hospital ten minutes later. He was transferred to a bed in a side room and hospital staff immediately began to take observations and blood samples. The man stopped breathing and hospital staff commenced cardio-pulmonary-resuscitation (CPR).

Hospital staff asked the officers who had escorted the man to find out his next of kin details as a matter of urgency. One of the officers contacted Albany for this information. The other officer was told that the prognosis was very poor.

The man stopped breathing again and hospital staff were unsuccessful in their attempts to resuscitate him. Death was pronounced at 11.55am.

When the man was in hospital earlier in 2008 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 revised on 4 October after his condition deteriorated and he was readmitted to hospital. Handcuffs were not used when he left the prison.

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 a post mortem examination. The coroner's officer told the Principal Officer (PO), who was managing the prison's response following the death, that he had died from natural causes. Both the PO and the police tried unsuccessfully to contact any remaining members of the man's family to inform them.

As the man had no family or friends to organise a funeral, the prison took responsibility. The PO registered the death, co-ordinated arrangements for the funeral and ensured that the man's property was catalogued and put into central storage.

The clinical review carried out by the appointed doctor and a panel of his colleagues has considered the care provided for the man. In the doctor's view, the quality of care given to the man was good and equivalent to that he would have received in the community. The reviewer makes two recommendations for service improvement. 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 7 October 2008 when one of my investigators 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 relating to the man, they included his main prison record and his medical records.
2. My investigator visited Albany on 26 November and 9 December and discussed aspects of the man's treatment with staff. He interviewed prison staff and a Sister, who was a member of the prison chaplaincy. The Sister was able to provide background information concerning the man's time in custody.
3. The local Primary Care Trust commissioned a doctor from their Public Health Department, to lead a panel review of the man's clinical care. I am grateful to them for undertaking such a thorough 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 in his enquiries into the man's death.
5. The man had told Albany that he had no living relatives. Sadly, therefore, the prison has been unable to locate any family members to inform them of his passing. I too have no contact details for any members of his family and this has meant that we have been unable to involve them in the investigation or to address specific concerns that the family might have liked explored in this report.

HMP ALBANY

6. Albany is a category B training prison situated near Newport on the Isle of Wight. It opened in 1967 on the site of a former military barracks. Albany offers a varied regime with education and several offending behaviour programmes.
7. At the time of the man's death, the prison could hold up to 566 adult male prisoners. The average age of Albany's population is high when compared to most jails.
8. 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 (this is when the cell door unlocks for a limited amount of 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 Albany and at the other two prisons on the Isle of Wight are commissioned by the local Primary Care Trust. The prison's healthcare is clustered with HMP Camp Hill and provided by HMP Parkhurst. In total, Parkhurst provides healthcare to 1,500 or so prisoners on the island. Prisoners' daily medical needs at Albany 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 Monday to Friday. During weekends and evenings, one member of healthcare staff is on duty. Doctors from Medina Healthcare, a local community practice, attend Albany for three-hour sessions four times 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.
10. During 2008, my office investigated five deaths through natural causes at Albany. There was no common factor between the circumstances surrounding this investigation and those into previous deaths.

Independent Monitoring Board Report

11. 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 2006/07, drew attention to the limited access for prisoners with mobility problems, but said that the management team was aware of this. Every effort was being made to accommodate prisoners with mobility difficulties in appropriate locations. The IMB report also discussed the limited availability of staff to act as escorts to accompany prisoners to the local hospital. The report said, "this problem will not go away due to the age of our prisoners".

