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

Report by the Prisons and Probation Ombudsman for England and Wales

November 2011

This is the report of an investigation into the death of a prisoner at HMP Isle of Wight - Albany, who died on 6 December 2010. He had complained of feeling unwell the previous evening and was checked throughout the night but was found dead when his cell was unlocked the following morning. The man was 72 years old.

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

The investigation was carried out by one of the Ombudsman's 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. I am grateful for the report.

The clinical review carried out by a doctor and a panel of his colleagues concludes that the man's clinical care was not comparable to what he could have expected in the community. Whilst this did not directly cause or significantly contribute to the death, I endorse their recommendations concerning delays to hospital appointments, screening of medication for new prisoners, ensuring information is fully recorded in medical records and reviewing arrangements for access to health services during patrol state.

The problems encountered by the man in relation to postponed and cancelled hospital appointments has been previously raised by my office in relation to other deaths at Albany. It has also been highlighted in reports by Her Majesty's Inspector of Prisons and the Independent Monitoring Board at HMP Isle of Wight. I would ask the Governor and Head of Prison Healthcare to review this in light of the further evidence of delays and postponements highlighted in this report.

All of the recommendations made in the draft report have been accepted by HMP Isle of Wight I have included the prison's response to the recommendations at the end of this report.

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
Deputy Prisons and Probation Ombudsman **November 2011**

SUMMARY

1. The man was born in 1938. He was 72 years old when he died on 6 December 2010 in his cell on B wing at HMP Isle of Wight - Albany. 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).

2. On 23 June 2006, the man was sentenced to an indeterminate prison sentence for public protection (IPP) and was given a tariff of three years and six months. He arrived at HMP Bullingdon on the same day. The man transferred to HMP Isle of Wight – Albany on 22 February 2007.

3. During the man's first reception health screening interviews at Bullingdon, staff recorded that he had a history of depression, stomach ulcers and could only walk short distances. They also recorded that the man had been previously living in sheltered accommodation and had been supported by carers.

4. The man developed a hernia (a lump that results from a part of the bowel slipping through a weakness in the abdominal wall) in February 2009. There were a series of cancelled and missed appointments until he was seen by a consultant in August 2010. The man also developed leg ulcers which were treated with antibiotics. An operation to repair his hernia took place on 14 September at an outside hospital.

5. Following his operation, the man's ill health continued. Around 9.00pm on 5 December, the man informed staff that he was feeling unwell. The out of hours General Practitioner (GP) service was contacted and they suggested that a recent change in his medication could have caused the man to feel nauseous. He was advised to keep hydrated, to prop himself up and to see the prison doctor on the following day. The man was not visited in his cell by a member of healthcare staff or someone from the out of hours GP service. During the roll check (count of prisoners) early in the morning of 6 December, staff discovered him in bed and he appeared to be dead. Medical assistance was requested and both healthcare staff and paramedics confirmed that the man had died. The prison doctor confirmed his death at 8.58am.

6. The prison appointed a family liaison officer who visited the family to break the news of the man's death. He subsequently assisted with the funeral arrangements and processed the prison's financial contribution. Staff told prisoners later that morning and offered them support. The staff who found the man were also offered support by the prison. Prisoners who were subject to the suicide prevention and self-harm management procedures were also reviewed.

7. 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. I endorse the clinical reviewer's seven recommendations concerning the cancellation of medical appointments, adopting an antibiotic formulary (list of medicines),

reviewing medication for new prisoners, better use of the healthcare computer system, all staff preparing statements after a death in custody, medical care during the night and the recording of information in medical records. I understand that the prison health partnership is considering the findings from the review and developing an action plan to address them.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 6 December 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 comparable with that he would have been expected to be offered 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. The panel met on 25 March 2011 and the investigator attended their meeting. I am grateful for the review, which I received on 18 April, 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. One of my Family Liaison Officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The family raised the following matters:

    - Whether he was sharing a cell at the time of his death.
    - Details of the medication prescribed to the man.
    - Whether he had made any complaints to the prison authorities prior to his death.
    - Why officers did not go into the man's cell when they saw him sitting propped up against the wall.
    - Whether he had been involved in any incidents (for example assaults).

