

**Investigation into the circumstances surrounding the
death of a man in hospital whilst in the custody of
HMP Albany**

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

December 2008

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

This is the report of an investigation into the death of a prisoner at HMP Albany who died in hospital from natural causes on 8 June 2008. The man was 73 years old.

When the man entered custody in 2003, it was noted that he had a history of heart and lung disease. He was not a well man and was also a smoker who refused help to stop smoking. In April 2008, the man was moved from HMP Parkhurst to HMP Albany. He was admitted to a local hospital on 27 May and it was here that he died of a heart attack less than a fortnight later.

I would like to extend my condolences to all those touched by the man's death.

The investigation was undertaken by one of my investigators. I am grateful for the assistance he received from staff at HMP Albany and would ask the Governor to pass on those sentiments. A clinical reviewer was asked by Isle of Wight Primary Care Trust to undertake a review of the man's clinical care and I also appreciate his assistance.

The clinical review concludes that the man's clinical care was good and comparable to that available in the community. I have noted the issues highlighted by the clinical reviewer and I endorse the two recommendations made in the review.

I have made no separate recommendations of my own. However, I offer some comments in paragraph 58 that I hope may be helpful to those drawing up policy on the use of restraints on prisoner-patients in hospital. I understand why the current policy and practice is extremely risk averse. However, this report and many others for which I have been responsible suggest that it has become too risk averse. The man was an elderly man with limited mobility, in serious ill health, and with no known relations. He was a most unlikely escape risk. Yet for all of his time in hospital he had a two-officer bedwatch, and he was cuffed for most of the time too.

Stephen Shaw CBE
Prisons and Probation Ombudsman

December 2008

CONTENTS

Summary	3
The investigation process	4
HMP Albany	6
Key events	9
Issues considered	14
Conclusion	17
Recommendations	18

SUMMARY

The man was born in 1935. He was 73 years old when he died in June 2008. The man died from natural causes as a consequence of a myocardial infarction (heart attack).

The man had been sentenced to life imprisonment at Wolverhampton Crown Court in 2003. He was in custody at HMP Shrewsbury, HMP Blakenhurst and HMP Parkhurst, before transferring to HMP Albany on 15 April 2008.

During his first reception health screens, it was recorded that the man was a smoker who had previously been diagnosed with ischaemic heart disease, chronic obstructive pulmonary disease (COPD), two frozen shoulders, a hiatus hernia, angina, emphysema, two prolapsed discs of the spine, and arthritis in his right hip. Due to his mobility problems, the man used a walking stick, and had access to a wheelchair when he had travel any long distances. He had been prescribed a glyceryl trinitrate (GTN) spray which he used when he experienced problems with his chest.

When the man transferred to Albany he was given a single cell on F wing because of his limited mobility. The wing is located near to the prison's healthcare centre.

Around 1:00pm on 25 May 2008, the man rang his cell bell and told staff that he was suffering with chest pain. He was visited by a member of healthcare staff who thought he had indigestion and gave him some Gaviscon (a proprietary medicine). The man was seen again by healthcare staff around 4:00pm and the original diagnosis of indigestion was maintained.

On 27 May, the man again complained of having chest pains. He was seen by a prison doctor in the healthcare centre and an electrocardiogram (ECG) was conducted. The doctor decided that the man should be taken by ambulance to outside hospital. The man was seen by a hospital doctor at around 6:00pm and was located on the Coronary Care Unit (CCU) where his condition was monitored.

Around 10:46am on 28 May, the man was seen by a doctor who confirmed that he had suffered a heart attack. The doctor also confirmed that the man would be in hospital for a number of days.

Whilst the man was in hospital, prison staff carried out a bedwatch. The initial security risk assessment concluded that handcuffs were to be used and two officers needed to be at his bedside.

At around 3:10am on 1 June, the man had another ECG. The staff on bedwatch duty were informed that there was a possibility that heart start paddles might be used if the man's condition deteriorated. Permission was sought from the prison to remove the man's restraints and they were duly removed at 3:30am. His condition stabilised again around 3:40am. At around 9:50am, the Duty Governor visited the man. He revised the risk assessment for the man and restraints were not re-applied. The risk assessment was revised again on the following day (June 2) as the man's

condition had improved. The revised risk assessment was that restraints were to be re-applied.

