Investigation into the circumstances surrounding the death of a prisoner at HMP Albany, in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2008

This is an investigation into the circumstances surrounding the death of a prisoner at HMP Albany. The man died on 3 March 2008 at a hospital local to the prison. The cause of death was recorded as disseminated clear-cell renal adenocarcinoma (cancer of the kidney). Sadly, the man died just 20 days before he was due to be released from prison.

The man was visited in hospital by his brother and sister on the night before his death. I offer them my sincere sympathy and condolences for their loss, as I do to all of those affected by the man's death. I must also apologise for the delay in issuing this report. This was due in part to the unexpected sickness absence of the clinical review report writer.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was managed on behalf of the Isle of Wight Primary Care Trust. As ever, I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Albany for their full and ready co-operation during the course of the investigation. I am particularly indebted to the head of the communications and standards department, and his team, at Albany for the assistance that they provided my investigator.

My investigation found that the man received care equivalent to that which he would have received in the community. I make four recommendations and highlight one example of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2008**

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SUMMARY

The man was sentenced to six years imprisonment on 26 March 2004. He had a number of health problems at the time, including diabetes and asthma. The man settled well into prison life and reported few additional health problems during his first three years in custody.

After complaining of a chesty cough in March 2007, the man was referred for a chest x-ray by a prison doctor. The results showed cancer, possibly originating in the lung. A scan in May confirmed that the man had cancer of the kidney that had spread to other parts of his body.

The man started a six week course of interferon (a drug that can help to control or stabilise cancer) in July. He tolerated the interferon well, and a further six week course was therefore prescribed in September. Throughout the remainder of the year the man had very few symptoms, including little pain or nausea.

A further scan on 11 February 2008 showed that the primary lesion, in the man's right kidney, had enlarged and extended compared to May 2007. The lesions in his lung were also larger and more numerous. Despite this, at a review with a prison doctor on 19 February, the man continued to say that he was not experiencing pain or nausea.

As he was due for release on 23 March, prison staff began to make plans for the man to take a place at a hostel near to where his brother lives. However, following a sudden deterioration and increase in pain on the morning of 2 March, the man was admitted to a hospital local to the prison. His family were informed, and he was visited by his brother and sister that evening. The man's condition did not improve. He died at 5.05am the following morning.

The clinical review panel found that the man received care equivalent to that which he would have done in the community. I make four recommendations, two of which relate to information sharing between the prison and the local hospital. I also highlight one example of good practice.

THE INVESTIGATION PROCESS

1. The investigation was opened 25 March 2008 when notices announcing the investigation were issued 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. No prisoners came forward as a result.

2. My investigator was given access to the man's prison files, including his medical record. He visited Albany on 26 June 2008 and interviewed one member of staff. A clinical review panel was arranged on behalf of the Isle of Wight Primary Care Trust. The panel, including the investigator, clinical reviewer and several members of staff from Albany, met on 18 July to discuss the medical care provided by the prison. Following the meeting a clinical review report was written.

3. My senior family liaison officer wrote to the man's brother, his nominated next of kin, on 4 April 2008. No reply was received. A copy of this report will be sent to him.

HMP ALBANY

4. Albany is an establishment for category B and category C vulnerable prisoners. The prison currently holds up to 566 adult male prisoners. The average age of the population is significantly higher than in most prisons.

5. Health services at Albany are commissioned by the Isle of Wight Primary Care Trust (PCT). The healthcare arrangements are managed in a cluster which includes the two other prisons on the Isle of Wight, HMP Parkhurst and HMP Camp Hill. Parkhurst is the only one of these establishments with inpatient facilities.

6. At Albany, prisoners' medical needs are catered for by way of outpatient clinics and core day primary nursing cover, from 7.30am to 5.30pm Monday to Friday. During weekends and evenings, one member of healthcare staff is on duty. Doctors from a local practice attend Albany for four sessions each week. Evenings and weekends are covered by on-call doctors from the PCT. There is no nursing or healthcare cover based at Albany overnight.

7. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, last inspected Albany in November 2007. Ms Owers found "a serious and chronic shortage" of healthcare staff, which meant that only basic health interventions could be delivered. There was usually only one trained nurse and a support worker on duty at any one time. Ms Owers also found that a high number of outside hospital appointments were cancelled due to a shortage of escort staff.

8. The Independent Monitoring Board (IMB) annual report of 2006/07 also noted problems with the availability of escorts to the local hospital. The Board reported that only two escorts could be carried out per day, with some appointments having to be cancelled.

9. This is the 12th death that I have investigated at Albany since April 2004, when I began investigating all deaths in custody in England and Wales. It is the 11th death to be due to natural causes. There have subsequently been three further deaths at the establishment, all due to natural causes. In previous reports I have made recommendations regarding the development of a care pathway for prisoners diagnosed with cancer.

