Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Albany, who died in hospital, Isle of Wight, 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the death of a man who died on 8 December 2006 in hospital, whilst a prisoner at HMP Albany.

The man was a life sentence prisoner. He had been admitted to hospital four weeks before he died, suffering from a terminal illness. A post mortem was held at the request of the Coroner and confirmed the cause of death as carcinoma of the kidney. The man was 55 years old.

I extend my sincere condolences to the man's family.

I would like to thank the Governor of Albany, and his staff for their help during this investigation. I am particularly gratefully to a governor for his assistance. I would also like to thank the Isle of Wight Primary Care Trust (PCT) for the clinical review into the man's medical care.

Although he had been unwell and losing weight for several months, the diagnosis of the man's cancer was only made at the end of September 2006. By this time, the tumour had progressed and surgery was unable to remove it. The clinical review concludes that diagnosis of cancer of the kidney was delayed. This report makes five recommendations for the attention of the Isle of Wight PCT in relation to healthcare medication routines, the care of long term sick prisoners, and the assessments of prisoners with physical illnesses.

I have also identified three points of good practice for the attention of the Governor. The man was supported and assisted by dedicated prison staff. Regular risk assessments ensured that during the last few weeks of the man's life, whilst he was an in-patient in hospital, restraints were only used when appropriate.

Albany has developed an excellent Family Liaison Officer Protocol. This document was used from the man's admittance into hospital until his funeral. The man's family were appreciative of the support they received from Albany and they are still in contact with one of the governors. The family further commented on the caring attitude of prison staff towards their brother. They particularly singled out a governor and the chaplain who conducted their brother's funeral.

In this final report all recommendations have been accepted by the Isle of Wight PCT.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

CONTENTS

Summary

The Investigation Process

HMP Albany

Key Findings

Issues

Recommendations

SUMMARY

The man was a life sentence prisoner who had been convicted in 1978 for serious sexual offences. He was released on life licence in 1995, but in 1999 he was accused of another serious offence and his licence was revoked. In 2000, he was convicted and sentenced for this further offence. The man served most of his sentence at HMP Albany.

The man became unwell in late 2005 with symptoms of a severe skin rash, excessive sweating, loss of appetite and weight. He was prescribed medication in the form of lotions and creams. In September 2005, the man was referred to the Consultant Haematologist at a hospital, but when the appointment became available in January 2006 he declined to attend. During this period, the man was having regular sessions with a psychotherapist, trying to address matters around his depression and other personal problems. A psychiatrist assessed the man in 2006. The assessment considered options for the man's future mental health care.

In the spring of 2006, wing staff at Albany became very concerned over the man's physical health. He was losing weight, becoming lethargic and his skin rash was not improving. On 24 April, a wing a senior officer submitted a report to a medical officer raising concerns over the man's health. The senior officer did not receive any feedback from this report. However, the man was seen by a medical officer on 25 April. The medical officer noted that no abnormal physical signs were present but, in view of the man's weight loss and pallor, he arranged for a chest x-ray and further blood tests.

A doctor saw the man on 26 April. He decided to give the man some high calorie drinks to help try and build him up. The doctor noted that the man's weight had been 69.8 kgs in 2004 but had fallen to only 53kgs. The doctor was to chase up the blood test results and repeat them if necessary. The blood test results on 1 May revealed a number of abnormalities including anaemia. The man was referred for gastric endoscopy at hospital on 16 May. He did not receive an appointment date until 10 July.

During the summer, the man continued to lose weight and became increasingly frail. He experienced great difficulty in collecting his medication from the healthcare unit. The man was assisted by wing staff and fellow prisoners to help with his personal care as it became harder for him to carry out these tasks. Prisoners and wing staff brought the man's food to his cell, although his appetite was very small by this time. The man went on taking his prescribed nutritional supplement drinks to try to counter his weight loss.