A consultant saw the man on 3 June and told him that he would be transferred to another hospital in the next few days. On the following day, prison staff were informed by a doctor that he expected the man to remain in hospital for the next few days. On 5 June, the man moved to a side room.

On 8 June 2008 at approximately 10:20pm, the man suffered a cardiac arrest. Hospital staff were unsuccessful in their attempts to resuscitate him. Death was pronounced at 10:37pm.

After the man died, the prison activated its death in custody contingency plan. The police were informed and visited the local hospital. They found no suspicious circumstances. The man's body was therefore released to the undertakers who removed him to the mortuary for post mortem examination. The coroner's officer informed a Principal Officer, who was managing the prison's response following the man's death, that he had died from natural causes. Both the Principal Officer and the police tried unsuccessfully to contact any remaining family to inform them of the man's passing.

As the man had no family or friends to organise a funeral, the responsibility fell to the prison. The principal officer registered the death, co-ordinated arrangements for the funeral and ensured that the man's property was catalogued and put into central storage.

A clinical review was carried out and considered the care provided for the man. In the review, the quality of care given to the man was good and equivalent to that he would have received in the community. The review makes a total of two recommendations for service improvement. I understand that the prison health partnership is considering the findings from this review and is developing an action plan to address them.

I have made no additional recommendations of my own. However, I have commented on the bedwatch arrangements and the extent to which Prison Service policy and practice may have become too risk averse.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 June 2008 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. In the event no one came forward. My investigator also studied all relevant prison records relating to the man. These included his main prison record and his medical records.
2. My investigator visited Albany on 17 and 23 June and discussed aspects of the man's treatment with staff. He interviewed a second Principal Officer and two prison officers. My investigator also visited Parkhurst on 29 August and interviewed the man's personal officer. She was able to provide background information concerning the man and his care whilst he was in custody.
3. The Isle of Wight Primary Care Trust commissioned a clinical reviewer to lead a panel review of the man's clinical care. I am grateful to the clinical reviewer for undertaking such a thorough review.
4. 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 in his enquiries into the man's death.
5. The man had a large family. However, he had not maintained contact with any family members whilst he was in custody. After his death, Albany contacted both the police in the man's home town and the solicitors who had represented his ex-wife in their divorce proceedings. Unfortunately, the prison was unable to locate any family members to inform them of the man's passing. I too have no contact details for any members of the man's family, and this has meant that we have been unable to involve them in the investigation or to address specific concerns that the family might have liked explored in this report.

HMP ALBANY

6. Albany is a category B training prison situated near Newport on the Isle of Wight. It opened in 1967 on the site of a former military barracks. Albany offers a varied regime with education and several offending behaviour programmes.
7. At the time of the man's death, the prison could hold up to 566 adult male prisoners. The average age of Albany's population is high when compared to most jails.
8. There are five wings (A – E) which are almost identical and hold between 94 and 96 prisoners in single cells with in cell power and access to electronic night sanitation (this is where the cell door unlocks for a limited amount of 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 comprise single cell accommodation with en-suite facilities.
9. Health services at Albany and at the other two prisons on the Isle of Wight are commissioned by the Isle of Wight NHS Primary Care Trust. The prison's healthcare is clustered with HMP Camp Hill and provided by HMP Parkhurst. In total, Parkhurst provides healthcare to 1,500 or so prisoners on the island. Prisoners' daily medical needs at Albany are catered for by way of out-patient clinics and core day primary nursing cover. There are three nurses on duty from 7:30am to 5.30pm Monday to Friday. During weekends and evenings, one member of healthcare staff is on duty. GPs from a local community practice, attend Albany for three-hour sessions four times each week. Evenings and weekends are covered by on call GPs from the local PCT. There is no nursing or healthcare cover based at Albany during the night.
10. During 2008, my office has investigated five deaths through natural causes at Albany. There was no common factor between the circumstances surrounding this investigation and those into previous deaths.

HM Chief Inspector of Prisons' Report

11. The most recent report on Albany by HM Chief Inspector of Prisons followed a full announced inspection in November 2007. The Chief Inspector's report noted that public protection and the range of activities provided were good. Offending programmes were of a very high standard. However, the Chief Inspector noted that relationships between staff and prisoners were distant and mistrustful. There were insufficient work places and systems to protect prisoners against bullying and self-harm were not sufficiently robust.

Independent Monitoring Board Report

12. The latest report from the prison's Independent Monitoring Board (IMB) is for the period 2006 – 2007. The IMB drew attention to the limited access for prisoners with mobility problems, but said that the management team was

aware of this. Every effort was being made to accommodate prisoners with mobility difficulties in appropriate locations.