    I have attempted to address these issues within the report. I hope that this helps the man's family to understand the events leading up to his death. The solicitors representing the man's family received a copy of my draft report and commented on it. They wrote that the family were dismayed and distressed to learn that postponed and cancelled medical appointment had occurred. They drew attention to the lack of response from staff to the notices of investigation. They would like to be reassured that consideration would be given to formal training for healthcare staff on how to conduct triage over the telephone when seeking out of hours assistance. They questioned the assertion that the man was suffering from pneumonia because when he spoke to his family on the telephone shortly before his death he appeared well. They noted the difficulties encountered in finding information in the man's medical records. They queried

why the man was taken to outside hospital or transferred to the Inpatient Healthcare Unit within the prison. They felt that an earlier intervention may have saved the man's life. They also believed that lessons had not been learned from previous failure and that the man's death was avoidable.

12. The investigator visited HMP Isle of Wight – Albany on 6 December. He returned on 15 February and 18 March. He interviewed both discipline and medical staff. All interviews were recorded and transcripts are annexed to this report.

13. After completing the interviews, the investigator wrote to the Acting Governor, on 28 March 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. 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. General practitioner (GP) services in the prison healthcare department are provided by Beacon - a partnership between the provider arm of the Primary Care Trust and Lighthouse Medical Ltd. The GPs undertake a total of seven 3.5 hour sessions 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, Newport. The same group of doctors cover the out of hours' prisoner needs – with first point triage (The process of determining the priority of patients' treatments based on the severity of their condition.) 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 indicates they are necessary, and prison staff are allocated to escort the prisoner to hospital. If a prisoner is admitted to hospital, prison staff will remain beside their bed at all times and this is known as a bedwatch. The escort officers also complete a bedwatch log, a record of events during the hospital admission. A regular management check of the bedwatch is carried out by a duty governor. Visits from family may be allowed but these will be closely monitored to ensure that they do not adversely affect the security of the prisoner and the protection of the public.

20. The investigator reviewed the Ombudsman's reports into earlier deaths at HMP Isle of Wight - Albany. Delays in attending hospital appointments have been previously raised by my office and I am concerned that I have to raise it yet again in this report.

HM Chief Inspector of Prisons' report

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

22. Mr Hardwick recorded that the accommodation at the prison was: "generally satisfactory, with the glaring exception of Albany's poorly functioning night sanitation arrangements, which remained unacceptable and degrading."

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

Independent Monitoring Board (IMB) report

24. Each prison has an Independent Monitoring Board (IMB), appointed by the Secretary of State for Justice. The board is made up of voluntary, unpaid members of the local 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.

25. The most recent annual report published by the IMB at Isle of Wight – Albany 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."

26. 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 benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA.

27. 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 3.

KEY EVENTS

28. The man was born in 1938. He was 72 years old when he died on 6 December 2010 at HMP Isle of Wight – Albany.

29. After he left school, the man went to sea for some years and also worked in a shipyard. He moved to England in the mid 1950s to join his aunt and uncle. The man initially worked in a brick factory and on building sites. From the mid 1960s he worked as a painter and decorator until he retired due to ill health.

30. After being convicted, the man was sentenced, on 23 June 2006 at Crown Court, to an indeterminate sentence prison sentence for public protection (IPP)[1] and was given a tariff of three years and six months. He was received into the custody of HMP Bullingdon on the same day. This was his first time in prison. The man transferred to HMP Isle of Wight - Albany on 22 February 2007 where he was housed in a single cell (B1-16) on B wing.

31. During the man's first reception health screening interviews, staff recorded that he had a history of depression, stomach ulcers and could only walk short distances as he had mobility problems. They also recorded that the man had been living in sheltered accommodation.

32. The following medication was prescribed for the man whilst he was in custody at Albany: amlodipine (for high blood pressure), bendroflumethiazide (a diuretic), citalopram (an anti-depressant), lansoprazole (for stomach problems), lisinopril (this is used to treat hypertension, congestive heart failure and to improve survival after a heart attack), loperamide (an anti-diarrhoea preparation), cefalexin, ciprofloxacin, doxycycline, erythromycin, flucloxacillin, metrobidazole and oxytetracycline (all antibiotics).