The endoscopy on 10 July showed some oesophageal thrush and mild gastritis. The endoscopist said that the diagnosis could be carcinoma, lymphoma, hepatitis or HIV and recommended further tests. An abdominal computerised tomography (CT) scan was booked for 28 September 2006. On 1 September, the doctor saw the man again because he felt unwell and an abdominal mass was felt. The doctor made a further referral for suspected colorectal cancer, but the CT scan was not brought forward and took place as originally booked on 28 September.

A governor submitted a report to healthcare after speaking to the man on the wing. The governor was extremely alarmed at the man's physical condition. A few days later, he underwent his CT scan where a tumour was observed near to his right kidney. In mid October, the man attended hospital for blood transfusions in preparation for surgery to remove the tumour.

On 31 October, the man was admitted to hospital for his surgery which he underwent on 1 November. Sadly, the surgery was unsuccessful and the tumour was not removed, having been deemed as inoperable due to its large size and attachment to other tissue. The man remained at the hospital, and was given palliative care until his death on 8 December.

My investigation found several areas of healthcare to be lacking. The time lapse from the prescribing of medication to the wait for prisoners to be issued with their medication fell below the expected standard. There was no in-cell issuing of medication for frail, elderly or disabled prisoners. Moreover, in his review of the man's clinical care, the clinical review felt that the diagnosis of cancer was delayed.

On a much more positive note, the wing staff assisted and helped the man exceptionally well. Senior management carried out risk assessments to ensure he was only restrained in hospital when appropriate. An excellent Family Liaison Officer Protocol ensured the man's family were fully supported following his death.

THE INVESTIGATION PRCESS

On 19 December 2006, my colleague, visited Albany to open the investigation into the man's death. She met with the Governor, and a governor, Delivery Strategy and Programme Manager. This governor was also the prison's Family Liaison Officer.

The Ombudsman's Terms of References and Notices had been sent in advance of my colleague's visit. A Principal Officer (PO)representative of the local branch of the Prison Officers' Association, met with her and she explained the investigation process. The Independent Monitoring Board (IMB) chose not to meet with my colleague.

My colleague reviewed the man's medical record and prison files, and requested copies from those files to be forwarded to her. She visited B wing where the man had been located before his admittance to hospital. She spoke to an officer and two prisoners who had known the man.

A request was made to the Isle of Wight PCT for a clinical review of the man's health care. A doctor carried out this review on behalf of the PCT. I am most grateful to him for his review.

One of my family liaison officers made contact with the man's sister. No issues were raised by her and she told my liaison officer that Albany had been very supportive following her brother's death.

On 23 and 24 January 2007, my colleague re-visited Albany to interview staff and prisoners. She interviewed seven members of prison staff and four prisoners. My colleague found wing staff and prisoners had showed great concern for the man whilst he was resident on B wing. She also noted the positive attitude on the wing.

HMP ALBANY

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 1967, it was decided to upgrade the security and in 1970 Albany became part of the dispersal (high security) system.

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 other vulnerable prisoners and operates one regime. In 2002, a Category C Unit was added and the certified normal accommodation is now 526. The average age of the population is significantly higher than in most prisons.

The healthcare arrangements are managed in a cluster which includes HMP Parkhurst and HMP Camp Hill. Parkhurst is the only establishment with in-patient facilities. Albany itself has a healthcare unit designated for the delivery of primary care services.

Her Majesty's Chief Inspector of Prisons, published a report on an unannounced short follow-up inspection of Albany during October 2005. The last full inspection was in 2002. In the short inspection report, it referred to healthcare, and said:

> "Although progress had been made since the last inspection in some healthcare areas, many had either stood still or regressed. The perception of patients we spoke to was that healthcare generally had deteriorated and was poor. This was in contrast to the last inspection when 53% of prisoners in our survey thought that healthcare was good or very good."

The report offered 13 recommendations in relation to healthcare services. None of those recommendations relate to any issues that have been raised during the present investigation.

KEY FINDINGS

The man was received into Albany in 2004 from Frankland. He was located on B wing and allocated work as a wing cleaner. Although he was receiving medication for depression, the man was a fit and active man, exercising regularly and taking part in long distance running within the confines of the prison grounds and gymnasium.

