PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in June 2011 at HMP Albany

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Albany. He died in June 2011 aged 52 years old, due to acute suppurative pneumonia and ishaemic heart disease. I would like to offer my condolences to those affected by his death.

The investigation was carried out on my behalf by an investigator. I would like to thank the Governor of HMP Isle of Wight and his staff for their co-operation with the investigation. The local Primary Care Trust (PCT) commissioned a clinical review into the standard of healthcare the man received HMP Albany. I would like to thank them for appointing a clinical reviewer. I apologise for the delay in publishing this report.

The man had suffered from ill health for some time, having suffered two heart attacks and a stroke. His health declined over his years in prison and he was treated in both the inpatient healthcare unit (IHU) at Albany and outside hospital. He also had appointments with specialist services.

Overall, the investigation found that the level of care he received was, at least, equivalent with that he might have expected in the community. The man's death was expected and plans were put into place by the prison to ensure he was cared for appropriately. I make one recommendation to further improve Albany's end of life policy.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2012**

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SUMMARY

1. The man was remanded into HMP Pentonville in 2004, charged with serious offences. He was sentenced to 11 years imprisonment and, on 5 July 2005, transferred to HMP Albany.

2. He suffered a heart attack in 1998, from which he fully recovered. He had a stroke in August 2006 and another heart attack in December of that year. Due to his health problems, he had limited mobility and used a wheelchair.

3. On 27 January 2010, the man was admitted to hospital with shortness of breath and other symptoms. He was diagnosed as suffering from acute left ventricular failure and was noted to be weak and unable to mobilise on his own. He was cared for by prison healthcare over the following year with no further significant health problems.

4. The man was admitted to hospital on 1 May 2011 with acute heart failure. An echo scan (this is an ultrasound test on the heart, also known as an echocardiogram) showed left ventricular impairment to be the cause of these symptoms. Prison healthcare staff made plans to ensure his health needs were met. On 16 May, his cardiologist informed the prison doctor that surgical treatment was not an option and, as his condition was terminal, he would need palliative care. He was admitted to hospital twice in ten days and was not fully stable. He was closely monitored by staff in the in-patient healthcare unit at Albany and advice was sought from outside specialist services.

5. Three days later a request for compassionate release was made by one of the prison chaplains as he considered that the man's ability to re-offend was "severely curtailed" by his health. As he had no contact with his family, the reverend suggested he would require accommodation in a nursing home.

6. The following day, a prison doctor and the consultant in palliative care from an outside hospital discussed his care. They decided it would not be appropriate to conduct resuscitation if he suffered from a cardiac arrest and the appropriate forms were completed. This was not discussed with him as the doctor thought it would be too distressing for him.

7. The man's condition deteriorated and, on 1 June, he said he did not want to be offered oxygen and said that he was not uncomfortable or in pain. His cell was left fully accessible as he was totally immobile which enabled staff to give immediate medical supervision. On 2 June, he was diagnosed with pneumonia and the Liverpool Care Pathway (this is a plan of action for medical staff to follow when managing the final days and hours of a patient's life) was implemented. On 4 June, he drifted into a comatose state.

8. The man was checked hourly by staff and, at 11.43am an officer noticed that he was not breathing. Nurses attended his cell who confirmed that there were no signs of life. Paramedics and the prison doctor attended and he was pronounced dead at 12.40pm.

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened by an investigator, on behalf of the assigned investigator, on 16 June 2011. Notices were issued to staff and prisoners at Albany informing them of the investigation and inviting them to contact the investigator should they wish to talk to her regarding the investigation. No-one came forward in regard to the notices.

10. The investigator spoke to senior prison managers and received copies of all documentation relating to the man's time in custody. She reviewed the documentation enabling her to create a chronology of events of his time at Albany.

11. The investigator liaised with the Governor throughout the course of the investigation, informing him of preliminary findings and highlighting any issues that had become apparent and would be investigated further. The delay in the publication of this report was caused by workload pressures in the office.

12. HM Coroner for Isle of Wight was contacted and informed of the nature and scope of the investigation. On completion, a copy of this report will be sent to Mr Matthews to assist his enquiries into the man's death.

13. An independent clinical review was undertaken on behalf of the local Primary Care Trust by a clinical reviewer. The clinical review was received on 21 October 2011.