33. 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.

34. The medical record shows that on 3 February 2009, the man was diagnosed with a hernia by a prison doctor and a referral was made to outside hospital. There followed a series of cancelled and missed appointments.

[1] An indeterminate sentence is a life sentence, where a minimum tariff is given, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner's risk factors are identified by psychological assessments and they are required to complete prison courses that might help to reduce their risk and improve their chances of being considered for parole.

35. On 6 May, the man was unable to attend his appointment due to problems transporting prisoners within the prison. On 18 August, the appointment scheduled for 9 October was cancelled by the hospital as the man was placed on the list for the wrong clinic and it was re-arranged for just over two months later, on 14 December. This appointment was cancelled, on 18 November, by a Consultant Surgeon who asked for it to be re-arranged. On 24 November, the man asked to be removed from the operation waiting list but later that same day changed his mind. The man also failed to attend appointments with the Consultant Surgeon on 17 May and 14 July, but no reasons were recorded for his non-attendance.

36. It was also noted on 14 May, that the man had developed leg ulcers which were treated with antibiotics. On 22 September, the man was prescribed flucloxacillin for his ulcers but it to be stopped as he appeared sensitive to penicillin.

37. On 28 January 2010, the healthcare administrator recorded the following entry:

> "The man attended healthcare today for an appointment. He was dissatisfied with the length of waiting time, became loud and inpatient and declined his treatment. When told to return at 1615 for his meds [medication] he declined these also."

38. On 25 May, the man made a formal complaint about access to the toilet during patrol state.[2] Each prisoner is allocated a personal officer, who is the first point of contact for them. In his response to the complaint, the man's personal officer wrote:

> "I apologise for the inconvenience that you incurred on the morning in question. The reason for this though was that the main night sanitation system had broken down and took a while to re-boot at this time of day. This has not happened since and every effort will be made in the future to rectify this system and hope that you get your nightly visits to the recess in the future. Thank you for your understanding in this matter."

39. After the man's death, the Chair of the Independent Monitoring Board for HMP Isle of Wight confirmed that he had not made any complaints to them whilst he was at Albany. I can confirm that the man did not make any formal complaints to the Ombudsman's office.

40. On 4 August, the Consultant Surgeon reviewed the man at a clinic held at the Inpatient Healthcare Unit (IHU) at Albany. The surgeon offered to repair the hernia under a local anaesthetic but the man preferred to wait for it to be carried out under a general anaesthetic. The operation to repair the hernia took place at outside hospital on 14 September and the man returned to Albany on the same day.

---

[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.'

41. Just over two weeks later, on 30 September, a prison doctor assessed the man as he was suffering from severe diarrhoea. The doctor prescribed loperamide. On 7 October, the man was seen by again by the same doctor regarding swelling at the site of his recent hernia operation. He prescribed antibiotics.

42. Nearly three weeks later, on 29 October, a locum prison doctor, reviewed the man. The locum prison doctor recorded that the site of the hernia operation was healing but he also noted a small firm lump under the wound.

43. The Parole Board held a hearing on 4 November to consider whether or not it was appropriate for the man to be released from custody.[3] Just under two weeks later, on 17 November, a letter was received from the Parole Board advising that the man would not be released or transferred to open conditions, due to the nature of his offence and his high risk of re-offending. The man was informed of the Parole Board's decision on the same day.

44. When interviewed as part of this investigation, the man's personal officer confirmed that he had no concerns about the man's behaviour on the wing but had been aware that he had health problems. In his entry recorded on 27 November, the officer wrote: "The man has had another good week on Bravo wing with good wing behaviour and no other problems or issues recorded on the wing."

45. When asked at interview about the negative response from the Parole Board, the officer could not recall how the man had taken the news. He confirmed that the man was a well-liked individual and there had been no friction between him and other prisoners. Neither could he recall any incidents (for example, assaults) involving the man. He could not remember the last time he saw the man or whether there were any concerns about his healthcare when they last met. The officer confirmed that he was not on duty during the weekend leading up to the man's death.