On 4 July 2005, his medical notes record that he attended the healthcare unit with a rash, saying that he was feeling tired and not sleeping. The man was prescribed some cream for the rash and medication to help restore his sleep pattern.

On 23 August, the man was seen again in healthcare. He complained that he was feeling tired, had a loss of appetite, excessive sweating and a rash at night. He was prescribed E45 cream. On 31 August, the man was seen in the healthcare unit because of night sweats, weight loss and feeling tired. The medical officer made a request for the man to have an x-ray. The appointment appears to have been offered for 9 January 2006, but on this date the man declined to attend and signed a 'prisoner hospital appointment cancellation form'.

Over the next few weeks, medical staff saw the man regularly in relation to his skin rash. Several medications were prescribed, none of which seemed to offer him any relief. Blood tests were also carried out during this time. The man was asked whether he was under stress, which he denied, although it was noted that he had been distressed following a psychological report. The notes record that the man would be referred to a visiting psychiatrist for assessment. The psychiatrist referred to the man's present physical health symptoms and indicated that, until these issues could be resolved, it would be difficult to address his psychological problems. The psychiatrist noted that the man was receiving sessions with a psychotherapist, and that this should continue.

An x-ray taken on 21 September did not reveal any abnormalities. On 23 September, a letter from the prison's medical officer to a Consultant Haematologist at a hospital was sent asking for a review of the man's rash and skin condition. On 19 October, a nurse saw the man. She noted that he looked unwell, but that his skin rash was being helped by the application of calamine lotion.

On 2 November, the man was seen by a Community Psychiatric Nurse (CPN). The CPN noted that he was exhibiting symptoms of depression, was tearful and in a negative thinking pattern. The note also records that the man was losing weight, had sleep disturbance and lethargy. The CPN wrote that these symptoms would probably be related to the man's physical health problems.

On 25 November, the man was seen in healthcare by a nurse. He complained of abdominal pain and of feeling nauseous. The man also told the nurse that he had been in pain on and off for a week in his left kidney. The nurse tested a urine sample which showed a trace of protein. The man was advised to drink plenty of fluids and was given some paracetamol and Gaviscon liquid. On 26 November,he had a medication review with the doctor.

Over the next few weeks, the man was seen regularly in the healthcare unit and his medication was subject to review. As noted above, he declined to attend the hospital appointment offered on 9 January 2006 concerning his rash.

On 24 April 2006, a senior officer (SO) submitted a report to the medical officer which noted his concerns regarding the deterioration in the man's physical health. The SO had observed the man's weight loss and lethargy. The SO had spoken to the man who had admitted to feeling unwell and a loss of appetite.

On 25 April, the man attended healthcare. A nurse noted that he looked pale and thin. He told the nurse that he could not stand prison food, only eating occasionally although drinking fluids, tea and coffee. Later that day, the man was seen by the medical officer, who ordered blood tests to be taken and sent as urgent to the pathology laboratory.

On 5 May, the man was seen in the healthcare unit. He was advised about the results of his recent blood tests which indicated that he was anaemic. Build Ups, a high calorie nutritional drink, was prescribed to help the man with his lack of appetite and to try to stabilise his weight.

On 16 May, the prison medical officer wrote a referral for the man to the gastroenterology department at a hospital. The letter noted that the man was anaemic, and had been suffering from dyspepsia and weight loss. An appointment was made for the man to attend the hospital for an endoscopy on 10 July. He was admitted to the local hospital for this investigation. No serious abnormalities were found, but the endoscopist stated that the differential diagnosis included cancer, lymphoma, hepatitis and HIV. It was suggested that an abdominal CT scan should be considered.

On 7 August, a request was made for a CT scan. The scan appointment was booked for late September. On 1 September, the prison's medical officer examined the man and felt an abdominal mass. The same day he made a referral for the man to see the first available consultant in relation to suspected colorectal cancer.

