

**Investigation into the circumstances surrounding the
death of a man,
in November 2010 at HMP Albany**

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

January 2012

This is the report of an investigation into the death of a prisoner at HMP Isle of Wight, Albany site. He died in November 2010, after collapsing in his cell. He was 65 years of age. He died because of myocardial fibrosis which was caused by coronary atheroma.

The man was remanded into custody on 11 August 2008, and sent first to HMP Lewes. He was sentenced to 21 years for serious offences and transferred to Albany. He was already an unwell man and he suffered from chronic obstructive pulmonary disease (COPD).

The man's next of kin was his wife from his second marriage. She made regular trips to visit him at the Isle of Wight. She wanted him to be buried in Portsmouth, where he grew up, as he had fond memories of the area. I would like to offer my sincere sympathy and condolences to her and to all who may have been affected by his death.

The investigation was carried out by my colleague. She and I would like to thank the Acting Governor of HMP Isle of Wight, the prison liaison Governor and all the staff for their assistance.

The local Primary Care Trust (PCT) commissioned a clinical reviewer to review the man's clinical care and I much appreciate his help and contribution to my investigation. I asked the clinical reviewer whether the care given to the man was equivalent to what he would have expected to be given if he was living in the community. He does not think that it was as good as he could have expected.

There are a number of recommendations that emerge from the investigation including issues such as his diet, the standard of the healthcare he received and actions of staff on the day the man died. I repeat my previous recommendations about staff going into cells at night and access to healthcare facilities during the night.

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
Prisons and Probation Ombudsman

January 2012

CONTENTS

Summary

The investigation process

HMP Isle of Wight, Albany site

Key events

Issues

Conclusion

Response to the draft report from the man's wife

Recommendations

SUMMARY

1. On 20 August 2008, the man was convicted of serious offences and sent to HMP Lewes. On 16 September, he was transferred to HMP Isle of Wight, Albany site. After an appeal his sentence was reduced from 21 to 16 years.
2. Even before sentencing he was an unwell man, suffering with chronic obstructive pulmonary disease (COPD), and a hospital admission on the day of his sentencing at court. COPD, also known as chronic obstructive respiratory disease, refers to chronic bronchitis and emphysema, a disease of the lungs in which the airways become narrowed. Further to his COPD, he was diagnosed with bilateral cataracts, and Reynaud's syndrome, a condition affecting the small blood vessels of the fingers and/ or toes, causing numbness and then pain.
3. Upon reception into Albany the man was accommodated on A wing. Due to his reduced mobility (because of his COPD) he experienced difficulties using the night time sanitation system. The night time sanitation system consisted of an electronic system that opens individual cell doors (in a queuing system) to allow prisoners out of their cells three times a night (for a maximum of nine minutes at a time) to use the communal toilets. A solution to this problem could not be found, and a move to a wing with in-cell sanitation was offered but he declined. Due to the issue with the sanitation system, he was required to use a bucket at night.
4. On 25 March 2009, the man complained of vomiting and abdominal pain. After further deterioration in his condition he was transferred to hospital. It was later discovered that he was suffering from a twisted bowel. He had corrective surgery to his bowel on 25 March and was moved to the intensive care unit. He returned to Albany on 24 April.
5. The man was seen by a prison doctor on 29 April, and it was noticed that he had lost a lot of weight. He now weighed 63kg as compared with his weight of 80kg on reception six months earlier. By 15 June, he had suffered a further weight loss of 3kg. He now weighed just 60kg, and had lost roughly one quarter of his total body weight. He made a complaint to the Independent Monitoring Board, (a body of people from the local community appointed to each prison by the Secretary of State for Justice to be independent watchdogs of the public interest) and to his solicitors in relation to his diet. He claimed that he should have been receiving (on the advice of his bowel surgeon) a liquid protein diet. There appears to have been some misunderstanding on his part regarding this diet, the advice from surgical out patients was for some energy building drinks and protein based diet.
6. On 18 August, the man saw a prison doctor complaining that his cataracts were getting worse. As a result of this he was referred to the ophthalmic department at hospital. An appointment was secured for 15 March 2010 the following year, but later cancelled by the hospital on 4 March. An alternative appointment was booked for the following month but, unaware of the new

date, he cancelled his appointment saying that he had been waiting too long and did not want to pursue the matter any further.

7. A very detailed social care plan was completed for the man on 16 April 2010. It recommended proactive management of his health in general, and his respiratory problems in particular. The care plan recommended that he should be provided with accommodation that would allow him to be self-caring, and a personal alarm to summon help, this being an important issue for him due to his mobility and breathing problems. I have found that these recommendations in this care plan were not acted on.
8. After numerous admissions to hospital, the man was seen by the prison doctor on 29 April. His COPD was worsening and he was offered accommodation on the inpatient health unit (IHU), but he declined saying that he preferred to stay where he was, in his cell.
9. On 26 May, a letter was received from the hospital confirming a cardiology appointment for 29 June. However, the next day he filled in a 'hospital appointment refusal form' asking to cancel his cardiology appointment. He wrote on his form: "I do not wish to attend this appointment or to make any further appointments. Thank you for your consideration."
10. The same day the man wrote a letter to staff returning his medication complaining that he kept seeing different doctors, being told something different every time he went. He said that he was confused and "I don't want any more medication and want to leave it in the lap of the gods. I want you to respect my wishes and D.N.R [Do Not Resuscitate] me." His DNR wishes were never formalised.
11. On 9 July, after speaking with a member of healthcare staff, the man accepted that he would be more suited to the accommodation in F and G Wing, a wing with in-cell sanitation, and he moved on 21 July.
12. The man collapsed on the wing on 4 September. Oxygen was administered and he was taken to hospital. He remained in hospital for 16 days, being discharged back to Albany on 20 September. The following month he was seen a further four times by healthcare staff. They had to administer oxygen to treat his severe shortness of breath and panic attacks.
13. At 12.25am on 12 November, the man pressed his cell bell complaining of chest pains and being short of breath. The officer support grades (OSG) on duty went to the cell and called a SO (Oscar 1) for further assistance. His cell was opened ten minutes later and he was found slumped in his chair showing no signs of life. The ambulance arrived at 12.45am to assess his condition. He was pronounced dead at 12.58am.
14. I make seven recommendations. My investigation has identified that improvements should be made by drawing up an End of Life policy. I consider that the arrangements for looking after prisoners at night were not entirely satisfactory. Prisoners whose health is poor would benefit from

carrying personal alarms so that they can summon help in an emergency. Finally there should be a risk assessment before providing oxygen to treat prisoners. The clinical reviewer makes three more recommendations which I endorse. They address delays going to hospital appointments, prescribing practices and supplying hospital records to the clinical reviewer.

