Investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Albany, in June 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of an investigation into the death of a man who died in June 2007 at a hospital on the Isle of Wight. The man had been taken ill in his cell at HMP Albany little more than an hour earlier. I offer my sincere sympathy and condolences to all of those affected by his loss.

The man had been diagnosed with cancer of the colon around one month previously. A post mortem examination confirmed the cause of death to be a disseminated carcinoma of the sigmoid colon with a secondary condition of chronic obstructive airways disease.

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 carried out by the Isle of Wight Primary Care Trust. 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 especially grateful to the Head of the Communication and Standards Department for the liaison that he provided my investigator.

In general, I believe that the man was treated appropriately. However, I have some concerns about the care he received on the day before he died. Given the number of elderly prisoners at Albany, the Governor will wish to consider if there are training and cultural issues amongst staff that need to be addressed.

I make six recommendations and highlight two examples of good practice.

This version of my report, published on my website, has been amended to remove the name of the deceased and the names of staff and prisoners who were involved in my investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman
January 2008

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SUMMARY

The man was remanded into custody at HMP Wormwood Scrubs on 24 July 2000. He did not settle well into prison life, and reported a number of panic attacks and periods of depression in the run up to and during his trial. On one occasion he apparently attempted suicide at court. He was convicted and sentenced to 16 years imprisonment on 16 March 2001.

On 20 April 2001, the man transferred to HMP Rye Hill where he remained for the following five years. His time at Rye Hill was not a happy one. He continued to experience spells of depression, and would go through periods in which he self-harmed and threatened suicide. There appear to have been various motives for the man's actions, including a lack of success with his appeal, anger with his family for "deserting him", his perceived treatment by staff at Rye Hill, and as a protest at not being given a transfer to a different prison. A total of 27 different F2052SH documents (the form used at the time by the Prison Service to monitor and support prisoners deemed at risk of suicide or self-harm) were opened by staff during the man's time at Rye Hill.

On 5 July 2006, the man transferred to HMP Albany. He was assessed by a nurse shortly after his arrival and reported a history of angina but no other health problems. The man was much more settled at Albany. Other than one occasion around two weeks after his arrival, he expressed no thoughts of suicide or self-harm during the remainder of his time in custody.

The man was seen by a prison GP on 19 April 2007 after reporting intermittent abdominal pain, constipation and weight loss. He attended an outpatient appointment on 1 May at which the Consultant observed a mass on his abdomen, and made a diagnosis of suspected cancer of the colon. A CT scan on 8 May confirmed this.

The man began to deteriorate following his return from hospital. Notes made by staff towards the end of the month indicate that they were concerned about his health and how he was being managed on E wing. On 6 June, the man moved to a cell on F&G wing, as this was a newly built wing with better facilities such as in-cell showers. He was assigned a fellow prisoner to act as his buddy (meaning that he would help the man with tasks such as collecting meals and cell cleaning).

One morning in June 2007, the man's buddy went to his cell and found that he had defecated and passed blood. He reported this to staff who called healthcare. The Healthcare Manager attended and noted that no member of wing staff had been to see the man. He commented in the Medical Record that, "I believe the officers are not taking any responsibility for this inmate."

The Healthcare Manager's assessment at the time was that the man was coherent and as well as could be expected. However, in the evening the man was seen by an officer who described him as being in "a bad state". The man deteriorated further and, at around 11.10pm, an officer was called to his cell. The man told the officer that he was having difficulty breathing. The officer

and the night orderly officer telephoned the healthcare centre at neighbouring HMP Parkhurst for guidance (there is no overnight healthcare facility at Albany), and were advised to call for an ambulance.

The ambulance subsequently arrived around 11.25pm, and the man was taken to a local hospital around 25 minutes later. While the ambulance crew were in attendance, the man deteriorated further. By the time he arrived at hospital he was unconscious. He did not regain consciousness, and was pronounced dead at 12.28am.

My report concludes that, judged overall, the man received care equivalent to that which he would have received in the community. However, I am concerned about the level of personal and social care that he received in the last couple of weeks of his life, most notably on the last day. The lines of responsibility for such provision are unclear, and I make a recommendation that guidelines are issued to clarify this.

I make six recommendations in total, and highlight two examples of good practice.

THE INVESTIGATION PROCESS

The investigation was opened on 12 June 2007 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. Three prisoners came forward as a result.

My investigator was given access to the man's prison files, including the medical record. He visited Albany on both 15 August 2007 and 24 September 2007, and interviewed six members of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the Isle of Wight Primary Care Trust.

My senior family liaison officer contacted the man's brother on 26 June 2007. He said that he had found it very difficult to arrange a visit to his brother in the final days of his life, and that he could not speak to anyone about his brother's medical condition.

HMP ALBANY

HMP Albany was designed and built as a category C training prison on the site of a former military barracks on the outskirts of Newport, Isle of Wight. Shortly after opening in 1967, it was decided to upgrade the security. In 1970, Albany subsequently became part of the dispersal (high security) system.

