Investigation into the circumstances surrounding the death of a man at HMP Isle of Wight in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

The man was a prisoner at HMP Isle of Wight (Albany site) when he died of disseminated adenocarcinoma of the stomach (stomach cancer) in March 2010. He was 52 years old when he died.

I would like to extend my condolences to the man's family and friends and all those affected by his death. I apologise for the delay in issuing this report and for any distress this has caused.

My colleague was appointed to investigate the circumstances of the man's death. A clinical review was commissioned from Isle of Wight Primary Care Trust and led by a clinical reviewer. I am grateful for his contribution to this investigation, and to the members of the panel convened to assist the review.

I am also grateful to the Governor of HMP Isle of Wight and his staff for their help and co-operation during this investigation. In particular I would like to thank the individuals who acted as liaison for the investigation.

The clinical review carried out by the clinical reviewer and his panel found that the man had received appropriate treatment after being diagnosed with cancer in 2009. However, they were concerned that an attempt was made to resuscitate the man when healthcare staff clearly thought that he had died. The man's family also had concerns about the manner in which they were informed of his death. I am satisfied that although staff acted according to the instruction of the relevant Prison Service Order, news of the man's death reached the family by other means before officers had left the island to break the news. In my opinion, this could have been avoided.

I make three recommendations as a result of this investigation. One relates to family liaison, and another the compassionate release process. I also make a recommendation about resuscitation.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **September 2011**

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SUMMARY

1. The man was convicted in 2004 of serious sexual offences. He arrived at Albany at the end of that year. He had little contact with healthcare during the first five years of his sentence, other than receiving painkillers for an old hip injury and medication to help him lose weight.

2. In the summer of 2009, the man reported having difficulty swallowing and mild stomach pain. He was prescribed medication and a follow-up appointment was made. However, he missed that appointment and it was over two months after he first reported symptoms before he was sent to hospital for an urgent endoscopy (a surgical procedure in which a camera is inserted into the oesophagus).

3. Shortly afterwards, the man was diagnosed with stomach cancer. Over the next few months, he had chemotherapy treatment and was seen regularly by specialists in palliative care.

4. In February 2010, the Parole Board rejected an application for his release, as they thought that he still needed to address his offending behaviour. His health began to deteriorate at the start of March and he agreed to move from the wing to the healthcare centre.

5. However, on the day of his proposed move, he was found unresponsive in his cell. Although most staff thought that he had died, they tried unsuccessfully to resuscitate him. Although family liaison officers left the prison soon after the man's death was confirmed, his family learnt of his death after another prisoner telephoned them.

6. I make three recommendations as a result of this investigation. One recommendation relates to family liaison, and another to the compassionate release process. I also make a recommendation about resuscitation.

THE INVESTIGATION PROCESS

7. Following notification of the man's death, one of my investigators was appointed to conduct the investigation. HMP Isle of Wight provided a copy of his prison records, including his medical records. Notices were issued to prisoners and staff inviting anyone who had information regarding the man's death to make themselves known to the investigator. No other witnesses came forward.

8. My investigator visited HMP Isle of Wight on 5 May 2010 to carry out recorded interviews with seven members of staff.

9. One of the Ombudsman's Family Liaison Officers contacted the man's family to explain the role of the Ombudsman and to offer the opportunity to participate in the investigation. They asked for the following concerns to be addressed.

10. The man's Parole Board hearing was in November 2009 and his consultant submitted a letter requesting that he should be moved nearer to his family due to his short life expectancy. The family were concerned that this was not granted and caused them difficulty in visiting him. They said they did not know when they could visit because of the man's hospital appointments and said they felt as if they were constantly asking the prison to try to arrange visits. The man's family said the prison did not seem to facilitate the visits and, given the gravity of his illness, they found this unacceptable. They believed a better system for visiting terminally ill prisoners should be in place that causes less stress and upset for families. The man's family said that he had been well cared for in prison, but felt that the problems were due to security issues.

