Investigation into the circumstances surrounding the death of a man in December 2011 at HMP Isle of Wight (Albany)

Report by the Prisons and Probation Ombudsman for England and Wales

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This is the report of an investigation into the circumstances surrounding the death of a man at HMP Isle of Wight. He died in December 2011 from a carcinoma of the penis which could not be treated. He was 35 years old. I offer my condolences to the man's family and those affected by his death.

The investigation was carried out by one of my investigators. I am grateful to the Isle of Wight Primary Care Trust for the appointment of a clinical reviewer. HMP Isle of Wight fully co-operated with the investigation.

The man was sentenced to life imprisonment in 1992 when he was 15 years old. He was in satisfactory health until August 2009 when he had a large mass removed from his chest. His health deteriorated in September 2011 and he was later found to have advanced cancer. Following his diagnosis, he told staff that he had deliberately concealed the symptoms of his condition.

The clinical review confirms that the man received good quality of healthcare while at Albany. It is, however, of considerable concern that restraints were used in hospital when this was not justified by the prison's own risk assessment or, indeed, by any reasonable appraisal of the apparent risk posed by this very sick man.

Despite not having any contact with his family for almost 20 years, the efforts made by the prison's family liaison officer enabled the man to get back in touch with them before his death. This was commendable and gave the man some comfort before he died. However, the investigation does identify the need for the prison to provide telephone facilities for men who are bedridden at the end of their lives to allow them the support of their family and friends at the time they need it most.

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 **July 2012**

CONTENTS

Summary

The investigation process

HMP Isle of Wight (Albany)

Issues

Recommendations

SUMMARY

1. On 24 March 1992, the man was convicted of manslaughter and sentenced to detention at Her Majesty's pleasure (life imprisonment) when he was 15 years old. There were no concerns about his physical health until September 2009 when he had a large bullous[1] mass removed from his right lung. At this time he was a patient at a high security psychiatric institution.

2. In January 2010, the man moved to HMP Isle of Wight (Albany). He raised no concerns about his health. In August 2011, wing staff complained that an unpleasant smell was coming from the man's cell which was not caused by his personal hygiene. He was examined by a prison doctor who concluded that the smell was not related to his chest scar. Following a deterioration in his health, the man was seen by another prison doctor on 22 September. A blood test indicated that he was suffering from a chronic loss of blood.

3. The man was immediately admitted to hospital and diagnosed with a squamous cell carcinoma of the penis (skin cancer). Unfortunately, by this stage his condition was not suitable for treatment and he was referred for palliative care. He returned to the inpatients healthcare unit at Albany.

4. During discussions with healthcare staff, the man said he had first become aware of his condition when he was in the high security psychiatric institution but had deliberately concealed his condition from staff. He had not been in contact with his family for almost 20 years. Following his diagnosis, contact was re-established and he was visited by his family twice before he died.

5. We make two recommendations. One concerns the availability of telephone's for prisoners receiving palliative care. The second refers to the quality of the risk assessments made when assessing the level of restraint required when prisoners are in hospital.

[1] Bullae are defined on x-rays as fine linear shadows and cavities, appearing as apparent holes in shadows. There are a number of conditions that can lead to 'bullae' forming in the lungs and some of these can lead to chronic progressive lung disease.

THE INVESTIGATION PROCESS

6. The investigation was undertaken by one of my investigators. She first visited Albany on 5 January 2012 and was given access to the man's prison records. The investigator saw the healthcare unit and the unit where the man lived during his time at the prison.

7. During the initial visit, the investigator met a member of the Independent Monitoring Board (IMB) and invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they thought relevant to the investigation. The IMB expressed concern that the designated cells for prisoners at the end of their life did not allow them access to a telephone. This issue is discussed in the family liaison section of this report. Notices to staff and prisoners were displayed at the prison, inviting anyone with information about the man's death to come forward. No-one raised any concerns with the investigator.

8. A clinical review of the man's healthcare was commissioned by the Isle of Wight Primary Care Trust (PCT). The review was undertaken by a clinical reviewer. A review panel took place on 16 February 2012, consisting of various health professionals on the Isle of Wight. The review panel was attended by the investigator, the clinical reviewer, a Governor, the man's prison doctor, nursing staff from the in-patients healthcare unit and other members of Isle of Wight NHS PCT. The man's healthcare was discussed and specific issues raised by the investigator and the clinical reviewer were considered.

9. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and to invite them to ask any questions or raise any issues for consideration. His family did not raise any issues for the investigation to consider. The man's family received the draft report as part of the consultation period and did not raise any concerns.

10. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

11. The National Offender Management Service responded to the draft report. They identified one factual inaccuracy which has been amended in the report. We include their response to the recommendations at the end of the report.

HMP ISLE OF WIGHT (ALBANY)

12. HMP Isle of Wight was formed on April 2009, by the merging of three prisons, HMP Albany, HMP Camp Hill and HMP Parkhurst. The prison accommodates approximately 1,700 prisoners on the three sites. Each site has its own director who reports to the Governor.

13. The Albany site is a category B training prison with an integrated population of prisoners serving a range of offences. It holds up to 567 men, consists of five wings located off one main corridor, plus a more modem unit of two wings opened in 2003, consisting of single cell accommodation with en-suite facilities, for up to 80 prisoners.

14. Health services at HMP Isle of Wight are commissioned and provided by the Isle of Wight Primary Care Trust (PCT). A new inpatient healthcare unit was opened in October 2009 at the Albany site. It has 12 beds and caters for prisoners with a wide range of mental health, general medical, rehabilitative and health-related respite needs.

Previous deaths at Albany

15. This office has investigated 33 previous deaths at what was HMP Albany, now part of HMP Isle of Wight, 25 of which were as a result of natural causes, reflecting Albany's relatively elderly population. The circumstances of this man's death are not directly comparable to those of other previous deaths.

Her Majesty's Inspectorate of Prisons

16. HM Chief Inspector of Prisons carried out an unannounced inspection of HMP Isle of Wight between 4 and 15 October 2010. The Inspectorate noted that the primary care environment was poor at Albany and there was no structured therapeutic activity for inpatients. There were reasonable links with palliative care services. The inpatient unit had two dedicated palliative care rooms and one of the nurses ran a cancer support group. Clinical care was generally satisfactory and patients in the unit told inspectors that nurses responded to their needs appropriately and sensitively. Inspectors were concerned that there was a high rate of prescribing of pain-killing drugs with inappropriately large quantities in prisoners' possession.

Independent Monitoring Board report

17. Each prison is monitored by an Independent Monitoring Board (IMB) of independent, unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained. The first IMB report for the combined Isle of Wight covered 2010. The IMB noted that at Albany the main healthcare problem was its ageing population. .

ISSUES

The diagnosis of the man's terminal illness

18. The man was convicted of abduction and manslaughter of a family member in March 1992 when he was 15 years old. During the first 18 years of his sentence he was located in various establishments including a mental health secure unit and several young offender institutions. He spent a period of time in HMP Albany (now HMP Isle of Wight) before being moved to a high security psychiatric institution in April 1994.

19. In September 2009, while at the high security psychiatric institution, the man underwent an operation to have a large bullous mass removed from his right lung at outside hospital. In January 2010, he returned to HMP Isle of Wight (Albany). During his first reception healthscreen, the man said he experienced occasional pain in his chest when staff examined his post-operative scar. He also told staff that he had a phobia of needles. The medical records show that he visited healthcare on several occasions during 2010, when he complained of feeling sick and being unable to work.

20. In March 2011, the discharge summary from outside hospital was requested by healthcare staff. This confirmed that the man was extremely needle phobic and gave details of the operation that he had underwent on his lung.

21. The man was seen by a prison doctor on 9 May 2011. He was diagnosed with emphysema[2] and referred for a spirometry[3] test. This took place on the following day but was unsuccessful because he was not relaxed. A further test took place on 23 June which showed that his lung function was within normal ranges.

22. On 4 August, a member of wing staff contacted healthcare to say that complaints had been received that the man appeared to smell unpleasantly, and this appeared to be unrelated to his personal hygiene. He was seen by a prison doctor on 8 August. The doctor confirmed that the smell was not associated with the man's chest scar. During the clinical review panel held on 16 February 2012, the doctor said that, when the man had attended that appointment on 8 August, he was wearing clean clothes and insisted that the only problem he had was related to the old scar in his chest area.

23. The man reported as unfit for work on 12 September. He was seen the following day by a nurse who made an appointment for the man to see the prison doctor. The man failed to attend this appointment and a subsequently rearranged appointment on 19 September.

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[2] Emphysema is a long-term, progressive disease of the lungs that primarily causes shortness of breath.