In 1992, Albany was re-designated as a category B closed training prison and, from 1998, became an establishment for vulnerable prisoners only. In 2002, a category C Unit was added and the certified normal accommodation is currently 526. The average age of the population is significantly higher than in most prisons.

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 establishment with in-patient facilities. Albany itself has a healthcare unit designated for the delivery of primary care services.

HM Chief Inspector of Prisons, Ms Anne Owers, published a report on an unannounced short follow-up inspection of Albany during October 2005. (The last full inspection was in 2002.) In the short inspection report, Ms Owers referred to healthcare, and said:

> "Although progress had been made since the last inspection in some healthcare areas, many had either stood still or regressed. The perception of patients we spoke to was that healthcare generally had deteriorated and was poor. This was in contrast to the last inspection when 53% of prisoners in our survey thought that healthcare was good or very good."

This is the tenth death that I have investigated at Albany since April 2004, and the ninth due to natural causes. The last Albany case that I investigated (in December 2006) concluded that healthcare was lacking in several areas. A recommendation made in that report with regard to the care pathway for a prisoner who has been diagnosed with cancer is repeated in this one.

KEY EVENTS

The man was received as an unconvicted prisoner at HMP Wormwood Scrubs on 24 July 2000. He was admitted to the healthcare centre on arrival because of recent dizzy spells and a history of angina and ischaemic heart disease (the narrowing of the blood vessels supplying the heart, leading to a reduced supply of blood). The man settled in well and made no complaints of chest pain or of any discomfort overnight.

The man was assessed by a prison doctor the following day. The doctor noted that he appeared well on examination and was not taking any medication. The doctor also noted a family history of cancer. Two days later, the man was passed fit by the doctor to live on a wing in the vulnerable prisoners unit.

The man did not settle well into prison life. On 12 September, he reported chest pain and, on the following day, was admitted to healthcare after he was found to be hyperventilating. Entries over the following days indicate that the man was suffering from depression, anxiety and panic attacks. He said that this was because he felt that his family was "deserting him". After five days in healthcare, the man returned to the wing on 18 September.

Over the following months, the man experienced further depression and panic attacks. An F2052SH (the form used at the time by the Prison Service to monitor and support prisoners deemed at risk of suicide or self-harm) was opened on 31 October for a few days. The man was subsequently referred to a Specialist Registrar in Forensic Psychiatry. He was assessed on 20 November, and it was concluded that the man was suffering from an "adjustment reaction" to imprisonment and the charges against him, rather than a mental disorder.

The man continued to suffer anxiety and panic attacks in the lead up to and during his trial. On 21 February 2001, an F2052SH was opened following an incident at court in which the man was said to have "collapsed". He later claimed that he had attempted to kill himself. The F2052SH remained open when the man was convicted and sentenced to 16 years imprisonment on 8 March. In the following days he said that he would kill himself if he was unsuccessful with his appeal. The man was soon judged to be coping better, however, and the F2052SH was closed on 21 March.

On 20 April, the man transferred to HMP Rye Hill. His history of angina and panic attacks was noted on reception, and his general health was recorded to be "satisfactory". That evening, an F2052SH was opened on account of the man's "low mood". It is not clear how long this form remained open. On 31 May, a further F2052SH was opened as the man's appeal had been turned down. Again, it is not clear how long this document remained open.

On 9 September, the man complained to wing staff that he was suffering "heart pain". A nurse was called out to see him, and noted that the man did not look sweaty or clammy and was not short of breath. The nurse advised

him to rest and relax, and to contact healthcare if he had any further problems.

Another F2052SH was opened on 14 November as the man had threatened to self-harm when a further appeal was refused. An assessment noted that he had “no suicidal ideation at present” but that the man said he would refuse to eat and take medication. The man was noted to have refused breakfast on 15 November and 18 November. It is again unclear when the F2052SH was closed.

The man attended an angina clinic on 16 February 2002, and again on 27 February. He was assessed by a psychiatrist on 25 February who noted that he complained of feeling depressed and suffering panic attacks, but that he was better when taking propranolol (a beta blocker, used to treat various conditions including angina and anxiety).

On 11 July, the man was seen by a surgeon at a hospital local to Rye Hill. He had been referred in April, having complained of pain and swelling in his right testicle. The surgeon diagnosed a hydrocele (fluid on the testicle), and requested an ultrasound to confirm this. An appointment was subsequently booked for surgery to remove the hydrocele to take place on 29 October.

However, the surgery was cancelled as the man had not yet undergone the requested ultrasound procedure by 29 October. It was noted in his medical record that the man “will not let a female touch him”, and a male radiographer only visited the hospital infrequently.

On 16 December, an F2052SH was opened as the man was noted to be very low in mood. He said that he had deliberately banged his head on his cell wall the previous night “to end it all”. The document was closed on the following day when the man was noted to be calmer.

At around 10.30am on 23 January 2003, the man barricaded himself in his cell and was observed to be carrying a bladed weapon. He had also been seen to take all of his in-possession medication. The poisons unit at HMP Birmingham was contacted for advice. At 12.20pm, Birmingham advised that the man needed to be taken out of the cell within the hour. Around five minutes later, the man began to complain of light-headedness. A Control and Restraint team (C&R, the approved method to restrain violent prisoners by use of force) therefore entered the cell at around 12.35pm and removed the man. He was cuffed and taken to the local hospital by ambulance at around 12.45pm.

