Investigation into the circumstances surrounding the death of a man in October 2010 whilst in the custody of HMP Isle of Wight - Albany

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the death of a prisoner at HMP Isle of Wight - Albany who died on 24 October 2010. He was taken to outside hospital on 21 October and he remained there until he died of pneumonia three days later. He was 80 years old.

I would like to offer my sincere condolences to all those affected by his death.

The investigation was undertaken by one of my investigators. I would like to thank the Acting Governor of HMP Isle of Wight - Albany and his staff for their assistance during the investigation. A clinical review into the man's medical care at Albany was commissioned from Isle of Wight Primary Care Trust. They appointed a doctor to conduct the review and I am grateful for his report.

The clinical review carried out by the doctor and a panel of his colleagues concludes that the man's clinical care was not comparable to what could have been expected in the community. I endorse their recommendations concerning delays to hospital appointments, appointing lead clinicians, reviewing end of life policy, access to prisoners at night and ensuring information is fully recorded in medical records.

I make no separate recommendations.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman October 2011

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SUMMARY

1. The man was born in 1930. He was 80 years old when he died on 24 October 2010 at outside hospital. The man died of natural causes as a consequence of pneumonia caused by chronic obstructive pulmonary disease (narrowing of the airways causing shortness of breath), ischaemic heart disease, diabetes and peripheral vascular disease (blocked arteries).

2. The man was remanded into custody by a Magistrates' Court on 17 March 2006. He was later sentenced to ten years imprisonment and transferred to HMP Isle of Wight – Albany on 21 September.

3. Whilst he was in custody the man was diagnosed with diabetes, an abdominal aortic aneurysm (a defect in the large blood vessel in the abdomen) and blocked arteries in his leg. The man was also a smoker, he was offered and declined assistance to help him stop smoking.

4. In July 2008, the man was diagnosed with blocked arteries in his left leg. A referral was made to a podiatrist for tests to be carried out. Nearly a year later, on 29 June 2009, it was recorded that the tests had still not been carried out on the man's leg and this was arranged for 3 July. After the tests were carried out it was decided to refer the man to a vascular surgeon. He was seen on 17 September, and diagnosed with an abdominal aortic aneurysm. An operation to repair the aneurysm took place on 9 March 2010.

5. On 27 June, the man was taken to outside hospital where he was diagnosed with pneumonia. He was discharged from hospital on 5 August. On 23 September, the man returned to hospital suffering from dehydration, urinary tract infection and infected ulcers. However, he discharged himself three days later and was admitted to the Inpatient Healthcare Unit on his return to Albany. On 22 October, after the man was seen by a prison doctor he was again taken to hospital. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment concluded that restraints were not to be used and two officers remained at the man's bedside. His health continued to deteriorate and the man passed away at 5.12pm on 24 October.

6. The clinical review carried out by a doctor and a panel of his colleagues, on behalf of Isle of Wight Primary Care Trust, considered the care provided for the man. In the clinical reviewer's view, the quality of care given to the man was not equivalent to what he would have received in the community. The clinical reviewer makes seven recommendations for service improvement which I endorse. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them.

7. I make no further recommendations.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 25 October 2010. Notices were subsequently issued to both staff and prisoners at HMP Isle of Wight – Albany to inform them of the investigation process and asking anyone who had information relevant to my investigation to contact the investigator. No responses were received. The investigator also studied all the relevant prison records relating to the man. They included his main prison record and his medical records.

9. A clinical review was commissioned from Isle of Wight Primary Care Trust into the care provided for the man during his time in custody. The purpose of this review is to establish whether the care which the man received in prison was equitable with that he would have expected in the community and to identify any points of learning. A doctor was appointed to lead the panel review of the man's clinical care. I am grateful for his review, which I received on 25 March 2011, and it is annexed to my report.

10. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

11. The man was estranged from his family and sadly, therefore, the prison has been unable to locate any family members to inform them of his passing. I too have no contact details for any members of the family. This has meant that my office has been unable to address specific concerns that the family might have had, as part of this investigation.

12. The investigator visited HMP Isle of Wight – Albany on 28 October spoke to the Head of Healthcare as well as other staff involved in the care of the man. He returned on 6 and 13 December and 6 January 2011. The investigator interviewed both medical and discipline staff. All interviews were recorded and transcripts are appended to this report.