13. The IMB report also drew attention to the limited availability of staff for escorts to accompany prisoners to the local hospital. The report said, “this problem will not go away due to the age of our prisoners.”

KEY EVENTS

14. The man was received into custody (on remand) at HMP Shrewsbury on 28 March 2003. He transferred to HMP Blakenhurst on 7 April. He was convicted on 18 August and on 3 October was sentenced to life imprisonment at Wolverhampton Crown Court. The man transferred to HMP Parkhurst on 14 April 2004 and arrived at HMP Albany on 15 April 2008.
15. During his first reception health screen on 28 March 2003, it was recorded that the man had ischaemic heart disease, chronic obstructive pulmonary disease, two frozen shoulders, a hiatus hernia, angina, emphysema, two prolapsed discs of the spine, and arthritis of the right hip. The man had been prescribed a glyceryl trinitrate (GTN) spray which he used when he experienced chest problems. Due to his mobility problems, the man used a walking stick. Shortly before he was received into custody he had suffered three bouts of pneumonia. It was also noted that he had attempted suicide in 1972.
16. The man was a smoker who refused assistance to help him stop.
17. When the man was at Parkhurst, he was located on the ground floor (known as the 1s landing) of one of the vulnerable prisoner wings. When interviewed as part of this investigation, his former personal officer was able to give background information on the time the man spent at Parkhurst. She explained that the man was given a cell on the lower level due to his health and mobility problems. The man's personal officer said the man worked as a rug maker alongside other prisoners on the ground floor of the wing. Because of his mobility problems, the man's medication was brought to him by healthcare staff. If the man wanted to have a shower, staff on the wing would use a wheelchair to take him.
18. The man's personal officer confirmed that, although the man had difficulties with mobility, he was mostly able to collect his food and get about the ground floor of the wing. The man's personal officer said that, although the man was not a very demanding prisoner, he did not have a very positive outlook and complained a lot. The man's personal officer recalled one occasion when the man complained about his health, and she suggested that he stop smoking. He replied, "Well I've been smoking since I was 11 so I'm not going to change now."
19. The man's personal officer said that he was not an enhanced prisoner as he denied his offences and as a result did not take part in any offending behaviour courses. (The Incentives and Earned Privileges Scheme (IEPS) is designed to encourage and reward good behaviour by prisoners. There are three tiers – Basic, Standard and Enhanced, and the incentives include in-cell televisions, more private cash, wearing of own clothes, more time out of cell and community visits.)
20. At 9:36am on 19 February 2007, an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime was started for the man. (ACCT is used to monitor and support those prisoners who are felt to

be at risk of suicide or self-harm.) It was decided that a number of events had led to the man feeling in a low mood. He had made several references in a conversation with an instructor about “sometimes feeling like ending it all”. The man was observed during the day and had a number of conversations with staff. The ACCT document was closed at 3:15pm on the same day after a further assessment by staff.

21. The man was seen by a prison doctor on 28 November 2007 as he had been suffering from insomnia. This a known side effects of Prednisolone (his steroid medication). A fortnight later the man was prescribed Zopiclone (a hypnotic drug – medication to help induce sleep – that is used to treat insomnia and other sleep disorders).
22. On 6 February 2008, the man had a mental health review and his medication was reviewed. Another mental health review was carried out a month later.
23. The man transferred to HMP Albany on 15 April 2008. He was located on F wing in a single cell with en-suite facilities. He was placed on F wing because of his limited mobility and as the wing is located near to the healthcare centre.
24. The man collapsed on 26 April, and was taken to the Accident and Emergency (A&E) Department at a local hospital. Once he arrived in hospital he recovered very quickly, and returned to Albany the same day. It was thought that he had collapsed after taking too much of his GTN spray.
25. On 6 May, a referral was made to the Ear, Nose and Throat (ENT) Department at a local hospital. The man had been experiencing chronic rhinitis (inflammation of the nasal lining). An appointment was arranged for 13 October.
26. Around 1:00pm on 25 May, the man rang his cell bell and told an officer that he was suffering with chest pain. The officer asked staff from healthcare to attend. A nurse saw the man and, as he thought the man had indigestion, gave him some Gaviscon (a proprietary medicine). The man rang his cell bell again at 2:30pm and told another officer that he wanted a second opinion on his health issues. The same nurse saw the man again around 4:00pm and maintained his original diagnosis of indigestion. The man reluctantly accepted the diagnosis. The nurse advised the man to take fluids and avoid solid foods.
27. On 27 May, the man complained of having chest pains. He was seen by a prison doctor in the healthcare centre. The doctor ordered an electrocardiogram (ECG) and recorded the following about the man’s heart:

“Broad complexes with tachycardia and RBBB [right bundle branch block]. No acute ischaemic changes noted discussed with CCU [the Coronary Care Unit at St Mary’s Hospital], not happy to accept and says it sounds like a gastric problem.”
28. As the prison doctor’s note indicates, CCU staff were initially reluctant to admit the man. This was quickly resolved and after an hour they agreed to accept

him. He was taken by ambulance to the hospital accompanied by a principal officer and prison officer. The man arrived at the local hospital around 5:10pm and was seen by a doctor at around 6:00pm. The man was located on the CCU where his condition was monitored.

29. Whilst the man was an in-patient at the hospital, a bedwatch was carried out by prison staff. The security risk assessment identified that an escort chain should be used and that two officers needed to be in attendance. This was entirely appropriate and enabled the nursing staff to have easy access when they carried out their duties.
30. The staff on bedwatch duty were informed the following day that as the man had suffered a heart attack he would be in hospital for a number of days. To help to rectify an irregular heart beat, the man was given an intravenous drip. The Head of Security and Operations visited the man during the late afternoon.
31. In his statement to the Coroner, the consultant cardiologist at the local hospital said that he first assessed the man during the morning on 28 May. The consultant cardiologist's initial diagnosis was that the man had suffered a heart attack. As his condition worsened during the day, the consultant cardiologist thought that if the man had further problems he should be moved to the Cardiac Unit at another hospital. The consultant cardiologist wrote that the man was reasonably stable for the next two days, but his condition was such that on 1 June agreement was reached in principle that he would be transferred to the other hospital later in the week.
32. Around 7:15pm on 31 May, the man was told by nursing staff to get back into his bed. They were concerned about his fast heart beat and high blood pressure. The man was seen by a doctor and was given medication to slow down his heart and oxygen to help him breathe. His condition stabilised around 8:25pm.
33. At around 3:10am on 1 June, the man had an ECG. The staff on bedwatch duty were told there was a possibility that heart start paddles could be used if the man's condition deteriorated. Permission was sought from the prison to remove the man's restraints and these were removed at 3:30am. His condition stabilised again around 3:40am. At around 9:50am, the duty governor visited the man. The duty governor revised the risk assessment for the man so restraints were not re-applied.
34. The head of security and operations visited the hospital around 10:30am the following day. As the man's condition had improved, the head of security and operations revised the risk assessment and restraints were re-applied.
35. At 10:35am on 3 June, the man was seen by a consultant who said that he would be transferred to another hospital in the next few days.
36. The hospital doctor who saw the man on the following day told the officers on bedwatch duty that he expected him to remain in hospital for the next few days.

37. Around 10:50am on 5 June, the man was moved to a side room with an ensuite bathroom. This meant that he was no longer on the main CCU ward although he was still attached to a heart monitor.
38. On 8 June 2008 at 6:25pm, two officers commenced their bedwatch duty. When interviewed by my investigator, the second prison officer said he had been on bedwatch duty for the man on 28 May, 2 June and 8 June. The second prison officer recalled that when he first saw the man on 28 May he appeared to be very ill. He said:
- “They [hospital staff] monitored his heartbeat all day long and he had ups and downs. One minute he was okay, talkative, liked to have a drink, the next minute it [the heart monitor] was going off again, his heart rate was going up.”
39. The second prison officer said that when he was on bedwatch duty on 2 June, the man:
- “Seemed okay, he seemed I mean for a man with a heart condition he seemed a lot better than when first, the first time I saw [him]. He was talkative, he was okay, he had a dry sense of humour, you know. For someone in his condition at the time he seemed okay, he seemed pretty upbeat as you can be ... he was in safe hands, if you know what I mean. He was the best place he could be.”
40. When asked about the events on 8 June, the second prison officer said that:
- “He was the best I’d seen him and just before his death, I mean I was handcuffed to him and the other officer was opposite me with the keys [to the restraints] and the nurse came in and asked him [The man] if he’d like any drinks and he sat up and he was quite happy and it was a drink I wouldn’t have myself but he asked for a Bovril with salt in it. Which I thought was very odd but he sat up, drunk it, loved it and 14 minutes, 15 minutes later he lent forward, went back then obviously it came up on the monitors. The nurse came in took one look, hit the crash button, they came in and the officer very quickly got the cuffs taken off and 17 minutes later he was pronounced dead.”
41. It was noted in the bedwatch log that at approximately 10:20pm, whilst he was still in the CCU, the man suffered a cardiac arrest. The crash team worked for some time to try to resuscitate him but were unsuccessful in their attempts. Death was pronounced at 10:37pm. The officer then reported to Albany that the man had died.
42. The prisoners on F wing were told about the man’s death the following morning. Staff on the wing also asked prisoners whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) When the officers on bedwatch duty returned to Albany they were offered support from the prison’s care team.