[3] Spirometry is a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease (COPD). Spirometry is also used to monitor the severity of some other lung conditions, and their response to treatment.

24. The man was seen by a doctor on 22 September because he had vomited for the previous two weeks and said he had a severe burning sensation in both legs. The doctor admitted him to the prison's inpatients healthcare unit (IHU) and requested that a full set of observation tests should be undertaken immediately. The results of the man's blood tests were received the same day. The doctor noted in the medical record that the results indicated that the man had suffered a chronic loss of blood.

25. Due to the concern about these results, the man was admitted to outside hospital on the same day. During admission, staff discovered that he had a severe cavity in his groin. He told hospital staff that he had deliberately concealed his condition from prison and healthcare staff. A scan on 26 September showed that his pubic bone had been damaged, and an irregular soft tissue mass was where his penis had been. A biopsy was taken on 4 October which confirmed that he was suffering from squamous cell carcinoma of the penis. Following the man's admission to hospital, the clinical reviewer considers that appropriate investigations were carried out over the next two weeks. He writes:

> "Appropriate investigations including a CT Scan, tissue biopsy and further blood investigations were carried out over the next two weeks and, although it was initially considered that [the man's] condition might have resulted from a deep tissue and bone infection secondary to self-harm (considering the nature of his index offence and his previous psychiatric morbidity), the histology report showed that the underlying condition was a squamous cell carcinoma of the penis which had caused gangrene of his penis and invaded his scrotum and his pubic bones during the two years during which he had concealed its existence."

26. The clinical reviewer notes that, by 22 September, the man's condition had deteriorated to such an extent that he had difficulty in walking and was suffering from repeated episodes of vomiting. This meant that he was unable any longer to conceal the seriousness of his condition, as he had done for the previous two years.

27. Following his return to prison on 19 October, the man told healthcare staff and other prisoners in IHU that he had controlled his pain with paracetamol and co-codamol which had been able to obtain from other prisoners. This allowed him to continue with daily life on the wing. He had tried to conceal the smell from his wound by pouring aftershave into the hole in his groin.

28. The clinical reviewer raises no concerns about the timeliness of the man's diagnosis. He considers that it is unlikely that the prison doctor would have discovered the man's condition on 8 August unless he had carried out an intimate examination. He writes:

> "It is extremely unfortunate that [the man] concealed his illness from medical staff for so long. If the history he gave to medical staff at [outside hospital] was accurate then when the initial lesion appeared on

his penis in September 2009 his cancer might have been eminently treatable by a combination of surgery and radiotherapy, possibly even curable."

29. He considers that once the seriousness of the man's condition had become apparent he was investigated and managed appropriately. Although it is concerning that the man concealed his illness for such a long time, he did so deliberately and staff were not remiss in not discovering his illness.

Informing the man about his condition and treatment

30. The man was informed about his condition by a consultant in radiotherapy and oncology[4] at outside hospital on 13 October. The consultant explained that the cancer was advanced and could no longer be cured by any treatment. The man was told that his life expectancy could be as little as three to four months.

31. Following his return to Albany on 19 October, the man was seen by a community psychiatric nurse. The man spoke freely regarding his terminal diagnosis. The CPN noted in the medical record that the man acknowledged that he had hidden his condition from staff while he was at the high security psychiatric institution and this was the real reason why he had wanted to return to prison. He was also seen by the prison's mental health in-reach team. The same day he asked to join the support group on IHU. The group was attended by a nurse who noted that the man spoke freely with healthcare staff and other group members.

32. A 'do not resuscitate' form was completed on 26 October by a prison doctor following a discussion with the man in which he indicated he did not wish to be revived or given advanced life support if his heart stopped or if he stopped breathing.

33. The clinical reviewer considers that the man was appropriately informed of his diagnosis and offered sufficient support from hospital and prison healthcare staff. We agree with the clinical reviewer's conclusion.

The man's medical appointments and treatment

34. On 27 October, the consultant in radiotherapy and oncology wrote to a consultant gastroenterologist[5] at outside hospital. The letter said that a frank discussion had taken place with the man during which he was told about his diagnosis and options for treatment. The consultant in radiotherapy and oncology said he thought there was an infection in the site of the cancer which would prove difficult to control. The consultant gastroenterologist wrote that the man's treatment would be symptomatic, with the aim of controlling his pain and cleaning the discharging wound. The consultant in radiotherapy and oncology considered that the man was too weak to undergo palliative radiotherapy, while the infection was not under control.