An F2052SH had been opened at 10.30am when the man first barricaded himself into the cell. The document remained open during his time in hospital. Whilst there, the man was seen by a psychiatrist who judged that he had no mental health problems. The man returned to Rye Hill on 24 January, and stayed in the healthcare centre overnight. The F2052SH was closed on 25 January.

The man attended the local hospital on 28 February for his ultrasound. The results confirmed a right hydrocele. On 20 March, an F2052SH was opened as the man said that he had broken a blade and swallowed it. He claimed to have been assaulted during the C&R operation on 23 January, and was aggrieved that he had not seen the police liaison officer. The man threatened to overdose again, and said that he would cut himself if he was not given the tablets. The psychiatrist deemed that the man was not depressed or psychotic, and advised that he be given a chance to see the police liaison officer. The F2052SH was closed on 4 April.

Another F2052SH was opened on 4 May when the man again claimed to have swallowed a blade. He asked to see a nurse, and complained to her about the structure of the prison, and discipline and healthcare staff. Two days later, the man attempted to cut his left wrist. He said that the blade was blunt and that otherwise, "I would have done it properly." He alleged that he was being bullied by both prisoners and staff. It is not clear whether these allegations were investigated at the time.

The man made four lacerations to his left arm on 9 May, and on 11 May was reported to have lacerated his arm again. He also claimed to have swallowed two pieces of razor blade on this second occasion, and refused to be taken to hospital. The F2052SH was closed on 14 May. By 11 July, the man said that he was feeling better and had no thoughts of suicide or deliberate self-harm.

Surgery to remove the fluid on the man's testicle was booked for 29 September. However, the operation had to be cancelled as there were not enough staff available for the escort. The man was not happy about this and, on 30 September, threatened to carry out the operation himself using blades he had hidden on the wing. An F2052SH was therefore opened. At a psychiatric review on 3 October, the man said that he no longer had any thoughts of carrying out the operation himself. He also said that he did not like being on an F2052SH, and that these events had taught him to be more patient. The document was subsequently closed on 7 October. The man's operation was carried out on 18 November.

On 6 February 2004, the man reported he had heard voices in his head. He saw a mental health nurse the same day, and told her that he was very upset by this and did not want it to happen again. The nurse noted that the man's case had not been accepted by the Criminal Cases Review Commission. The man was reviewed by a psychiatrist on 13 February who noted that he was now doing well and feeling brighter in mood.

The remainder of 2004 was very difficult for the man. On 7 April, an F2052SH was opened as he said that he had attempted to hang himself because he had been turned down for a transfer. This was closed on 13 April, but another document was opened on 21 April when the man made three incisions to his arm. Two days later, the man said that he would hang himself if he was not given a transfer. On 30 April, he said that he had swallowed a blade and repeated his threat to kill himself if he was not given a transfer. On 6 May, the man again cut his arm with a razor blade and claimed to be innocent.

The F2052SH was closed on 18 May. However, additional F2052SHs were opened on ten further occasions through the remainder of 2004. The documents were usually open for periods ranging from one to three weeks. The man cut himself on at least two further occasions during the year, and threatened suicide or self-harm on a number of other instances. He continued to demand a transfer and to profess his innocence, and also claimed on one occasion that his actions were due to bullying on the wing.

The man's state of mind was better in early 2005, although a further F2052SH was opened for a few days in the first week of January. Documents were also opened on four more occasions through 2005 for periods ranging between one and six days. The man was still prone to periods of depression, and said on a couple of occasions that he found prison life stressful.

On 29 November, the man was due to undergo an x-ray at a local hospital, but declined to attend. It is not clear from the records why he was due to have this x-ray. On 28 January 2006, he complained of chest pain and was assessed by a nurse. His blood pressure and pulse were taken and were normal. The nurse noted that the man had recently received a letter from his daughter, and thought that his pain may be anxiety related. She referred him to a counsellor and advised on deep breathing exercises.

The man was noted to be suffering from ongoing depression over the first six months of 2006, and F2052SHs were opened on three occasions during this period. On 5 July, he transferred to HMP Albany. The man arrived on 6 July, having stopped overnight at HMP Wandsworth.

The man was assessed by a nurse shortly after his arrival at Albany. He told her that he had no medical problems other than angina which he said he had around 30 years previously. The nurse noted that the man suffered from depression and had been on a number of F2052SHs, but that he was not on any medication at present.

The man was seen in a general medical clinic on 10 July as his blood pressure had been raised over the weekend. It was noted to be fine. A further check was taken on 15 July at which the man's blood pressure was again normal.

An F2052SH was opened on 17 July 2006 after the man apparently told a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress) that he intended to kill himself. The man had been upset by an earlier interview with Public Protection Unit staff at which his offence was discussed. There were also indications that he had failed to settle at Albany. The document was closed on 22 July following an interview at which the man said that he no longer had thoughts of killing himself. The man appeared to settle more readily into life at Albany following this. He spoke of meeting up with people whom he had known at other prisons, and expressed no further thoughts of suicide or self-harm during the remainder of his time in custody.