Her Majesty's Chief Inspector of Prisons

12. The most recent report on Albany by HM Chief Inspector of Prisons 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 programmes were 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

13. The man was remanded into custody at HMP Parc on 9 December 2000. He was convicted and sentenced to 14 years imprisonment at Crown Court in 2001. He transferred to HMP Albany on 23 May 2002.
14. During his first reception health screens, it was recorded that the man was a smoker. He did attend a smoking cessation course in early 2004 but was unable to complete it.
15. When interviewed as part of this investigation, a Sister from the chaplaincy at Albany said that the man:

“... came across as a very extrovert person ... a great sense of humour. He tried every religion that was available in the prison, went round full circle a few times. At one stage I did a short course on social awareness and he was very interested in seeing what he could do, write petitions to the Government on behalf of the poor of the third world, he was very enthusiastic about that. He came regularly to services when he was registered as Catholic, Church of England or Orthodox, but I only saw him occasionally on the wings when he was registered under another faith. He was always very pleasant about it ... would go round and just say hello, how are you getting on, I never rejected people just because they moved on, but I didn't want to put pressure under them by ... following them around, trying to influence their choices. He was always very, very pleasant ... I used to call him Mr Heinz and say which variety are you today, and he always laughed.”
16. On 2 July 2006, the man was taken by ambulance to the Medical Assessment Unit at the local hospital after he complained of having extreme shortness of breath and pains in his chest. He was admitted and found a bed on the ward where further tests were carried out. He was discharged from hospital on 15 July and returned to Albany. Whilst he was an in-patient at the hospital, a bedwatch was carried out by prison staff. The initial risk assessment concluded that an escort chain should be used and two officers needed to be in attendance at his bedside.
17. The man had a computerised tomography (CT) scan on 25 July. A prison doctor noted in the medical record that the result was: “Abnormal left Hilum mass; awaiting biopsy result.”
18. On 7 August, another prison doctor recorded in the medical record that he had referred the man to a thoracic surgeon at a different hospital. This was because the result of his biopsies had been inconclusive. This prison doctor recorded that he had also been informed by a doctor from the local hospital that there was no value in repeating the tests.
19. The man saw the thoracic surgeon on 10 August 2006. The thoracic surgeon told him that his diagnosis was lung cancer (adenocarcinoma of the left lower lobar bronchus). The surgeon intended to confirm this by performing a

bronchoscopy (an examination of the interior of the lung) and taking a biopsy. When healthcare staff saw the man in general surgery on 15 August, he discussed his diagnosis of lung cancer. Healthcare staff contacted the Respiratory Nurse/Clinical Nurse Specialist from the local hospital, who explained the process more fully to the man. She also asked for him to attend an appointment on 17 August with the Chest Investigation Unit at the hospital for respiratory tests.

20. On 22 August, the man was admitted to another hospital and a bronchoscopy and left lower lobectomy (surgical removal of part or all of a lung) was performed the following day. A week later on 29 August, he returned to Albany and was located back to his cell on the wing. Healthcare staff visited him on the wing and noted that he had a large scar down the right side of his back which had healed well. Arrangements were made for someone to bring his meals to him.
21. Shortly afterwards, healthcare staff were contacted by the hospital that he left on 29 August, who informed them that the man had given a positive MRSA (methicillin resistant staphylococcus aureus) nasal swab when tested before his operation. This is an infection which is resistant to commonly used antibiotics. They were advised to prescribe Bactoban nasal cream and to repeat the nasal swabs three times until the man's result was clear.
22. The man's sutures were removed on 2 September, and it was noted that the wound site looked very clean and dry. On 14 September, after his wound became infected, he returned to the local hospital and antibiotics were administered intravenously. He was discharged from hospital the following day and returned to Albany. He was located on F and G wing as the cells on this wing had en-suite sanitation and were located next to the healthcare centre.
23. The man declined to attend an out-patient appointment with the thoracic surgeon on 9 November. Healthcare staff recorded that he was worried about contracting MRSA again and he signed a disclaimer saying he did not want to attend the appointment. The Respiratory Nurse was informed of the man's decision on 11 December and visited the jail the next day to see him. In interview, the Respiratory Nurse explained that whilst the man was infectious he was shunned by other prisoners.
24. When the Respiratory Nurse saw the man on the following day, they discussed his concerns about MRSA. She was able to address his worries and put him at ease. He agreed to attend his out-patient appointment which was re-arranged for the following day. When he went to his appointment, he agreed to start a course of chemotherapy.
25. An appointment was made for him to attend the Oncology Department at the local hospital on 11 January 2007. Due to stormy weather conditions, the ferries were cancelled and his appointment was cancelled as the specialist was unable to travel to the island. The appointment was re-arranged for 1 February when it was decided that chemotherapy would not be given as so much time had elapsed since the surgery.