43. The principal officer was appointed as the prison's Family Liaison Officer. He contacted both the man's ex-wife's solicitors and the police in the man's home town but was unsuccessful in his attempts to inform the family of his death. The man's funeral took place on 26 June and he was buried on the Isle of Wight.
44. The post mortem report records the man's death as being due to natural causes, as a consequence of a myocardial infarction (heart attack) caused by coronary thrombosis (heart disease). The report says:

"The death of the man was clearly the result of natural disease. A large portion of the heart wall had died (myocardial infarct) as the result of blockage of one of the major coronary arteries supplying the heart ... in an area of degenerative narrowing (coronary thrombosis). This is a common form of 'heart attack' which, despite initial survival, was very likely to have ended fatally before long in this case because of the extent of narrowing of the coronary arteries and the large proportion of the heart wall involved. There were no features to suggest that the man had been the victim of inflicted injury of any kind."

ISSUES CONSIDERED

Clinical care

45. As noted, a review of the man's medical care was undertaken by the clinical reviewer on behalf of Isle of Wight Primary Care Trust, who convened a review panel.
46. The review found that the man had suffered from significant long-term chronic diseases. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services.
47. The review panel noted that, in late May 2008, a gastric (stomach) bug was prevalent at Albany. When the man was seen by healthcare staff on 25 May he was complaining of pain which was suggestive of a gastric and not a cardiac (heart) problem. The doctor has confirmed that gastric and cardiac symptoms can present in the same way. When the prison doctor, tried to refer the man to the local hospital on 27 May, he initially encountered resistance from the Accident and Emergency (A&E) doctors. This was quickly resolved and within an hour the admission was accepted.
48. My investigator asked the panel whether the man's myocardial infarction (heart attack) condition could have been diagnosed earlier. The doctor said that the man did not present with chest pain and his chronic obstructive pulmonary disease (COPD) was too severe for clot busting drugs to be effective. He pointed out that the man also continued to smoke against medical advice. The clinical reviewer confirmed that earlier admission to hospital would not have made a difference to the outcome, and the doctor said that an earlier electrocardiogram (ECG) would not have made any difference. The prison doctor did not see anything acute on the ECG on 27 May. It only showed expected changes due to the man's medical condition.
49. The clinical reviewer pointed out that the man suffered from insomnia caused by his steroid medication and was prescribed sleeping tablets to alleviate this. The man had been restarted on anti-depressants which were supposed to be reviewed after two weeks. This did not happen and it was unclear to the panel why it was not followed up.
50. The panel noted that the man's frozen shoulder was not treated straightaway but that it had taken a number of months for steroid injections to be given. The doctor highlighted the use of appropriate clinic time slots: a 20 minute appointment is required and patients can feel faint after the procedure. If the service were to be extended, there would be an issue with commissioning and sacrificing other appointments to allow for it. In primary care, physiotherapy followed by an orthopaedic referral would be considered as an alternative. The doctor also mentioned that in primary care patients are seen by the practice nurse for disease management of COPD and ischaemic heart disease. The doctor has suggested that this could be developed within prison healthcare.

51. The clinical reviewer has questioned the long wait for an Ear, Nose and Throat (ENT) appointment for the man. The man was referred on 6 May and the appointment was made for 13 October. However, when the referral letter was discovered after the review it was found to read:

“Thank you very much for seeing this 73 year old patient, who appears to have a hair stuck to his right tympanic membrane. This seems to cause him constant irritation and itchiness, ‘like a spider in my ear’. He was first noticed by a colleague of mine some time ago and it has not shifted at all. There is no wax present. I would be very grateful if you could consider having this removed.”