THE INVESTIGATION PROCESS

15. The investigation was opened on 19 November 2010, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator.
16. During the investigator's opening visit a prisoner came forward. He explained that he was a friend of the man's, and that he was also a disability representative for Albany. He told her that, when she returned to carry out her interviews, he would like to speak with her regarding a number of concerns he had in relation to him.
17. During the opening visit the investigator collected copies of the man's prison files, including his medical records. She visited the healthcare unit, speaking with a nurse and visited the new inpatient healthcare unit (IHU) based at Albany. She also viewed the man's cell and introduced herself to the staff on the wing.
18. The investigator returned to Albany on 14 December 2010 and 6 January 2011, to interview five members of staff and three prisoners. Throughout the investigation, feedback was given to her prison liaison, the Head of Assurance. On completion of her investigation, she wrote to the Acting Governor of HMP Isle of Wight highlighting areas of potential concern.
19. To gather further information for the purposes of the investigation on 22 December, the investigator contacted a consultant surgeon at the hospital. An issue highlighted in this report relates to the man's diet. She contacted the doctor in relation to treatment received for a small bowel obstruction whilst he was at Albany, requesting information about the aftercare instructions given to the prison.
20. The investigator also contacted the Independent Monitoring Board (IMB) representative at Albany to see if they had come into contact with the man during his time there. It was discovered that the man had made a complaint on 1 May 2009 in relation to his diet after a bowel operation. This is discussed later in my report.
21. A clinical review of the man's health care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust.
22. On 28 January 2011, a review panel consisting of Isle of Wight PCT staff, Albany healthcare staff, the investigator and the clinical reviewer met to discuss the care the man received. As a result of this panel meeting a number of recommendations were made. A full list of these recommendations is contained in this report.
23. One of my family liaison officers contacted the man's next of kin, his second wife and son (from his first marriage) to inform them of my investigation and provide them with an opportunity to raise any issues for consideration as part

of this. No issues were raised by the family at the outset of my investigation. However, after further consideration the man's wife sought the assistance of solicitors, and after receiving the draft report raised a number of issues about the care he received. We are grateful for her contribution. The issues raised by her can be seen further in this report.

24. The man's son also received a copy of the draft report. In his response he said he, and other family members who read the report, felt that some of the recommendations were good and recognised that whilst the Prison Service tried to do their best for their father, in the end his own stubbornness was his undoing. They felt strongly that all services did their best for him and did not wish to apportion blame for any perceived failings. They commented that the Prison Service is in a difficult position and, from their consideration of the report, felt staff had tried their best, however, this requires two way co-operation.
25. This report will be forwarded to the coroner to assist in his enquiries.

HMP ISLE OF WIGHT, ALBANY SITE

26. HMP Isle of Wight was established as a cluster prison on 1 April 2009. It accommodates prisoners on the three sites, Albany, Parkhurst and Camp Hill. The sites are approximately equal in size, with a total operational capacity of just under 1,700 places. The Camp Hill site is a category C training prison, Albany is a category B training prison for sex offenders, and Parkhurst is a category B training prison.
27. The Albany site has five main wings (A – E) that are almost identical holding between 94 and 96 prisoners in single cells with in-cell power. Prisoners have 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 'spurs' on each landing, with communal recesses containing showers, toilets and wash basins. In addition to this there is a newly built unit (F and G wing) which has 40 single cells all with en-suite facilities. These wings accommodate a large number of elderly or infirm prisoners and this is where the man lived.
28. Health services at HMP Isle of Wight are commissioned and provided by the local Primary Care Trust (PCT). A new inpatient healthcare unit (IHU) was opened in October 2009 and is situated on the Albany site. It is a 'closed' unit with 14 beds designed for prisoners with a wide range of general medical, surgical, rehabilitative and health-related respite needs. The primary healthcare services run from 7.30am to 5.30pm. Any medical emergency/healthcare after 5.30pm have to be referred to the hospital wait for an out of hours GP to visit.
29. Prison healthcare general practitioner services are provided by Beacon - a partnership between the Primary Care Trust and Lighthouse Medical Ltd. The GPs undertake a total of seven 3.5 hour sessions in the primary care centre, segregation unit and IHU. The same group of doctors cover the out of hours' service.
30. The Independent Monitoring Board (IMB) visited the prison and produced an annual report on their findings. The IMB are appointed to each prison by the Secretary of State for Justice as independent watchdogs of the public interest. They are not members of the Prison Service nor are they part of the management team. They are required to produce an annual report to the Secretary of State on the prison, highlighting good practice and flagging up areas of concern. Their latest report was published in December 2010. The IMB commented that:

“Major work was done this year to the centres, which over the summer leading to clinics being cancelled. At present the prison is working with reduced staff numbers with one being on maternity leave and one position remaining unfilled. The main problem facing Albany is its ageing population of which 60 are diabetics. This leads to long periods of waiting for the optician and the chiropodist as prisoners are checked annually”.