On 24 July, the man reported a sudden pain and swelling in his right testicle. He was seen by a prison GP, who prescribed doxycycline (an antibiotic). However, the man's condition did not improve and on 25 August he was referred to a local hospital. He attended an outpatient appointment on 13 November at which a recurring hydrocele was diagnosed. The man was subsequently placed on the waiting list for surgery.

The man had no further problems with his health until, on 19 April 2007, he reported severe constipation during the previous three weeks. He also said that he had been experiencing intermittent abdominal pain and had lost weight. The man was seen by a prison GP, who referred him for a colonoscopy (an examination of the colon).

On 30 April, the man said that he was experiencing dizzy spells at work. He was allowed to rest in his cell rather than go to work for the remainder of the week. He attended an outpatient appointment at the local hospital on 1 May at which the consultant observed a palpable mass (a growth under the skin that can be felt by the hands) on his abdomen. The consultant suspected cancer of the colon and requested a CT scan and colonoscopy which was booked for 22 May.

The man was admitted to hospital on 4 May for surgery on his hydrocele. Given the suspicion of cancer, however, this procedure was cancelled and the time was used instead to confirm the diagnosis. The man had a CT scan on 8 May, the results of which confirmed cancer of the colon with deposits in the liver and lungs. A colonoscopy was attempted on 10 May, but was unsuccessful and rebooked.

The man returned to Albany on 11 May, and was noted to be weak but comfortable and not in undue pain. However, the following day he said that he was experiencing acute abdominal pain when opening his bowels. As he was taking Movicol (a laxative), this was happening frequently. The man had also been observed by wing staff to be tearful. He was seen by a prison GP, who prescribed co-codomol (a painkiller) and zopiclone (to aid sleeping). The man was reviewed on 14 May and noted to be in good spirits and pain free.

The following day, the man requested diclofenac as he felt that this was a better painkiller than co-codomol. He was seen by a prison GP who felt that diclofenac was not appropriate and that the man would need a more effective painkiller for his cancer. The man continued to request diclofenac over the next two days. On 17 May, he was seen by a different prison GP, who ceded to his wishes. The prison GP also prescribed omeprazole (a drug used to reduce the production of gastric acid).

On 18 May, a prison officer made an entry in the wing observation book to say that he had, "contacted HCC (Healthcare Centre) about the man and his deteriorating state of health." The officer went on to say that he had been told by healthcare staff that the man had been seen the previous day and, "there was not much more they could do for him." The officer added that he asked if

anyone from healthcare was coming to see the man and had been told, "not now but they may try again later." A follow-up entry from a senior officer on 20 May said that healthcare had "belatedly arrived" and issued the man with medication.

On 21 May, the man was admitted to the local hospital in preparation for his rearranged colonoscopy. There had been some confusion at Albany as the prison had not been informed of the date of the re-booked procedure. As a consequence, a member of staff at the hospital had telephoned the prison to enquire as to the man's whereabouts. An escort was arranged at short notice and the man was transferred to hospital the same day.

The colonoscopy went ahead on 22 May, and the man returned to Albany that day. On 28 May, he was seen by a Healthcare Officer (HCO), who noted that the man "continues to have problems on the wing … as management is becoming a problem."

The man was visited on the wing at lunchtime on 29 May by a nurse. She noted that he was sitting up in bed and was alert and chatty, but that he complained of diarrhoea around two hours after eating. The man was seen later by a prison GP, who suggested he try immodium for the diarrhoea. The prison GP also said that he would contact Occupational Therapy for an assessment of the man's daily care.

At 4.40pm on 29 May, a senior officer wrote in the wing observation book that he was "very concerned" about the man's health. He went on to say that he had asked for a doctor to come and see the man but "healthcare seem reluctant to do this, they say we should get him to them in a wheelchair." However, the senior officer added that staff were reluctant to do this "due to stairs and lack of training". He added that the man was "too weak to walk". It is not clear if this entry was made before or after the man saw the prison GP that day.

On the following morning, the senior officer made a follow-up entry in which he noted that he had been informed by another senior officer that the disability liaison officer was dealing with the issue. The senior officer also wrote that, "we are not equipped to cope with all the problems presented by the man's condition."

On 31 May, the man was seen a prison GP. The man said that he still had diarrhoea, and that his legs were weak meaning that he could not get out of bed. The prison GP also noted that, on examination, the man's liver was grossly enlarged. He advised the man to eat what he could and, after determining that there was no loss of muscle power in his legs, to try to start moving around.

The same prison GP saw the man on 4 June. He noted that the man's condition was deteriorating and that he had still not got out of bed. The man was also mildly dehydrated. The prison GP discussed with the man the importance of taking fluids and trying to mobilise himself.