14. The man had no contact with his family and despite extensive efforts by staff and outside agencies to try and trace them none were located before he died. Therefore, there has been no involvement with his family during the course of this investigation.

15. The investigation assesses the following aspects of the man's care and treatment:

- Whether his diagnosis was made in a timely fashion?
- Whether he was treated properly and attended hospital appointments as necessary?
- Whether he was told about his condition and the treatment which followed?
- Whether the liaison with his family was appropriate?
- Whether he was accommodated in the most appropriate part of the prison?
- Whether consideration was given to compassionate release from prison?
- Whether appropriate palliative care was provided?

HMP ISLE OF WIGHT – ALBANY SITE

16. HMP Isle of Wight was opened on 1 April 2009 as an 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. The Albany site is a category B training prison with seven residential units. It offers a varied regime including education and several offending behaviour programmes.

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 is situated at Albany. It has 12 beds and provides 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.

Her Majesty's Chief Inspector of Prisons

19. The last inspection report covering Albany was that following a full, announced inspection of HMP Isle of Wight conducted in October 2010. The Chief Inspector of Prisons noted that:

> "In Parkhurst and Albany the primary care environments were poor. Nurse-led clinics varied across the sites, as did waiting times for the GP and other health professionals, which were long. There were numerous problems with medicines management, and dentistry services were not at full strength. There were long delays and cancellations for secondary care appointments. The inpatient unit environment had improved but lacked structured or therapeutic activity for patients."

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 ensuring proper standards of care and decency are maintained. Each IMB produces an annual report and the latest one for HMP Isle of Wight in 2010 focuses on all three sites. The report commented on healthcare at the Albany site:

> "Major work was done this year to the centres, which over the summer lead to clinics being cancelled. In the past 3 months there has been a reduction in waiting lists… The doctor attends the site 7 sessions per week… There are approximately 150 supervised medications every day."

> "Since July this year there have been 336 cancelled appointments; 11% attributed to the prison not being able to deliver the prisoner, 19% the prisoner not wanting to attend, and remainder being the hospital cancelling the appointment. There is often a lack of communication between the hospital, the Healthcare Centre and IHU."

Previous deaths in custody at Albany

21. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 26 deaths at Albany, of which 23 were due to natural causes. Since the man died there have been a further five deaths at the prison. One death also concerned end of life care and noted that, where a prisoner is not suitable for resuscitation, the decision should be made after discussion and be properly documented.

ISSUES

The diagnosis of the man's terminal illness

22. The man had a history of heart problems having suffered heart attacks in 1998 and 2006. He also had a stroke in 2006 and, by 2010, was described as very weak and unable to mobilise on his own.

23. His health continued to decline and, on 1 May 2011, he was admitted to hospital. He was diagnosed with left ventricular impairment and the clinical review notes "it was clear that his heart function was so badly compromised that he was unlikely to recover".

24. A prison doctor had a discussion with a consultant cardiologist regarding the man's condition on 16 May. He noted the consultant said "no implantable/transplantable treatment was presently being considered and that he would be reviewed in outpatients". The doctor made a note to discuss this with "dr cairns re palliation".

25. An entry in his medical record on 18 May shows that the doctor circulated information to doctors involved in his care, following his conversation two days earlier. He said the man had heart failure, had been admitted to hospital twice in the previous ten days and had been discharged to the inpatient healthcare unit (IHU) "sort of stable". The doctor informed staff they were to monitor his general observations to help decide whether he needed hospital admission. He noted his "prognosis is poor" and he was not being considered for any surgical treatment. The doctor was: "trying to get the consultant along to discuss palliation with the patient and this would mean DNAR would be on the agenda, as if he arrested CPR would be hugely pointless".

26. Although the man's health had declined over a number of years, it is unclear when he was formally diagnosed as being terminally ill. The clinical reviewer examined the hospital records and notes: "there is no clear record of this decision, but in discussion between the Cardiologist and the treating GP, it was clear that he was terminally ill". There is nothing to suggest this diagnosis was inaccurate or should have been made earlier.

The man's medical appointments and treatment

Appointments and hospital liaison

27. The man was admitted to hospital a number of times but had a history of discharging himself against staff's advice and would often refuse to attend further appointments. When he was admitted to hospital due to having had a stroke in August 2006 he discharged himself four days later. After being hospitalised due to his heart attack in 2006, he refused help offered by healthcare staff on discharge. He was also referred for physiotherapy but his attendance was poor.