31. The most recent published report by Her Majesty's Chief Inspector of Prisons (HMCIP) was dated October 2010. The Inspectorate criticised the healthcare which was provided at the time. Their report commented:

“Clinical governance arrangements were variable, with primary care trust policies not adapted appropriately for the prison environment. There were few care plans and some were out of date and not adhered to. Treatment times clashed with regime provision. In 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 long delays and cancellations for secondary care appointments. The inpatient unit environment had improved but lacked structured or therapeutic activity for patients. Mental health services were good but service capacity was inadequate for the needs of this complex population”.

32. The man was the fourth person to die from natural causes at Albany during 2010. As a result of his death, I repeat two recommendations made in previous investigations. These recommendations are in relation to going into cells at night and access to healthcare facilities out of hours.

KEY EVENTS

33. The man was born in September 1945. He was convicted and sentenced on 20 August 2008 to 20 counts of serious sexual offences. He committed his first offence in 1973. Due to the nature of his offences, he was estranged from his wife and children from his first marriage. His second wife is listed as his next of kin.
34. The man was remanded into custody on 11 August 2008 and sent to HMP Lewes. On 20 August, he was convicted at Crown Court and sentenced to 21 years imprisonment.
35. During his reception health screen at HMP Lewes, the man was assessed as having chronic obstructive pulmonary disease (COPD). Chronic obstructive pulmonary disease, also known as chronic obstructive respiratory disease, refers to chronic bronchitis and emphysema, a disease of the lungs in which the airways become narrowed. He was provided with a nebuliser to treat his COPD. This is a device used to administer medication in the form of a mist inhaled into the lungs to assist breathing. Further to this he was diagnosed with bilateral cataracts. It was also noted that he was a heavy smoker, smoking 25 roll-up cigarettes a day.
36. On 16 September, the man was transferred to HMP Isle of Wight, Albany site. He was given a cell on A wing. Because of his COPD, he was allowed to keep his nebuliser in possession. His reception health screening identified that he had low blood pressure and appeared breathless. He was deemed unfit for education/ labour and tested for tuberculosis. His weight was recorded as 80.6 kg. The clinical reviewer comments in his clinical review that:

“... his reception screening at Albany on 16.09.08 revealed a blood pressure of 75/57 [this being low]. Though it was noted that he required medical follow-up, this did not appear to have happened. Given his history of frequent oral steroids, and treatment for hypertension, yet having such a low BP, this was surprising.”
37. The clinical review indicates that the man's first appointment with a GP at Albany was on 2 October, in response to acute exacerbation of his COPD.
38. The man was diagnosed with Reynaud's Syndrome on 4 December. Reynaud's syndrome is a disease where the small blood vessels of the fingers or toes go into spasm unpredictably, causing numbness and then pain, and then dilate to give equally painful red skin. The clinical reviewer comments that:

“.. elsewhere in the records it suggests that his diagnosis was made based on a blood test. I could not find any evidence for this in the records. He was started on a low dose Cefalexin for his recurrent chest infections and Nifedipine for his Raynauds. This Nifedipine may

well have exacerbated his oedema (swollen legs and feet) which troubled him later in his illness.”

39. The man’s reduced mobility (due to his COPD) made it difficult for him to use the night time sanitation system. This electronic system opens individual cell doors (in a queuing system) to allow prisoners out of their cells three times a night (for a maximum of nine minutes at a time) to use the communal toilets. The problem was that if a prisoner does not return within the allocated nine minutes, they are locked out of their cell. He could not walk back to his cell within this timescale. He used a bucket instead of going to the toilet.
40. On 25 March 2009, a prison doctor examined the man after he complained of vomiting and abdominal pain. The doctor prescribed anti sickness and pain relief medication. It was also noted that that he appeared to have lost weight. The doctor recorded on his medical notes that he supported a transfer to F and G wing on medical grounds. The record explained that, due to mobility issues, he had to use a bucket at night and was only able to have a strip wash, rather than using the communal shower facilities. The doctor discussed the possibility of a move to F and G with him but he declined, saying that he was reluctant to leave his friends and buddy on the wing. A ‘buddy’ is another prisoner on the same wing who helps another less able prisoner (whether it is due to old age, illness or a disability) with their everyday tasks such as cleaning their cell or collecting their food.
41. By the evening of the same day the man’s condition had deteriorated. He had continued to vomit throughout the day and was found to be incoherent, drifting in and out of consciousness. He was given oxygen and taken by ambulance to hospital. After examination it was discovered that he was suffering from a twisted bowel. He had corrective surgery on 25 March 2009 and was moved to the intensive care unit.
42. On 14 April, a note was made to show that the man was feeling well and walking better in hospital. On 19 April, a nurse visited him at the request of a governor after he tried to discharge himself. This visit appears to have been successful as he remained in hospital until 22 April, when he attempted to discharge himself again. At interview the nurse explained to the investigator how difficult he found it being in hospital. He explained that he had been a life long smoker, smoking 25 cigarettes a day, which was not allowed in hospital.
43. After the man’s second attempt to discharge himself from hospital an entry was made in his clinical notes by the prison to say:

“... has again tried to discharge himself and he is currently unable to walk 30 metres with a frame. It would be difficult to re-site him in the wing as he currently needs more support than would be available at a wing based level.”
44. The hospital physiotherapy team were asked to assess the man, but he would not co-operate and so they refused to see him. On 23 April, a member of healthcare staff explained to the hospital staff that, before he could return to

prison, he would need to be able walk a distance of six steps, including stairs, without supervision. It was explained that if he chose to discharge himself from hospital before he was able to do this, he would not be able to return to his own cell and would have to be admitted to the inpatient ward in Parkhurst.