11. The man's family contacted the prison at 12.30pm on the day of his death and were told that the Governor would telephone them back. They were then told by another family member that the man had died. They contacted the prison again and were once again told that someone would call them back, but again nobody telephoned. The Governor eventually telephoned at 4.00pm and explained that he could not discuss the man over the telephone and was sending two staff members to their home. The family expressed concern that another family member had already been telephoned by a prisoner and told that the man had died. They were concerned about the prisoner's offences and wondered how he had obtained the telephone number and been allowed to speak to the family member and her children. The family confirmed that the man's property had been returned to them, apart from a couple of photographs and that the prison had assisted with the cost of funeral expenses.

12. Isle of Wight Primary Care Trust were commissioned to conduct a clinical review. They appointed a clinical reviewer to conduct the review. The clinical reviewer also carried out some joint interviews with my investigator. A review panel meeting was held in June 2010, and the minutes of this meeting forwarded to my investigator late in August.

13. Both the prison and the man's family were given the opportunity to comment on the draft report. The prison responded on 4 May and my family liaison officer spoke to members of the man's family who gave their response in September 2011. Both the prison and the man's family give different accounts of the issue regarding family visits. This is covered in detail in the issues section of this report.

HMP ISLE OF WIGHT – ALBANY SITE

14. HMP Isle of Wight was inaugurated on 1 April 2009. It is the amalgamation of the former Albany, Camp Hill and Parkhurst prisons. HMP Isle of Wight holds approximately 1,700 prisoners across the three sites. Each site has its own Director who reports to the Governor of HMP Isle of Wight.

15. Albany is a category B training prison. It opened in 1967 on the site of a former military barracks. It offers a varied regime with education and several offending behaviour programmes.

16. There are five wings that have single cells and access to electronic night sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small areas on each landing with communal recesses containing showers, toilets and wash basins.

17. Health services at HMP Isle of Wight are commissioned and provided by Isle of Wight Primary Care Trust (PCT). A new in-patient healthcare unit (IHU) was opened in October 2009 and situated at Albany. It has 12 beds and provides for prisoners with a wide range of health needs who require a hospital type in-patient care within a prison setting.

18. Doctors from a local community practice attend Albany for four three hour sessions each week. Evenings and weekends are covered by on-call doctors from the same practice. Prisoners with more serious conditions or clinical needs are referred to the local hospital.

19. A risk assessment must be completed when prisoners attend hospital in-patient and out-patient appointments. This is to determine the level of escort and restraints (handcuffs) required to ensure the safe custody of the prisoner. Restraints are applied if the risk assessment states they are necessary. If a prisoner is admitted to outside hospital, prison staff will carry out a bedwatch duty. This means the staff will stay with the prisoner at all times and maintain a log of all activity. Visits may be allowed from the prisoner's family, but these will be closely monitored to ensure they do not interfere with security.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The latest available report for Albany, for the year 2007/08, drew attention to limitations in the healthcare services at Albany. However, since this report was issued, the new healthcare centre has been completed.

Her Majesty's Chief Inspector of Prisons

21. The last inspection report covering Albany was published following a full, announced inspection conducted between 12 and 16 November 2007. In her

foreword, the then Chief Inspector of Prisons noted that five of the wings at Albany lacked internal sanitation, a practice that she called "unacceptable in a 21st century prison". However, she described Albany overall as having an "important, difficult and specialist role" and that it delivered "well-run and effective [offender] treatment programmes".

22. Inspectors also found that access to primary medical services was good, although staffing more generally was a problem across the Isle of Wight cluster. Secondary healthcare was provided by hospitals on the island and mainland, but appointments were often cancelled because of a lack of escorts.

Previous deaths in custody at Albany

23. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 23 deaths at Albany, of which 19 occurred before that of the man who is the subject of this report. All but two of these deaths have been because of natural causes. Although several of these deaths were due to cancer, there are few similarities in the circumstances between those and this man's death. I have, however, made a recommendation in the past about visiting orders for the families of terminally ill prisoners.