13. After completing the interviews, the investigator wrote to the Acting Governor, on 31 January 2011, to confirm the emerging issues from the investigation.

HMP ISLE OF WIGHT - ALBANY

14. HMP Isle of Wight was established on 1 April 2009 and has approximately 1,700 prisoners on the three sites, Albany, Parkhurst and Camp Hill. Each site has its own Director who reports to the Acting Governor.

15. Albany is a category B training prison. It opened in 1967 on the site of a former military barracks. Albany offers a varied regime with education and several offending behaviour programmes (designed to assist prisoners in addressing their offending behaviour). At the time of the man's death, the prison could hold up to 567 adult male prisoners. The average age of Albany's population is high compared to most jails.

16. The Albany site has five wings (A – E) that are almost identical and hold between 94 and 96 prisoners in single cells with in-cell power. Prisoners have access to electronic night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small 'spurs' on each landing, with communal recesses containing showers, toilets and wash basins. There are also two 40-bed units (F and G) which consist of single cell accommodation with en-suite facilities.

17. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). A new Inpatient Healthcare Unit (IHU) was opened in October 2009 and is situated on the Albany site. It has 14 beds and is designed for prisoners with a wide range of mental health, general medical, surgical, rehabilitative and health-related respite needs, who require inpatient care within a prison setting.

18. Prison Healthcare General Practitioner (GP) services are provided by Beacon - a partnership between the provider arm of the PCT and Lighthouse Medical Ltd. The GPs undertake a total of seven 3.5 hour sessions per week in Albany – this covers the primary care centre, segregation unit and IHU. Beacon also provides the GP cover for the walk in centre at St Marys Hospital. The same group of doctors cover the out of hours' prisoner needs – with first point triage (decision making process designed to manage clinical risk) by a GP.

19. A risk assessment must be completed when a prisoner attends hospital inpatient and outpatient appointments. This is to determine the level of escort and the restraints (handcuffs or an escort chain - a set of handcuffs connected by a length of chain) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary, and prison staff are allocated to carry out an escort for the prisoner. If a prisoner is admitted to hospital, prison staff will carry out a bedwatch duty and complete a log of activities. A regular management check of the bedwatch will be carried out by a duty governor. (Visits from family may be allowed but these will be closely monitored to ensure that they do not affect on the security of the bedwatch.)

20. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders. The aim of MAPPA is to ensure that a risk management plan that is drawn up

for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA.

21. There are three levels of MAPPA:

- Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
- Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
- Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

When the man arrived in custody he was assessed as MAPPA Level 1.

22. The investigator reviewed the Ombudsman's reports into earlier deaths at HMP Isle of Wight - Albany. He found no issues in common between the earlier deaths and that of the man.

HM Chief Inspector of Prisons report

23. The first inspection of the new HMP Isle of Wight by HM Chief Inspector of Prisons was in October 2010.

24. In his introduction to the report of the inspection, the Chief Inspector, Nick Hardwick, said:

> "HMP Isle of Wight is, in many ways, the sum of its three disparate parts: Parkhurst, Albany and Camp Hill prisons. However, the single senior management team has worked hard to combat the many frailties and unique – and sometimes negative – cultures of the three sites, and has had some success. Thus Parkhurst, which was the subject of coruscating previous criticism from the Inspectorate, has demonstrated considerable improvements in terms of safety and decency. There has also been some improvement at Albany."

25. With regard to hospital appointments, Mr Hardwick recorded that a large number of appointments had to be rescheduled and that an average of 40% of the external appointments had been cancelled on at least one occasion.

Independent Monitoring Board (IMB) Report

26. A prison's Independent Monitoring Board (IMB) is appointed by the Secretary of State for Justice from volunteer members of the community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also

submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.

27. The most recent annual report published by the IMB at HMP Isle of Wight is from 2009/2010, and also drew attention to the number of hospital appointments which were cancelled. The report said:

> "The lack of transport of prisoners to a hospital appointment has caused problems. Since July this year [2010] there have been 336 cancelled appointments; 11% attributed to the prison not being able to deliver the prisoner, 19% the prisoner not wanting to attend, and remainder being the hospital cancelling the appointment. There is often a lack of communication between St Mary's, the Healthcare Centre and IHU."