In September, a governor submitted a report to the Head of Healthcare documenting concerns of staff about the continued deterioration in the man's health. The governor had intervened on behalf of wing staff who had requested his involvement. The report by the governor was filed in the man's medical notes. A note on the report by the Head of Healthcare indicated that the man had numerous appointments at the hospital and with the prison's medical officers. She further noted that it was, 'already in hand', but this was not communicated back to the governor. On 28 September, the man underwent his CT scan at hospital. The scan found a 9cm lesion arising from the left adrenal gland in contact with the pancreas, left kidney and spleen.

On 2 October, the man was again seen in healthcare. A treatment plan was being developed and he was prescribed Ensure to help with his nutritional intake. On Friday 6 October, the man was told the results from the scan by the medical officer who discussed the illness and issues around anxiety. Later that day, the man was taken by ambulance to a hospital, Accident and Emergency Department, as he was

in severe pain. The man was given an x-ray which was noted to be abnormal. However, no further information was disclosed on the patient discharge form. The man went back to Albany after being prescribed painkillers.

The following day, the man was seen in healthcare. It was noted he was very weak and sleeping most of the time. A prescription was written for continuous pain control. On 9 October, the man attend hospital for a further out-patient appointment. He returned to Albany but was then re-admitted to hospital as an in-patient the following day. This was to conduct tests prior to surgery. The man was discharged from hospital on 12 October.

On 15 October, the man was seen at a hospital's out-patient department. He returned to Albany later that day. On 25 October, the man attended hospital for a blood transfusion. He was discharged the next day and again returned to Albany.

On 31 October, the man was again admitted to hospital in preparation for surgery. A two-officer bed watch escorted him. On 1 November, he underwent surgery to remove the tumour. The operation was unsuccessful and the tumour was not removed due to its advanced state. Mechanical restraints were not used following the surgery. The restraints were re-applied on 4 November, following a risk assessment, as the man's condition had slightly improved.

On 10 November, the restraints were again removed following a further risk assessment. On 13 November, the man was seen by a palliative care doctor and nurse from a local hospice. Hospice care was not available for him at that time, but it was agreed that the situation would be reviewed in three weeks. The restraints were later re-applied, as it was understood that the man could be discharged back to Albany in the very near future. Over the following two days, discussion took place between hospital staff and healthcare staff at Albany regarding a suitable location to which the man could be discharged.

On 18 November, following a further risk assessment and the man's continuing in-patient care at the hospital, the restraints were once more removed. They were not re-applied before his death.

On 22 November, a PCT funding panel met to discuss the man's palliative care. It was agreed that neither a discharge back to Albany nor his current palliative care on the hospital ward were appropriate. Instead, it was agreed that the man would transfer to a continuing care bed within the hospital. It was noted that the hospice would be prepared to offer the man a bed when he reached the end stages of his life.

On 25 November, the man was transferred to the continuing care ward in the hospital. He received care from hospital staff and Macmillan nurses. On 27 November, the man consented for a governor to make contact with his sister when he died. Over the next two weeks, the man was cared for in the hospital. He was prescribed analgesia for pain control which included the use of a syringe pump.

On 8 December, the man died. In accordance with his wishes, the governor contacted HMP Manchester to establish if a senior manager at the prison could visit

the man's sister and give the news of her brother's death. The Deputy Governor, and Manchester's Safer Custody Manager carried out this request.

A funeral service for the man was held at a local Crematorium. It was the wish of the man's sister that the funeral service take place locally. The man's sister and husband travelled to the Isle of Wight on 19 December for the service and to visit Albany to speak to staff and her brother's friends. All their expenses were met by the prison.

ISSUES

Clinical Review

A doctor from the Isle of Wight PCT carried out a review of the man's medical care. The review is based on clinical notes kept on the man and the transcripts of a number of interviews undertaken by my investigator with officers and prisoners.

The doctor noted that the itchy rash that the man developed in July 2005 did not resolve in spite of treatment with several medications. His referral to a hospital specialist in September 2005 did not result in an appointment until January 2006 and, at this point, the man refused to attend.