45. The man was discharged back to Albany on 24 April, after the physiotherapy department confirmed that he was now able to get out of bed, and walk the required distance. He had been at hospital for just under one month.
46. A prison doctor saw the man on 29 April. The doctor noted that his weight had fallen to 63kg (and not the 80kg as he had when he came into Albany six months earlier) and was unable to tolerate solid food. He was advised to try and start eating small meals and told that he should be weighed weekly. A follow-up appointment was made for him to be seen at hospital in relation to his bowel operation.
47. The man contacted the Independent Monitoring Board (IMB) on 1 May, complaining that:

“I recently came out of hospital after an operation for surgery on my bowel. The consultant prescribed me a high protein liquid diet. They tried me on solid foods but it made matters worse, so he said I was to stay on a liquid diet until it settled, down then he would review the situation. Back in Albany the doctor prescribed me the same but the nurse overruled him saying it was too expensive and that I was to eat prison food which I can’t.”
48. My investigator contacted the IMB representative to find out how the complaint had been resolved. He said that the complaint had been investigated by a member who had since retired. He was unable to find any record of the outcome of the complaint, so he contacted the former member to see if he could recall what had happened. The former member told him that he had given the man’s complaint to a civilian employee working in the prison. The investigator spoke to her about the man’s complaint. She explained that she knew him well, as he attended an activities club which she runs for the older residents. However, she explained that she was not aware of any complaint he had made and so it appears that it was never investigated.
49. On 15 June, a prison doctor noted that the man had lost more weight loss and he now weighed 60.3kg, losing a further 3kg in five weeks since his earlier appointment on 29 April.
50. The man went back to hospital on 13 July, for a follow-up appointment in relation to his previous bowel obstruction. The Locum in Surgery at the hospital wrote to the prison saying:

“His main complaint at the moment is that of trying to adjust with different types of food. He tells me he was prescribed some protein based drinks but that he has not been getting them on a regular basis as the prison staff think it’s too expensive. Abdominal examination

today showed extensive scarring on the abdomen but no other abnormality as such. The patient does seem quite cachectic and it would help if he could be started on some energy building drink and a protein based diet. [Cachexia is the loss of weight, muscle tone, fatigue, weakness, and significant loss of appetite in someone who is not actively trying to lose weight.] Please arrange a referral to the dietician for further advice on dietary build-up if required.”

51. On 11 August, a nurse was asked to go to the wing to see the man as his COPD was worse. He was very breathless and coughing up thick green sputum. The nurse arranged for a doctor to see him later in the day.
52. Three days later, 14 August, a letter was received from the man’s solicitors. He had informed them that he was not being provided with the specialised diet that he required. They explained that he had been advised to have a diet containing liquid protein and to avoid anything spicy. Further to this the solicitors said that they believed that his health had deteriorated since he had been in prison and they asked how they planned to resolve the issue.
53. My investigator contacted the man’s consultant surgeon at hospital to try and clarify the issues surrounding his diet. He, in his letter of reply, wrote:

“At the time he [the man] underwent an operation for a small bowel obstruction. This was performed by a surgeon, and his notes indicate a single band adhesion causing small bowel obstruction, which was treated by a simple division of the adhesion. This is a very straightforward operation, and in itself would not indicate the need for any special nutritional support following recovery from surgery.

The patient’s medical notes do not, as far as I can see refer to any special dietary requirements during the recovery period after surgery. I can also locate no entries by a dietician, who I would expect to have been involved if a specialised diet or supplementation was considered necessary. There are various comments at different stages in his recovery that he was eating and drinking satisfactorily, the implication being that he was taking a normal diet, and this was confirmed on the final entry prior to discharge from hospital on the 24th of April 2009. The only specific reference that I can find to specific dietary requirements in is in a clinic letter dated 13 July 2009. The doctor who saw the patient mentions the issue of difficulty obtaining protein based drinks, and advice was given to the prison medical officer that it would help if he could be started on some energy building drink and a protein based diet.”

54. The man saw a prison doctor again on 18 August. He complained that his cataracts were getting worse and that he had lost his appetite. The doctor wrote:

“Appetite loss, surviving on soup with added cereals; bowels disrupted and incontinent. Says he’s alright where he is and doesn’t want to

move to obs unit. Chest better with moderate air entry. With his permission I will talk to wing staff.”

55. As a result of this appointment the man was referred to the hospital’s ophthalmologic department. The referral letter read:
- “This patient presents with bilateral lens opacities and is complaining of rapidly worsening visual acuity, especially in the right side. I would be grateful if you could assess his need for surgery.”
56. The man was seen by a member of the healthcare team in his cell on 24 October, as he felt unwell. He was pale in colour and complained of a headache, saying that he felt as though he had a cold. He had just had his flu jab and it was thought that his symptoms were a reaction to it. He was prescribed paracetamol and told that he would be checked that afternoon. When seen at 2.30pm that afternoon, he appeared to be worse and short of breath. The nurse helped him sit in his chair and helped him to use his nebuliser. By the evening his condition had improved, and his breathing was more settled. He was advised to rest.
57. A letter was received from the hospital’s Ophthalmologic department on 13 November. The man’s appointment at the cataract clinic had been scheduled for 15 March 2010.
58. The man was admitted to hospital on 20 November, due to shortness of breath with his COPD becoming unstable. He returned to the prison the following day and was admitted to the inpatient healthcare unit where he was monitored over the weekend. When he improved, he moved back to A Wing.
59. However, on 7 December, the man suffered another acute exacerbation of his COPD. Healthcare staff decided that they would try to keep him away from the hospital due to a recent outbreak of Norovirus (sometimes called the vomiting bug). He had further episodes of acute COPD symptoms on 18 December, 11 January 2010 and 2 February.
60. On 21 February, wing staff asked for someone from healthcare to encourage the man to be more active as he only came out of his cell to use the toilet. When the investigator asked the nurse about this, he explained that due to the man’s COPD he was unable to walk long distances without becoming stressed. He said that such stress would often be the trigger for an attack.
61. The man’s appointment at the cataract clinic was cancelled by the hospital on 4 March and an alternative was booked for 7 April. Unaware of the change of date he submitted a hospital appointment refusal/cancellation form to healthcare staff on 8 March. The reason which he gave for cancelling his appointment was:
- “I feel it has been a long time waiting – 6 months and my eyesight in my right eye continues to deteriorate dramatically and I do not want to pursue the matter any further.”