KEY EVENTS

24. The man arrived at HMP Isle of Wight from HMP Exeter on 12 November 2004. He had been convicted of several sexual offences at a crown court and, on 26 October 2004, was sentenced to ten years in custody. He was due for a parole review in December 2009. This was his first prison sentence.

25. As is usual on reception, the man was seen by healthcare staff when first remanded in custody at Exeter. He reported that following a motor cycle accident when he was 20, he had arthritis in his hips and was waiting for a hip replacement operation. (He later agreed that the operation should be left until after his release.) At both Exeter and Albany, the man was accommodated in suitable locations to help him cope with his lack of mobility.

26. After he arrived at Albany in November 2004, the man was given a cell on C wing and worked as a cleaner on the wing for a short while, until starting work at the wood mill. He remained working at the wood mill until shortly before his death. The man also completed several treatment programmes. In an assessment for a parole application in 2009, an officer wrote that the man had completed the Sex Offender Treatment Programme and the Enhanced Thinking Skills programme with "good reviews". The officer said that the man "appears to have benefited considerably [and] understands his offending behaviour".

27. The man was seen by healthcare staff on a number of occasions between his reception into Isle of Wight and 2009, although none of these appointments appear to have been significant. On several occasions, the man reported having pain in his hip. In addition to being given painkillers, he was advised to try and lose some weight. He was also prescribed orlistat, a medication which assists weight loss, in December 2008. Over the next four months, the man's weight was monitored, and it was noted that he was "responding to orlistat".

28. However, on 23 June 2009, the man reported a short history of weight loss (although he had been on a diet), difficulty in swallowing and mild abdominal discomfort. He was prescribed a 28 day course of omeprazole (a drug which inhibits the production of stomach acid) and a nasal spray. The next entry in the medical records shows that the man was prescribed a further 28 day course of omeprazole on 21 July. Six days later, he was issued with paracetomol (a pain killer) and Gaviscon tablets (also for stomach acid problems).

29. The man failed to attend a doctor's appointment arranged for 31 July. He did not go to healthcare again until 18 August, when another course of omeprazole was prescribed.

30. On 7 September, the man attended healthcare as he was again having difficulty swallowing. He said that solid food kept getting stuck in his throat. He was referred to outside hospital for an urgent gastroscopy (a procedure in which a camera is used to view the upper alimentary canal). This took place three days later.

31. Just over a week later, the man was seen by a doctor at Albany who had received a letter from a consultant at outside hospital. The letter confirmed that the man had a malignant neoplasm (cancer) of the pyloric canal (the pyloric canal is the opening between the stomach and the small intestine). The doctor at Albany discussed the diagnosis with the man, and prescribed two antibiotic drugs, clarithromycin and amoxicillin, and Lansoprazole, to help combat stomach acid.

32. The next day, the man had a further CT scan (computerised tomography, an imaging method that uses x-rays to produce a cross sectional view of the body). On 29 September, the hospital tests confirmed that the man had adenocarcinoma (a form of cancer) of the stomach and oesophagus with extensive metastatic deposits in his liver and lymph nodes (which means that the cancer had spread from its initial location). At first, the man appeared to be in shock when he was given the news, and was tearful and low for a number of weeks. An officer on the man's wing said that after a while he appeared to come to terms with his diagnosis and began to put his affairs in order.

33. The man spoke to an officer on his wing about his parole application. He asked the officer whether he thought he might be eligible for compassionate release. The officer suggested that he should speak to his offender supervisor in the first instance.

34. On 13 October, the man began chemotherapy treatment after seeing an oncologist the week before. He discussed his diagnosis with a consultant in palliative care at outside hospital, and he was told that his cancer was inoperable but that palliative chemotherapy was an option. A senior staff nurse at Albany also discussed the man's care with the consultant in palliative care. They discussed the possibility of bacterial infection while the man was undergoing chemotherapy, and the consultant in palliative care stressed the importance of monitoring the man's temperature. The senior staff nurse arranged for a thermometer to help the man monitor his own temperature.