KEY EVENTS

28. The man was born in 1930 in Manchester. He was 80 years old when he died on 24 October 2010 at outside hospital.

29. After he left school the man joined the Merchant Navy. He left after serving for 20 years and then worked as a lorry driver until he retired. The man was single and told staff at Albany that he had a brother living in Australia but had no contact with him nor wanted any. Prior to his arrival in custody the man was in receipt of state benefits.

30. The man was remanded into custody on 17 March 2006 by a Magistrates' Court after being charged with sexual offences. He arrived at HMP High Down on the same day and moved to HMP Wandsworth on 3 April 2006. The man was sentenced on 12 June to ten years imprisonment at Crown Court. He transferred to HMP Isle of Wight - Albany on 21 September. This was his first time in prison.

31. The first reception health screening forms completed when the man arrived at High Down were blank apart from his name, date of birth and his offence. When the man moved to Wandsworth it was recorded that he been previously diagnosed with angina but had not seen a cardiologist. It was also recorded he had no chest pain at that time. When the man arrived at Albany, it was recorded that he was fit and well on admission. It was also recorded that the man was smoker but refused any assistance to help stop.

32. The man was categorised as a category B prisoner. (All adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape.)

33. On 11 July 2008, the man was seen by a prison doctor who found that he had claudication (this is the name given to pain in the leg caused by "furred up" or blocked arteries) in his left leg. The man was referred to a podiatrist (who assess, diagnose and treat abnormalities and diseases of the lower limbs) for tests to be carried out. He was also referred to the Urology Department at a local hospital as the doctor had concerns about the man's testes. Nearly two months later, on 10 September, the man attended an out-patient urology appointment.

34. Following blood tests which were carried out in August and October, the man was diagnosed, on 4 November, with Type 2 diabetes (also known as non-insulin dependent diabetes mellitus) and prescribed metformin (an oral antidiabetic medication).

35. The man attended a further outpatient urology appointment on 10 December.

36. On 8 May 2009, the man was seen in a pre-operative clinic regarding an operation on his testes which was due to take place on 21 May. However, three days before the operation on 19 May, the man was told that it was going be postponed by the hospital until 23 September.

37. On 27 May, the man was seen by prison doctor concerning the claudication in his leg. The doctor who noted that the podiatrist referral appeared to not have been sent as it had still not taken place and re-referred the man.

38. In her letter dated 18 June, in response to an enquiry from the man's solicitor, the Head of Reducing Re-offending at the prison clarified the criteria for early release on compassionate grounds. The criteria are that early release may be considered when a prisoner is suffering from a terminal illness and death is likely to occur soon. Early release may also be considered where the prisoner is bedridden or severely incapacitated. She confirmed that the man did not meet the criteria for early release on compassionate release.

39. On 29 June, the man was seen by a prison doctor as he still had pain in his leg. The doctor noted that the tests had still not been carried out on the man's leg and this was arranged for 3 July, almost a year after he was first referred. After the tests were carried out it was decided to refer the man to a vascular surgeon.

40. On 4 September, the man was told that the operation on his testes was being rescheduled by the hospital and would now take place on 16 December. Just under two weeks later, on 17 September, the man was seen by a vascular surgeon who diagnosed an abdominal aortic aneurysm[1].

41. On 30 November, the man's operation on his testes was again cancelled by the hospital. It was later recorded that the operation would be postponed until the issues relating to his aneurysm were fully resolved. The man went to a hospital on the mainland, on 9 March 2010, for an operation to repair his abdominal aortic aneurysm.

42. The man was discharged from hospital on 23 March and was initially admitted to the Inpatient Healthcare Unit (IHU) at Albany. The following day he requested to return to his own cell on the wing.

43. On 2 April, staff on the wing asked if someone from healthcare could see the man. Wing staff were concerned that he appeared to be frail and very weak. The man was also not coming out of his cell. A Healthcare Manager visited the man and made the following entry in the medical record: "… not his usual feisty self has not mobilised and is spending long periods in his chair, I have said that he can mobilise within the confines of the unit but not to over do it."

[1] This is widening or bulging of the aorta (the largest blood vessel) in the abdomen. This usually occurs at a weak spot in the aortic wall. It often does not cause any symptoms, but if the aneurysm widens rapidly it may cause abdominal pain which can be severe. If it bursts (ruptures) this can be fatal.