46. On 29 November, a nurse recorded that the ulcerated areas on the man's leg appeared to have deteriorated since the last time she had dressed them. The results of a swab of the ulcers showed staphyloccus aureus (bacteria found on the skin). The nurse made a referral for a prison doctor to see the man to prescribe suitable medication. On the following day, as a result of the wound swab, a prison doctor an alternative antibiotic (doxycycline).

---

[3] The Parole Board is an independent body that works with its criminal justice partners to protect the public by risk assessing prisoners to decide whether they can be safely released into the community. The Parole Board aims to:

- Make risk assessments which are rigorous, fair and timely with the primary aim of protecting the public and which contribute to the rehabilitation of prisoners where appropriate.
- Demonstrate effective and accountable corporate governance by maintaining strong internal control, setting clear objectives and managing corporate risk and to deliver best value by optimum use of resources.
- Promote the independence of and public confidence in the work of the Board, while effectively managing change.

47. In his report to the clinical review panel, the clinical reviewer drew attention to the use of various antibiotics to treat the man's leg ulcers. He noted that several swabs were taken, but as recorded in previous investigations, crucial information was often missing on the request form. the clinical reviewer wrote: "The long term prescription of ciprofloxacin, together with other antibiotics, in a 72 year old patient on lansoprazole put him at significant risk of developing Clostridium Difficile [type of bacteria which causes diarrhoea and abdominal pain] infection."

48. During the day on 5 December, the man mentioned to fellow prisoners on the wing that he was not feeling well. This information was passed from staff on the day shift to Operational Support Grade (OSG)[4] ,who was the on-coming member of the night staff, in the form of a verbal briefing and handover. This ensured that the OSG had been given information on the welfare and wellbeing of prisoners under her charge. The prison then entered patrol state. (This is also known as night state. At night, all prisoners are locked in their cells and the number of staff in the establishment is much lower than during the day. Wings and units are in the care of night patrol officers, responsible for monitoring security and safety.)

49. Around 9.00pm that evening, the OSG the Night Orderly Officer[5] to go to B wing as the man was unwell. On arrival at his cell the NOO asked the control room to unlock the door (during the night the cell doors are locked electronically from a control room). Whilst the NOO was in the cell, the man vomited into a bucket and told him that he had recently changed his medication. Following his visit, the NOO made arrangements for escort documents to be prepared in case the man was taken to outside hospital.

50. The NOO also contacted a nurse who was based in the IHU, for advice and to confirm the information he had been told by the man. The nurse then contacted the out of hours GP service for their advice about the man's condition. Their response was that the recent change to his antibiotic medication could have caused the nausea. It was recommended that the man keep hydrated (drink fluids), prop himself up (as this would make him more comfortable) and that he should attend the IHU the following morning.

51. After he was interviewed as part of this investigation, the nurse suggested that consideration should be given to formal training for healthcare staff on how to conduct triage over the telephone when seeking out of hours assistance. (Triage is the process of determining the priority of patients' treatments based on the severity of their condition.)

52. After the nurse passed on the advice from the out of hours service, the NOO requested that the OSG maintain an hourly check on the man which she did throughout the night. On those occasions, she saw that he was lying down and

[4] An Operational Support Grade (OSG) is a member of prison staff at a grade below prison officer. They work in many areas of the prison, normally where there is little or no contact with prisoners.

[5] The Night Orderly Officer is the person in charge of the prison at night time.

breathing. However, at around 4.15am, she noticed he was sitting on his bed with his feet on the floor but could not recall whether he appeared to be breathing. At the roll check (the count of the number of prisoners in the prison) at 5.15am on 6 December, she noted that the man was sitting propped up on his bed, leaning with his back against the wall.

53. At approximately 7.05am, the 'early start' officer arrived on B wing and received a verbal briefing from the OSG. His first duties include verifying the wing roll and at 7.20am he arrived at the man's cell. When he looked through the cell observation panel the officer could see the man sitting on his bed and leaning against the wall.