35. By late October, staff at Albany began collating evidence for a parole application. The man confirmed to healthcare staff that he was happy for details of his illness to be shared with prison and probation staff.

36. The man saw a doctor at Albany on 29 October. He reported having several side effects, including diarrhoea and insomnia, for which he was prescribed Immodium and zopiclone respectively. The next day, the man was seen by healthcare for a flu vaccination. His temperature was recorded as 37.4C, and he was taken to outside hospital as a precaution. He returned to Albany on the same day, and eventually had the vaccination on 20 November.

37. From paperwork held on the man's file, it is clear that by January 2010 staff at Albany had started to prepare an application for compassionate release. A woman from the Offender Management Unit at Albany explained the process for applying for parole to my investigator. She explained that the man had

completed the application for parole which had been forwarded to her department. As there is a considerable amount of paperwork, including reports, which need to be compiled, the process can take three or four months. The woman from the Offender Management Unit at Albany recalled that an officer told her around this time that the man was unwell and asked her to look into raising an application for early release. She explained that as he was going through the normal parole process anyway, it would be ideal to send all the paperwork to the Parole Board so they could consider the man's release under normal procedures and also under compassionate release.

38. The woman from the Offender Management Unit at Albany also explained that her department were still awaiting an internal probation report, a governor's report and a healthcare report for the man. She eventually received two of these reports, but the governor's report remained outstanding. While the medical case for release was made, the prison probation officer thought that the application was "premature", as the man continued to be "quite active". The prison probation officer noted though that he hoped that a future application would be expedited if the man's condition deteriorated

39. The woman from the Offender Management Unit at Albany sent the paperwork she had to the Parole Board, for the man to be considered for release under normal parole conditions, as they did not have the governor's report to submit for consideration for compassionate release. (My investigator also interviewed the governor who the woman from the Offender Management Unit at Albany said she requested the governor's report from. The governor told my investigator that he did not recall seeing any paperwork for the man, and in any case, was not the governor responsible for parole. The governor presumed that if such paperwork had been sent to him, he would have forwarded it to the Governor or Deputy Governor of the Isle of Wight site.)

40. For the next three months, the man continued to receive chemotherapy at regular intervals. In a letter to his solicitors on 29 January, the consultant in palliative care reported that the man had responded well to chemotherapy, although he had started to deteriorate. However, he was also being treated for a pain in his right side, which the consultant in palliative care thought might represent a sign that his cancer had started to progress. The man also had a low blood count. (Blood counts count the number of cells in the blood. A low blood count is often a side effect of chemotherapy.)

41. The Parole Board met on 9 February to discuss the man's parole application. The Board decided that the risk he presented was such that he could not be safely managed in the community, and they refused the application. In refusing the application, they noted that he pleaded guilty at court and had completed a number of courses to address his offending behaviour. They also noted his illness and the likely prognosis. They found, however, that further offender treatment work was necessary, and also took into account that both the man's offender manager and senior probation officer had recommended that the application be refused.

42. In the meantime, the consultant in palliative care wrote to the prison suggesting that they considered compassionate release. A doctor at Albany saw the man and passed him fit to work in his old workshop.

43. A consultant of palliative medicine saw the man in his cell at Albany on 26 February. The consultant of palliative medicine later wrote to the consultant in palliative care describing the man as being "in good spirits" and being able to swallow comfortably. They discussed the possibility of the man being released and returning to the south-west of England to be near his family. The consultant of palliative medicine agreed to meet the man a month later.

44. On 4 March, the man attended a support group with a nurse. The nurse noted that he looked pale, and asked the man if he wished to speak to her alone. He told her that he was starting to find it hard on the wing, with some insensitive comments from other prisoners. The nurse suggested that he move to the impatient unit for a few days for some respite, and the man agreed to consider this.

