Investigation into the death of a man, who was a prisoner at HMP Albany, on 26 October 2005

Report by the Prisons and Probation Ombudsman for England and Wales

April 2006

This is the report of an investigation into the death of a man who died from apparently natural causes on 26 October 2005 at St Mary's Hospital, Isle of Wight. He was 73 years old.

The loss of a loved one is always distressing. I would like to add my personal condolences to the man's family to those already expressed by one of my Family Liaison Officers on behalf of this office.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of HMP Albany and his staff for their participation in the investigation. A doctor was commissioned by Isle of Wight Primary Care Trust to undertake a review of the man's clinical care, and I appreciate his assistance.

The roots of The man's illness were not spotted by healthcare staff in prison or in outside hospital, but the review finds that no grounds for criticism on that score. In light of the findings of the clinical review, I have concluded that the medical and other care the man received from Albany was entirely appropriate. Indeed, my own investigation uncovered sensitive and professional practice that reflects well upon the Prison Service.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2006**

CONTENTS

ANNEXES

Summary

1. The man was born in 1932. He was 73 years old when he died on 26 October 2005.

2. The man had been sentenced to life imprisonment in 1972. He was released on life licence in 1994 but recalled into custody in 1996. He arrived at HMP Albany on 24 September 1996.

3. On 18 October 2005, the man was taken to St Mary's Hospital as he had an infection behind his left knee. Whilst he was an in-patient at the hospital, a bedwatch was carried out by prison officers. The security risk assessment identified that a closeting (escort) chain was used. However, this was removed when the man's condition started to deteriorate on 21 October. The man died in hospital five days later.

4. The clinical review concludes that the man's medical care whilst in prison was appropriate.

5. On 18 November, one of my Family Liaison Officers contacted the man's family. Their concerns centred on the medical care that he had received whilst in prison and the notification of his referral to hospital.

The investigation process

6. My investigator studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements from prison staff.

7. The Isle of Wight Primary Care Trust carried out a clinical review of the medical care the man received while in prison. I am grateful to the reviewer for undertaking this review in a most timely manner.

8. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

9. One of my Family Liaison Officers contacted the man's family who told her of their concerns. These centred on the medical care the man received whilst he was in custody. The family also said that no-one was aware of the man's medical condition until very late on. The family wanted to know why they were not informed immediately after the man was taken into hospital. I hope the report provides the man's relations with answers to their concerns.

10. My investigator discussed aspects of the man's treatment and the issues raised by his family with both staff at Albany and the clinical reviewer.

Background

11. The man was born in the north of England in 1932. He had been married on two occasions and was the father to six children.

12. After finishing his education, the man joined the army. He was discharged after 20 years service, having achieved the rank as a sergeant. His conduct on discharge from the army was described as exemplary. After leaving the army, he gained employment as an estate/housing agent until his arrest.

13. Before being arrested, the man had been involved in a serious car accident and had undergone surgery for internal injuries. The man was sentenced to life imprisonment for murder in 1972 and was released on licence in 1994.

14. The man was recalled into custody in August 1996 and arrived at Albany in September 1996. Staff at Albany described the man as quite a solitary individual who kept himself to himself and did not interact with staff or other prisoners.

HMP Albany

15. 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, a decision was taken to upgrade the security to make Albany part of the dispersal (now high security) system. A later review concluded that Albany should no longer be a dispersal prison and in 1992 it was re-designated as a category B closed training prison.

16. Albany runs an integrated regime which means that it does not separate vulnerable prisoners from the main prison population. Up to 530 prisoners can be held at Albany. The accommodation consists of five four-storey cell blocks (A to E wings). There is an 11 cell induction unit and a nine cell segregation unit with two special cells. All wings are identical and hold a maximum of 88 prisoners in single cells with in-cell power and electronic access to night sanitation. In May 2003, a new ready to use unit opened holding 80 category C prisoners.

17. Albany specialises in the management and treatment of sex offenders and other vulnerable prisoners. The average age of the population is significantly higher than in most prisons.

18. The prison's healthcare is clustered with Camp Hill prison and is provided by Parkhurst prison. Parkhurst provides healthcare to the 1,500 or so prisoners on the island and has a 12 bed in patient facility (mainly psychiatric). Prisoners' medical needs are catered for by way of out patient clinics and core day primary nursing cover. Neither Albany nor Camp Hill has 24 hour nursing cover, but there is an on-call doctor who covers all three prisons. Albany's healthcare unit is designated for the delivery of primary care services. When prisoners require urgent medical nursing care, they are transferred to outside hospital.