26. One of the prison doctors saw the man on 26 March as he had been suffering with headaches. The doctor arranged an appointment for a CT scan which took place two days later. The result of the scan was normal.
27. The man saw the thoracic surgeon on 14 June 2007 for a surgery follow up appointment. It was noted that he was doing very well and would next need to be seen for review after a further 12 months.
28. On 2 March 2008, the man was taken to the Accident and Emergency (A&E) Department at the local hospital. He had been very wheezy, and had vomited and coughed up significant quantities of blood stained sputum. He was admitted and a chest x-ray was carried out. On the following day, after the results of the x-ray showed no recurrence of his cancer, he was discharged and returned to Albany.
29. The man was seen by a second prison doctor on 14 March as he was still coughing up blood stained sputum. The doctor referred him back to the thoracic surgeon. The referral was passed to the Respiratory Nurse who saw the man at the local hospital on 17 April. The nurse arranged for an immediate CT scan to be carried out. This showed that the man had suspected lung cancer. A repeat bronchoscopy was performed on 22 April at the local hospital and this confirmed a recurrence of the cancer.
30. On 16 May, the man attended an appointment at the Oncology Department at the local hospital and a course of palliative chemotherapy and radiotherapy was completed.
31. Six days later on 22 May, the man was seen by healthcare staff at the request of officers on the wing. The officers were concerned that he was unable to walk due to pain in the back of his legs. Healthcare staff noted that his left leg was swollen and a blood test was carried out. On the following day, after the results of the blood test were received, the man was taken to the local hospital for an ultrasound appointment. He was seen in the Deep Vein Thrombosis (DVT) Clinic and diagnosed with extensive lower leg DVT. His treatment was discussed with oncologists and it was agreed that he should receive a daily injection of Heparin (an anticoagulation therapy).
32. When interviewed as part of this investigation, the Resettlement Manager at Albany, said:

“I knew [the man] very well, a lot better than most for a number of reasons. One was because he'd been here quite a few years. He'd held some quite high profile jobs within the prison: as the prison hairdresser [and] he worked on all three hotplates in the prison – A and B wing have got their own hotplates where they serve all their meals from for those wings. He then moved up to C, D and E hotplates during his sentence, so again he was a high profile role. He worked within the library as one of the library orderlies. All of those were high profile roles, so staff were coming into contact with him a lot more than

a lot of prisoners. The other side of [him] was a very personable man, he was very jolly all the time, he was very polite, he always engaged staff in conversation ... I'm not aware of anyone having an issue with [him] at all – prisoner or staff. And that's why he did things like the prison barber; you know it's quite a personal thing having your hair cut by someone who's got a pair of scissors in their hand. He was a very personable man."

33. On 8 September, papers for compassionate release were sent off to the Parole Board. The panel was due to sit on 15 October 2008 to consider the matter. After the papers had been submitted to the Board, the man told a member of staff from the Offender Management Unit at Albany that "he did not want it and had not asked for it, he said he had nothing outside and wanted to stay in Albany as long as possible". In an e-mail to my investigator the Head of Communications and Standards Department at Albany wrote:

"[The man] spoke to me on several occasions in the month prior to his death. On all these visits [he] would mention the fact that he had come to terms with his life and that he would like to die in Albany amongst his friends and this included staff as well as other offenders. He told me that we were his family and he had no reason to leave his home (Albany prison). Sometime during the week prior to [his] death I met with him in his room on F and G wing to see how he was progressing with his illness. Again [he] stated that he had no one on the outside and he hoped to die amongst his friends here at Albany - I promised [him] at this meeting that I would ensure he remained on F and G wing until his death. This made [him] cry and the reason he cried was because he had a fear of being moved to another wing (this would not have happened to [the man] even if he had lived through this illness) so by confirming he would remain on F and G put his mind at ease."