62. The clinical reviewer commented in his report that there were several occasions when his referral for treatment at hospital was delayed. Some of the appointments were re-arranged by the hospital and the dates were beyond the 18 week standard which prevailed at the time. He particularly noted the cataract referral. The quality of the information in this referral letter was poor. There was no accompanying GOS18 (Optician's letter) and the first appointment was months after the man was referred with another month's delay caused by the hospital. This is just one of a few issues highlighted by him which are discussed later on in the report.
63. On 17 March, the man was visited by a member of staff from healthcare following a telephone call from wing staff. He was breathless, and said that he had been coughing blood. He was seen by a prison doctor who prescribed Prednisolone which is used to treat a wide range of inflammatory and auto-immune conditions such as asthma.
64. The man was next seen on 21 March, complaining of lower chest pain. His breathing difficulties had not improved despite taking Prednisolone for four days. Healthcare staff decided to take him to hospital and, as he improved, he was discharged that evening.
65. The issue of the man's accommodation and his suitability to stay on A wing was raised again on 31 March. A nurse made an entry in his medical records to say that:
- “... due to chronic ill health this man has a problem of fitting in with the night unlocking system and this is now creating issues. Having explored the various avenues to allow him longer night sanitation it is impossible to override the system and it will lock him out after two extended stays out. I would suggest that he is reassessed OT [OT meaning Occupational Therapy] wise to ensure his needs can be met by alternative accommodation within the prison.”
66. The man failed to attend a doctor's appointment and to collect his medication from healthcare on 16 April. A member of staff from healthcare visited him to deliver his medication and he explained that the reason for his non attendance was because “all I hear is bad news”.
67. The same day, an employee from the Isle of Wight Social Services completed a care plan for the man. It read:
- “The man is currently accommodated on A wing and has chosen to remain there previously due to the support he receives from his buddy; however he now recognises that his health is deteriorating and this is impacting on his management of his personal care needs and his increasing dependency on his buddy for support. He is unable to use the night sanitation system due to his poor mobility and he is unable to access the toilet in the time allocated. He uses the bucket provided in his room at night; however due to his increasing medical issues,

including poor balance, he is a high risk of falls and potential injury. He is no longer able to access the communal shower due to his decreasing mobility and respiratory issues. His buddy provides him with hot water daily to enable him to have a strip wash. He does not have grab rails in his room and uses furniture in the room to hold on to. Recently he slipped and banged his head on shelving whilst he was washing. He wants to be able to manage to remain independent in managing his personal care needs; however, his present accommodation is not conducive to enabling him to be self supportive”.

68. The care plan identified key areas where action should be taken. It made a number of recommendations which included:
- Armchair exercise regime.
 - To provide accommodation that would enable him to be self caring. Preferably ground floor accommodation with easy access to communal areas.
 - To provide aids and adaptations to help maintain independence.
 - Personal lifeline alarm to enable support to be summoned immediately.
 - Risk assessment conducted on accommodation provided.
69. After investigation the investigator was told that this care plan and the recommendations were not acted on by wing or healthcare staff.
70. On 29 April, a prison doctor saw the man as his COPD was worsening. He was offered accommodation on IHU, but he declined, saying that he preferred to stay where he was, in his cell. He was referred to the cardiology department at the hospital and a review was scheduled for two weeks time.
71. The nurse next visited the man on the wing just over two weeks later on 15 May. He had again become quite breathless and was given oxygen to try and alleviate the problem. Wing staff were asked to keep an eye on him. Two days later, on 17 May, he was still breathless but, despite his condition, he again refused admission to the IHU, saying that he wanted to stay on the wing.
72. On 26 May, the hospital sent confirmation of the man’s cardiology appointment. The appointment was booked for 29 June and he was told about it. However, on 27 May, he filled in another ‘hospital appointment refusal form’ asking to cancel his cardiology appointment. He wrote: “I do not wish to attend this appointment or to make any further appointments. Thank you for your consideration.”
73. On the same day the man wrote a letter to the healthcare staff saying:
- “I am returning the medication that I have as they are not doing me any good. I keep seeing different doctors and they keep saying something different and I am confused. I don’t want anymore medication and want to leave it in the lap of the gods. I want you to respect my wishes and D.N.R me.” (DNR or Do Not Resuscitate, often called a living will,

is a legal document that states resuscitation should not be attempted if a person suffers cardiac or respiratory arrest.)

74. A note in the man's medical notes says:

"... received a letter from the man outlining his issues with his ongoing poor health. As part of this letter he has expressed his wish not to be resuscitated. We will advise GP re this and make app for him to see GP ASAP".

The same day he returned his medication to the pharmacy saying that he was fed up with everything and he preferred to leave his life "in the lap of the gods".

75. A doctor's appointment was made for the man on 1 June. It is unclear whether the appointment was made to discuss his DNR wishes, as no note was made in his clinical record, and in any event he did not go.
76. The investigator spoke with a nurse in relation to the DNR request. The nurse confirmed that he was not aware of the man's DNR wishes. An officer who had worked on F and G wing, said that she was not aware of any DNR notification being in place for him. She did however comment that another prisoner, who was a friend of his, spoke to her a few days before the man died. The officer said that the prisoner had asked her (on the man's behalf) if she could look up the Prison Service Order (PSO) that detailed the procedures for obtaining a DNR notification. The prisoner had told her that the man did not want to be revived. After investigation it appears that the paperwork required to formalise his DNR wishes was not completed.
77. The man suffered further episodes of shortness of breath on 3 and 13 June. Staff noticed on 13 June that he was using the nebuliser more often and so healthcare staff were notified.
78. On 22 June, the man was very breathless, and complained of a pain in his side. It appears that he had agreed to restart taking his medication. The issue of moving from A wing to more suitable accommodation on F and G was discussed with him but he again declined.
79. A Healthcare Assistant spoke to the man on 9 July about the suitability of his current accommodation. She explained that the current arrangement whereby his medication was delivered to him in his cell would not continue long term. One of his prescriptions, Tramadol, had to be delivered to him each day, and he would find it difficult to collect it if he stayed on A wing. (Tramadol is an opiate drug which is classified as a controlled medication to be given under supervision and cannot be given as in-possession medication. A prisoner who is prescribed a controlled drug has to be seen taking their medication.) As a result of this discussion, he accepted that he would be more suited to the accommodation in F and G Wing. Enquiries were made with F and G wing and he was told that there would be space for him later in the month.