44. On 27 June, the man was taken to outside hospital as he was having problems with his breathing. After his admission to hospital he was diagnosed with pneumonia. His condition continued to deteriorate and he was admitted to the Intensive Treatment Unit as he required assistance with his breathing. Just under a month later, on 26 July, the man came off of the ventilator and moved onto a general ward. He was discharged from hospital on 5 August but refused to be admitted to the IHU and chose to return to the wing. On his return from hospital it was recorded that the man had painful heels and that these were to be monitored. Three days later, on 12 August, the man was seen on the wing and still refused to transfer to the IHU.

45. After being visited by a nurse the man was admitted to the IHU at Albany on 21 August due to the problems with his heels. An urgent order was made for a pressure relieving mattress which was received nine days later, on 30 August. The man's heels were dressed and treated with antibiotics. During the night of 4 September, the following entry was made in the man's record: "Speak with tissue viability nurse for advice when necessary – Due to the deterioration of the man's left foot, I will ring on Monday for advice."

46. There were no further entries about contact with the tissue viability specialist until 16 September when it was recorded that a message had been left on their answer phone.

47. In the prison assessment for the Parole Board completed on 23 September, the following entries were made by a Nursing Sister and the man's personal officer (each prisoner is allocated a personal officer, who is the first point of contact for them). The personal officer wrote:

> "I have known and worked with the man since he transferred to Albany in 2006 as I have been a wing officer on C wing and now G wing. He was an OAP [old aged pensioner] and therefore did not attend any workshop. He is now located [on] IHU due to health problems where he can receive 24 hour medical treatment. I would state that release on parole to some form of hospital or home should be an option."

48. The Sister wrote:

> "As the senior nurse in the IHU due to the man's age and current medical state I am not able to give an opinion at this time on his diagnosis as test from hospital have not been sent to us yet. His current medical state is such that it will input severely on any release plan."

49. When interviewed as part of this investigation, the Sister described the man as "a grumpy old man" and that she found him "quite endearing even though he was quite rude when he wanted to be". The Sister confirmed that the man was reluctant to initially move to the IHU. She said that it was only after his return from hospital in August that he agreed to be admitted to the IHU. The Sister also confirmed that, after the man had been admitted to IHU and had been

"quite poorly", permission was given for his cell door to be left unlocked during patrol state. [2]

50. Following the interview with the Sister, the problem of access to prisoners during patrol state was discussed with the Head of Healthcare. He was concerned that healthcare staff were giving incorrect information during interviews about the issue of access to prisoners during patrol state. The Head of Healthcare shared the agreed policy between the prison and IHU and it decided that access to prisoners during patrol state would be discussed at the review panel meeting.

51. The man was admitted to hospital, on 23 September, suffering from dehydration, urinary tract infection and infected ulcers. He discharged himself from hospital three days later, on 27 September, against medical advice, and was again admitted to the IHU on his return to Albany. On 30 September, the man was taken to a hospital on the mainland for an angiogram (blood vessel x-ray) returning to Albany on the same day.

52. At around 9.00am on 21 October, the man was discovered by a nurse on his knees in front of his wheelchair. There was no apparent injury and the man did not complain of any pain. The report form (F213) completed later by staff contained the following information:

> "He said he came out of bed because he saw a 'man' in the corner and people were interfering with the electricity. He was obviously hallucinating. The out of hours GP service contacted 2pm approx to inform a doctor of the man's fall and also his deteriorating condition i.e. confusion."

53. During the morning of the following day, the man was seen by a prison doctor who recommended that the man be taken to the Medical Assessment Unit at the local hospital. He was later admitted to a ward at 8.30pm. Whilst the man was in hospital his health continued to deteriorate. The initial risk assessment was that restraints were not to be used and two officers should remain on duty at his bedside ('bedwatch'). A log of activities was maintained by the officers on bedwatch duty and this was checked on a regular basis by a visiting duty governor.

54. The bedwatch log entry records that the man died at 5.12pm on 24 October.

55. After the man died, the prison activated its death in custody contingency plan. The police visited the hospital and found no suspicious circumstances.