KEY FINDINGS

10. The man was received at HMP Winchester on 26 March 2004, having been sentenced to six years imprisonment on the same day. A reception health screen (a routine health assessment for all new arrivals into prison) was carried out following his arrival. At the health screen the man spoke of his diabetes and asthma and also said that he had arthritis and suffered recurrent headaches.

11. After three weeks at Winchester, the man transferred to HMP Albany on 16 April. He was seen by a nurse on the day of his arrival. The nurse recorded that there were no immediate problems and that the man seemed to be happy at Albany.

12. The man initially lived on A wing at Albany, and was noted to have settled in well. On 6 May, his blood pressure was noted to be high at 169/117. As a result, he was prescribed a course of lisinopril (medication to treat high blood pressure) and was asked to come back for weekly checks.

13. On 27 October 2004, the man was reviewed by a prison doctor. His blood pressure was now more stable at 136/90, and he was reported to have no other problems. Through 2005, the man reported few health problems other than some shoulder pain from an old injury and the occasional nosebleed.

14. In early 2006, the man again reported few problems with his health. His wife sadly died on 30 May, three days after he had been able to visit her in hospital. The man attended her funeral on 7 June. As one would expect, he was affected by his wife’s death over the following weeks but said that talking to his friends on the wing helped.

15. The man complained of having a cough and cold and of feeling “a bit wheezy” on 5 December. He was seen by a nurse who, given his history of asthma, referred him to a prison doctor. The man was subsequently seen by a doctor later on the same day and prescribed a course of amoxicillin (an antibiotic).

16. In January 2007, the man reported experiencing a number of nosebleeds. After complaining of a productive cough that had lasted for some time he was seen by a second prison doctor, on 22 March. The doctor prescribed a further course of amoxicillin and asked that the man be referred for a chest x-ray. On 29 March, an appointment came through for 24 April.

17. The results of the chest x-ray showed pulmonary metastases, possibly from a lung primary (cancer, possibly originating in the lung). The consultant at the local hospital arranged for the man to undergo a bronchoscopy (an examination of the airways of the lungs) on 8 May. This showed nothing significant, and a CT scan (similar to an x-ray) was arranged for 10 May.

18. The results of the CT scan showed a large renal mass with multiple bilateral pulmonary metastases (cancer of the kidney, which has spread to other parts of the body). On 22 May, the urologist (specialist in the urinary tract, including the kidneys) at the hospital wrote to the medical director at a local hospice, to refer the man with a view to offering palliative care (symptom control for the terminally ill). An appointment was later arranged for 5 July.

19. The man was reviewed by a prison doctor, on 5 June, after complaining of increased pain in his shoulder. The doctor prescribed co-codomol (pain relief).

20. The medical director at the hospice wrote to Albany on 9 July, following his appointment with the man four days earlier. He noted that the man was displaying no symptoms of illness, but that any treatment would essentially be palliative rather than curative.

21. Three days later, on 12 July, the man attended an appointment at the hospital with a consultant oncologist (cancer specialist). The consultant recommended that the man take a course of interferon (a drug that can help to control or stabilise cancer that has spread). It was stressed to the man that the response rate to interferon is only around 15 per cent and it can have a number of side effects, including headaches, fatigue and flu-like symptoms. The drug is injected three times a week, and the man began his course on 19 July. He attended the healthcare centre for each injection, which was carried out by a prison nurse.

22. A fortnight into his course, on 2 August, the man was reviewed by the medical director at the hospice. The medical director noted that the man was doing well at the time and determined that he did not need to see him for another three months, unless he were to develop further symptoms.

23. The man attended a second appointment with the consultant oncologist on 6 September. The consultant oncologist noted that the man was well and had been tolerating his course of interferon reasonably well. He therefore prescribed a further six week course.

24. Over the next six weeks, the man continued to tolerate the interferon well. At his next appointment with the consultant oncologist, on 18 October, he said that he had experienced a few side effects, but overall felt better since he had been receiving the treatment. The consultant oncologist requested that an appointment be made for the man to have another CT scan to assess his response to the treatment.

25. Around three weeks later, on 8 November, the man attended an appointment with the medical director at the hospice. The man told the medical director that he was feeling very well at present. He also said that he was due for release in early 2008 and was likely to be moving to a town in southern England at that point.

26. At a review with a prison doctor, on 30 November, the man said that he was experiencing no pain or nausea at the time. Indeed, three days previously he had returned 50 unused co-codamol tablets that had been dispensed on 19 November. The doctor reported that the man was upbeat, but noted that he might not be fully aware of his likely prognosis.

