Investigation into the death of a man in June 2004 at a hospital in Newport, Isle of Wight whilst a serving prisoner at HMP Albany

Prisons and Probation Ombudsman for England and Wales
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This is the report of an investigation into the death of a man on 22 June 2004 at a hospital on the Isle of Wight whilst a serving prisoner at HMP Albany.

My office investigates the death of all prisoners in custody including those due to apparent natural causes. In this case the investigation was carried out by my Deputy Ombudsman who is also a registered general nurse. As a clinician she was able to incorporate the clinical care afforded to the man as part of the investigation process.

I wish to extend my condolences to the family and friends of this man for their loss.

This report demonstrates the compassion and sensitivity with which the man was cared for by the staff and management of HMP Albany. They have reason to be proud of their efforts.

This version of my report, published on my website, has been amended to remove the name of the deceased and any names of staff or prisoners that assisted with this investigation.

Stephen Shaw
Prisons and Probation Ombudsman for England and Wales

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Summary

In 1996, this man was convicted of rape and sentenced to 15 years imprisonment. He transferred to HMP Albany to undertaken offending behaviour courses.

In 2002, he complained of chest pains and was promptly referred to specialist healthcare services. By February 2004, he had undergone two major cardiothoracic operations and had been diagnosed with terminal lung cancer. The man was admitted to the local hospital in June 2004 with end stage cancer. Whilst in hospital the escorting staff assisted in the care of him, actively supporting him and his social and emotional needs.

He died peacefully on 22 June 2004 in hospital. The cause of death was cancer of the lungs.

HMP Albany

HMP Albany occupies the site of a former military barracks on the outskirts of Newport, Isle of Wight. Albany has never been particularly popular with most prisoners due to a location that can make domestic visiting difficult.

Albany operates as an Assessment Centre for the core Sex Offender Treatment Programme. The population is almost entirely made up of sex offenders.

The medical services are clustered with Parkhurst and Camp Hill. A primary care centre provides healthcare services during the core day and at weekends. Those prisoners requiring 24-hour healthcare are either admitted to the local acute hospital or transferred to HMP Parkhurst which has an inpatient facility.

Events leading up to the man's death

The man had an unremarkable first six months in custody. He was transferred to HMP Albany to undertake the Sex Offender Treatment Programme and address his offending behaviour.

In April 2004 he started to complain of chest problems. He was immediately referred to the cardiothoracic consultant. By July 2002, a cardiac catheterisation had been arranged to establish a formal diagnosis. Following the catheterisation it was decided that the man required coronary artery bypass grafts.

In September, he was admitted to the cardiac unit at a hospital in Brighton. The admission to Brighton was because there were no available beds at the nearby general hospital's cardio-thoracic unit. Despite the distances involved for the escorting staff, the Governor ensured that the admission went ahead. It did cause the Governor significant staffing problems at Albany and meant the regime for the other prisoners was affected.

The man underwent a triple coronary artery bypass graft on 27 September 2002. He made a good recovery and returned to Albany in October.

On 14 March 2003, he experienced an episode of chest pain and was promptly referred to Accident and Emergency at the local hospital. The man was subsequently admitted to the Coronary Care Unit for a period of assessment and pain management.

In late January 2004, he underwent a thoracotomy for further chest problems. No interventions were carried out during the operation due to the extent of the disease process. His thoracic cavity was therefore surgically closed immediately.

Following the 'open and closed thoracotomy', healthcare staff contacted the consultant to discuss the prognosis. Arrangements were made for the man to transfer to HMP Winchester if required.

On 20 April 2004, the man was formally advised that he had inoperable and incurable cancer of the left lung that had spread to his lymph nodes. He asked to know how long he "had left". Whilst not making any guarantees, the consultant advised him on 27 April that he thought it would be three to six months.

The consultant arranged for palliative radiotherapy to commence in May. Whilst this would not cure the man's cancer it would provide palliative support. The local McMillan Nurses were also contacted and began visiting at Albany to provide terminal care and support for the patient and those caring for him. A good relationship was developed with the McMillan nursing team and healthcare staff felt well supported by them.

The man was managed in the normal residential environment. This ensured that he was in familiar surroundings with people whom he knew well and trusted. Whilst arrangements had been put in place for his to transfer to HMP Winchester, it was

decided that this was not appropriate. Agreement was reached with the man that, as long as he could physically tolerate the daily trips over the Solent for radiotherapy treatment, they would be facilitated by Albany.

On 14 June 2004, the man was admitted to hospital. His health continued to deteriorate and on 16 June a decision was taken to remove the physical restraints.

Whilst in hospital, the man requested to make his Last Will and Testament. An officer e facilitated this and arranged for a prisoner to be escorted to the hospital to visit the man and witness his Last Will and Testament.

Following the man's admission to hospital, his sister was informed of his condition and prognosis. She was able to visit her brother and officers ensured she was given support and privacy during these visits.

The man died peacefully on 22 June 2004 accompanied by two officers. Throughout his final admission to hospital the escorting officers were fully engaged in his care, ensuring his needs were promptly and appropriately met.

Response of the establishment post death

Following the death of the man, the establishment activated the necessary procedures. All staff and prisoners were informed of his death and support made available if required.

The funeral was held on the morning of 5 July followed by a memorial service at the prison that had his sister's blessing.

The Deputy Governor ensured that the requests of the man's Last Will and Testament were actioned promptly and sensitively.

Conclusions and Recommendations

The man first experienced chest problems in April 2002. He was promptly referred to secondary care services and then onto specialist cardiac care services. Despite the distances involved in facilitating the clinical care and management of him escorts were quickly arranged and managed appropriately and effectively.

In 2004, when he was given a diagnosis of terminal lung cancer, a professional relationship was established with the local McMillan Nursing Services. This ensured that the care received was effective palliative care and support. It also ensured that the healthcare team at Albany were aware of the man's management and care plan.

Following the man's final admission to the local hospital, a security risk assessment quickly identified that he was low risk. It was decided that the cuffs should be removed and he would be formally on an escorted absence. The man had staff with him whilst in hospital which ensured his social care needs were met.

The man made a request to an officer to make his Last Will and Testament. The officer arranged for this request to be met and furthermore made arrangements for another prisoner to visit the man and act as witness to the Will.

The officer should be commended for the compassionate, prompt and timely manner in which he facilitated the man's request.

In conclusion, this man was cared for and managed in a sensitive way throughout his illness by all staff at HMP Albany.

Recommendations

The officer should be commended for the compassionate, prompt and timely manner in which he facilitated the man's request to make his Last Will and Testament.