

**The death of a man in October 2005 at St Mary's Hospital,
Newport, Isle of Wight, whilst a prisoner at HMP Albany**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2006

This is the report of an investigation into the death on 22 October 2005 of a male prisoner. The man, who was 48 years old, died at St Mary's Hospital, Newport, whilst a prisoner at HMP Albany.

The man's death was caused by lung cancer. My colleagues and I would like to extend our condolences to his family for their loss.

This office investigates all deaths of prisoners in custody, including those due to natural causes. In this case, the investigation was carried out by one of my investigators on my behalf. The clinical review was carried out by a representative from the Department of Health, Isle of Wight, and I am grateful for his help. Both the clinical reviewer and I are satisfied that the medical care provided for the man was detailed and comprehensive, and equivalent to that he would have received in the community.

I commend Albany for the efforts they made in support of applications to have the man released on compassionate licence and, when these were not successful, their referrals to a local hospice. Unfortunately, at the time of the man's death, a place had not yet become available. The prison was also sensitive to the man's changing health and ensured that the use of escorts and handcuffs was continually reviewed, and reduced as his condition deteriorated. In my view, the prison balanced well the needs of the man and his family with their duty to protect the public. However, whilst I make no specific recommendations in this report, I believe there are some learning points for Albany concerning communication with families, and I have some concerns about a disciplinary punishment imposed in August, two months after the man had suffered a serious heart attack.

I would like especially to thank the prison appointed liaison Governor for his help in ensuring all the relevant information was passed promptly to my investigator. The liaison Governor was Albany's Duty Governor on 22 October and was with the man when he died.

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Prisons and Probation Ombudsman

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Summary

- The man died, aged 48, on 22 October 2005 at St Mary's Hospital, Newport, Isle of Wight, whilst a serving prisoner at HMP Albany.
- Since June 2005, the man had suffered from several medical complaints and spent considerable amounts of time at St Mary's Hospital. He had had further admissions to Southampton Hospital and to the Healthcentre at HMP Parkhurst.
- This was not the man's first time in prison. Prison staff described him as generally keeping himself to himself, polite and having trusted employment within the prison. However, they said he had begun to experience what they perceived as a relapse in his mental state and described some unpredictable behaviour. Whilst serving an eight and a half year sentence during the 1990s, he had been treated for paranoid schizophrenia.
- The man had asked for a transfer to Albany to enable him to undertake programmes to address his offending behaviour. These were successfully completed before his health deteriorated.
- He was diagnosed with lung cancer in August 2005. He was scheduled to attend Southampton Hospital to have a procedure to remove fluid from his lungs and to apply talc which would discourage further fluid from accumulating. Whilst he was generally co-operative in hospital, on two occasions he refused to accept treatment. From reports, it would appear that the main reason he refused was because he was afraid of what would happen to him.
- Applications were made by Albany for him to be released on early compassionate licence and to be referred to a hospice. Unfortunately, neither was successful before his death.
- There was a delay and some confusion in informing his family of his passing.

Background

1. The man was born in 1957 in Aldershot, and was 48 years old when he died on 22 October 2005.
2. During the considerable time he spent in hospital, he had regular contact with one sister in particular and she visited him with her own family a few days before he passed away. He received a card from her and entries in bedwatch logs show that he appreciated this greatly, showing it to staff and keeping it by his side.
3. In reports, the man described himself as having had an isolated social life and having sought company by visiting local pubs. There is some evidence that he had been a heavy drinker. However, in recent reception health screens, he stated that he did not drink excessively and did not therefore engage in any treatment for this. He was a smoker and on occasion whilst in prison told staff that he considered giving up.
4. The man had worked as a labourer in the building industry and felt that finding employment would not be a problem on release. In the early 1990s, he was exposed to asbestos which was initially considered to be the explanation for his poor health. However, the post mortem showed that this was not the case.
5. On 30 July 2001, he was remanded to HMP Bristol. He had been living in the area although denied having a fixed address. Release plans show that, due to unstable living conditions, the man would have initially been released to live at an Approved Probation Premises in Bristol. He had decided that he would then like to live near his family in Farnham, rather than Bristol, this being somewhere he “just ended up for a while”.
6. The man had previously spent considerable amounts of time in prison, the longest of these being an eight and a half year sentence received in 1992.