45. Two days later, the nurse saw the man again. He asked if he could be moved to a lower level of the wing as he was getting breathless walking up the stairs. Staff agreed to consider this. The man also said that he would see a doctor the following week to review his pain control medication. The nurse recorded that the man was being "positive" about his condition, although he was concerned about telling his partner, a prisoner on another wing, about how bad his condition was.

46. The man was seen in healthcare by a senior staff nurse on 8 March. The senior staff nurse noted his severe weight loss and telephoned the consultant in palliative care for advice. The consultant in palliative care asked how the application for compassionate release was progressing, and the senior staff nurse told her that the paperwork was still being prepared. The next day, the consultant in palliative care advised that the review with the consultant of palliative medicine should be brought forward in light of the man's deterioration and increasing pain. At the same time, an officer asked him if he would be prepared to move to healthcare.

47. The next day, the same officer unlocked the man at approximately 9.30am. The man confirmed that he would like to move to healthcare. The officer arranged for some other prisoners to help the man pack his belongings and, while they were doing so, the man went to speak to a prisoner in another cell. Shortly afterwards, the man said he felt unwell and was seen by a senior staff nurse who noted that he looked "sallow and waxy and … ill at ease with his various aches and pains". A further nurse checked on him at about 10.45am. By this time, the man was back in his own cell. His belongings were packed and he was ready to move.

48. An officer was on duty that day and was responsible for locking prisoners back in their cells for lunch on the man's landing. At approximately 12.15pm, he went to the man's cell and found the door closed but unlocked. He opened the observation panel on the door and thought that the man was sleeping as

he was lying on the bed. As he was about to lock the door, the officer remembered that the man was ill and instead went into the cell to check on him. However, he could not get a response from the man, and noted that his lips were blue and "his skin did not look natural". As he did not have a radio (not all officers on the wing are allocated a radio when they begin their shift), the officer locked the cell and went to get help. He saw an officer further along the landing and asked him to come to the cell.

49. The officer who came to help his colleague confirmed to the investigator that he thought the man had died, and called for urgent medical help on his radio. (Unlike other prisons, Albany does not use a code system to describe the type of emergency.) Two nurses went to the cell with an emergency bag and checked for signs of life, but were unable to find any. The officer who had first found the man in his cell was asked to contact the control room and paramedics were called. They were joined shortly afterwards by a senior staff nurse and another colleague who was also a nurse.

50. The senior staff nurse assessed the man and found that he had no pulse, was not breathing and had fixed pupils. When interviewed by my investigator, the senior staff nurse told her that he thought that the man was dead and that he had died peacefully. He believed that the most dignified course of action would have been to leave the man, but he was also aware that other members of staff were questioning whether they should attempt to resuscitate him. As a result, the senior staff nurse decided that they should attempt to resuscitate the man and, with another nurse, he started chest compressions. He also used the emergency defibrillator (a machine which detects electrical activity in the heart and advises on what action to take) but was advised by the defibrillator not to administer any shocks.

51. Shortly afterwards, at 12.35pm, paramedics arrived and took over the resuscitation, moving the man to the corridor (other prisoners had been locked in their cells by officers shortly after the man had been found). They continued until a doctor arrived from the Parkhurst site after being asked to attend. At 12.55pm, the doctor confirmed that the man had died.

52. Following the man's death, two family liaison officers were appointed. After making some checks, arranging a hire car and collecting some overnight clothes, they left the prison at 3.30pm to visit the man's family in Devon.

53. However, before they had left the island, the SOs were told that the family had already been informed of the man's death by a prisoner at Albany. They continued the journey, but agreed to visit the family the following day rather than the same evening.