The man was seen by the disability liaison officer on the same day. She spent around 30 minutes with him during which the man said that he was not eating much. He said that he liked Cup-a-Soups but could not afford them, so the disability liaison officer bought him two boxes. She told the man that she would request a move to F&G wing for him, as this was a new wing with better facilities such as in-cell sanitation and showers.

The man subsequently moved to F&G wing on 6 June, and was allocated a cell on the ground floor. He was assigned a buddy on his new wing. (Albany operates a 'buddy' system, whereby prisoners who are ill or have mobility problems are assigned a fellow prisoner to help them with tasks such as collecting meals and cell cleaning.)

One morning shortly after his move to F&G wing, the man experienced a dizzy spell when going to the toilet. His buddy helped him back to his bed and later recalled that the man was quite panicked, but that he calmed down after a while. Later on the same morning, the man's buddy returned to see him and discovered that he had defecated and passed blood in his bed. The man was embarrassed about this, and his buddy got him some clean underwear and went to report what had happened to staff.

The man's buddy went to the wing office and spoke to an officer. The officer telephoned healthcare to request that someone come out and see the man. He did not go and see the man himself and, at interview, said that he passed on the same information that he had been given by the man's buddy.

The Healthcare Manager came to see the man. He made the following entry in the Medical Record:

> "Had phone call from F&G re the man they stating he was covered in shit and blood. On arriving on the wing officers were all sitting in the office. The man was lying on his bed, no faeces or blood on his person but two small areas of blood on his bottom sheet … talked to his personal officer asking why we had a call regarding the man when he was not covered in anything, he stated he had been told by an inmate that he was in this state. I asked if he had checked and he said no as this was not his job and he didn't fancy looking at someone like that."

At interview, the Healthcare Manager recalled that he spoke to the man and that he was coherent. The man was able to stand and move between his bed and his chair. However, the chair in his cell was too low, so the Healthcare Manager asked wing staff to arrange for a high-backed chair to be brought in instead. He also asked wing staff to arrange for a plastic cover for the man's mattress, and helped him to shave. The Healthcare Manager's overall impression was that the man presented quite well and was quite good at the time.

The officer to whom the man's buddy had earlier spoken went to the man's cell in the evening, to see how he was. He said that the man "was in a bad

state" and looked really ill. He described the man as lying on his back in bed with his covers pulled up to his chin.

At around 11.10pm, an officer working the night shift went to the man's neighbour's cell, having been alerted by the call bell. The man's neighbour told the officer that the man had been banging on the wall. The officer therefore looked through the flap of the man's cell. The man saw him and said, "Help me, I can't breathe properly." The officer told the man to calm down and not to panic, and said that he would go to get help.

The officer then returned to the wing office and telephoned the senior who was Oscar 1 that night (Oscar 1 is the radio call sign of the Night Orderly Officer, the person who is in charge of the prison overnight). He explained the situation to the senior officer and asked for permission to unlock the man's cell, in line with local policy. The senior officer agreed, and the officer therefore returned to the cell with an Operational Support Grade (OSG).

On entering the cell, the officer considered the man to be, "clearly having difficulty breathing, but coherent and talking to me." The man said that he could not feel his legs and asked for oxygen. The officer told him that he did not have oxygen and would have to contact healthcare. He helped the man to sit up and rest on his pillow. This calmed the man down a little.

The officer then returned to the wing office so that he could telephone healthcare. He met a senior officer and another officer, who was the Assistant Night Orderly Officer, on arrival and updated them. As there is no overnight healthcare provision at Albany, staff are required to telephone the healthcare centre at HMP Parkhurst for advice. The senior officer duly spoke to a nurse at Parkhurst. She said she would look up the man's record and phone back.

The nurse phoned back within a short while, and advised that they should call an ambulance. At around 11.20pm, the senior officer contacted the control room and passed this message on. The ambulance arrived at around 11.25pm, prior to which the senior officer and the F&G officer sat in the man's cell with him. The officer recalled that the man was coherent at this time and able to hold a conversation. When the ambulance crew arrived, however, the man's condition deteriorated.

The ambulance left the prison at around 11.50pm. The man was accompanied by the F&G officer and another officer, and cuffs were not used. The man deteriorated further in the ambulance, and was unconscious when it arrived at the local hospital. He did not recover consciousness, and was pronounced dead at 12.28am. A post mortem report later gave the cause of death as a disseminated carcinoma of the sigmoid colon with a secondary condition of chronic obstructive airways disease.

The news of the man's death was broken to his brother on 8 June. Due to the distance that the man's brother lived from Albany, a chaplain at a prison closer to his house was asked to break the news. The chaplain agreed, and

visited the man's brother and sister-in-law in their home. The man's funeral was held in early July, with the prison acting in accordance with Prison Service Order (PSO) 2710.

ISSUES

The provision of personal and social care

The clinical review was conducted by the Isle of Wight Primary Care Trust. The clinical reviewer notes that the healthcare that the man received was "equivalent to care provided to patients in the community". However, he goes on to say that the personal care that the man received on the last day of his life was a "possible exception" to this.