The doctor concluded that the cause of his rash is unclear and that it may or may not have been related to the renal cancer that was finally diagnosed in September 2006. The doctor felt that it was unfortunate that the man declined the appointment in January 2006. If he had attended, the outcome might have been different.

The man was seen promptly by prison healthcare in response to the representations of the Senior Officer in April 2006, but the subsequent response to the confirmation of abnormal blood tests was slow. The results of the blood test came back on 1 May, but they do not seem to have been discussed with the man until 11 May (the date of the urgent referral for endoscopy of his oesophagus and stomach). The possibility of cancer was raised in this referral letter but the man still had to wait eight weeks for his endoscopy appointment. The endoscopy on 10 July showed some mild thrush and mild gastritis. The endoscopist said that diagnosis could include carcinoma, lymphoma, hepatitis and HIV. The endoscopist recommended an abdominal CT scan, referral to haematology and further blood tests.

The prison's medical officer did not make the referral for the CT scan until 7 August and it was not marked urgent. The hospital received the form on 14 August and booked the scan for 28 September.

When the prison's medical officer palpated an abdominal mass during his examination of the man on 1 September, he made an urgent referral to the Surgical Department at the hospital. One of the surgeons there tried unsuccessfully to expedite the CT scan. It was eventually undertaken as originally booked on 28 September.

The clinical reviewer felt that the abdominal CT scan request on 7 August should have been marked as urgent, particularly as the possibility of malignancy had already been endorsed by the endoscopist.

The clinical reviewer was unclear why healthcare staff did not respond to repeated concerns expressed by prison officers about the man's declining health.

The clinical reviewer made the following recommendation which I endorse:

Prison healthcare should review with the PCT Clinical Governance Unit the care pathway for a prisoner where the diagnosis of cancer is a significant possibility.

The clinical reviewer was unable to conclude that the man's care was equivalent to that which he might have received in the community. Although the man declined to see a consultant haematologist in January 2006, the clinical reviewer considered that his diagnosis of cancer of the kidney was delayed.

The man's location on the wing

The man first became unwell during the summer of 2005. He had a bad skin rash and was losing weight. The man was working in the servery at this time and was located on the fourth landing of B wing. As his condition started to deteriorate, officers moved him onto the first landing. Subsequently, the man was moved to the ground floor into a cell located nearest to the recess (toilet and showers). The cells in B wing do not have in-cell sanitation, and the move to the ground floor enabled the man to have ease of access to the toilet as his health further declined.

The man was allowed to go first to the servery to collect his meals. Staff offered him first choice from the menu so he could choose food that appealed to his decreasing appetite. Often the man would prefer to eat two puddings rather than a main meal and a pudding. When it became difficult for him to collect his food from the servery, which is located a short walk from the wing, either fellow prisoners, or prison staff would collect his food for him.

In July 2006, a PO made an entry in the man's wing history sheet relating his concerns over the man's physical condition and deteriorating health. This was followed by a further entry in early October. In this entry, the PO said that the man's condition was so severe he could no longer be supported on the wing. This was endorsed by a senior manager who noted that the prison's medical officer was seeing the man. Two weeks later, he was admitted to hospital. In interview, the PO said he was conscious that two officers had supported Mr Monk's needs, and he described their assistance as exemplary.

A member of staff is an instructor and the disability liaison representative at Albany. The instructor had known the man since his arrival at the prison. She had not seen him for a long while until she observed him on the wing just before he was admitted to hospital in October 2006. The instructor was shocked by the man's appearance. In interview, she described him as shuffling along like a man of 90 and said he looked very ill. An officer told the instructor he was worried about the man's deteriorating health. The instructor told my investigator that, if she had been made aware of the man's illness she would have assessed his situation, although she was conscious of issues around patient confidentiality. She said that healthcare staff normally made such a request.

It is clear from the accounts of staff and prisoners that the man was extremely ill and finding it hard to cope on the wing. His suffering was distressing for all those working and residing on B wing to witness.

Healthcare staff should involve the prison's disability liaison representative in completing assessments about prisoners where appropriate.