HMP Albany

7. HMP Albany was designed and built as a Category C training prison on the site of a former military barracks on the outskirts of Newport, Isle of Wight. Soon after it opened in the 1960s, it was decided to upgrade the security and in 1970 Albany became part of the dispersal (high security) system.
8. In 1992, the prison was redesignated as a Category B closed training prison. In 1998, Albany changed from being half Vulnerable Prisoner Unit, half Normal Location. It now only holds sex offenders and vulnerable prisoners and operates one regime. In 2003, a Category C Unit was added and the certified normal accommodation is now 530. The average age of the population is significantly higher than in most prisons.
9. The healthcare arrangements are managed in a cluster, which includes HMP Parkhurst and HMP Camp Hill, all within a short distance of one another on the Isle of Wight. Parkhurst is the only one with in-patient facilities. Albany itself has a healthcare unit designated for the delivery of Primary Care services.

The investigation process

10. My investigator requested all the relevant prison records relating to the man. These included his medical records and core prison record. She also visited the prison.
11. A representative from the Department of Health, Isle of Wight undertook the clinical review on behalf of the Isle of Wight Primary Care Trust.
12. The Isle of Wight Coroner was informed of the Prisons and Probation Ombudsman's investigation. He kindly provided my office with the post mortem report. The Coroner will receive a copy of this report when it is completed.
13. The man's sister was named by him as his next of kin. She was contacted by one of my Family Liaison Officers and asked whether she or other members of the family had any comments or concerns about her brother's death. The family raised the following matters:
 - Whether the health care was appropriate and consistent with what it would have been in the community?
 - That the escorts at the hospital were excessive.
 - A lack of communication from the prison and the hospital in the final couple of weeks of the man's life and at the time of his death.
14. Notices to staff and prisoners were supplied and displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, only one other prisoner wished to be interviewed and he raised general concerns about access to healthcare rather than information relating to the man. His concerns have been passed to the clinical reviewer and have not been included in this report.
15. A draft copy of this report was sent to the man's family and Albany to enable them to make any comments. All of their comments have been reflected in the text of this final report.

Key Findings

16. The man was remanded into custody at HMP Bristol on 31 July 2001. He was convicted at Bristol Crown Court on 16 December 2002, and on 25 April 2003 he was sentenced to nine years imprisonment with a one year extended licence. The man was transferred to HMP Parkhurst on the Isle of Wight on 23 May 2005. An application was made to the Court of Appeal and, on 3 December 2003, his sentence was reduced to seven years imprisonment with three years extended licence.
17. The man's sentence plan included attending Offending Behaviour Programmes and he requested a transfer to Albany to enable him to attend the identified courses. The transfer took place on 16 April 2004.
18. Wing records show many entries referring to the man's polite, amiable manner and how he seemed settled. A representative entry said he was "progressing quietly through his sentence" and presented no real problems. This continued until January 2005, when staff started to notice a difference in his behaviour.
19. In that month, the man became aggressive with an officer during a cell search, which his personal officer felt was out of character. The officers reported that he "kept his head down" for a while, but then at the end of March, he lost his job as a cleaner due to lack of interest and a poor attitude toward the job. Staff recorded on 5 April that he seemed to have "a real split personality at times", and his personal officer told my investigator that she had seen a different side to him.
20. On 10 June, the man suffered a heart attack. He was taken to St Mary's Hospital after he had started experiencing chest pains and remained there until 16 June. The man's personal officer said that he (the man) had initially denied having a heart attack, stating that it was just a build up of anger and then an "explosion". There are several entries by various members of staff who believed that the man had not entirely understood the severity of his condition. The prison arranged for him to be moved to a ground floor cell so that there was less need for him to use the stairs.
21. The man's sisters have raised concerns that they were not informed that he had had a heart attack. The relevant bedwatch log shows an entry by an officer who had telephoned the prison control room to ascertain whether or not the next of kin had been informed. The next of kin identified at that time was the man's brother. The officer does not remember the conversation or what action was taken. The protocol at the moment is that it is the responsibility of the hospital to inform next of kin in there is a life threatening situation and/or for the prisoner to make the choice if he is able. I am pleased to note that as a result of the concerns made by the family, the Director of the Prison Healthcare Cluster will draw up a procedure with St Mary's Hospital to ensure that there is clarity about their respective roles and that families are informed where appropriate.

