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

December 2008

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Albany. The man died on 29 March 2008 at a hospice close to the prison. The cause of death was recorded as bronchopneumonia due to disseminated rectal adenocarcinoma (cancer of the rectum).

Shortly before his death, the man told prison staff that he had a sister but was unable to provide any contact details for her. Sadly, she could not be traced. Nevertheless I offer my sincere sympathy and condolences to the man's sister, and to all of those affected by his death. I must also apologise for the delay in issuing this report. This was due in part to unexpected sickness absence on the part of the clinical review report writer.

The investigation was carried out by my colleague. 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 grateful to the head of the communications and standards department, and his team, at Albany for the assistance that they provided my investigator.

My report finds that the man received care equivalent to that which he might have expected to have received in the community. I make two recommendations regarding communication between the prison and the local hospital. I believe the correct decisions were made in respect of escort arrangements.

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

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SUMMARY

The man was received at HMP High Down on 14 August 2007, having been recalled to custody following a breach of the terms of his licence. He had been released on licence on 10 August, at around the half way point of an eight year sentence. On arrival at High Down, The man told the nurse who carried out his routine health assessment that he was asthmatic.

Having transferred to HMP Albany in October, the man was seen by a prison doctor in late November for an annual asthma review. He complained of a chronic cough and the doctor therefore requested a chest x-ray. An appointment at a hospital in Newport, was subsequently made for 28 February 2008.

On 16 January 2008, the man reported an upset stomach. He was advised to rest and was given Gaviscon (medication for indigestion) at his request. Two weeks later, on 29 January, the man was seen by a prison doctor after he complained of recent constipation and rectal bleeding. The doctor examined the man's abdomen and felt a lump. He made a fast track cancer referral to the hospital that day.

Towards the end of February, the man's mobility deteriorated. After twice falling in his cell, he moved to the inpatients wing at neighbouring HMP Parkhurst on 25 February (there are no inpatients facilities at Albany). However, after three days at Parkhurst, a prison doctor concluded that the man was too frail to be looked after there. He was therefore admitted to hospital for further investigation of his condition on 28 February.

The man's condition improved slightly at the hospital, so that he was able to walk to the bathroom by himself. However, after a few days as an inpatient he was diagnosed with cancer of the rectum which had spread to his liver.

On 20 March, the man's health deteriorated significantly. A place was arranged for him at a hospice in Newport, which the man took up the next day. His condition did not improve. He died at 10.45pm on 29 March.

The clinical review panel found that the man received care equivalent to that which he would have done in the community. The panel made two recommendations, both of which relate to communication with the hospital. First, the panel recommended that the prison establish a single point of contact for hospital appointments. Secondly, they recommended that prison healthcare look to work with the cancer care team at the hospital in preparing the necessary documents to support an application for early release on compassionate grounds.

THE INVESTIGATION PROCESS

1. The investigation was opened on 31 March 2008 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. One prisoner came forward as a result.

2. The investigator was given access to the man's prison files, including his medical record. He spoke over the telephone to the prisoner who had come forward on 9 May 2008, and visited Albany on 26 June. During his visit, the investigator interviewed one member of staff.

3. A clinical review panel was arranged by the clinical reviewer on behalf of the Isle of Wight Primary Care Trust. The panel, including the investigator the 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 report was written.

HMP ALBANY

4. HMP Albany is an establishment for category B and category C vulnerable prisoners only. 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, prisoner's 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 in the prison 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. They reported that only two escorts could be carried out per day, with some appointments having to be cancelled.

9. This is the 13th death that I have investigated at Albany since April 2004, when I began investigating all deaths in prison custody in England and Wales. It is the 12th death to be due to natural causes. There have subsequently been four further deaths at the establishment, three due to natural causes and one apparently self-inflicted. In previous reports I have made recommendations regarding the development of a care pathway for prisoners diagnosed with cancer. In my last report into a death at Albany, regarding a man who died of cancer around three weeks before the man, I made a recommendation regarding communication between the prison and the hospital.

KEY FINDINGS

10. The man was recalled to custody on 14 August 2007, and arrived at HMP High Down the same day. A reception health screen (a routine health assessment for all new arrivals into prison) was carried out following his arrival. At his screen, the man said that he was asthmatic, for which he used an inhaler. He also said that he was taking amitriptyline (an antidepressant).

11. After three weeks at High Down, the man saw a prison doctor on 7 September after complaining of chronic lower back pain. The doctor prescribed a course of diclofenac (pain relief).