[4] An oncologist is a doctor who specialises in the treatment of patients with cancer.
[5] A gastroenterologist specialises in the treatment of patient conditions affecting the liver, intestine and pancreas.

35. The man returned to the IHU on 19 October where he remained until his death.

36. The clinical reviewer considers that once the seriousness and extent of his illness became apparent his medical management was carried out to a "very high standard". He notes that there was good communication between outside hospital and the prison healthcare department. We agree with the clinical reviewer's findings.

The man's pain relief and medication

37. Following the man's admission to hospital on 22 September, he was prescribed oramorph[6] and paracetamol to control his pain. Following his return to Albany, his pain relief was regularly reviewed by prison doctors. On 21 October, he was seen by a consultant in palliative[7] care from outside hospital, to review his pain relief. The consultant in palliative care advised that the man's medication should be increased to reflect the severity of his pain. He continued to review the man's pain relief in the IHU and increased the prescribed medication when his condition deteriorated.

38. The man's medical record shows that he was offered oramorph to control his breakthrough pain. An entry made on 7 November noted that his pain was well controlled and he was aware of the need to inform staff if he experienced any breakthrough pain.

39. On 11 November, a prison doctor advised the man that he should be provided with a syringe driver[8] to deliver more effective pain relief. He was not willing to undergo the procedure at this point but agreed to reconsider in a few days. The medical notes show that his pain relief was reviewed daily and he received regular reminders from healthcare staff that he should inform them if his pain increased. His medical record shows that healthcare staff sought further advice from the hospice on 17 November regarding his pain relief. They were encouraged to contact the hospice if there were any further concerns regarding his palliative care and they discussed pain relief with the hospice and a community McMillan nurse before he was provided with a syringe driver on 7 December. At the same time he was prescribed diamorphine and haloperidol for pain relief.

40. The clinical reviewer considers that the man's pain relief was "entirely appropriate, not to say exemplary". We consider that his pain relief was well managed by healthcare and palliative care staff.

[6] Oramorph is a medicine which is used in relieving severe pain. It contains morphine sulphate.
[7] Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness
[8] A syringe driver is a battery-operated pump that delivers continuous medication under the skin for 12 or 24 hours.

Liaison with the man's family

41. Due to the circumstances of his offence, the man had no contact with his family, although it is noted in his prison records that the Prison Service kept them informed of his location.

42. A senior officer (SO) was appointed as the prison's family liaison officer (FLO). The FLO first visited the man when he was in outside hospital, following his diagnosis. During this meeting, the man said that he wished his family to be informed of his diagnosis and was keen to initiate contact with them. The FLO log shows that a victim liaison officer first contacted the man's family on 15 November. A few days later, the man was told by the FLO that his family wished to visit him.

43. On 23 November, the man was visited in the IHU by his parents, two brothers and his sister-in-law. The FLO and the prison chaplain were also in attendance. The records show that the man and his family were provided with emotional support and the IHU staff were able to address any questions that his family raised regarding their relative's medical condition.

44. The prison FLO arranged a further visit from the man's family on 21 December. The FLO log shows that the following day he contacted them to say that their relative's condition had deteriorated. The man's family said that that they wished to be contacted by telephone when he died. The prison FLO telephoned to inform them of their relative's death on the day he died.

45. While it would be usual to inform a family of a death personally, we are satisfied in this case that telephone contact was appropriate and in accordance with the man's family's wishes. The FLO's efforts to establish contact and provide support to both the man and his family were commendable.

46. HMP Isle of Wight met the funeral expenses in accordance with Prison Service Order 2710 "Follow up to a Death in Custody". The man's funeral took place on 20 January 2012.

The man's location

47. Following the decision that the man's condition would be managed by palliative care, he was eager to return to the IHU at Albany. A meeting was held between hospital and prison healthcare staff before his return to prison to discuss the management of the extensive dressing in his groin area.

48. The man returned to Albany on 19 October and was located in a designated end of life cell in the IHU, designed to provide a more comfortable environment than a standard prison cell. On 21 October, the Head of Operations authorised that the man's cell could be unlocked at all times. He was able to receive regular visits from prisoners on his previous wing.