When he saw the man on that day, the Healthcare Manager commented in the Medical Record, "I believe the officers are not taking any responsibility for this inmate". He also noted that he had asked the man's personal officer why he had not gone to see the man when told that he had defecated and passed blood. The officer apparently replied that it was, "not his job and he didn't fancy looking at someone like that."

At interview, the Healthcare Manager said that his opinion was that wing staff "thought that they couldn't cope" with the man, and that they "didn't feel it was a wing matter". He went on to say that he thought that there was a lack of clarity and misunderstanding with regard to whose responsibility it was for a prisoner's personal and social care. He said that he felt this was a shared responsibility.

The officer said at interview that he did not go to the man's cell because "the buddies actually deal with that sort of thing," and he had to trust them to deal with it. He went on to say, "I am a prison officer not a hospital officer, and part of our remit is not dealing with bodily fluids." In terms of the responsibility of wing staff for helping prisoners like the man with their personal care, the officer said that they are a "go between, between the prisoner and healthcare". He added that there is the issue of "healthcare in confidence", meaning that wing staff cannot ask questions of healthcare staff about the needs of prisoners.

The principal officer who is the manager of E wing and F&G wing, said at interview that he would have expected a member of staff to go and see a prisoner if they were told that the prisoner had defecated and passed blood. He went on to say that the relationship between healthcare staff and wing staff was good, and that there was a good rapport between staff.

The Director of Healthcare for the Isle of Wight prisons, said at interview that there was increasing concern over the man's personal and social care. She explained that they were only commissioned to provide primary healthcare (those health services that provide a central role in the local community, such as GPs, pharmacists and dentists) at Albany, and that this does not include personal and social care. The Director of Healthcare said that she would not like to comment on the responsibilities of a wing officer in this area, but thought that many staff go "above and beyond their duty".

As the clinical reviewer notes, Albany is accommodating greater numbers of older and frail prisoners. There appears to be some confusion as to where the responsibility lies for providing personal and social care for those who need it. The man's buddies, on both F&G wing and on E wing, were a great help to him in this area and should be commended for their efforts. However, I am quite clear that it should not be the role of the buddy to help with the personal care of another prisoner. However, from interviews and statements of staff the lines of responsibility appear to be blurred. This has the potential to create conflict between healthcare and wing staff that is detrimental to the care of the prisoner.

The clinical reviewer makes the following recommendation, which I endorse:

The Governor and Director of Healthcare, together with the Primary Care Trust, should jointly discuss and produce guidelines on the provision of personal and social care for older or frail prisoners, including the roles and responsibilities of healthcare and wing staff.

Terminal care plans

The man's death, although expected, came about sooner than anticipated. The Director of Healthcare said at interview that staff were caught unaware by his death. She said that the expectation of how much longer the man might live varied from three or four weeks to five or six months. She added that they would expect the hospital consultant to lead on a terminal care pathway and plans for future hospice care.

The Director of Healthcare also said that she thought that the man's location on F&G wing was suitable. HMP Parkhurst has inpatient facilities, but she said that this would be very inappropriate for the man as it is used for prisoners with mental health problems. The Healthcare Manager agreed that the wing was a suitable location for the man. He said that, when he saw him on the last day of his life, the man presented well and seemed quite good, and he could not see any reason why he would need to be moved elsewhere. He added that, had there been the time, they would have looked at hospice care further down the line.

On the other hand, the man's personal officer felt that he should not have been on the wing and that hospital was "the only place for him". He raised this concern with the Duty Governor on the last day of the man's life. The wing manager agreed with the officer, and said that he felt that the best place for the man was a loca hospital. The disability liaison officer also felt that the man should have been in hospital rather than on the wing.

The clinical reviewer notes that, "no clear plan for advanced cancer/terminal care was agreed either between the cancer team (at the local hospital) or within the prison". There also appear to have been widely differing views on the most suitable accommodation where the man could be located. I do not consider that the prison should wait for the hospital consultant to take the lead in initiating this process. Rather, it should be a joint responsibility.

The clinical reviewer makes the following recommendation, which he repeats from a previous report into a death in custody at Albany:

Prison healthcare should review with the PCT Clinical Governance Unit the care pathway for a prisoner, where diagnosis of cancer is a significant possibility.

This recommendation was accepted in my previous report, and the prison provided the following response:

> "A care pathway will be developed which will detail the prisoner's wishes, attitudes and behaviour which may inform the care provided."

A target date of 1 December 2007 was given for completion of this action. I hope that this can be achieved.

The clinical reviewer also makes the following recommendation:

Where a prisoner is diagnosed with advanced cancer a case conference should be held, including clinicians from the local hospital, the healthcare team and PCT Commissioners.

Arrangements for outpatient appointments

On 2 May 2007, an appointment for a colonoscopy was booked for the man for 22 May. He subsequently spent time as an inpatient at the local hospital from 4-11 May, during which time he had a colonoscopy. The Healthcare Administrator at Albany spoke to the ward clerk at the hospital and confirmed that the procedure booked for 22 May would therefore be cancelled.