34. The man went to the local hospital on 10 September for a chest x-ray which confirmed the earlier diagnosis. He was seen by the Respiratory Nurse eight days later as the man had been complaining of having a headache, ear discomfort and a sore throat. Swabs were taken and a CT scan of his head and neck was arranged. The scan was carried out on 2 October but the result showed no evidence of any abnormalities.
35. The Primary Care Team Leader saw the man on 3 October. He recorded the following entry in his medical record:

"We also discussed patient's understanding of his illness and treatment plan. He is aware that he still has an active cancer and that his prognosis is still uncertain, he is happy for HCC [healthcare centre] to share information with wing staff to assist in his care. He would like to remain in present location for as long as possible but understands that should his symptoms become greater it may not be possible to manage them in house and that he may then require treatment in hospital. We also discussed the situation regard hospice care and how it relates to prisoners with escorts. He appears to understand all this and I am

happy that he is not in denial as related to his illness and possible prognosis.”

36. On 4 October at 9.45am, the man pressed his cell bell. He was found struggling for breath, suffering from chest pains and retching. Healthcare staff were requested to attend and they arrived within five minutes. They were joined shortly afterwards by a third prison doctor. The doctor assessed the man and concluded that he had possibly developed arterial fibrillation with acute congestive cardiac (heart) failure.

37. When interviewed as part of this investigation the Resettlement Manager said:

“[The man] was located in F and G wing. Now F and G wing is the only unit within the prison that have got integral toilets and showers. And it’s a modern building as well, as opposed to the rest of the wings which are quite old. So [he] was moved there, again, I don’t want to mislead you, I’m not saying it was solely because of his medical illness, but certainly F and G houses people with mobility impairment and people that are ill. Because it’s easier for them to get to the toilet and to clean themselves with a shower and so forth than it is if they were on what we would call ‘normal location’. My personal belief, and I stress it’s my personal belief, that the staff in F and G wing as prison officers aren’t any more trained in dealing with the social care needs of offenders than anyone else but I think they do a very good job of filling that gap. To the point that when the cell bell registered in the office, the staff knew immediately, without having to refer to the roll board, that that was [the man’s] cell and the fact that two of them acted immediately to go there, is a level of their professionalism if you like, that they had a genuine concern for his welfare and went immediately, not one officer but two, because [he] wasn’t a complainer. So the fact that he rang his cell bell again [meant] there was something serious that [he] needed help with ... The two officers that went in response to the cell bell being rung were [names removed]. I just happened to be on the wing at the time by coincidence just because I was doing my rounds as First Line Commander, as I said earlier I visit all the areas. So the display comes up with the cell number and the staff said, ‘Oh, that’s [the man]’ and they both went off. I then followed them and when I got to the cell doorway [he] was sat up in his bed with a bowl and he was retching, trying to be sick into this bowl. He didn’t look well at all. He was labouring his breathing and so the healthcare was contacted.”

38. At 10.30am, the Resettlement Manager asked officers to make preparations to take the man to hospital. The risk assessment carried out by the Resettlement Manager was that two officers were to be on bedwatch duty and no restraints were to be used.

39. An ambulance was called at 10.50am and arrived five minutes later. When the ambulance arrived, the allocated escorting officers walked over to F and G wing where the man was being treated by paramedics. In his statement to the Governor one of the escorting officers wrote that the man:

“... was looking very ill and could not speak, his responses were slow nodding and shaking of his head. The paramedics did the best they could to stabilise him before we left the prison. Cuffs [handcuffs] were not used at any point.”

40. The ambulance left Albany at 11.20am and the man arrived in the A&E Department at the local hospital ten minutes later. He was taken to a bed in a side room, and hospital staff immediately began to take observations and blood samples. The curtains were closed around the bay but, although the officers could not see the man, they could hear what was happening. In his statement to the Governor, the escorting officer wrote:

“There were five or six nurses and doctors around the bed, I heard a male voice say words that I took to mean that his [the man’s] left lung had collapsed, after a couple of minutes, through a gap in the curtains, I could see [the man], who was propped up at the time. I saw his eyes roll up, they laid him flat and commenced CPR [cardio-pulmonary-resuscitation]. I then saw his monitor give a good read-out.”