80. After suffering further problems with his breathing on 18 July, the man again declined admission to IHU. He moved to F and G wing three days later on 21 July. The nurse spoke to him after the move to see if he liked it, with him commenting that he “wished he had done it sooner”.
81. After the man had lived in the new wing for three weeks, concerns were raised that he was still staying in his cell for most of the day. Healthcare staff encouraged him to walk about at least once a day. My investigator spoke to his buddy. The buddy said that he tried to encourage him to become more mobile, even offering to wheel him in his wheelchair around the exercise yard to get some fresh air. He said that he would often decline, and wanted to stay in his cell. The buddy commented that he was able to walk around without his wheelchair but chose not to.
82. On 4 September, the man was found collapsed on the wing. He was given oxygen and taken to hospital. Because of his worsening COPD, he remained in hospital for 16 days, being discharged back to Albany on 20 September. He had a broken sacral (lower back/ tailbone area) pressure sore when he returned from hospital. The clinical reviewer comments in his report that:

“... though this was treated, it does not appear that the advice or support of a Tissue Viability Nurse was sought, and no equipment was provided to ensure healing of the ulcer. Given his frequent doses of oral steroids, and general condition, he was at high risk of progression of his ulcer.”
83. On 13, 19 and 26 October the man was seen by healthcare staff, who administered oxygen as he was severely short of breath and having panic attacks. On the third occasion, 26 October, the Modern Matron (a Modern Matron is a senior nurse or clinical nurse manager) went to see him herself due to the concerns about his health. He told the staff that he had been suffering from chest pains in the night. Admission to the IHU was offered (and again declined) and he was seen by a doctor later that day.
84. The man’s health deteriorated and, due to further shortness of breath on 29 October, he was advised that he would need to be admitted to either IHU or to hospital. He again refused to move to either location. Healthcare staff deemed that he was competent to make this decision and allowed him to remain in his cell. However, by the next morning, his condition had deteriorated further. The nurse told my investigator that when he went to see him that morning he (the man) said to him “I give in”.
85. The man was transferred to hospital for assessment. However, after just five days, he discharged himself from hospital against the advice of hospital staff. The nurse explained to the investigator that the man was a lifelong smoker and found it very hard to be in hospital where smoking is not permitted. The nurse said that he would often only last a few days in hospital before discharging himself and be able to have a cigarette.

86. On 8 November, six days after coming back to prison, the man was seen by healthcare staff as he was again short of breath. It was suggested that he should have a medication review but he declined. He continued to experience shortness of breath and on 11 November asked to see a doctor.
87. At 12.25am on 12 November, the man pressed his cell bell complaining of chest pains and being short of breath. Two OSGs were on duty on F and G wing that night. It is unclear who went to his cell due to the different statements given by the OSGs in interview for this investigation. OSG A advised the investigator that, on speaking to the man, he told him to sit down on his chair and use his nebuliser. The OSG then returned to the wing office to telephone the control room to speak to Oscar 1 who was Senior Officer (SO) Mark Sheen. Oscar 1 is the radio name given to the person in charge of the prison) to inform him of the situation. The OSG explained that he chose to telephone the control room rather than use his radio, because the telephone would connect directly to control room staff.
88. Two minutes after the man rang his bell, at 12.27am, the SO spoke to OSG A to be briefed on the situation, and he came to the wing approximately five minutes later. The SO explained that, at the time he received the telephone call, he was some distance away. He said that on his way to F and G wing, he collected the necessary paperwork to avoid any delay if an emergency admission to hospital was required.
89. The SO was accompanied by Oscar 2 (second in charge of the prison that night). The SO unlocked the cell door at 12.35am. Apart from Oscar 1 as the officer in charge of the prison, other staff do not carry keys at night. They carry cell keys in a sealed pouch which can be broken in the event of an emergency. OSGs do not have the same level of training to work with prisoners as the officers do.
90. The SO and officer went into the cell and found the man slumped in his chair, with no signs of life. The SO explained to the investigator that he spoke to him to get a verbal response. After gaining no response, he tried to find a pulse in his neck and checked his eyes. The SO commented that he noticed that his pupils were dilated, and the tips of his fingers were blue. Because the SO was unable find any signs of life, cardio pulmonary resuscitation was not attempted. At 12.38am the SO asked OSG B to contact the control room to ask for an ambulance. The ambulance arrived at 12.45am and the paramedics examined him, pronouncing at 12.58am that he had died.
91. At 5.30am that morning a governor held a debriefing session with all the staff involved, offering the services of the care team. The same morning, the prison family liaison officer and a governor visited the man's wife at her home to inform her of her husband's death.
92. Notices were put up at the main gate informing staff of the man's death, with prisoners on F and G, and friends of his (from A wing) being told the news by a governor.