12. On 25 October, the man transferred to Albany. A health assessment was carried out the following day at which the man said that he had difficulty breathing on account of his asthma. Four days later, the man attended a clinic at the healthcare centre at which he complained of back pain. It was suggested that he undertake rehabilitative gym work.

13. A month later, on 26 November, the man attended the healthcare centre for his annual asthma review. He complained of a chronic cough to a prison doctor who made a referral for a chest x-ray. Around two weeks later an appointment came in for 28 February 2008. Blood tests were also taken as part of the man's annual review. The results, which came in on 6 December, indicated some abnormal levels. These were not considered significant at the time and no action was taken.

14. The man reported an upset stomach on 16 January 2008. He saw a nurse who advised him to rest for 24 hours. This advice was repeated on the following two days by different members of staff. The man requested and was given Gaviscon (medication for indigestion) by the prison doctor following a review of his notes.

15. Two weeks later, on 29 January 2008, the man was seen by a second prison doctor. The man spoke of a recent history of constipation and rectal bleeding. On examination, the second prison doctor felt a lump on the man's abdomen. He therefore made a suspected colorectal cancer referral. An appointment was, apparently, made by the hospital for 7 February. However, this communication did not reach prison healthcare staff and they were therefore unable to acknowledge it. The following day, therefore, an alternative appointment came through for the man to see a consultant on 14 February.

16. On 31 January, the man was reviewed by the prison doctor. He told the doctor that he first noticed the lump a week ago. The man spoke of increased abdominal pain and requested medication to help with this. The prison doctor therefore prescribed a course of tramadol 50mg (pain relief). He also prescribed zopiclone to help the man sleep. On the following day, the results of a blood test that the man had recently taken came in. The prison doctor noted that the results were "highly suspicious of a

malignancy [a cancerous tumour]". On the same day, the man's appointment for a chest x-ray was brought forward to 14 February to coincide with his appointment with the consultant.

17. A nurse was called to see the man in his cell on 8 February as the wing staff said that he was too ill to be seen in healthcare. The man said that he was in a lot of pain. It transpired that he had not been taking the correct dose of tramadol. The medication should be taken four times a day, as required. However, the man thought that he should only take one tablet per day. The nurse advised him of the correct dose.

18. The disability liaison officer at Albany assessed the man on 14 February. She noted that he was not sleeping and was still experiencing some pain. The disability liaison officer made an urgent recommendation that the man move to F&G wing, as this is a newer wing with better facilities such as in-cell sanitation and showers. The man transferred wings that day.

19. On the same day, the man attended the hospital for his appointment with the consultant. The consultant examined the man's abdomen and found it to be normal except for a tender liver. He also considered the results of the man's January blood tests, and thought that they might indicate a case of abdominal pain from hypocalcaemia (too little calcium in the blood). The consultant requested an ultrasound of the man's neck, which was later booked for 26 February.

20. On 15 February, the prison doctor increased the man's dose of tramadol to 150mg, which he would now take twice a day rather than four times as previously. The man was reviewed by the prison doctor a week later on 21 February. He said that his pain was well controlled with tramadol for about eight hours, but there was then a gap until it was time to take his next dose. The prison doctor therefore prescribed paracetamol in addition to the tramadol.

21. The manager of F&G wing, requested that a nurse see the man on 25 February. The nurse attended and was told that staff had concerns about the man as his mobility was very poor and he was unable to manage his personal hygiene. The nurse discussed the case with the duty doctor at HMP Parkhurst. They agreed that the man should be transferred to Parkhurst and admitted to the inpatients unit there.

22. On his arrival on the inpatients unit, the man was assessed by the duty doctor. His mobility was noted to be very poor, although the man said that he was not in pain at present. At around 5.30am the following morning, the man slipped to the floor of his cell. He was examined by a nurse but was not found to be injured. Later that day, a nurse made a note in the man's medical record in which she described his current difficulties. She noted that he needed help to wash and shower and change his clothes, and that he was just about able to walk across his cell to take his medication.

23. On the same day, the man attended the hospital for his ultrasound. The scan showed evidence of a solitary hypoechoic oval nodule (a mass that could be a cancerous tumour).

24. The deputy governor at Albany initiated an application for early release on compassionate grounds on 26 February. In the section to be completed by the Governor, the duty governor wrote that the man represented a "high risk to the public". However, he went on to say that:

    "Release on compassionate grounds may be appropriate in view of likelihood of death due to terminal illness. Not expected to recover."