41. One of the nurses who was looking after the man then approached the officers and asked them to find out next of kin details as a matter of urgency. The second escorting officer went to telephone Albany for this information. A third officer arrived around this time to take over the bedwatch duties. The first escorting officer was also informed by the nurse that the man’s prognosis was very poor. When the second escorting officer returned he said that Albany would find out the next of kin details. In his statement the first escorting officer wrote:

“We then realised that [the man] had arrested again, the curtains were blocking my view, after a couple of minutes I heard a male voice ask aloud ‘Is there anything we might have missed?’ and then ‘Is there anything else we can do?’ We were advised that [the man] had been certified dead at 11.55am.”

42. The second escorting officer informed the Resettlement Manager that the man had died. Both officers were offered support from the care team and prisoners were immediately informed of the death. The prisoners 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 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.)

43. In his interview with my investigator, the Resettlement Manager said:

“I went to the wing at 12.15 and I brought the prisoners down into the two association rooms and then I briefed both groups separately. I told them what had happened, I mean one they’d all seen him go off in the ambulance at 11.20, so I told them that he’d died shortly afterwards. I offered the care team, sorry the Listeners, to the prisoners should anyone want to use them and I said or talk to the staff on duty. There was one prisoner who was in the cell opposite [the man] and he’d taken the news particularly badly and so we arranged for a Listener ... at 12.15 we were just locking up for dinner roll check and then for the staff to go off duty. So rather than leave him in the cell on his own we arranged for a Listener to spend the time in the cell with him during the dinner, which is unusual but in the circumstances I felt it was necessary.”

44. The Principal Officer who managed the prisons response was appointed as the prison’s Family Liaison Officer. He tried to trace remaining members of the man’s family to inform them but was unsuccessful in his attempts. A memorial service was held on 8 October and this was well attended. The funeral took place on 23 October and he was buried on the Isle of Wight.

45. The post mortem report records the man’s death as being due to natural causes, as a consequence of a pulmonary embolism (a blockage affecting blood flow into the heart) caused by blood clots which had travelled around his body. The report says:

“The death of [the man] was clearly the result of a recognised complication of natural disease. There were no features to suggest that he had been the victim of inflicted injury of any kind. [He] had been suffering for a long time from lung cancer (adenocarcinoma of the left lung) which had become disseminated to involve other vital organs. The original growth had been treated surgically and by radiotherapy but had recurred. Blood clots had more recently formed spontaneously in the deep veins of both calves (phlebothrombosis). These clots had eventually broken free and, travelling within the circulation, entered the great vessels of the lungs as a solid mass. The resulting blockage completely or substantially cut off the flow of blood from the right ventricle of the heart to the lungs (pulmonary embolism), a potentially fatal event depending upon the degree of obstruction which was in this case almost complete.”

ISSUES CONSIDERED

Clinical care

46. As noted, a review of the man's medical care was undertaken by a doctor on behalf of the Primary Care Trust. The doctor convened a review panel. The panel comprised of the Chair, the reviewer himself, a member of the Independent Monitoring Board, the third prison doctor, and the Risk Incident and Claims Manager. The panel met on 19 December 2008 and my investigator attended their meeting.
47. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that he was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
48. The man had smoked 40 cigarettes a day over a period of 40 years. He had attended a Smoking Cessation Course between 24 January and 17 February 2004. The panel were informed that the man did not finish the course as he was unable to cope without smoking. It was confirmed that his smoking pattern was discussed with him on many occasions, but that he had made an informed decision regarding his continued use of tobacco.
49. In her statement to the review panel, the Respiratory Nurse/Clinical Nurse Specialist from the local hospital who was the man's assigned key worker, said:

"On 26 August 2006 rigid bronchoscopy and left lower lobectomy for adenocarcinoma lung was performed, the patient recovered and was transferred back to prison. Unfortunately [he] developed post operative wound infection with MRSA present, he attended the local hospital, was given intravenous antibiotics. On his return to the prison because of the infection he was shunned by other inmates and then declined to attend any follow up appointments ... I visited the prison and discussed with [the man] the reasons that follow up was important and he began to attend clinics again. He finally saw the oncologist on 1 February 2007 ... it was considered at that time that adjuvant chemotherapy was not appropriate, as too much time had lapsed post surgery ... On 17 April 2008 I saw [the man], noted his symptoms and managed to arrange an immediate CT thorax. This showed recurrence of the primary tumour with adrenal metastasis. Bronchoscopy was repeated which showed at the orifice of the left upper lobe abnormal tissue, presumed recurrence, samples taken confirmed this."