54. When interviewed as part of this investigation, the officer said that when he looked through the hatch in the man's cell:

> "It appeared that he had been sat on his bed and he had fallen asleep and just gone back. I looked at him and, it was unusual because he was always sat on the edge of his bed in the morning always. No real alarm bells [went] off because I thought he was okay at that point but it was when I was continuing round doing the last eight cells on the 1's [ground floor of the wing] that it just didn't feel right."

55. After the officer completed his roll check he returned to the man's cell as it was unusual for him not to be awake. At 7.28am, a second and third member of day shift staff arrived at the cell and Officer Burgess informed them that he was concerned about the man. The staff banged on the door and as there was no noticeable response from the man they radioed the control room and asked for his cell to be unlocked.[6]

56. When the officers went into the cell it was apparent that the man had died. Assistance was requested and two members of healthcare staff responded. They confirmed following an examination that the man was dead. As it appeared that he had been dead for some time, and rigor mortis[7] had set in, resuscitation was not attempted. An ambulance was called and paramedics carried out an electrocardiogram (ECG is a graphical recording of the electrical activity of the heart) which indicated that there was no heart activity. A prison doctor confirmed the man's death at 8.58am.

57. A nurse later recorded the following entry in the medical record: "On examination, I was unable to locate a pulse and he was not breathing. The man's colour was a waxy appearance. His limbs were stiff, and life appeared extinct."

58. Following this, the prison put in place its death in custody contingency plan. The police visited the prison and interviewed staff. They found no suspicious circumstances.

---

[6] When entering a cell staff need to be aware of the possibility that the prisoner may be play acting and the risk of a possible hostage situation. It is therefore unusual for a member of staff to enter a cell by themselves.

[7] **Rigor mortis** is one of the recognisable signs of death that is caused by a chemical change in the muscles after death, it commences after about 3 hours, reaches maximum after 12 hours

59. Staff told the other prisoners of the man's death later that morning. They also asked whether they required any support or wanted to speak to a Listener. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.) All the prisoners on self-harm and suicide monitoring arrangements were reviewed.

60. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. A hot debrief took place at Albany on 6 December. There were no areas of concern raised at that time but staff were offered support from the prison's care team.

61. After the man died, Albany appointed a prison's family liaison officer. He and another officer visited the man's family to inform them about his death. He maintained contact with the family and assisted with the funeral arrangements. Albany also offered financial assistance towards the costs of the man's funeral. This took place on 15 December 2010.

Post mortem

62. The post mortem report records that the man's death was due to natural causes, as a consequence of pneumonia,[8] caused by a chronic obstructive pulmonary disease. After receipt of the draft report, the solicitors representing the man's family questioned the assertion that the man was suffering from pneumonia as when he spoke to his family on the telephone shortly before his death he appeared well. The clinical review panel summarises the post mortem findings as follows:

> "The pathologist noted at the post mortem examination that the man had a [right inguinal scrotal] hernia, despite his recent operation. The pathologist concludes that: "… the pains in his belly were attributable to the hernia." The man had a piece of fatty tissue (omentum) trapped in the hernia, and the pathologist concluded that this was the cause of the vomiting and abdominal pain of which he suffered in the days before his death.
>
> "Regarding the operation the man had to repair his hernia, the pathologist comments: "that there were no signs at autopsy to suggest that the surgery had not been skilfully performed in accordance with recognised medical practice." It is not possible to conclude whether the recurrent hernia was due to a failure to of the initial repair, failure of healing, or early re-opening due to raised intra-abdominal pressure such as results from chronic coughing.

[8] Pneumonia symptoms vary and can be similar to those of other chest infections, such as acute bronchitis, they can develop suddenly (for example, over 24-48 hours) or may sometimes come on more slowly, over several days.

“The pathologist also noted: “It was unclear whether this abdominal problem worsened his chest condition, or contributed to it, but it is likely to have had at least some adverse influence on his general health.”

ISSUES

Issues raised by the man's family

63. As mentioned earlier in the report, the man's family enquired about the circumstances surrounding his death, whether he was sharing a cell at the time of his death and details of his medication and why officers did not go into the man's cell when they saw him sitting propped up against the wall. I hope these have been addressed in the main body of the report.