Key Findings

19. The man arrived at Albany on 24 September 1996, after being recalled into custody. During his health screen interview it was noted that the man had cardio vascular disease (poor blood circulation) in his legs.

20. On 20 August 2000, the man complained of abdominal discomfort and constipation. He was admitted to St Mary's Hospital, where he had a laparotomy (abdominal surgery) and a small bowel resection.

21. On 23 August 2004, the man complained that he was experiencing pain in his right calf after walking. This complaint had been an ongoing problem for the man since 1997 when he had an operation to aid his circulation. Consequently, a referral was made to the vascular surgeon at St Mary's Hospital where the man was seen on 20 January 2005.

22. On 7 September 2005, the man complained of swollen ankles. The man had an electro cardio gram (ECG) and was referred for a chest x-ray.

23. On 14 September, the prison doctor saw the man. The doctor noted that the man had fluid in his thighs and reviewed his medication to deal with this condition. The result of the previous x-ray showed little of significance apart from two old rib injuries.

24. On 19 September, an ultrasound scan was performed which showed no deep vein thrombosis (DVT) in the man's left leg. However, support stockings were provided to aid the blood circulation in the man's legs.

25. On 21 September, The man underwent another chest x-ray which again showed little of significance.

26. On 12 October, The man saw the prison doctor who advised him to continue to use the support stockings, despite the man being unhappy to do so. It was noted that there was fluid accumulating around the man's knee region.

27. On 18 October, medical staff was called to the wing to see The man. The swelling on his leg had got much worse, with fluid still accumulating, and he also had a large inflamed area at the back of his calf. Due to his condition, it was decided that The man needed to be transferred to hospital for further assessment. He was later admitted to St Mary's Hospital. When The man left the prison a closeting (escort) chain was used following a security risk assessment.

28. The restraints were removed on 21 October after a review of The man's situation, when it was deemed that there was no longer a risk of him trying to escape from lawful custody.

29. Around 1.30pm on 26 October, The man's consultant informed the Head of Operations and Security at Albany that the man's death was imminent. The Head of Operations and Security immediately asked the prison to contact the man's family and notify them of his circumstances. The Head of Residence contacted the man's family by phone and informed them about his admission to hospital and his prognosis.

30. At 2:30pm on 26 October, the man's room was cleared in case resuscitation was required. It was noted on the bedwatch logs that he continued to deteriorate rapidly.

31. At 2:55pm, one of the officers on bedwatch duties contacted the prison to inform them that the man was going to be moved to the Intensive Care Unit (ICU). The man was moved at 3:05pm to Colwell Ward as there was no room on ICU.

32. At 4:25pm, a representative from the prison chaplaincy visited the man. The man was unconscious by this time and died shortly after. Doctors pronounced that the man was dead at 4:35pm.

33. The Duty Governor contacted the man's family to offer his condolences and support. He maintained contact with the family and offered to assist with arranging the funeral and providing financial help. The man's funeral took place in November and the Head of Operations and Security attended on behalf of the prison.

34. The post mortem identifies that the cause of death was due to natural causes as a consequence of multiple organ failure, sepsis (blood poisoning) and disseminated gastric carcinoma (stomach cancer).

35. The man's family asked whether he was displaying any symptoms that should have been identified and whether the level of medical care was appropriate. The Clinical Reviewer states that the man received appropriate care following his presentation to healthcare staff. In retrospect, the reviewer says that it would have been difficult for the healthcare team at the prison and hospital to link the signs and symptoms with which the man presented with what turned out to be the actual cause of his death.

36. The man's family also queried why they were not informed when the man was referred to hospital. In an interview with my investigator, the Head of Operations and Security said that the man had requested that no-one be notified of his referral to hospital and this request had been respected. When it became clear that the man was no longer able to make decisions for himself, and due to his condition rapidly deteriorating, the Head of Operations and Security decided that the family should be informed immediately.

37. In reviewing the bed watch log, it is clear that the staff involved with the man's care behaved with sensitivity. The decision to remove mechanical restraints, following a risk assessment, was right and proper given the circumstances. The security arrangements at the hospital seem to have been suitable, and struck a good balance between public protection and sensitivity to the situation.

38. In light of the findings of the Clinical Review, and my own investigation, I conclude that the medical and other care of the man was entirely appropriate. Indeed, I think that Albany treated the man with sensitivity and professionalism. I make no recommendations.