50. The clinical review panel has recommended that a protocol be developed to manage prisoners with MRSA returning to prison. It was suggested that this could include a short admission to healthcare before the prisoner returns to their normal location.

HMP Albany should develop and implement a protocol for management of prisoners returning to prison with MRSA. It should include a short admission to healthcare to enable preparation prior to the prisoner's return to his wing.

51. The review panel recorded that, in February 2008, the man developed a chest infection but that a subsequent x-ray showed no signs of recurrence his cancer. A referral was made to the cardiothoracic surgeon at another hospital. He was seen by a Respiratory Nurse in April 2008 when a CT scan showed that the cancer had returned. The review confirmed that the local hospital's cancer care pathway was delivered in a timely manner. The Respiratory Nurse told the panel that the care from the prison and the Oncology Department at the hospital was very good. She confirmed that the communication and support from Albany was excellent, and that the care was better than the man was likely to have received in the community.

Compassionate release

52. The panel discussed the man's anxiety about being given compassionate release. He had said that his wish was to remain in prison having 'no-one on the outside'. The head of the communications and standards department confirmed that he discussed this with him and had made it clear that he would be allowed to stay in custody. The panel noted that, on the day before his death, he was aware that should his symptoms worsen it might not be possible to manage them at Albany and he might require treatment in hospital. On the day of his death he was gasping for breath and asking for help. He could not have been managed within the prison at this stage. The review panel recommended that a protocol for end of life care pathway should be developed, and work should be carried out on cancer pathways for prisoners.

HMP Albany should progress work on a cancer care pathway and a protocol for end of life care pathways for prisoners.

Use of restraints

53. I am pleased to report that the risk assessment for the man was regularly reviewed and revised during his time in hospital. My investigator found that restraints were not used when he was taken to hospital for the last time and instead he was accompanied by two officers. This common sense approach adopted by the Resettlement Manager should be applauded. I commend Albany for treating a terminally ill man decently and thus enabling hospital staff to administer appropriately to his medical needs. My investigator found that the bedwatch notes were concise with legible and appropriate entries.

54. 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

55. The man moved to Albany in May 2002 and died from natural causes at the prisons local hospital on 4 October 2008. He had been diagnosed with cancer in 2006 and was in remission. Unfortunately, the cancer returned and, although it did not cause his death, it was a contributory factor.
56. He was a prisoner who had no family to support him. He viewed Albany as his home and was reluctant to leave the supportive environment of the prison. I would like to commend the common sense approach adopted by Albany with regard to the use of restraints. When the man left Albany for the last time he was accompanied by staff and not restrained. Prison staff were at hand but did not intrude on his last moments before his death.
57. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate and of a high standard. The review panel has made two recommendations which I endorse. They will need to be addressed by the Primary Care Trust in partnership with the Governor of Albany.

RECOMMENDATIONS

1. HMP Albany should develop and implement a protocol for management of prisoners returning to prison with MRSA. This would include a short admission to healthcare to enable preparation prior to the prisoner's return to his wing.

Accepted - It has been agreed that any prisoner with MRSA would return to the prison via healthcare but a protocol between Albany's healthcare and the Primary Care Trust is still in development at this stage.

2. HMP Albany should progress work on a cancer care pathway and a protocol for end of life care pathways for prisoners.

Accepted - Albany have secured funds from the Kings Fund for beds in the new healthcare centre dedicated to end of life care, and this facility should be open in May 2009. The protocols will be ready and tied in with the opening of this new facility.