54. Other prisoners on the man's wing were told of his death by the Head of Safer Custody. The Head of Safer Custody asked them to speak to staff if they were upset, and they were also offered the opportunity to speak to a Listener (Listeners are prisoners who are trained by the Samaritans to offer support to other prisoners). All prisoners who were receiving support under ACCT procedures (which aim to protect prisoners at risk of self harm or suicide). He

also confirmed to them that the man's partner, who was on a different wing, was being supported.

55. A briefing for staff was held, in which they discussed any concerns and were offered support. Notices were issued to prisoners and staff by the Director of Albany informing them that the man had died and explaining the support available to them.

56. The man's funeral was held on 25 March. One of the family liaison officers went to the funeral on behalf of Albany, accompanied by a Governor, and the prison contributed to the cost of the funeral. The family liaison officer met the man's sister the day before the funeral and returned his property.

ISSUES

Clinical care

57. A review of the clinical care provided to the man was conducted by a clinical reviewer. A panel review meeting was held on 29 June 2010.

Diagnosis of the man's illness

58. The first issue the panel reviewed was whether the man's cancer was diagnosed appropriately. He had initially complained of having difficulty swallowing on 23 June 2009 and was seen by a doctor. He was prescribed medication and a follow up appointment arranged. However, the man did not keep the appointment for 31 July, although it is not clear why. When he next saw the doctor, on 18 August, he was given further medication and was then seen again on 7 September. At this point, the man was referred to outside hospital for an urgent endoscopy.

59. The review panel noted that a prison doctor at Albany had arranged a follow up appointment for the man, but that he had not attended. The doctor from the Parkhurst site, who was a member of the clinical review panel, thought that the man did not meet the criteria for an urgent referral when he first saw the prison doctor and noted that a further follow up appointment was made for him.

Attempt to resuscitate the man

60. When the man was found in his cell on the day of his death, both officers who first attended to him thought that he was dead. The officer who had responded to the call for help from the original officer who had found the man confirmed when interviewed by the investigator that he thought the man had been dead for at least 20 minutes. He called for assistance, saying that there was a medical emergency, but did not give any further details as there were other prisoners on the landing.

61. It is clear that staff responded quickly to the officer's call. Two nurses arrived with appropriate medical equipment, and further help arrived shortly afterwards. A senior staff nurse told my investigator that, when he arrived, the nurses were checking for signs of life and that they believed that he had died.

62. The senior staff nurse also checked the man and believed that he had been dead for some time. Given his knowledge of the man's illness, he felt that it would be inappropriate to attempt to resuscitate him. However, while he was making his assessment, he became aware that other members of staff were suggesting that an attempt should be made and that they were becoming anxious. The senior staff nurse then decided to attempt to resuscitate the man. The doctor from the Parkhurst site noted at the panel review that, when she arrived, a resuscitation attempt was ongoing, which surprised her.

63. I am satisfied that the man was, in all likelihood, already dead when the first officer found him, and that he had died some time before. Given that he was terminally ill, I also agree with the senior staff nurse that resuscitation was not the most appropriate cause of action. The clinical review panel also found that the attempt to resuscitate the man was not respectful. I make a recommendation about this issue. This is to ensure that staff are aware whether terminally ill prisoners wish to be resuscitated when they die. (I accept that, when he died, the man was not on the healthcare unit and, even if this had been discussed with him, not all the staff on the wing would have been aware, given confidentiality issues.)

The Governor and Head of Healthcare should ensure that a Do Not Resuscitate (DNR) policy is in place for terminally ill prisoners and that the relevant staff are aware of the policy.

64. The review panel made a further recommendation about healthcare having the right to decide whether a resuscitation attempt should be made. They refer to PSO 2700 (a Prison Service Order which relates to suicide and self harm attempts) in their recommendation. I do not make a recommendation of my own, but would urge the Governor and Head of Healthcare to make sure that this issue is discussed openly at Albany, and that officers and healthcare staff feel able to make decisions in the best interests of terminally ill prisoners.

65. Overall, the panel found that the man received the equivalent standard of care to that of a patient in the community.