ISSUES

Clinical care

93. In his clinical review, the clinical reviewer comments that the care provided to the man whilst he was at Albany fell below that which is expected of normal NHS healthcare. He judges that there were areas for improvement in the delivery of both primary and secondary care. Although the doctor considers that his care was in some respects good, the deterioration of his health was largely unrelated to these issues. He says that opportunities might have been missed had other conditions been developing at a time, and that addressing these issues will benefit the care of other prisoners in the future.
94. The clinical reviewer comments that:
- “... despite several emergency admissions, he did not have spirometry, was not referred to a Chest Physician. He was seen by a Modern Matron, but does not appear to have been targeted for proactive admission avoidance [management of a person’s ill health to avoid unnecessary hospital admission/ attendance]. He was not referred to Pulmonary Rehabilitation, though he was noted on two admissions to have dysfunctional breathing, and may well have benefited from this.”
95. The clinical reviewer also noted that there were many episodes of reactive care, but very little evidence of pro-active care. For example, the man had a flu jab in November 2010, but it was missed out in earlier years and he missed the swine flu vaccination in 2009. He commented that he was aware that an invitation was made (which is documented in his medical notes) but without any reference to its importance being explained to someone with his health problems.
96. Similarly, the man had a cardiovascular risk score which was calculated as high on two occasions but the clinical reviewer noticed that no action appears to have been taken as a result. Further to this, although he was added to the stroke register in May 2009, this did not result in the usual secondary prevention therapy which would normally have been initiated in such a situation. The clinical reviewer recommends that healthcare staff should improve the quality of care provided to prisoners with long-term conditions such as chronic obstructive pulmonary disease.

The healthcare manager should improve the quality of care provided to prisoners with long-term conditions such as chronic obstructive pulmonary disease.

97. On 20 September, the man returned from hospital with a broken sacral (lower back/ tailbone area) pressure sore. The clinical reviewer comments in his report that:
- “Though this was treated, it does not appear that the advice or support of a Tissue Viability Nurse was sought, and no equipment was

provided to ensure healing of the ulcer. Given his frequent doses of oral steroids, and general condition, he was at high risk of progression of his ulcer, and this should have been managed pro-actively.”

Hospital referrals

98. The clinical reviewer goes on to comment that there were several occasions when his referral for treatment at hospital was delayed. Some of these appointments were re-arranged by the hospital, dates were well beyond the 18 week standard prevailing at this time – of particular note was the cataract referral. The quality of the information in this referral letter was poor. There was no accompanying GOS18 (Optician’s letter); and the first appointment was months after referral, which was subsequently delayed a further month by the hospital.

Prescribing medication

99. The clinical reviewer also considers that the standard of prescribing was below the level expected from most general practitioners.

“He appears to have had two diuretics for a considerable period of time; Bendroflumethiazide and Furosemide. His antibiotic prescribing was out of step with latest best practice, particularly with regard to avoiding the “4C’s”. [cephalosporins, co-amoxiclav, ciprofloxacin and clindamycin, are particularly associated with a high risk of causing clostridium difficile infection (CDI). CDI causes infection when antibiotics disturb the balance of bacteria in the gut and toxins are released]. He was on long term low dose cefalexin, and given co-amoxiclav and ciprofloxacin on several occasions (by GP’s and the hospitals). He did not have sputum culture arranged, despite this prescribing of repeated antibiotics, and when he had diarrhoea, a stool culture was arranged, but does not appear to have been tested for C. Diff as relevant information was omitted from the request form, though he was clearly at risk for contracting this”.

In view of this the clinical reviewer makes the following recommendation which I endorse.

The doctors at HMP Isle of Wight should review their antibiotic and general prescribing, and adopt an antibiotic formulary and ensure prescribing is in line with best practice.

Responding to night time healthcare emergencies

100. The inpatient healthcare unit (IHU) for all three sites (Albany, Parkhurst, and Camphill) at HMP Isle of Wight opened in October 2009. It is situated on the Albany site. The investigator was informed during her investigation that,

despite being on the Albany site and in close proximity to the wings, healthcare staff are not permitted to leave the building to attend to any medical emergency within the prison at night. Prison staff have been informed that, with prior notification, prisoners could be brought to the IHU for treatment 'out of hours' when the primary healthcare unit is closed. However, if the prisoner is unable to walk, (due to ill health) an ambulance should be called to take them to hospital which is located across the road to the prison.

101. When the investigator queried this she was informed that, when the unit opened there was just one member of staff on duty at night and, as they operated across the three sites they felt that they should not be expected to leave the inpatient unit to visit another prison site, which would mean leaving inpatients unattended. The healthcare manager explained that all staff were instructed that if an obvious health emergency arose, they should not delay seeking assistance and should contact the control room to ask for an ambulance.
102. This decision may well have been correct when the IHU only had one member of staff on site and I agree that it would have been unacceptable to leave the prisoners unattended in the inpatients unit. However, the investigator was informed on one of her visits to Albany, that the staffing levels have risen. The IHU now has two healthcare staff on duty at night. It may still be the case that asking staff from the IHU to leave the Albany site to go to Parkhurst and Camp Hill would be difficult. However, now that there is an additional member of staff on duty, I recommend that the decision not to respond to healthcare emergencies at night should be reviewed.
103. During the clinical review panel meeting on 28 January, the Senior Commissioner for Offender Health, Isle of Wight NHS PCT commented that they were looking at developing a planned or elective outreach programme, so that nurses could support the care given to prisoners on the wings. This outreach programme would allow medical staff to administer planned medication to prisoners on the wing at night, allowing them to stay within their normal location rather than be admitted to IHU. Whilst I agree that this is a step forward, I would still encourage the PCT to consider the advantages of allowing staff to attend medical emergencies within Albany during the out of hours period.
104. The issue of night time healthcare provision has recently been raised by two other deaths at HMP Isle of Wight at the Albany and Parkhurst sites. My most recent recommendation was that:

“The Governor, Head of Healthcare and the Primary Care Trust should work together to ensure that night healthcare provision sufficiently meets prisoners’ needs across the Isle of Wight prison estate”.
105. The prison’s response was that “work is ongoing in respect of ensuring clarity and equity of access to healthcare across the 24 hour day”. As the Senior Commissioner confirmed that the only planned change was for an outreach programme for ‘planned care’ such as delivery of medication out of hours, I

repeat my recommendation that the PCT should consider the advantages of allowing staff to attend medical emergencies during the out of hour's period.

I encourage the Primary Care Trust to consider the advantages of allowing staff to attend medical emergencies within Albany during the out of hour's period.