56. Prisoners were informed of the man's death after they were unlocked on 25 October. They were also asked whether they required any support or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide

[2] After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.'

confidential emotional support to fellow prisoners in distress.) All the prisoners on the Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime were reviewed. (ACCT is the Prison Service's procedure for supporting and monitoring prisoners believed to be at risk of suicide or self-harm.) When the officers on bedwatch duty returned to Albany, they were offered support from the prison's care team.

57. Staff at Albany tried unsuccessfully to contact any remaining members of the man's family to inform them of his death. As the man had no family or friends to organise a funeral, the prison took responsibility. The man's funeral took place on 9 November, the service was conducted by a prison chaplain and he was buried on the Isle of Wight. A memorial service was held at Albany on the following day, 10 November, and this was well attended by both prisoners and staff.

58. The post mortem report records the man's death as being due to natural causes, as a consequence of pneumonia, caused by a chronic obstructive pulmonary disease, ischaemic heart disease, diabetes and peripheral vascular disease.

ISSUES

Clinical care

59. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Isle of Wight Primary Care Trust. The clinical reviewer convened a review panel. The panel met on 28 January 2011.

60. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. However, in his review the clinical reviewer draws attention to the delays in the treatment received by the man. It appeared that referrals were not moved forward by healthcare staff. As mentioned previously, the man developed symptoms of poor circulation in his legs in July 2008 and it was nearly a year before he was referred to a vascular surgeon. He was diagnosed with an abdominal aortic aneurysm in September 2009 which was repaired in March 2010. The clinical reviewer also notes that there were delays in the man being diagnosed as a diabetic.

61. The panel recommends that staff at the prison work with colleagues from the local hospital to reduce the delays in prisoners being seen in outpatient clinics and other investigations. The panel recommends that healthcare staff improve the quality of care provided to prisoners with long term conditions, such as diabetes or heart disease. In addition the panel states that having lead GPs at each site (Albany, Camp Hill and Parkhurst) could lead to improvements in the continuity of care for prisoners. This will also help ensure that when abnormal test results are received they are acted upon in a more timely fashion.

62. I am concerned that the man clearly did not receive good continuity of care between the prison and hospital and endorse the following recommendations of the clinical review panel.

    The Head of Prison Healthcare should ensure that his staff liaise with colleagues at the local hospital to reduce delays for prisoners attending medical appointments.

    The Head of Prison Healthcare should review the services provided to prisoners with long term chronic conditions.

    The Head of Prison Healthcare should consider appointing lead GPs for each site to improve continuity of care for prisoners.

63. The panel were concerned that the healthcare unit of the prison does not appear to have adopted an End of Life policy, including the use of Do Not Actively Resuscitate forms. During discussions at the review panel, HMP Norwich was cited as having an effective policy in this area.

64. I would expect to see appropriate policies in place to ensure someone at the end of life is managed in an effective and dignified way. It is also extremely important that the issue of whether to resuscitate or not is effectively recorded.

The Head of Healthcare should consider adopting an End of Life policy for prisoners who are terminally ill and make use of Do Not Actively Resuscitate forms to effectively record such decisions.

65. When the man returned to Albany in August 2010 he was found to have "scuffed" his heels whilst in hospital but there were delays to him being assessed by a tissue viability specialist. From the records made available to the investigator and clinical reviewer it did not appear that prompt action was taken to deal with the man's condition. The panel were concerned with the lack of accurate assessments and access to suitable advice and appliances for the man. I am also concerned and endorse the panel's recommendation.

The Head of Healthcare should review care given to prisoners who need pressure area/bandaging care to ensure that proper, accurate and timely assessments are made and that support is available.

66. During the review meeting access to cells at night was discussed in detail and it was clear that this has been addressed in an agreement between the prison and healthcare staff. However, the policy appears to have not been widely disseminated, and it was felt that staff required training as to when risk assessments should be performed to facilitate appropriate access for prisoners. This agreement is a key policy in relation to speedy access to prisoners who may need healthcare assistance and it is important that staff are fully aware of when and how to safely access cells.

The Governor and Head of Healthcare should ensure that all staff are aware of the policy relating to access to cells at night and during patrol status and that staff receive appropriate training to support this.

67. Efficient record keeping ensures that key information is available when required. The panel agreed that healthcare staff need to ensure that all contacts with GPs out of hours are appropriately recorded in the prison medical records.