Collection of medication

The man spoke to an officer about the difficulty he had in collecting his medication. The walk from B wing to healthcare took him approximately 20 minutes (the walk for a fit and active person would take around one to two minutes). The man found it painful and difficult to make this trip. Currently, all prisoners are required to collect their medication from healthcare. There is no in cell medication routine at Albany. The man had to make this trip two to three times a week. This was raised with healthcare by wing staff but no action was taken to change the situation.

The man's trips to collect medication and visits to healthcare caused him great difficulty and distress. At no time did healthcare staff visit the man on the wing to assess his mobility and care needs. Nor, as mentioned, did they ask the disability liaison representative to carry out an assessment.

Albany does not operate a 24-hour healthcare facility. An assessment of the man's requirements might have led to a care package meeting some of his needs and ensuring some retention of dignity and respect before his admittance to outside hospital. For example, healthcare nurses could have brought his medication to his cell and assisted him with his general personal care. An assessment might also have identified the need for the man's transfer to a prison with 24-hour healthcare that could provide the health and social care appropriate to his needs.

During the course of my investigation, both prisoners and staff raised issues over the medication routines at Albany. All prisoners have to collect their medication from healthcare - even if they are disabled or unwell. They also described a delay between the prescribing of medication by the medical officer to it becoming available in the pharmacy. This was said to be up to four days.

My investigator wrote to the Deputy Director of Commissioning and Partnerships for the Isle of Wight PCT raising concerns over these medication routines. The Deputy Director replied that these concerns would be investigated further and the outcome reported to the Prison Commissioning Group and the Prison Partnership Board.

Healthcare staff should consider dispensing medication to prisoners in their cells when their mobility is impeded by their physical health.

The Prison Commissioning Group and Prison Partnership Board for the Isle of Wight Prisons should respond to any outcomes or recommendations as a result of the investigation into medication routines by the Isle of Wight PCT.

The man's failing health

During interview, two officers both indicated their concerns over the man's failing health. The officers had observed the man's deterioration and frailty. He had told one of the officers in December 2005 that he would not see another Christmas. The Officer continued to help the man on the wing, offering both practical and emotional

support. The officer remembered that in the summer of 2006 the man had removed his top, and that he was shocked by his physical appearance. His body muscle tissue had wasted away and skin was hanging from his body. The officer found it distressing to see the man decline and the obvious pain he was suffering.

A second officer knew the man from his arrival on B wing. Together with the other officer ensured the man was given the necessary and appropriate help as his deterioration became obvious. The second officer said he too found it hard to watch the man's continued suffering. On 5 June, the second officer wrote in the man's personal file about his concerns over the man's welfare and declining physical condition. The second officer spoke to a member of healthcare staff about the man's condition but was told there was nothing to worry about.

In early 2006, a second PO took the man to healthcare after observing him working in the servery. This PO Young noticed how unwell Mr Monks looked and that he was finding his work difficult. (the man was serving the puddings on the servery. Prison staff had allocated him this task as it involved little effort.) The PO was told by a member of healthcare staff they were aware of the man's ill health and were looking into it. In April, the PO wrote a memo to healthcare raising his concerns about the man's deteriorating condition. The PO did not receive any feedback from healthcare. In interview, the second PO praised two officers for their care and support for the man whilst he was on B wing. Both officers had ensured that the man was given practical help by other prisoners. The officers also spent time acting as emotional support for the man.

A governor saw the man on B wing in September. This was at the request of wing staff who were becoming increasingly alarmed about his wellbeing. The man showed the governor sores and rashes on his legs. They were bleeding. The man also removed his top and the governor saw how thin the man was and that the skin was hanging from his bones. The governor described the man as looking 'ghastly' and wrote a report for healthcare outlining his worries. The governor did not receive any feedback from this report. A few weeks later, the governor learnt that the man was to have a CT scan.

Several prisoners located on B wing spoke to my investigator about their observations of the man's declining health, and the struggle he had to see healthcare staff and collect his medication. They all described his weight loss, lack of appetite and lethargy. There was a general feeling that the man's health needs were not being met by healthcare staff. The prisoners praised the wing staff for supporting the man, in particular citing two officers.