27. The man attended the hospital on 27 December for an appointment with the consultant oncologist. The consultant oncologist noted that the man was well and had no symptoms at the time. However, the consultant oncologist observed that the man had yet to receive an appointment for the CT scan that had been requested after his last review in October. He had therefore put in an urgent request for a scan. On 3 January 2008, an appointment was arranged for 24 January.

28. An entry in the man's medical record indicates that the security department at Albany mistakenly cancelled the taxi that was due to take the man to hospital for his CT scan on 24 January. Once the mistake was realised, a second taxi was booked. Unfortunately, it arrived too late for the scan to go ahead. A new appointment was booked for 1 February.

29. On 1 February, the man duly attended the hospital in Newport for his scan. On his arrival, however, the escorting staff were informed that there was no appointment scheduled. The healthcare administrator at Albany subsequently telephoned the member of hospital staff with whom she had arranged the appointment the previous week. They were unable to offer any explanation for the confusion. The administrator later arranged a new appointment for 11 February.

30. The result of the man's CT scan showed that the lesions in his lung were larger and more numerous in comparison to his previous scan of May 2007. The primary lesion, in the man's right kidney, had also enlarged and extended further. The doctor discussed the results of the scan with the man at a review on 19 February. The man said that he was not in pain or experiencing nausea or shortness of breath, although the doctor noted that he had a chronic cough. The man added that he was due for release in March and would be staying in a town where his brother lived.

31. A week later, on 26 February, a nurse was called to see the man on the wing as he was reportedly in a lot of pain. On her arrival, the man complained of pain in his lower back and in his groin. He said that he was taking co-codamol for pain relief, but this was not working. The nurse spoke to a prison doctor who prescribed a course of dihydrocodeine (DHC, a strong painkiller) which was to be reviewed on 28 February.

32. At his review, the man told the prison doctor that his back pain had developed suddenly four days previously. The pain was worse when he moved but had been eased by the DHC. The prison doctor considered that, given the man's diagnosis, this was likely to be more than simple back pain. She noted that he had an appointment with the consultant oncologist in the next week (on 6 March) and made a note for it to be

followed up then. In the meantime, the prison doctor repeated the man's prescription of DHC.

33. On the following day, 29 February, an application for early release on compassionate grounds was initiated. The form has sections to be completed by a prison doctor, to detail the patient's diagnosis and prognosis, and the seconded offender manager, to detail the level of risk posed. The final section is completed by the Governor with his summary and recommendations.

34. A case conference was held to discuss the man on 1 March, attended by another prison doctor. The panel noted that the man's cancer was at the same stage as it had been in January and that, other than recent back pain, he was not feeling unwell.

35. On the following morning a prison nurse, was called to see the man in his cell by wing staff. She found him very breathless and with acute pain in his lower back. Due to the pain, the man was unable to walk. The prison nurse asked for an ambulance to be called and, at around 10.45am, the man was transferred to a local hospital. He was accompanied two officers and handcuffs were not used.

36. At around 1.45pm a prison chaplain contacted the man's brother, his nominated next of kin, to inform him of his brother's condition. Around an hour later, given the man's breathlessness and lack of mobility, the escort was reduced to one officer. The officer was instructed to sit in the waiting area and make frequent but irregular checks on the man. I consider this to be an example of good practice.

The man was immobile following his admission to hospital. The escorting officer was instructed to sit in the waiting area and to make irregular checks on him, rather than sitting in the ward next to the man.

37. In the evening, the man's brother and sister arrived to visit him. They were met by the chaplain and the principal officer (PO). During their visit, it was agreed that the principal officer would be the family's contact at the prison and that he would contact the man's brother by telephone if there was any news.

38. Sadly, the man's condition deteriorated. He died at 5.05am on 3 March. The cause of death was recorded as disseminated clear-cell renal adenocarcinoma (cancer of the kidney). The man had been due for release from prison just 20 days later.

39. Just over an hour after the man's death, the principal officer telephoned his brother at around 6.25am to break the news to him. The man's funeral was held on 27 March and was conducted by the chaplain. At the request of the family, all arrangements were made by the principal officer. The prison acted in accordance with the instructions of Prison Service Order

(PSO) 2710.

ISSUES

External hospital appointments

40. The man was due to attend an outpatient appointment at a hospital in Newport, on 24 January 2008. However, he was apparently unable to attend the appointment as the taxi due to take him to hospital was mistakenly cancelled by the security department. There is no record of the reason why the taxi might have been cancelled.

41. The clinical reviewer considers the effect that this cancellation would have had on the man. He concludes that “at this stage of his condition the cancellation would not have altered the outcome of his treatment or prognosis”.