However, the colonoscopy on 10 May was not a success and was rebooked for the original slot on 22 May. Prison healthcare was not informed of this. For this reason, a member of staff at the hospital had to telephone the prison on 21 May to enquire why the man had not arrived in preparation for the procedure the following day. Fortunately, an escort was arranged at short notice and the man was transferred to hospital the same day.

I accept that healthcare staff at Albany were unaware of the man's appointment on 22 May, having been told that it would be cancelled. Nevertheless, it is fortunate that hospital staff made enquiries as to his whereabouts for otherwise he would have missed the procedure. It cannot be guaranteed that such enquiries would be made in future. The clinical reviewer therefore makes the following recommendation, which I endorse:

The Director of Healthcare should review arrangements for ensuring prisoners attend urgent outpatient appointments.

Compassionate release

Chapter 12 of Prison Service Order 6000 sets out the following criteria for compassionate release on medical 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.

As I have already commented, the man's death came sooner than anticipated. The Director of Healthcare at Albany spoke at interview of the uncertainty over prognosis, with estimates ranging from three to four weeks to five or six months. Her opinion was that the man was not at the stage where an application for release on compassionate grounds would be successful. Given the uncertainty over prognosis, I agree with the Director of Healthcare's view.

I am concerned, however, by her comment at interview that an application for compassionate release would normally be generated by the patient, or their solicitor on their behalf. Not all terminally ill patients will be well enough to think about such issues, and some prisoners may not be aware of the possibility of compassionate release. An application for compassionate release on medical grounds is something that should be considered by the Head of Healthcare and/or the Governor once it becomes clear that a terminally ill prisoner is approaching the stage where such an application might be successful.

Chapter 12 of PSO 6000 is implicit that Governors are expected to submit applications in cases which merit them. Early release on compassionate grounds is also featured in PSO 3050 (Continuity of Healthcare for Prisoners). This too demonstrates that applications do not have to be submitted by prisoners and that the onus is on the Governor to submit the application.

Issues raised by the man's family

My senior family liaison officer contacted the man's brother on 26 June 2007. The man's brother said that he had found it very difficult to arrange a visit in the final days of his brother's life, and that he could not speak to anyone about his brother's medical condition.

The man had a CT scan on 8 May 2007 that confirmed he had cancer of the colon. On the following morning, he was allowed to telephone his brother from hospital to tell him the news. Later that day, the man's sister-in-law telephoned the Healthcare Administrator to say that she and her husband wished to visit the man in hospital. The Healthcare Administrator explained

the procedure for arranging a hospital visit, and gave them a contact number in the security department. The man returned to Albany on 11 May before a hospital visit could be arranged.

The process for booking a standard visit at Albany is that the prisoner completes a visiting order with details including the visitor's name, date of birth and address. This is then passed to the correspondence office, who post it out to the proposed visitor following approval from the security department. On receipt of the visiting order, the proposed visitor must then contact the prison to book the visit.

The man's brother said that he received a visiting order two days after the man had died, and that it was not filled in correctly. He felt that he should have been allowed to see his brother given that he was seriously ill.

Prison Service Order (PSO) 4410 says:

> "Governors may allow one or more special visits, subject to medical advice, to a prisoner who is seriously ill. Restrictions on the number of visitors or the time of the visits should, wherever practicable, be waived in such cases."

It is unfortunate that the man did not have the opportunity of receiving a visit from his brother in the last days of his life. However, as I have previously observed, his death occurred sooner than expected. It was thought that he might live for another three weeks at least, and possibly for several months. I do not therefore consider the timing of the visiting order to be inappropriate (although it may be advisable in future to warn the next of kin in advance if such an item has already been posted prior to a prisoner's death).

However, the visiting order was not completed correctly when it was received by the man's brother. As a result, a new order would have had to have been completed and posted in order to facilitate a visit and a delay of several days would have occurred. Whilst it is a prisoner's responsibility to ensure that the details on a visiting order are correct, it would be extremely unfortunate if a terminally ill prisoner were unable to receive a family visit on account of such a mistake.

The Governor should ensure that visiting orders submitted by terminally ill prisoners are checked by a member of staff.

The man's brother also said that he could not speak to anyone at the prison about his brother's medical condition. I note that the man was permitted to telephone his brother from hospital on 9 May 2007 after his condition was diagnosed. His sister-in-law then spoke to the Healthcare Administrator over the telephone on the same day.

The Healthcare Manager told my investigator that medical information must not be passed over the phone to a relative or friend of a prisoner without first obtaining the prisoner's permission. He added that, if the prisoner was happy

for his condition to be discussed with a particular individual, then they would do so and that this has happened many times in the past.

It is unfortunate that the man's brother feels that he did not have the opportunity to speak to a member of healthcare staff at Albany about his brother's condition. I am satisfied that healthcare staff would have been happy to do so had the man given his permission. It is not clear, however, if he was ever asked this.

The Governor should ensure that, when appropriate, the next of kin of a terminal patient are given the opportunity to discuss the circumstances of the illness in detail with a member of healthcare staff.

Family response to the draft report

On 10 December 2007, I received comments on my draft report from the man's brother, on behalf of the his family. He raised a number of issues, which I will deal with in turn.