My investigator also spoke with a psychotherapist who had worked with the man. The psychotherapist had recorded in the man's medical notes the decline in his physical appearance, his weight loss, night sweats and rashes. During the summer of 2006, the man would wear an excess of clothing and say he was cold even though it was high summer. The psychotherapist understood from healthcare that the man was undergoing tests and investigations. The psychotherapist said that the man was frustrated by his illness and his sessions with her involved untangling the emotional from the physical issues.

Healthcare staff should acknowledge the concerns of prison staff raised verbally or in a letter or memo and, within the bounds of confidentiality, demonstrate that they have noted their concerns and acted on them where appropriate.

Use of Restraints

The man was escorted by two officers on admission to hospital. At one stage, the escort was reduced to one officer. Restraints were removed for the operation and only re-applied on two occasions, two days after his operation and for a very short period when discussion was underway as to where the man would receive palliative care. A full risk assessment was conducted when the restraints were removed.

An application for release on compassionate grounds was being prepared by healthcare and hospital staff. However, given public protection concerns arising from the seriousness of the man's offences, the application might well not have been successful.

I commend the actions of senior management in carrying out regular risk assessments for the removal of restraints and in acting with compassion towards the man and his situation whilst in hospital.

The man's support whilst on B wing

The man received exceptional help from two officers whilst he was on B wing. Both officers went beyond the call of their normal duties in offering compassion, assistance and emotional support to the man. I note their concerns for the man over the 12 month period before he was admitted to hospital. I also happily record the PO's observation that both officers' attitudes were exemplary.

The man's friends on B wing were also supportive towards to him. The man was described as a likeable man who was well thought of by his friends. They visited him in his cell as he became weaker, talking to him and helping him with his daily routine.

My investigator was greatly impressed by the positive and caring attitude of both staff and prisoners on B wing.

I commend the actions of two officers for the compassionate care they gave to the man whilst he was located on B wing.

I note the good practice of the two Principal Officers for raising concerns about the man's health and actively responding to the views of wing staff.

RECOMMENDATIONS

For the Isle of Wight PCT:

1. **Prison healthcare should review with the PCT Clinical Governance Unit the care pathway for a prisoner where the diagnosis of cancer is a significant possibility.**

Accepted – A care pathway will be developed which will detail the prisoner's wishes, attitudes and behaviour which may inform the care provide.

2. **Healthcare staff should consider dispensing medication to prisoners in their cells when their mobility is impeded by their physical health.**

Accepted – If a prisoner is unable to attend healthcare due to mobility being impeded by their physical health, medication will be provided by the healthcare staff at the prisoner's cell.

3. **The Prison Commissioning Group and Prison Partnership Board for the Isle of Wight Prisons should respond to any outcomes or recommendations as a result of the investigation into medication routines by the Isle of Wight PCT.**

Accepted – A response will be generated following the publication of the investigation commissioned by the Deputy Director.

4. **Healthcare staff should involve the prison's disability liaison representative in completing assessments about prisoners where appropriate.**

Accepted – When a request for assessment is submitted to the Occupational Health Department at a hospital, Healthcare will add a note to the request application and advise the prisoner inviting both to contact the establishment's Disability Liaison Officer to attend the assessment.

5. **Healthcare staff should acknowledge the concerns of prison staff raised verbally or in a letter or memo and, within the bounds of confidentiality, demonstrate that they have noted their concerns and acted on them where appropriate.**

Accepted – All written correspondence will be replied to by Healthcare, within the bounds of confidentiality.

Good Practice

1. **I commend the actions of senior management in carrying out regular risk assessments for the removal of restraints and in acting with compassion towards the man and his situation whilst in hospital.**

Accepted

2. I commend the actions of two officers for the compassionate care they gave to the man whilst he was located on B wing.

Accepted

3. I note the good practice of two Principal Officers for raising concerns about the man's health and actively responding to the views of wing staff.

Accepted

ANNEXES

1. Documents considered during the investigation