28. The man said he felt unwell and complained of shortness of breath in January 2010. The prison called an ambulance and he was taken to hospital. He discharged himself from hospital on 1 February against medical advice. A nurse at Albany spoke with the hospital who said he had acute left ventricular failure but refused to be examined by the doctor.

29. He was referred to the Orthotics Department (specialist service treating bones and muscular conditions) at an outside hospital for various times in 2010 and his medical records show the appointment was rearranged three times. Although it is not always clear why these appointments were changed, on one occasion it was due to a prison escort not being available. He attended an appointment on 23 August and was listed for an operation. However, on 2 November he decided he did not want this treatment.

30. There is evidence that staff were concerned about the man's compliance with his appointments and treatment so a mental health assessment was requested. This was completed in 2008 and concluded he required no further input from the mental health team as he was able to make informed choices about his treatment. The clinical review notes:

> "There are documented episodes of frequent unwillingness to be assisted with washing, take his medication as prescribed and take part in physiotherapy. He underwent a mental health assessment to make sure that he was competent to refuse treatment, which confirmed that he was able to make these informed choices".

Treatment

31. Following his stroke in 2006, the man became incontinent and was prescribed appropriate male incontinence sheaths. Due to this and his reduced mobility, he suffered with skin sores, which were treated with cream and thick dressings. He was referred for further specialist treatment although there were delays in receiving these appointments. It is not clear from the medical records why these delays occurred. The clinical review raises concern of the overall standard of record keeping although there was a noticeable improvement once the recording system changed.

32. By 27 April 2011, he was no longer able to wash or dress himself. He had 'buddies' on his wing but his prison records note he was rude to them so they were reluctant to help him. (Buddies are fellow prisoners assigned to look after other prisoners who need extra support.) On 28 April, a new buddy was assigned to him and staff made it clear to him that they were not to do everything for him.

33. The man began to lose weight as his condition deteriorated and in May he was prescribed nutritional supplement drinks to try and help sustain his weight. He was given a specialist nursing bed designed for acute and long term illnesses, and he began to accept assistance with his personal care. On 9 May, care plans were implemented to monitor and assist with his

mobility and care needs. The care plans were amended when his condition and needs changed.

34. As he suffered from long term incontinence, he had sores and broken skin which needed regular monitoring and treatment to ensure he did not get an infection. Healthcare staff decided on 26 May that, to help relieve these symptoms, he was to have a catheter inserted and this took place the same day.

35. The doctor saw him on 1 June "as sats dropping…on arrival told he does not want oxygen, and says not anxious, uncomfortable or in pain. Expressed wish he wants to die here." Prison staff authorised his cell to remain unlocked at all times to enable healthcare staff to supervise his condition appropriately.

36. The following day, the doctor noted in the man's medical records that he was not likely to die imminently so the end of life care pathway (this refers to the Liverpool Care Pathway) was deferred. Once his condition started to deteriorate he was given further medication and was monitored using the Modified Early Warning Score (MEWS). (This is a simple guide used by emergency medical services to quickly determine the risk of death. A score of five or more suggests an increased likelihood of death or admission to an intensive care unit.)

37. The man was diagnosed with pneumonia on 3 June and the end of life care pathway was then implemented. Staff monitored him every hour. His outstanding hospital appointments were cancelled as he was too unwell to attend and his prognosis was poor. Staff ensured that he remained comfortable in IHU and his needs were met using the Liverpool Care Pathway.

38. The investigation found that his medical needs were met appropriately. Indeed, by being admitted to the IHU in his final days, it "allowed him to receive a higher level of nursing care than would have been available out in the community".

Informing the man about his condition and treatment

39. Following a hospital admission in January 2010, when he felt unwell and was short of breath, the man was diagnosed with heart failure. He discharged himself from hospital a few days later, against the advice of medical staff. A nurse telephoned the hospital and spoke with a nurse who had been involved in his care. The nurse explained that he had heart failure, but had left the hospital before being examined by a doctor. On his return to Albany, he was accommodated in the IHU where his condition was monitored.