49. The FLO log shows that, following the family visit on 23 November, the Head of Prisoner Rights and Responsibilities sought to arrange a daily telephone call between the man and his family. However, it became apparent that this would not be possible because there was no telephone point in his cell. The investigator sought further information regarding this from the Head of Prisoner Rights and Responsibilities. She said that prisoners in end of life cells, who were not bedridden, could be taken in a wheelchair to the telephone point in the IHU. However, the man was bedridden and could not be moved easily.

50. The Head of Prisoner Rights and Responsibilities explained that due to the nature of the man's offence his telephone calls were subject to public protection procedures which included monitoring. This meant that the use of a mobile telephone could not be authorised. We are not persuaded that this was an insuperable problem or a reasonable assessment in the circumstances. The prison FLO kept in regular telephone contact with the man's family. However, where a prisoner is terminally ill and bedridden, it is important that they should be able have telephone contact with their family provided that all involved agree.

    The Governor should ensure that prisoners in the end of life cells in the inpatients healthcare unit at Albany are able to make telephone calls.

Compassionate release

51. Prison Service Order 6000- (Parole Release and Recall) gives guidance on early release on compassionate grounds which might be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is granted only in exceptional circumstances. Early release might be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon, where the risk of re-offending is past and there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family. The decision to release a prisoner on compassionate grounds is made by the Secretary of State taking into account information provided by Prison Service staff and medical opinions.

52. On 19 December, the Head of Custody and a member of staff from the prison's offender management unit visited the man in the IHU to determine if he wanted to apply for early release on compassionate grounds, with the view to moving him to a hospice close to his family. However, at that stage the man's condition had deteriorated to the extent that he was unable to speak about his wishes.

53. The investigator sought further information from the Head of Custody who explained that he had discussed the man's condition with the modern matron in IHU. In her opinion, the man would have been unable to travel on any journey, either long or short. In an email sent to the Head of Custody on 19 December, the modern matron said that, before the deterioration in the man's condition, the staff in IHU had many discussions with him regarding his death and where he would like to be when he died. The man's wish was to remain in the IHU. This

is recorded in the 'Preferred Priorities for Care'[9] document which the man completed on 30 November and recorded his wishes for end of life care. He had made it clear that he wanted to remain in the IHU and to receive visits from his friends and family. It is therefore surprising that the prison should have considered the possibility of compassionate release a late stage in December and we are satisfied that remaining in the IHU was in accordance with the man's wishes.

Palliative care plans

54. The man was seen by a consultant in palliative care on 21 October who reviewed his pain relief. The consultant noted that the man was relaxed and confident with his care. He was seen again by him on 11 November and 30 November. On each occasion, he increased the man's medication to ensure that he was as comfortable as possible.

55. Following his diagnosis, the man was told that no active treatment was possible. The National End of Life Pathway Programme promotes a high standard of care for all prisoners regardless of diagnosis at the end of life. This is achieved by improving the quality of care offered and enhancing dignity and choice for serving prisoners approaching the end of life.

56. The core principles for the delivery of end of life care are :

    - Treat individuals with dignity and respect
    - Identify and respect people's preferences
    - Provide information and support to families and carers
    - Recognise and respect and individual's spiritual and religious needs
    - Provide effective pain and symptom management
    - Provide care after death
    - Ensure care is patient-centred and integrated
    - Provide a safe environment for care

57. The man was started on an end of life pathway on 19 December. The clinical reviewer comments that the end of life pathway was started at the appropriate time for the man. The investigation found that the man's wishes were fully considered by IHU staff and he was treated in a dignified and respectful manner.

Restraints, security and bedwatch

58. Before the man was taken to outside hospital on 22 September, the security department carried out an initial risk assessment based on his index offence and security categorisation. The outcome was that the man should be escorted by two members of staff and be handcuffed to one of them at all times. The decision was considered by the duty governor on that day. Having taken into account the man's level of mobility and health, in particular that he was unable

[9] The Preferred Priorities for Care document is a tool designed to facilitate individual choice in relation to end of life care. It provides the patient with the opportunity to discuss concerns that might not otherwise be addressed

to walk without assistance, she reduced his level of restraints to an escort chain[10] only. It is not clear whether the duty governor's assessment took place before or after the man arrived at the hospital and we were unable to clarify the issue as she has since retired.

59. Specific factors need to be considered when examining a prisoner's risk level, and any subsequent restraints. These include the risk to the public, the risk of hostage taking, escape potential and likelihood of outside assistance to escape. The prison's own risk assessment showed that the man was considered a low risk in all these areas. .