64. The family wanted to know whether the man had made any complaints prior to his death. The Independent Monitoring Board confirmed that they had not received any complaints from him. The investigator found a complaint made by the man concerning access to toilet facilities during the night of 25 May 2010 but this was dealt with by staff on the wing.

65. The family also wanted to know whether the man had been involved in any incidents (for example assaults). There was no evidence of any assaults in the records reviewed by the investigator and the pathologist found no evidence of any injuries during the post mortem. The prison wrote to the investigator, on 15 March 2011, to confirm that they had no records of any incidents involving the man. When interviewed as part of this investigation the man's personal officer also confirmed that he could not recall the man being involved in any incidents.

Clinical care

66. 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 to discuss the issues and agree the recommendations. The panel met on 25 March 2011 and the investigator attended their meeting.

67. The review finds 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, the clinical reviewer considers that the care given to the man at Albany "fell below that expected of normal NHS healthcare" and that improvements are required. He added that the shortcomings did not directly cause or significantly contribute to the death. I am concerned that the man did not receive good continuity of care between the prison and hospital and endorse the recommendations of the clinical review panel. The issues are considered in detail below.

Delays in providing treatment and missed hospital appointments

68. The clinical reviewer draws attention to the delays in the treatment received by the man. As mentioned previously, the man was diagnosed with a hernia in February 2009, which was repaired in September 2010 after a number of delayed and cancelled hospital appointments. The reasons for the delays varied. Some had been postponed by the hospital, others due to resource

difficulties within the prison and the reasons for the remainder were not recorded.

69. 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. They also consider that every effort should be made by all parties to avoid cancelling appointments as long delays then arise as a consequence of having to rebook the appointments. In addition, the panel believes that all failed appointments should be rebooked at the next available appointment, taking into account the availability of escorts, rather than going to the end of the queue. It was also suggested that consultants should ensure at the outset that appointments are arranged for the most appropriate location for the prisoner's condition to avoid last minute cancellations and rearrangements. The Ombudsman has raised this matter in previous investigations and both the Chief Inspector of Prisons and the IMB have also drawn attention to similar concerns. I am disappointed that this issue continues to arise at Albany and I urge the Governor and Head of Prison Healthcare to act on the following recommendation as a priority.

The Governor and the Head of Prison Healthcare should ensure that staff effectively liaise with colleagues at the local hospital to avoid cancelling important medical investigations and reduce delays for prisoners attending medical appointments. In the event of a cancellation, the reasons should be recorded.

After receipt of the draft report, the solicitors representing the man's family were concerned that postponed and cancelled appointments had occurred previously at the prison.

Record keeping

70. The man was in poor health before he went into prison. The clinical review lists a number of shortcomings in the management of his ailments. This included failing to appropriately monitor his raised blood pressure, not following up or reviewing symptoms and identified conditions as well as missing vaccinations and injections. It is evident that some of this was attributable to poor record keeping and a lack of clarity in the medical records.

71. The panel agrees that prison doctors should review their record keeping as a matter of high priority. It should be clear to a qualified independent observer what the history and examination findings were. Following on from the findings of the clinical reviewer, the panel also recommends that the doctors should adopt an antibiotic formulary (list of medicines) and ensure that all aspects of prescribing are in line with best practice. I endorse the panel's recommendation.

The Head of Prison Healthcare should ensure that doctors at HMP Isle of Wight adopt an antibiotic formulary and ensure that all aspects of prescribing are in line with best practice.

72. The clinical reviewer indicates that when the man transferred from Bullingdon to the Isle of Wight, he did not have a "formal documented reception health screening". This meant that some of his existing medical conditions were either missed or not reviewed. The panel agreed that screening of new prisoners arriving with medication should be carried out by prison doctors.

    The clinical review panel also advises better use of the healthcare computer system to monitor blood pressure levels, blood tests and other actions due for patients.

    The Head of Prison Healthcare should ensure that doctors at HMP Isle of Wight screen prisoners who arrive in custody with medication.