The Head of Healthcare should ensure that all staff promptly record all contacts with the out of hours service in the prisoners medical records.

68. In his review, the clinical reviewer said that the care provided to the man:

> "… fell below that expected of normal NHS care, both in primary and secondary care. His access to hospital services was affected by the many postponed appointments which were in part due to the lack of escorts from the prison, but also cancelled appointments by the hospital. Though his care was in some respects sub optimal, the deterioration of his health was largely unrelated to these issues. It was more that opportunities might have been missed had other conditions

been developing at that time, and addressing these issues will benefit the care of others in the future."

Use of restraints

69. As previously mentioned, when the man returned to hospital, on 22 October, two officers remained with him at his bedside and restraints were not used. I am pleased that the prison adopted this sensitive approach, affording the man some dignity in what were to be his last days.

70. The investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Albany. The Governor may wish to share this with his managers and staff.

CONCLUSION

71. The man arrived at HMP Isle of Wight – Albany on 21 September 2006. He was an elderly prisoner who had an operation to repair an abdominal aortic aneurysm on 9 March 2010. Just over six months later, on 21 October, he was taken to outside hospital where he died three days later of pneumonia.

72. I concur with the view of the clinical review panel that the standard of the man's medical care whilst he was at Albany was not equivalent to what can be expected in the community, particularly in relation to continuity of care between the hospital and the prison. The review panel has made seven recommendations which I endorse. These will need to be addressed by the Isle of Wight Primary Care Trust in partnership with the Governor of HMP Isle of Wight.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations made. That response is included in italics below each recommendation.

1. The Head of Prison Healthcare should ensure that his staff liaise with colleagues at the local hospital to reduce delays for prisoners attending medical appointments.

   Accepted - There is already a considerable degree of liaison and joint working in place on the matter of access to secondary care appointments and this work is ongoing. A further meeting is planned in August 2011 with the relevant service managers at St Mary's Hospital aimed at agreeing further measures to streamline systems at the St Mary's end of the process.

2. The Head of Prison Healthcare should review the services provided to prisoners with long term chronic conditions.

   Accepted - These services are already under review and are the focus of further work to develop improved chronic disease registers, Quality and Outcomes Framework compliant services and an increased range of nurse led clinics.

3. The Head of Prison Healthcare should consider appointing lead GPs for each site to improve continuity of care for prisoners.

   Partially accepted - It is not within the authority of the Head of Prison Healthcare to appoint lead GPs for each site of HMP Isle of Wight. The GP service is provided under a separate contract with local NHS Commissioning. A Lead GP for each prison site is already in place to improve continuity of care but with other GPs also providing clinics in order to offer a choice of GPs to patients and ensure a robust service.

4. The Head of Prison Healthcare should consider adopting an End of Life policy for prisoners who are terminally ill.

   Accepted - As an integral part of NHS Isle of Wight, we implemented the procedures and documentation for the "Liverpool Care Pathway for the Dying Patient (LCP) supporting care in the last hours or days of life" within Prison Healthcare Services in HMP Isle of Wight in February 2011 as part of work already identified and underway in 2010, that included training of staff. The South Central Do Not Attempt Resuscitation documentation is integral to this and is now in use.

5. The Head of Prison Healthcare should review care given to prisoners who need pressure area/bandaging care to ensure proper assessments and support is available.

Accepted - The Lead Nurse/Modern Matron for Prison Healthcare is working in conjunction with the NHS Isle of Wight Tissue Viability Specialist Nurse to address this particular issue.

6. The Governor and Head of Healthcare should ensure that all staff are aware of the policy relating to access to cells at night and during patrol status.

   Accepted - The existing jointly agreed arrangements relating to access to bedrooms/cells in the Inpatient Healthcare Unit (IHU) have been re-circulated to all Prison Healthcare staff and also to senior HMP Isle of Wight colleagues for communication to colleagues in the wider local prison context.
   The IHU Operational Procedures are currently being updated to reflect developments and changes within systems and processes (including adjustments to prison regime).

7. The Head of Prison Healthcare should ensure that staff promptly record all contacts with the out of hours service in the prisoners medical records.

   Accepted - Audits of records and documentation are undertaken. It is likely that during 2010/11 we will be adopting a similar audit system to that used by other areas within NHS Isle of Wight for auditing records under the "Productive Ward" framework.