Refusal of parole

66. The man's family have asked me to look at the decision of the Parole Board in November 2009, when his application for parole was refused. Decisions of the Parole Board do not fall within my terms of reference and I am unable to comment on the decision itself. However, I have given a copy of the Parole Board's refusal to his family, and I hope this will help them understand the decision.

The delay in submitting documents for compassionate release

67. There seemed to be some confusion about who the man's application for release on compassionate grounds was forwarded to. The Executive Officer in charge of the Offender Management Unit said that she forwarded the governor's report to the Director of Albany but had not received a completed copy. She said that without this report, the man could not be considered for compassionate release, but only for parole under normal conditions. It is unclear how much effort was made to chase up the outstanding report. It appears that it took the intervention of a senior officer, who asked about the man's parole decision, to alert staff to the outstanding report. This was only a short time before the man died. In any case, it appears that the paperwork was not sent to the correct governor, and was mislaid.

The Governor should ensure that staff are aware of the roles and responsibilities of staff in compassionate release applications, and that there is a system in place to ensure the appropriate actions are taken in a timely manner.

Family visits

68. The man's family have also said that they found it difficult to visit him, partly because of his medical treatment. My investigator has not found any record that the man had any difficulty arranging visit orders and, indeed, an officer said at interview that the man did not mention having any difficulties. I am also aware that one of the man's sisters spoke to outside hospital and knew when his appointments were, as this was recorded in his file. There was no mention there that his prison visits should be curtailed. It is clear, however, that the man's family feel that it was very difficult to visit him, which distressed them especially given the nature of his illness. I have previously made a recommendation in another case about visiting orders for terminally ill prisoners at Albany. While I do not repeat the recommendation here, I suggest that the Governor assures himself that the visit process for those with terminal illnesses is as straightforward as possible.

69. The man's family were given the opportunity to comment on the draft report. They had felt extremely distressed and upset by the report and gave their comments to my family liaison officer on 6 September. In their response they told my family liaison officer that their most significant concern was their inability to see the man towards the end of his life. They said they found the prison unhelpful and felt that due to the man's terminal condition, special consideration should have been given to the family when arranging visits. The man's family lived 150 miles from the prison and when they contacted the prison to arrange a visit for that or the following day, they report that the prison refused to tell them if the man was there or not. The man's family feel that concessions should have been made when he became seriously ill and the facilitation of visits made a little easier.

70. However, the prison's response on 4 May on this matter differs from the family's account. They reported as follows:

    "[The man's] sister and brother-in-law…. (nominated NOK), stated to establishment FLO's that the reason that they had not been able to visit [the man] recently was because he had instructed them not to come to the Island as he was undergoing lots of tests and treatment at hospital and he did not want them to have a wasted journey if on the day of a visit he was taken to hospital for an appointment. He told them to wait until he had a better idea of what was happening and then to arrange visits. Unfortunately [the man] died several weeks before the doctors predicted that he would and obviously before his family had visited.

    During my conversations with them they expressed sadness that they had not seen [the man] before he died but did appreciate that he had put off their visits himself with their best interest at heart.

This is contrary to the Ombudsman's investigator's draft report which seems to indicate that they were refused or stalled in their attempts to visit by the prison. It is the establishment's practice to be extremely flexible with family visits for terminally ill prisoners but if the prisoner restricts the family that is his decision. I feel that this is not accurate and that the report should be amended to reflect my comments above."

Informing the man's family of his death

71. Prison Service Order (PSO) 2710 (Follow up to deaths in custody) provides guidance for prison staff on the best and preferred ways to inform families of a death. The recommended option is that "the family should be informed face to face as soon as possible after the death". It is clear to me that staff at Albany were trying to comply with this, the recommended, option. However, the PSO also lists other options, and in particular mentions that they might be used when the next of kin live at some distance from the prison. The location of the prison on the Isle of Wight is clearly a factor which should be taken into account in deciding what might be the best way to break such bad news. I believe that the Governor should make sure that family liaison officers are aware that they should use the appropriate option according to individual circumstances.