22. On 6 August, wing staff recorded that they noticed that the man did not seem his usual self, "although he says he feels okay".
23. The man disobeyed an order to return to his cell on 9 August. He was placed on a disciplinary report and attended the adjudication on 10 August. However, he again refused to move to his cell. He remained in the segregation unit overnight to attend another adjudication the following morning. During the night he complained of chest pains. The Orderly Officer was called and the man was given medication to ease the pain. An adjudication hearing took place on 11 August, where he pleaded guilty to both offences. He received seven days stoppage of earnings and three days cellular confinement respectively.
24. On 14 August, the man experienced more chest pain and was admitted to St Mary's Hospital where he had chest x-rays which showed one of his lungs to be grossly abnormal. There was fluid on his lungs, a sample of which was taken for tests, and he underwent a procedure to drain the fluid. On 17 August, he was informed that the tests showed that he had lung cancer. He was understandably shocked, although the prison records show that he remained "upbeat". Referrals were made to four different specialists who prepared a treatment plan. He was discharged from hospital on 18 August with a palliative care plan.
25. The man was re-admitted to St Mary's on 30 August with abdominal and back pain, and the hospital contacted his sister to inform her of the situation.
26. A thoracoscopy (a procedure to view the chest wall) was scheduled for 12 September at Southampton Hospital. Another procedure to drain the fluid from the chest and apply talc to discourage a re-accumulation was also due to be carried out. The man was transferred to Southampton, but then refused to have blood tests, blood pressure checks and either procedure. The next day, prison staff recorded that he felt stressed about the way he was being treated by medical staff and had no "faith in what may happen to him". He said that he wanted time to discuss matters with his family, and St Mary's informed his sister of the situation. The man returned to St Mary's on 15 September, and steps were taken to try and rearrange the procedures.
27. A risk assessment is carried out whenever a prisoner is taken to hospital. The man was assessed as high risk, having escaped from custody during a previous sentence. He was escorted by two officers and also restrained by handcuffs. These arrangements are common practice when prisoners are admitted to hospital. The risk assessment is regularly reviewed and can be amended according to the health and risk of the prisoner. On 16 September, his health had deteriorated and a decision was taken to remove the handcuffs although he remained subject to a two-person escort.
28. Bedwatch logs show that on 18 September he appeared to become paranoid about his medication, claiming that hospital staff were "messing around" with the dosage of painkillers and sleeping tablets. This was the first of many entries recording his confused and somewhat incoherent state at times.

29. The man had more treatment to remove fluid from his lungs. After a visit from the Duty Governor on 19 September, the handcuffs were reapplied as there had been an improvement in his mobility. This was to be reviewed daily.
30. On 20 September, the Governor signed an application for Early Release on Compassionate Grounds due to the man's ill health. It was not granted because he was still considered to be at risk of committing further offences. The man's medical condition had deteriorated, but he was still mobile and had been assessed as presenting medium/high psychopathic traits.
31. Two days later on 22 September, he discharged himself from hospital and was returned to Albany. Staff at the prison were concerned about his health, so he was taken to HMP Parkhurst which has inpatient facilities. Again he presented as being confused, and started saying that everyone was trying to stop him contacting his family. In fact the man had been in regular contact with his sister throughout the time he was in hospital.
32. He experienced chest pains again on 25 September, and was readmitted to St Mary's by ambulance. He was escorted by two members of staff and restrained with handcuffs. During the next few days, he found it difficult to get comfortable and his medication was increased. From 29 September, the records show that prison staff were increasingly concerned about his mental state. Although, he was polite and co-operative when coherent, he sometimes struggled to sleep and became increasingly confused.
33. Albany changed to a new format of bedwatch logs whilst the man was in hospital. Those received by my investigator were of a good standard with many detailed entries. From these and, discussions with staff, it seems clear that the man was well cared for by the escort staff, who would open his sweets for him, take him out onto the balcony for a change of scenery and attend to his needs in conjunction with the medical staff. His sister is concerned about occasions when she telephoned but did not get through to him and feels that escort staff could have done more to help him answer the telephone. My investigator could find no evidence that this was the case, and it may be that during these occasions the man and the staff were not actually at the bedside.
34. The thoracoscopy was rescheduled for 5 October, and the man was transferred to Southampton a day earlier. During the evening he was booked to go for an x-ray. He became confused and abusive, threatening to walk out saying he was going to get the police as he believed that staff wanted to kill him. Staff tried to reassure him and he telephoned his sister. He was also given oxygen and calmed down. At 12:00am, he agreed to have the x-ray. The operation was scheduled for 8:00am, but when he had a pre-operation shower at 6:00am he told prison and hospital staff that he refused to go ahead with the operation. His family have commented that as a result of a bad experience during a separate sentence at another prison, he was genuinely afraid of his medication being tampered with.
35. A report written about the bedwatch said that most of the time he was at his bedside and settled. The report said that the man's anxiety and paranoia