40. The discussion between the consultant and the doctor, on 16 May 2011, concluded he was not suitable for an implant or transplant treatment and the medical record notes he had chronic low blood pressure with a fast

heartbeat. The doctor also discussed his condition with the palliative care consultant at the local hospice. They decided that if he was to suffer a cardiac arrest, it would not be appropriate to undertake any form of resuscitation. The doctor completed the "do not resuscitate" form and put it in his file. However, the decision was not discussed with him, as the doctor thought this might be too distressing for him. The clinical review notes: "Given the difficult relationship the man had with his professional carers, and his reluctance to sign forms, this decision is well documented and justified in the Prison Medical record." However, the clinical reviewer recommends that a policy should be in place to cover such situations when it is thought inappropriate for certain decisions in relation to end of life care to be discussed with the prisoner. We agree and set out the recommendation below:

The Head of Healthcare should ensure the end of life policy includes a requirement to record where it is not appropriate to obtain the signature or agreement of the patient.

41. The doctors involved in the man's care did not formally tell him his condition was terminal, nor did they discuss the decision not to resuscitate him. Although some elements of communication with him could have been improved there is evidence as to why this decision was made which the clinical reviewer believes was justified.

The man's pain relief and medication

42. The man was on a variety of medication for his heart condition. The clinical review notes he was advised to stop smoking "but it is unclear if he received any secondary preventative therapy (cholesterol lowering treatment) prior to his stroke and further heart attack in 2006".

43. Medication and pain relief was amended as necessary for him and, when his condition worsened in May 2011, he was given further pain relief. An entry in his medical records by a nurse on 17 May 2011 noted he was "on regular paracetemol but will make a note to the GP to see if he may need further analgesia". He also received regular monitoring and care of his pressure areas.

44. The man's condition began to deteriorate further on 29 May. It was noted that he was suffering from a chest infection and he was started on a course of antibiotics, before seeing a doctor the following morning.

45. On 1 June, a supply of opiate pain relief was obtained from the pharmacy for him to have every three to four hours, as well as morphine and anti-sickness medication should he need it. Entries in his medical record show that he was subsequently free from pain and distress even as his condition continued to get worse. He was aware that he could have oxygen administered if he was feeling short of breath; however there is no record of him requesting this.

46. On 3 June, the man's general medications were stopped, although he continued to receive pain relief and drugs to treat pneumonia. He began to struggle to swallow tablet form medication and so they were administered in liquid form orally and intravenously. His medical record on 4 June notes he "appears comfortable, free from pain, no signs of restlessness or agitation".

47. The clinical review notes he "passed away peacefully" with the "expected level of care". We are satisfied his medication and pain relief was appropriate for his needs.

Liaison with the man's family

48. Following his stroke in August 2006, the man asked the chaplaincy for help to trace his family. Contact was made with the Salvation Army and the Roman Catholic priest at the church he said his mother used to go to in Hackney, London. The priest did not know the family, but said further enquiries would be made. His family were not found and, without further information, the chaplain was unable to help. On 13 March 2007, the prison chaplaincy wrote to the probation service to try and trace his youth probation worker at his request. However, they were also unable to help.

49. Due to the man's poor health, a chaplain was assigned the role of family liaison officer (FLO) and he explained his role when he met with him on 19 May. He said that he wanted his solicitor to act for him, but gave the chaplain no instructions to contact them for him. He said that he might want a girlfriend contacted, but could not remember her address although he thought he may be able to find it on an A-Z map. The chaplain said that he would provide a map for him. He searched the electoral register for two of his friends but this proved unsuccessful.

50. The man's solicitors were informed of his death by the chaplain on 6 June. As there were no known family members, the reverend arranged the funeral with the Imam. He had specified to staff while they were implementing the end of life care pathway that he wanted his funeral carried out according to the Islamic faith. The investigator was told the funeral service took place in Southampton according to Islamic tradition.

51. We found that the efforts made by the prison to find the man's family were thorough, sensitive and appropriate.

The man's location

52. When the man discharged himself from hospital on 15 August 2006, he lived on normal location. Although he had some left sided weakness and was incontinent, healthcare staff felt he was still able to care for himself. Following his heart attack on 1 December, he was discharged to Parkhurst healthcare centre on 4 January 2007, where staff attempted to provide help with his general care, which he refused to accept.