52. Due to the problems encountered with record keeping, the review panel recommended that improvements should be made in this area. There should also be increased awareness for all staff in communication and recording of conversations with other agencies.

Albany should conduct a review of medical record keeping and improvements should be made in this area.

There should be increased awareness for all staff at Albany in communication and keeping records of conversations with other agencies.

53. The clinical reviewer has concluded that, judged overall, the man’s care was good and equivalent to that he would have received in the community.

Restraints

54. The use of handcuffs for prisoners on escort to hospital has been the subject of recent case law. (Judgement by Mr Justice Mitting on 23 November 2007 in case of (1) Graham (2) Allen v Secretary of State for Justice.) The Prison Service is currently drawing up new guidance in relation to this matter.

55. When interviewed as part of this investigation, the second principal officer said:

“Our [Albany’s] policy is quite clear with staff, that if there is any deterioration in a patient’s condition or the medical staff ask that restraints are removed then the restraints are removed, if it is a life-threatening condition or on approval of the duty governor and a risk assessment and the risk assessment is carried out ... The man must have been mobile for the restraints or the risk assessment to be altered and the restraints re-applied ... I think any heart attack was a surprise to any of us because he was deemed to be on the road to recovery.”

56. According to Albany’s own policy for performing hospital bedwatches (revised March 2005) the following options are available to the Governor:

- i. Escort and bedwatch with two officers or more with restraints.
- ii. Escort and bedwatch with two officers or more, without restraints.

- iii. Escort and bedwatch with one officer, without restraints.
- iv. If eligible, release on temporary licence under Prison Rule 9 (YOI Rule 6).
- v. To allow, exceptionally temporary release for remand prisoners if they are so seriously ill or incapacitated as to be incapable of escaping and for who there is no danger of assisted escape (this power is allowed under Section 22(2)(b) of the Prison Act 1952).

The level of security necessary for all cases should be kept under review to take into account the prisoner's developing medical condition, the physical surroundings in which the prisoner is located and any emerging intelligence.

- 57. It was in line with standard procedures that the man was handcuffed in the first instance. At the time the handcuffs were first applied, the man was conscious and could have been judged to have posed a security risk. The risk assessment for the man was revised during his time in hospital when his condition deteriorated. Restraints were removed and then re-applied when the man's condition improved. Whilst the man was in hospital two officers always remained on bedwatch duty.
- 58. Policy and practice in the Prison Service in respect of the use of restraints on prisoner-patients in hospital is extremely risk averse. My own sense is that it has become too risk averse and that an elderly man with limited mobility, in serious ill health, and with no known relations, did not constitute a likely escapee. However, I do not criticise the decisions taken by Albany given the prevailing climate and the expectations of the Service as a whole. That said, I would ask the NOMS Safer Custody and Offender Policy Group to draw my comments in this paragraph to the attention of those drawing up the new guidance.
- 59. In a written response dated 28 November 2008, the NOMS Safer Custody and Offender Policy Group wrote:

"With regard to the comments on restraints, in this particular case staff acted quite correctly in reviewing the risk assessments. The Graham Judgement was quite particular in that its criticism was about restraining prisoners receiving life saving treatment such as chemotherapy. Revised national guidance on restraints will have a specific new section dealing with terminally ill or seriously ill prisoners."

CONCLUSION

60. The man moved to Albany in April 2008 and died from natural causes in outside hospital on June 8 2008.
61. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were in line with current policy and expectations, although my own view is that Prison Service practice has become unduly risk averse.
62. The man entered custody in 2003 with very serious physical health problems. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. The review panel has made two recommendations which I endorse. They will need to be addressed by the Isle of Wight Primary Care Trust in partnership with the Governor of Albany.

RECOMMENDATIONS

1. Albany should conduct a review of medical record keeping and improvements should be made in this area.

Accepted - The Healthcare and In-patient Managers have reviewed and disseminated good practice guidelines through the teams, this is also included in induction of new staff

2. There should be increased awareness for all staff at Albany in communication and keeping records of conversations with other agencies.

Accepted - Work has been undertaken with the healthcare teams across all three prisons (Albany, Camp Hill and Parkhurst) highlighting the importance of accurate, timely records and communication with other agencies. Healthcare staff assess all patients prior to their return to prison to ensure continuity of and appropriate levels of care are maintained.