    The Head of Prison Healthcare should ensure that the healthcare computer system is utilised to monitor blood pressure levels, blood tests and other actions due for prisoners.

73. Healthcare staff assessed the man when he became ill the night before he died and also went to his cell when he was found with no signs of life the following morning. Although some discipline staff were required to give statements, this did not apply to the medical staff. I concur with the panel's view on this and make the following recommendation.

    The Governor and Head of Prison Healthcare should ensure that following a death in custody, key staff who were involved in the emergency response or urgent treatment immediately preceding the death are asked to provide a statement of their involvement in the same way as discipline staff.

74. Both the clinical reviewer and my investigator encountered problems finding information in the man's records. It is important that copies of all hospital records are included with the prison healthcare records following a death in custody. In their response to the draft report, the solicitors representing the man's family noted the difficulties encountered in finding information in the medical records.

Management of the man's illness the night before he died

75. The evening before he died, the man's condition deteriorated. The senior officer in charge of the prison contacted a nurse based in the IHU, who in turn telephoned a doctor from the out of hours GP service. As the prison was in patrol state, the nurse was unable to personally assess the man and the information given to the doctor was based on the details received from the discipline staff. I am concerned that the doctor was required to base his assessment on third hand information via a layperson who had simply communicated with the prisoner through a cell door and a clinician who had not seen the patient. Indeed, at interview, the nurse described it as "Chinese whispers". I am also surprised that no consideration was given to moving the man to the IHU, where he could have been monitored by medical staff as opposed to the OSG while conducting routine patrols of the landing.

The solicitors representing the man's family queried why the man was taken to outside hospital or transferred to the IHU within the prison. They felt that an earlier intervention may have saved the man's life. They also believed that lessons had not been from previous deaths at the prison and that the man's death was avoidable.

76. The review panel had similar concerns and considers that there should be a review of the arrangements for nurses assessing and prioritising requests for out of hours assistance. The panel suggested that consideration should be given to the training of staff in conducting triage as well as accessing the healthcare computer system. They also point out that the working practices in the IHU should be reviewed to enable nurses to carry out face to face assessments during patrol state. This would mean that when the out of hours service was contacted they would be able to speak to a nurse who had seen the prisoner at first hand. In their response to the draft report, the solicitors representing the man's family sought reassurance that the training for staff in conducting triage would be put in place.

77. The panel states that where a doctor, who does not normally work at the prison, is working for the out of hours service they should be made aware of the level of care which can be provided to prisoners at night. For example, they should be made aware that, during patrol state, staff in the IHU cannot physically visit a prisoner. The panel also pointed out that healthcare staff need to ensure that all contacts with the out of hours service are appropriately recorded and sent to the prison to be included in the prison medical records. It was suggested that the telephone calls should be voice recorded and available for review and transcription (as is the practice in the general community). I endorse and extend the panel's recommendation on this point.

The Head of Prison Healthcare should carry out a review of the medical arrangements for conducting urgent clinical assessments during the night. In particular, clinical staff should be able to make face to face assessments of prisoners requiring treatment and the advice from doctors at the out of hours service should be sent to the prison. Consideration should also be given to the arrangements for transferring prisoners to the inpatient unit at night if the doctor advises that they should be monitored.

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

CONCLUSION

78. The man arrived at HMP Isle of Wight – Albany on 22 February 2007. He was an elderly prisoner, with a number of existing ailments, who had operation to repair a hernia on 14 September 2010. Almost three months later, during the evening of 5 December, the man told staff that he felt unwell. Advice was sought from an out of hours doctor who advised that the man be observed throughout the night and that he should prop himself up in his bed. It was discovered during the morning roll check early the following day, 6 December, that the man had died.

79. The investigation has found a number of shortcomings in the management of the man's care during his time at Albany and in the hours leading up to his death. I concur with the view of the clinical review panel that the standard of his medical care whilst he was at Albany was not equivalent to that which he would have expected to receive in the community. However, it is clear that the failings identified did not directly contribute to his death.