were exacerbated by fear of having an operation. Whilst prison staff were sympathetic, they were also conscious of the risk of escape and danger to the public. They recommended that the man be situated in a side room.

36. Medical staff offered to postpone the operation to the end of the day so that the man could have time to think about it. He still declined and arrangements were made for him to return to prison. Medical staff felt that he was in a “comfortable state” and there was no need for him to return to St Mary’s Hospital.
37. Unfortunately, he had to be re-admitted to St Mary’s the next day, when he was placed on a drip and had more x-rays. On 7 October, he was seen by a doctor who explained that he was unhappy that the man had refused to have the operation. The man was reportedly very confused about it all and said that he was frightened of the operation. The doctor said he would re-apply for the operation, but if it could not proceed he would continue to drain the fluid from his chest.
38. Over the next few days, staff reported that the man deteriorated quickly. On 11 October, the Director of the Prison Healthcare Cluster, telephoned the man’s sister who was going to try to visit him in the following couple of days.
39. On 12 October, the man was visited by the Macmillan Nurses who visited regularly until he passed away. On 15 October, he experienced a lot of chest pain and more fluid was drained from his chest and painkillers were administered. Prison staff asked for the risk assessment to be reviewed as his health had deteriorated. Later that day, they were permitted to remove the restraints on the condition they were re-applied if there was any improvement in his health or if any problems arose. At no time was it necessary for the handcuffs to be re-applied. Two officers remained with him at all times until he died.
40. Over the next couple of days, the man slept much better and seemed a lot brighter. His sister was due to visit on 17 October and he was said to be looking forward to seeing her.
41. His sister and her family visited as arranged and he remained in good spirits after the visit. His sister has raised some concerns over the escort arrangements. This is discussed later in the report.
42. The Duty Governor visited on 21 October, and saw that the man was in very poor health, and was not drinking or eating very much. He and the medical staff discussed the issues and possibilities of moving him to a hospice. This was the second time that a hospice place had been considered, the first having been unsuccessful because no places were available. Later that evening, the man was taken out to the balcony for a change of view, and when he returned he had a new bottle attached to his chest drain. In the early hours of the morning he became restless, moving from his bed to his chair and back again. At 4:50am, he said he was “fed up” and wanted to go outside, moved across his bed pulling his drain bottle and knocking over

another bottle. He became very agitated and breathless and was given medication to calm him down and ease the pain.

43. Next morning, the man was given more medication for his pain. He became very confused about who was with him and talked loudly about some of his offences. At 9:40am, he was given oxygen and managed to sleep for a couple of hours. By lunchtime, he was awake and refused more oxygen. He became abusive to prison and hospital staff who accepted that it was due to his medication and poor health. He settled later that afternoon, although he continued to take off the oxygen mask and was very breathless.
44. The Director of the Prison Healthcare Cluster contacted the man's sister at 4:30pm to let her know that his condition was deteriorating. At 4:55pm, and again an hour later, nurses were called because he was having problems breathing. The oxygen level was increased, but again the man tried to remove the mask. The prison officers and the nurse tried to hold his hand to reassure him. He slipped into unconsciousness at 6:25pm and a few minutes later the nurse listened to his heart and felt for a pulse. She notified staff that he had passed away and at 6:50pm the man was pronounced dead.
45. The man's family were not informed of his death until the following morning. This caused some distress and the family are concerned that they were not told sooner. My investigator could not find a clear explanation why this had occurred. As the man's family live on the mainland, Albany followed their procedure and informed the police so that they could break the news face to face. A telephone call had been made in the evening but the man's sister was at work. The caller was supposed to return the call at 11.00pm when she would have returned. As far as I can determine, the initial call was made by the police. The hospital did not contact the family because they believed the prison had. It is clear that the Director of the Prison Healthcare Cluster contacted the family the following day to extend the prison's condolences. It would appear that there was miscommunication which should have been avoided.