Emergency response on the night that the man died

The man's brother commented that it was some time before his cell was unlocked on the night of his death, as a result of which it was some time before he was transferred to hospital. The man's brother therefore felt that he was denied medical care from hospital staff.

When he unlocked the man shortly after 11.10pm, the prison officer noted that, whilst he was "clearly having difficulty breathing", the man was coherent and able to hold a conversation. The officer helped the man to sit up on his pillow, and this calmed him down a little. At this point, the officer returned to the wing office to seek the appropriate medical advice (by telephone to the night nurse at HMP Parkhurst). Shortly afterwards the call was returned to the night orderly officer and he was advised to request an ambulance, which he did.

The telephone call to request an ambulance was made from the prison at around 11.20pm, approximately ten minutes after the officer was first alerted to the man's cell. The ambulance arrived at around 11.25pm, and it was at this point that the man began to deteriorate. The ambulance crew treated the man in his cell for around 25 minutes before he was transferred to hospital, where he later died.

Given these circumstances, I am satisfied that the officer and night orderly officer acted appropriately on the night in question.

Was the wing a suitable environment for the man?

The man's brother thought that he should have been in hospital several months before his death, rather than being cared for on a prison wing.

There was a difference of opinion between those persons interviewed by my investigator with regard to the most suitable environment in which to care for the man. The healthcare professionals who were interviewed thought that the wing was a suitable environment. However, the discipline staff who were interviewed all thought that the man should have been in a hospital rather than on the wing.

As I have noted previously in this report, the man's death came about sooner than expected. However, the clinical reviewer notes that there was "no clear plan" agreed for the man's advanced care either between the cancer team at the local hospital or within the prison. The clinical reviewer subsequently made two recommendations with regard to terminal care plans (see recommendations 2 and 3), both of which were accepted.

The visiting system at Albany

The man's brother was critical of the visiting system at Albany, in particular that his brother had to complete the visiting order himself despite being very ill. In my draft report, I recommended that "the Governor should ensure that visiting orders submitted by terminally ill prisoners are checked by a member of staff". This recommendation was partially accepted by the Governor, and he commented that "the FLO (Family Liaison Officer) team will monitor visit applications and maintain personal family contact if the offender gives agreement".

The buddy system

The man's brother was complimentary about the work done by the buddies, and said that he would write to them to thank him for the care that they gave his brother. The man's brother went on to say that he thought that the buddies should receive medical training.

The purpose of the buddy system is to help with social care for those prisoners who need it. This encompasses tasks such as collecting meals for a prisoner, or helping with cell cleaning. In the man's case his buddies went a step further and helped with his personal care, a task that is beyond their remit but for which, as I have said earlier, they should be commended.

As I discussed earlier, it should not be the role of the buddy to help with the personal care of another prisoner. I am also clear that it would not be appropriate for buddies to provide medical care for another prisoner. I do not therefore consider it necessary for buddies to undertake formal medical training.

RECOMMENDATIONS AND GOOD PRACTICE

The Governor and Director of Healthcare, together with the Primary Care Trust, should jointly discuss and produce guidelines on the provision of personal and social care for older or frail prisoners, including the roles and responsibilities of healthcare and wing staff.

Accepted – a joint proposal has been submitted to the PCT.

Prison healthcare should review with the PCT Clinical Governance Unit the care pathway for a prisoner, where diagnosis of cancer is a significant possibility.

Accepted – Prison Care Pathway now in place. This will be reviewed by the Task Force and the PCT.

(This recommendation was made in a previous PPO report on a death at Albany. The response was: "A care pathway will be developed which will detail the prisoner's wishes, attitudes and behaviour which may inform the care provided". This was completed on 1 December 2007.)

Where a prisoner is diagnosed with advanced cancer a case conference should be held, including clinicians from the local hospital, the healthcare team and PCT Commissioners.

Partially accepted – Involvement with PCT Commissioning occurs but clinical involvement is subject to ongoing discussions. Talks are ongoing through the Task Force and the PCT.

The Director of Healthcare should review arrangements for ensuring prisoners attend urgent outpatient appointments.

Partially accepted – No urgent appointments have been missed. This was an administrative error by the PCT. The establishment Health Care had not been advised of the appointment. In the event, the appointment was still attended on the day listed by the PCT.

The Governor should ensure that visiting orders submitted by terminally ill prisoners are checked by a member of staff.

Partially accepted – When this information is known to staff, the FLO team will monitor visit applications and maintain personal family contact if the offender gives agreement.

The Governor should ensure that, when appropriate, the next of kin of a terminal patient are given the opportunity to discuss the circumstances of the illness in detail with a member of healthcare staff.

Partially accepted – Information must not be passed over the phone to a relative or friend of an offender without first obtaining the offender's

permission. If the offender is agreeable for his condition to be discussed with a particular individual, then Health Care staff would do so. This is currently the method in place and has happened numerous times in the past.

GOOD PRACTICE

The buddy system at Albany works well. The man's buddies should be commended for the help and support that they gave him.

A Family Liaison Officer at another prison was asked to break the news of his death to the man's next of kin, as they lived near to that prison.