The Governor should ensure that family liaison officers choose the most appropriate method to inform a family of a death in custody.

72. The PSO also states that "Using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort". It is unfortunate that the man's family telephoned the prison on the day that he died but staff did not feel that they were able to tell them about his death. However, a senior staff nurse, in particular, commented that he had spoken previously to the man's family and would have been comfortable about breaking the news to them.

73. The man's family have also asked how another prisoner was able to telephone them with news of his death. On 24 November 2008, the man's partner asked to be allowed to include the telephone number of one of the man's sisters on his agreed list (prisoners are only allowed to make calls to numbers on the list). On a security report for this date, an officer recorded that he spoke to the man's sister and she agreed to the request as her brother was expecting to be transferred and wanted his partner to let his family know where he was. This explains why the prisoner had the man's sister's number and, as it was on his agreed list (known as a PIN list), why he was able to call her. I hope that this explanation answers the family's concerns.

CONCLUSION

74. The man was serving a long prison sentence when he was diagnosed with stomach cancer in 2009. An application for parole was refused and, after his health began to decline, he was about to move to the healthcare unit when he died suddenly.

75. While, overall, the man was well cared for at Albany, I have found that there are three areas for improvement. These include that a do not resuscitate policy is put in place, and that consideration is given to changes in how families are informed of deaths in custody.

76. The prison and the man's nominated next of kin have different accounts of their experience of facilitating family visits. Both forwarded their comments to the Ombudsman's office after the draft report was issued. It is not for the Ombudsman to judge which account is most accurate, but it is important to record that these differences exist.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that a Do Not Resuscitate (DNR) policy is in place for terminally ill prisoners and that the relevant staff are aware of the policy.

   Accepted by the prison. They responded as follows:
   "Staff will use the UNIFIED DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) ADULT POLICY which is available on the Trust website a copy has been sent to all Nursing Leads for dissemination to all Prison Healthcare staff."

2. The Governor should ensure that staff are aware of the roles and responsibilities of staff in compassionate release applications, and that there is a system in place to ensure the appropriate actions are taken in a timely manner.

   Partially accepted by the prison. They responded as follows:
   "The system for Compassionate Release has historically been appropriate – at the time of [the man's] death the establishment was going through major changes with respect to 'Clustering' of three sites. This did cause confusion over overall responsibility for Compassionate Release Applications at the senior level. However, [the man's] case and poor prognosis was taken into consideration by the Parole Board and early release was declined. A system is in place to monitor and manage the remaining time for terminally ill prisoners at HM Prison Isle of Wight. When the establishment is made aware of a prisoner's poor prognosis, the Death in Custody Lead meets regularly with the prisoners on a personal basis to discuss their wishes (this includes Compassionate Release) and to help smooth the way for family contact. Due to Medical in Confidence policies, the establishment will not always be aware of an accurate prognosis of a terminally ill prisoner and often relies upon the prisoner informing the staff of his prognosis."

3. The Governor should ensure that Family Liaison Officers choose the most appropriate method of informing a family of a death in custody.

   Not accepted by the prison. They responded as follows:
   "This issue arose due to [the man's] family dynamics; the establishment carried out the Family Liaison role appropriately with the nominated next of kin. [The man's] two sisters held differing views on the fact that [the man] had been in a long term relationship with another prisoner. [The man's] 'partner' had authorised telephone contact with one of [the man's] sisters who was accepting of the relationship, but no contact with the sister who was nominated Next of Kin. When [the man] died, the establishment deployed FLO's to visit the nominated Next of Kin. This was to conduct the face to face breaking of the news of the death of [the man]. [The man's 'partner' contacted one of [the man's] sisters and broke the news of the death of [the man] whilst the FLOs were travelling to the nominated Next of Kin. This situation could not have been avoided if the establishment had chosen other options to inform the Next of Kin.'