60. Once in the hospital, further assessments took place which considered an assessment of the room/ward where the man stayed. This included a score dependent on the number of windows and doors in the room and bathroom, and the floor level. A score of 0-45 is considered low risk. The man moved from a room to a ward and back to a room during his stay from 22 September to 19 October. The score ranged (dependant on the room) from 9 to 18 but remained low risk.

61. Apart from two days in October, the man remained on an escort chain attached to an officer, with two officers with him at all times. He was very ill and weak, was receiving a considerable amount of pain relief, and found it difficult to walk.

62. During the consultation period Albany said that the man had remained on an escort chain because there was conflicting information regarding his mobility. They said that the bedwatch officers were found by the Duty Governor having let the man use the shower without any restraints when they had not sought authority. Subsequently there was an internal investigation which resulted in a disciplinary hearing.

63. On 4 October, it appears the bedwatch officers told governors that the escort chain was not long enough to allow the officers to sit outside when the man was using the toilet or shower. The record indicates that a Governor directed that if the chain was not long enough, then officers would have to go into the toilet or shower area with him.

64. The same day there was a discussion about whether the man should remain cuffed during the surgery he was due that day. Shortly before the operation was to take place, a Governor authorised the removal of the restraints. They were reapplied an hour later once the surgery had been completed.

65. Comments in the bedwatch log over the coming days include reference to the level of pain the man was experiencing, and that he required the use of a wheelchair to use the toilet.

66. The restraints were removed so that an X-ray could be performed, but reapplied afterwards on 11 October. The following day, the bedwatch officers note that an infection had spread to the man's groin and was causing him pain.

[10] An escort chain allows a prisoner officer to maintain discreet control of a prisoner.

67. By 15 October, the man was in a side room once more. He had a high temperature, was receiving blood transfusions and had a catheter. It had been difficult to weigh him using a chair, and he had X-rays taken in his room. All this time he was in restraints.

68. At 8.30pm, the prison FLO contacted the duty governor regarding restraints. He wrote in the bedwatch log

> "… it is clear that [the man] is in a lot of pain and needs morphine before he can move. He is also located in a side room on the first floor and is having blood transfusions and is on a drip. It was agreed that restraints could be removed but one officer must be in the room at all times. [The Head of Operations] will amend the risk assessment tomorrow".

69. However, when the Head of Operations visited the man on 17 October, he wrote in the bedwatch record that he had spoken with the nurse about the man's mobility and that restraints were to be reapplied. He wrote "may remove for use of facilities within room only i.e. shower. Duty Gov to approve removal. Restraints must be on when leaving room". He also wrote in capital letters that restraints must be on.

70. The restraints were removed when the man used the shower but reapplied when he was in bed. By this time palliative care nurses were visiting him. He could not attend the toilet unaided and was having regular injections.

71. The man returned to Albany on 19 October for him to continue palliative care. He remained in restraints until his return to Albany, although he was moved in a wheelchair.

72. It is not apparent from the documents why, when his risk of offending and likelihood and ability to escape was assessed as low, the man was subject to restraints. The bedwatch records indicate that there was insufficient consideration of his health and mobility. He needed help with day to day tasks, was in pain and on strong medication and accompanied by two officers. This was not humane treatment of a dying man.

    The Governor should review the risk assessment process at Isle of Wight and ensure that full account is taken of the risk factors and health of a prisoner when determining the level of restraint for a prisoner in hospital.

RECOMMENDATIONS

1. The Governor should ensure that a telephone point is installed in the two end of life cells in the in patients healthcare unit at Albany.

   The National Offender Management Service accepted this recommendation:

   "The Head of Prisoner Rights and Responsibilities to liaise with the Head of Healthcare and discuss the possibility of installing a telephone point, that HMP Isle of Wight can still monitor, in the two end of life cells in the IHU at Albany site."

2. The Governor should review the risk assessment process at Isle of Wight and ensure that full account is taken of the risk factors and health of a prisoner when determining the level of restraint for a prisoner in hospital.

   The National Offender Management Service accepted this recommendation:

   "The Head of Security to review the current escort risk assessment with the view to enhancing the medical contribution section to ensure that these are balanced against the risk that the prisoner presents to the public enabling a better informed the decision making process in relation to the appropriateness of restraints."