Issues considered during the investigation

Communication

46. Throughout the man's admissions to hospital he was subject to several restrictions regarding visitors, including the visit by his sister and her family. The restrictions were due to the nature of his offence. The prison recognised that his health was deteriorating and carried out a further risk assessment, which led to scheduled visitors being allowed to visit. Escort staff were instructed to remain present during the visit and not to allow physical contact. They were reminded to be compassionate and sensitive. The man was said to be in good spirits after seeing his visitors.
47. The man's sister expressed concern that she was not provided with information about his condition in the last few weeks. It is known that he had regular contact with his sister whilst he was in hospital. Furthermore, the

Director of the Prison Healthcare Cluster contacted her on 11 October and again on 22 October and she was able to visit her brother at St Mary's Hospital. She was also able to contact both the prison and the hospital for an update on his condition at anytime. It is known too that the man telephoned his sister on a number of occasions prior to her visit.

48. It is most regrettable that the way the news of the man's death was passed to his family was mishandled. I acknowledge the need to ask police to break the news in this instance. However, it would have been best practice for the prison to have asked the police to confirm when this had been done. I am pleased to have been told that Albany are introducing the role of the Family Liaison Officer into the contingency plans for informing next of kin. I hope this will include clear arrangements for appropriate and timely communication to avoid any such miscommunication in the future.

Escorts

49. The escort arrangements, which were a concern of his family, were consistent with Prison Service procedures and the assessment of the man's risk. The prison reviewed the arrangements regularly and, when appropriate, removed the handcuffs. I am satisfied that the escorting arrangements were appropriate and sensitive to the man's needs and presenting risk factors.

Healthcare and Discipline

50. The man had developed a terminal illness and palliative care was all the treatment that could be given. It is clear from the records that he was given a great deal of care by hospital staff and prison staff. The clinical review which is annexed supports the view that the medical care the man received in prison was equivalent to that which he would have received in the community. He was looked after in hospital in the community for most of the last two months of his life.
51. The man's mental state also deteriorated, and I believe this accounted for much of his confused and sometimes aggressive behaviour. My investigator was advised that this would be consistent with his previous psychotic illness coupled with the terminal illness. Both medical and prison staff were sympathetic and tried to give reassurance as well as medical treatment. However, the punishment of three days cellular confinement imposed in August, just two months after the man had suffered a serious heart attack, was a severe one and I doubt it was appropriate, especially as it followed a plea of guilty. I make no recommendation, but the Governor will wish to share my views with his fellow adjudicators.

Identified areas of good practice

52. Staff at Albany applied for Early Release on Compassionate Grounds and tried to find the man a place in a hospice. Unfortunately, at the time of his death, neither application had been successful.
53. Albany provided funds so that the man had money to buy snacks, drinks and phonecards whilst he was in hospital.
54. The bedwatch logs produced by prison staff are excellent, and contain a large amount of information on which my own report is now based. The majority of entries made by escort staff are informative. Importantly, they are respectful and demonstrate compassion for the man.
55. The liaison Governor, as Duty Governor, was present when the man passed away. He has commended the care and compassion shown by other staff in the hours leading up to the man's death. The Governing Governor has written to the staff present to show his appreciation.
56. The prison met the costs of the funeral and the Governing Governor and liaison Governor attended the funeral. They also took the man's possessions to his family.
57. A memorial service was held in the prison for those who wished to pay their respects.
58. I am pleased to note that as a result of the family's concerns about notification of admissions to hospital, the Director of Prison Healthcare Cluster is taking forward a protocol between Albany and St Mary's Hospital.

Recommendations

59. I make no formal recommendations in this case, but believe there is some learning for Albany in respect of communication with families which I hope they will take on board as the new Family Liaison role develops.
60. I have also commented on the punishment imposed on the man in August 2005, just two months after he suffered a serious heart attack.