25. The man was noted to have slept well on the night of 26-27 February, with no complaints of pain or discomfort. He was given assistance to bath and shave and had to use a wheelchair to get to the bath due to his poor mobility. The man told a nurse that he could not eat anything as it hurt him to swallow. She therefore arranged for him to have soups and Ensure (a nutritional supplement) from the kitchen.

26. On the following morning, the man again fell onto the floor of his cell. He was noted by nursing staff to be very confused and disoriented. Later that morning, the man was reviewed by a third prison doctor. The doctor noted that the man was:

    "Very unwell. Frail and confused now. Now unable to stand. Not eating and drinking very little. Denies any pain but feels unwell. Barely communicating. Answers questions slowly only and unable to say what day, month, year it is."

27. The doctor concluded that the man was too frail to be looked after on the inpatients wing at Parkhurst. She arranged for him to be admitted to the hospital for a full investigation, and an ambulance was arranged. The man left Parkhurst at around 11.00am. He was accompanied by two officers and, following admission, cuffed to one of them by means of an escort chain (a long chain with handcuffs at both ends). That evening, the man was told by a hospital doctor that he would be likely to be staying for at least a week for tests.

28. Over the following days, the man's condition improved. He was able to walk to the toilet by himself and was able to shower on occasions. The man had a CT scan of his abdomen on 4 March. The results of the scan showed a rectal tumour (cancer of the rectum). The cancer had spread to the man's liver, but not to the lungs. His case was discussed at a multi-disciplinary meeting at the hospital on 13 March at which it was decided to refer him for palliative care. The man was visited by a Macmillan nurse on the same day.

29. The man was on the same ward at the hospital as another prisoner. The escort was reduced to three officers for the two prisoners on 14 March, although the man's escort chain remained in place. On 17 March, the

second prison doctor wrote to the consultant to request information regarding the diagnosis and prognosis for use in an application for early release on compassionate grounds. A reply was written by another consultant, the following day, although this was not received at Albany until 3 April. The other consultant said that:

> "His prognosis is clearly very poor but he is not in need of hospice care for symptom control at present and we have not reached end of life management."

30. Shortly after this letter was dictated, the man deteriorated significantly. On 20 March, the escort chain was removed. The same day, a place was arranged for the man at a hospice in Newport. He moved there on 21 March. The escort was increased to two officers because the man was "still mobile", although the escorting staff were asked to wear plain clothes.

31. Before his letter of 18 March was sent to the second prison doctor, the consultant added the following addendum:

> "Following dictating this letter the man deteriorated dramatically and it was felt he had reached end of life management. He was transferred to the hospice for palliative care."

32. Around the same time, a principal officer began to try to contact the man's next of kin. The man had said that he had a sister, but was unable to provide any contact details for her. The principal officer passed the available details onto the police and the probation service, but neither was able to locate her.

33. The escort was again reduced to one officer on 27 March, as the man was now bed-ridden. He died at 10.45pm on 29 March. The cause of death was recorded as bronchopneumonia due to disseminated rectal adenocarcinoma (cancer of the rectum). The man's funeral was arranged by a principal officer and a prison chaplain. The prison chaplain conducted the service, which was held on 15 April. A number of staff from Albany attended, including the Governor.

ISSUES

Issues raised by a prisoner

34. During the course of the investigation, one prisoner came forward to speak to my investigator. The prisoner was a colleague of the man's on A wing. He said that there was a period of around three weeks after Christmas 2007 when the man was on rest in cell (when a prisoner is signed off work or other activities, usually due to illness) and did not see a doctor. The prisoner said that the man was weak during this time and could hardly walk. He said that the man did not see a doctor until mid-February 2008, and the prisoner thought that he should have done so earlier.

35. The man was seen by a nurse on 16 January after he complained of an upset stomach. The nurse advised the man that he rest in cell for 24 hours. This advice was repeated by other members of healthcare staff on each of the following two days. The man was also given Gaviscon (medication for indigestion) at his request.

36. When he was seen by the nurse, the man reported no symptoms other than an upset stomach. The clinical review notes that he made no further report of any symptoms of this nature following this period. The man was seen by a prison doctor on 29 January, after complaining of different symptoms. The doctor found a lump on the man's abdomen and therefore made a suspected cancer referral that day.