80. I make seven recommendations based on the findings of the clinical review. They 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 Governor and the Head of Prison Healthcare should ensure that staff effectively liaise with colleagues at the local hospital to avoid cancelling important medical investigations and reduce delays for prisoners attending medical appointments. In the event of a cancellation, the reasons should be recorded.

   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 took place in August 2011 with the relevant service managers at St Mary's Hospital at which further measures to streamline systems at the St Mary's end of the process were agreed.

   Within the prison itself, alerting systems have been clarified between Prison Healthcare and Detail/Duty Governor to avoid cancellations occurring before immediate actions can be put into place to avoid them. In addition, a more detailed database in now in place to record reasons for cancellation in order to inform longer term remedial actions by all involved stakeholders.

2. The Head of Prison Healthcare should ensure that doctors at HMP Isle of Wight adopt an antibiotic formulary and ensure that all aspects of prescribing are in line with best practice.

   Accepted - Copies of the Hampshire and Isle of Wight antibiotic guidelines have been made available to all GPs with a copy in each site. Regular meetings have been set up with pharmacists to support best practice, evidence based prescribing.

3. The Head of Prison Healthcare should ensure that doctors at HMP Isle of Wight screen prisoners who arrive in custody with medication.

   Accepted - On reception the nurse will check if the patient is on medication. Transfers from other prisons arrive with medication in most cases. If the sending prison fails to send medication, Prison Healthcare staff will arrange for a GP to re write the prescription and send to pharmacy and use the emergency cupboard to issue for the first evening/night. Prisoners arriving late in the day without medication will be assessed and where appropriate the prescription will completed the following morning. Any medication required urgently/before the following day is dealt with at the time via the GP Out of Hours Service and the on call Pharmacist at St Mary's. The proposed single Reception into HMP Isle of Wight will be of considerable assistance in streamlining and improving the efficiency and effectiveness of the healthcare elements of the Reception process.

4. The Head of Prison Healthcare should ensure that the healthcare computer system is utilised to monitor blood pressure levels, blood tests and other actions due for prisoners.

   Accepted - Prison Healthcare staff are subject to the same expectations and standards for the recording of clinical information as staff within the wider NHS Isle of Wight organisation. This has been reiterated to all Prison Healthcare staff. Clinical records are subject to audit using appropriate audit tools as part of "Productive Ward" procedures.

5. The Governor and Head of Prison Healthcare should ensure that following a death in custody, key staff who were involved in the emergency response or urgent treatment immediately preceding the death are asked to provide a statement of their involvement in the same way as discipline staff.

   Accepted - Expectation is already in place within overall NHS Isle of Wight post incident procedures. These have been reiterated to all Prison Healthcare staff.

6. The Head of Prison Healthcare should carry out a review of the medical arrangements for conducting urgent clinical assessments during the night. In particular, clinical staff should be able to make face to face assessments of prisoners requiring treatment and the advice from doctors at the out of hours service should be sent to the prison. Consideration should also be given to the arrangements for transferring prisoners to the inpatient unit at night if the doctor advises that they should be monitored.

   Accepted - Action and consideration of this is already in place as part of general review and update of Inpatient Healthcare Unit's (IHU) operations and procedures since opening in October 2009. This is being undertaken in conjunction with HMP Isle of Wight colleagues and within the existing partnership arrangements led by the NHS isle of Wight. Review due to conclude and report provided for discussion within partnership in October 2011. Any changes to processes will be agreed within these arrangements.

   The Inpatient Healthcare Unit is already able to accept prisoner transfers outside the core day if the clinical situation is assessed as requiring it. The actual process of delivering the prisoner to the IHU from elsewhere within HMP isle of Wight is the responsibility of prison colleagues and subject to any applicable operational constraints.

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

   Accepted - As for 4. above. Prison Healthcare staff are subject to the same expectations and standards for the recording of clinical information as staff within the wider NHS Isle of Wight organisation. This has been reiterated to all Prison Healthcare staff. Clinical records are subject to audit using appropriate audit tools as part of "Productive Ward" procedures. There is also now a feedback loop back into Prison Healthcare from the "Adastra" recording system at the Prison GP Out of Hours service.