42. Nevertheless, there might be occasions in future in which a missed hospital appointment could have more serious consequences for the patient. It would be disappointing if such a situation were to arise.

    The Governor should review procedures for arranging transport for patients to outside hospital appointments, and the reasons for cancelling booked escorts should be recorded.

43. The cancelled appointment was rearranged for 1 February. However, on arrival at the rescheduled appointment the escorting staff were told that the hospital had no record of it. The man therefore had to return to Albany without having his scan. The scan eventually went ahead on 11 February when the appointment was rearranged for a second time.

44. Albany has provision for staffing escorts for two hospital appointments per day. This means that, if more than two outpatient appointments are booked for the same day, they may need to cancel and rearrange those that are deemed to be a lower priority. Due to the nature of his illness, the man’s scan would have been a higher priority appointment. Having to re-arrange his scan on two separate occasions might have resulted in other patients’ appointments being cancelled.

45. The clinical review makes the following recommendation, to be taken forward by the clinical risk and claims manager at Albany:

    Prison healthcare should work to improve communication and understanding with the hospital regarding the difficulties involved in maintaining outpatient appointments.

Quality of care provided at Albany

46. The clinical review concludes that the care that the man received at Albany was “comparative to that which he would have received in the community”. The man was reviewed appropriately by the healthcare team at Albany. Indeed, as he attended healthcare three times a week for his

course of interferon he was able to benefit from more regular contact with healthcare staff than those in the community who would normally self-administer.

47. The review panel found that there were some areas of record-keeping that could be improved. The following recommendation was made in the clinical review, addressed to the primary healthcare manager:

    The primary healthcare manager should review and seek to improve the standard of record keeping and documentation.

Compassionate release

48. Chapter 12 of Prison Service Order (PSO) 6000 sets out the following criteria for early release on compassionate grounds:

    - the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
    - the risk of re-offending is past; and
    - there are adequate arrangements for the prisoner's care and treatment outside prison; and
    - early release will bring some significant benefit to the prisoner or his/her family.

49. The man was due to be released from prison on 23 March 2008. As he was mobile and outwardly well for most of his illness, plans were being made for him to take a place at a hostel in Havant, near to where his brother lives. However, following the man's sudden deterioration on 2 March, prison staff began to look for a hospice place instead.

50. It is standard practice at Albany to initiate an application form for early release on compassionate grounds. Such action is commendable. In the man's case, an application was raised on 29 February 2008. At the time, he was expected to live beyond his release date of 23 March and the form was not therefore completed or sent to the Pre Release Section of the Ministry of Justice. Sadly, the man deteriorated suddenly on 2 March and died the following day.

51. It appears that the man's family were given information regarding his prognosis by staff at the hospital which was not provided to the prison. Such information, in other circumstances, could be crucial in determining the success of an application for compassionate release. The clinical review notes that "it would be beneficial to aid documentation for the early compassionate release if hospital records of a poor prognosis could be shared with the prison". The review panel makes the following recommendation, addressed to the primary healthcare manager:

The primary healthcare manager should ensure there is better communication and information sharing by the specialist nursing teams at the hospital and prison healthcare.

RECOMMENDATIONS

1. The Governor should review procedures for arranging transport for patients to outside hospital appointments, and the reasons for cancelling booked escorts should be recorded.

   Accepted – although the original taxi was cancelled by Security, another taxi was provided for the escort. This was human error on the day and not a breakdown of systems or procedures. This has been reviewed and we are satisfied our escort transport systems operate well. This was the first time such an occurrence had taken place and there has not been a repeat since this event. The Security department will provide a log of cancelled escorts including reason/accountable manager.

2. Prison healthcare should work to improve communication and understanding with the hospital regarding the difficulties involved in maintaining outpatient appointments.

   Accepted – extensive work has been undertaken between prison healthcare and the hospital's clinical areas to improve understanding. Updating of staff is recognised as being imperative in order to support this process and is therefore ongoing. Work is ongoing in relation to bringing specialists into the prison rather than the patient attending outpatients. This closer working has enabled a single point of contact in relation to appointments.

3. The primary healthcare manager should review and seek to improve the standard of record keeping and documentation.

   Accepted – staff awareness, training, and updates have been undertaken and good practice in record keeping is now included in new staff induction process.

4. The primary healthcare manager should ensure there is better communication and information sharing by the specialist nursing teams at the hospital and prison healthcare.

   As point 2, and updating staff is recognised as being imperative in order to support this process and is therefore ongoing. Initiatives such as interdepartmental staff swaps, care pathways for prisoners and proactive communication with departments are being explored.

GOOD PRACTICE

1. The man was immobile following his admission to hospital. The escorting officer was instructed to sit in the waiting area and to make irregular checks on him, rather than sitting in the ward next to the man.