Hospital outpatient appointments

37. After finding a lump on the man's abdomen, a prison doctor made a fast track cancer referral on 29 January 2008. Apparently, the local hospital initially booked an appointment, on receipt of the faxed referral, for the man to see the consultant on 7 February. However, this communication did not reach prison healthcare staff and they were unable to acknowledge it. An alternative appointment was therefore made, on 30 January, for the man to see the consultant on 14 February.

38. The appointment on 14 February was outside of the two week wait timescale, by which a suspected cancer patient should be seen within 14 days of referral. The clinical review panel, however, has concluded that the delay to the man's appointment "made no effective difference" as he already had advanced cancer at this stage.

39. The panel considered the appointment for 7 February that did not reach healthcare staff. It was agreed that sending all outside hospital appointments to a named individual within prison healthcare would reduce the risk of them not being received. The panel made the following recommendation (it is to be taken forward by, the acting head of prison healthcare, and the clinical risks and claims manager):

The head of healthcare should ensure that information regarding the hospital appointments for prisoners is sent to a named individual within the prison cluster.

Quality of care provided to the man

40. The clinical review panel concluded that the care that the man received at Albany was "equivalent to the care that he would have received in the community". At the time of his diagnosis, the man's cancer was widespread and at an advanced stage. The panel noted that, "it is surprising that he did not present with any symptoms at an earlier date". However, the panel considered that, following the cancer referral on 29 January, "all care was undertaken quickly and appropriately".

41. The panel also considered the abnormal blood test results of 6 December 2007. They judged that these results were not significant at the time. In particular, the man's serum calcium level, that was significantly high in February 2008 and led to suspicions of a cancerous tumour, was normal in December.

Cuffing arrangements

42. The man was admitted to hospital as an inpatient on 28 February 2008. He was accompanied by two officers and cuffed to one of these by means of a closeting chain (a long chain with handcuffs at both ends). On 14 March, the escort was reduced to three officers between the man and another prisoner who was on the same ward. The closeting chain was removed on 20 March after the man deteriorated significantly.

43. A prison doctor admitted the man to the hospital because he was too frail to be looked after on the inpatients wing at Parkhurst. The doctor noted that the man was "frail and confused … unable to stand … barely communicating".

44. However, over the following days the man's condition improved to the extent that he was able to walk to the toilet by himself and walk to the balcony for fresh air. He was also able to shower on occasions.

45. The man was serving a long sentence for a sexual offence. In 2003, he was arrested and remanded into custody just four days after he had been released from serving a lengthy sentence for a similar crime. Indeed, during this previous sentence he had been released on licence and recalled just one day later amid fears that he was planning to carry out another such offence.

46. In the application for early release on compassionate grounds, the deputy governor concluded that the man represented a "high risk to the public". Given his offending history, it is hard to argue with this assessment.

47. Considering the risk of re-offending that the man posed and his level of mobility whilst in hospital, I judge that the decision to cuff him was a reasonable one. I also note that the cuffs were removed following the man's sudden deterioration on 20 March. Again, I agree with this decision. I also support the decision to ask staff who escorted the man at the hospice to wear plain clothes.

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. A prison doctor wrote to the consultant at the hospital on 17 March to request information regarding the man's diagnosis and prognosis for use in an application for early release. A reply was written by another consultant on 18 March, which he amended on 20 March following the man's deterioration. However, the letter was not received at Albany until 3 April, five days after the man's death. It is also likely that the other consultants' letter, which I have included as Annex 4, does not contain the level of detailed prognosis required for an application to succeed.

50. The clinical review panel considered the delay to receiving the other consultants' letter. It was agreed that there was a need for better information sharing between the cancer care team at the hospital and the prison healthcare team. The panel made the following recommendation, to be taken forward by the primary healthcare manager at Albany, and the colorectal nurse specialist at the hospital:

    The primary healthcare manager should work to establish a system whereby both prison healthcare and the cancer care team are involved in completing the relevant documentation to assist the early compassionate release process.

RECOMMENDATIONS

1. The head of healthcare should ensure that information regarding the hospital appointments for prisoners is sent to a named individual within the prison cluster.

   Accepted – the majority of outpatient appointments for the cluster are now received centrally by a named individual.

2. The primary healthcare manager should work to establish a system whereby both prison healthcare and the cancer care team are involved in completing the relevant documentation to assist the early compassionate release process.

   Accepted – some early work has been undertaken with prison healthcare and the Trust lead cancer nurse on a cancer care pathway. This will include earlier communication and feedback to relevant prison personnel in order to initiate the compassionate release process. In the interim the Primary Healthcare Manager has discussed with teams who will ensure they are more proactive in administering the process.