53. When he discharged himself from hospital in January 2010, healthcare decided he was unfit to go back to the wing so admitted him to the inpatient healthcare unit at Albany. On examining him the following day, the doctor decided he was fit to transfer back to the wing.

54. On 23 March 2011, he transferred to Wandsworth although it is unclear from his prison documentation why this occurred. He could only walk a few steps and was in poor health so he was located in the Jones Unit, a specialist wing for prisoners with health needs. He told staff he felt depressed, did not want to eat or drink and requested a return to Albany. He was transferred back to Albany on 30 March.

55. The man had further intermittent hospital admissions with the last one being on 11 May. He was discharged back to IHU where staff were able to care for him and meet his needs. He stated that he did not wish to die in hospital and wanted to be made comfortable in IHU. Staff facilitated his wishes and implemented care plans to ensure his mobility and medical needs were met appropriately.

56. We are satisfied that the man was appropriately accommodated according to his medical needs.

Compassionate release

57. On 1 January 2011, the man's application for early release was refused by the parole board. He had not undertaken any offending behaviour work and he continually failed to co-operate with prison and probation staff. He stated that he would not comply with licence conditions and so, due to the nature of his offences and a long history of offending, he was deemed a "dangerous man" and his risk was "far too high" to be managed in the community.

58. Due to the man's deteriorating health, the chaplain was asked to be the prison's family liaison officer on 12 May. He saw him on 19 May and explained his role to him. Following this meeting, the chaplain emailed other prison staff asking about his release on compassionate grounds. He wrote that although "he is capable of being verbally abusive, he is no longer in a position to be physically aggressive. Thereby his ability to reoffend is severely curtailed". He said that there was no trace of his family and that he would need to be cared for in a nursing home. There is no evidence of a response to this email in his record but the man had said he wanted to stay in the IHU at Albany and we are satisfied this was in accordance with his wishes.

Palliative care

59. After the doctor had a discussion with a palliative care consultant on 20 May 2011 a decision was made not to attempt resuscitation in the event of a collapse although this was not discussed with the man "because it was thought it would be too distressing for him". The clinical reviewer agrees this decision was justified.

60. During the morning of 3 June, the man was short of breath and strong crackles could be heard on his lungs. He was diagnosed with pneumonia and, although he said he was not distressed, the Liverpool Care Pathway was implemented. .

61. His final days were in the prison following his discharge from hospital and his condition deteriorated further on 1 June. He said he did not want oxygen and was not anxious or in pain. He told staff he wanted to be made comfortable and to die in IHU, rather than outside hospital. It was authorised for his cell to remain unlocked at all times to enable healthcare staff to supervise his condition appropriately and to have easy access to administer medical care. This was an appropriate response to allow care to be given during his final hours.

62. He remained in the IHU and healthcare staff followed the care pathway. The clinical review notes he received "a higher level of care than would have been available out in the community". We support this conclusion and the evidence indicates that his needs in this regard were met appropriately.

CONCLUSION

63. The man had a long history of cardiovascular disease and his general health was poor. By April 2011, he was acutely unwell due to his long term heart problems. He was treated with medication but doctors agreed he would be unlikely to recover and no further treatment would be offered, beyond making him comfortable. The prison put in place a care pathway to ensure he was appropriately cared for in his final days. Although some elements of communication with him could have been improved, the investigation found that the level of care he received was appropriate and at least equivalent to what would have been expected in the community.

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RECOMMENDATIONS

1. The Head of Healthcare should ensure the end of life policy includes a requirement to record where it is not appropriate to obtain the signature or agreement of the patient.

This recommendation was not accepted by the prison. Their response was:

> "Two policies relating to this situation were already in place at the time of the man's death and both the clinical review and the draft PPO report acknowledge that a record was made of this decision in his medical records.
>
> The South Central Strategic Health Authority (SCSHA) Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was adopted by NHS Isle of Wight (of which the Prison Healthcare Services at HMP Isle of Wight are a part) in June 2010. The Liverpool Care Pathway for the Dying Patient (LCP) was also adopted in November 2010.
>
> There is a clear expectation in both documents that a record is made in the clinical information system of any decision not to resuscitate and where it is not felt appropriate to discuss this with the patient.
>
> Prison Healthcare staff work to both these policies in line with the principle of equivalence of care.
>
> As indicated left, this was undertaken as expected and the rationale also recorded."