The man's 'Do Not Resuscitate' wishes

106. In a letter on 27 May 2010, the man made it clear that he did not wish to be resuscitated, in the event that he should collapse. This request was not formalised by completing the necessary DNR document, or completing an Advance Directive. In the event, his rapid deterioration meant that his wishes were complied with, as he was found dead in his cell.
107. Nevertheless I think that the man's DNR wish should have been formalised. The clinical reviewer commented in his review that a named GP taking responsibility for holistic care may have facilitated this, and also better monitoring of his chronic diseases, as is incentivised by the Quality and Outcome Framework in regular NHS general practice.
108. I agree with the clinical reviewer who recommends that the prison should adopt an end of life policy, to include the use of the South Central Do Not Actively Resuscitate forms. The South Central Do Not Actively Resuscitate policy provides clear guidance for local NHS staff and others providing end of life care about when resuscitation should and should not take place, taking into account the wishes of patients.

The Head of Healthcare should adopt an End of Life policy; to include the use of the South Central Do Not Actively Resuscitate forms.

The man's diet and loss of weight

109. The man arrived at Albany on 16 September 2008. At the reception health screen he weighed 80kg with a BMI [Body Mass Index] of 24.1. Body Mass Index, or BMI, is a tool that helps you measure the amount of body fat you have based on your height and weight. According to the BMI index his weight was classed as 'normal', in the sense that he was neither overweight nor underweight.
110. He was seen by a prison doctor on 29 April, when it was discovered that his weight had fallen to 63kg, that is 17kg than the 80kg which is what he weighed at reception into Albany six months earlier. He was advised that he should be weighed weekly. This did not happen as recommended and, on 15 June, it was discovered that he had lost more weight. He now weighed 60.3kg, and had therefore lost a quarter of his body weight in just nine months. His BMI was now 18.8, which is on the border between normal and underweight.

111. The man underwent surgery for a twisted bowel on 25 March 2009, and the clinical reviewer commented in his review that:

“... though there appears to have been some misunderstanding on his part regarding a liquid protein diet, the advice from surgical out patients 13.07.09 was for some energy building drink and protein based diet.”

This did lead to a discussion with wing staff by the doctor, but no supplements were prescribed. When they were prescribed in September 2010, a GP queried this in November 2010, and said he should be seen to discuss this.

112. The criteria for prescribing build-up drinks was explored by the investigator and healthcare staff at the review panel on 28 January 2011. She was advised that the prescribing of dietary supplements such as the build up drinks the man wanted is covered by the Advisory Committee of Borderline Substances rules. (Borderline substances are items that are not classed as drugs which can be given in a doctor's prescription such as specialist foods, dietary supplements, sun creams and the like.)
113. It was explained to the investigator that in order to qualify for prescribed build-up drinks the man would have had to have suffered from either disease-related malnutrition, intractable malabsorption, pre-operative preparation of malnourished patients, dysphagia, proven inflammatory bowel disease, following total gastrectomy, short-bowel syndrome or bowel fistula. As he did not have any of these conditions, he therefore did not qualify for prescribed build-up drinks.
114. The man's post mortem report described him as being “a well nourished late middle-aged white male”. Despite having continued health problems, the autopsy report showed him to weigh 74kg with a BMI of 22.8 having gained most of his weight back. Despite the weight gain I feel that his weight should have been monitored more closely, and his previous large weight loss should have been investigated further (especially after an entry in his medical records on 18 August 2009, saying “appetite loss, surviving on soup with added cereals”). The clinical reviewer commented that “the regular weighings were pretty erratic”.

The man's accommodation in the prison

115. The man initially lived in A wing where, due to difficulty walking, he found it difficult to use the night time sanitation system. This resulted in him having to use a bucket at night. On 25 March 2009, a prison doctor wrote in his medical notes that he would support a move to F/G wing on medical grounds. Moving to F/G was discussed several times with him, but he declined. He did not want to move to a different wing due to friends he had made on the wing. One simple solution to this problem could have been moving to a cell closer to the toilets but this does not appear to have been considered as there is no mention in his prison records.

116. Despite repeated admissions to hospital and deterioration in his health, the next time that the issue of the man's accommodation (and his suitability to stay on A wing) was documented was 31 March 2010, some 12 months later.
117. The man's care plan (April 2010) commented that "his present accommodation is not conducive to enabling him to be self supportive". The care plan highlighted that he was using a bucket instead of the normal toilet and, due to poor balance; he was at risk of injuring himself. He had recently banged his head on shelving whilst washing.
118. A move to different accommodation was discussed again on 22 June 2010, but he again declined. It was only on 9 July, when a healthcare assistant told him that healthcare staff could not deliver his medication to him indefinitely and so he would have to collect it himself, that he agreed to move to F/G wing.
119. The investigator asked the nurse about the man's unwillingness to move to F and G wing. The nurse said that, once he moved to F/G, he said "I wish I'd done this ages ago", commenting that he often needed coaxing to do something.
120. The nurse also discussed the differences with healthcare services since it has been run by the Primary Care Trust (PCT) and not the Prison Service. He explained that, since the PCT had taken over, the care was much more patient centred, giving the prisoner more say over the care which they received. The nurse said that:
- "... in the old days of prison work you used to say, 'you're going there mate' and that was it. I think with the way that the PCT have taken over, the way that the patient can actually think has changed somewhat and they actually have the same, almost like the same rules that exist outside".
121. I agree that allowing prisoners to have more control over the care they receive, as they would do in the community, is a good thing. However the problem with the man's mobility and the night sanitation system was first highlighted (and discussed with him) on 25 March 2009, some 15 months before he moved cells on 22 June 2010. It was undignified that he had to use a bucket at night instead of being able to use a toilet.
122. The IMB's National report "Slopping Out, A report on the lack of in-cell sanitation in Her Majesty's Prisons in England and Wales" dated August 2010, explains that the practice of 'slopping out' (use of a bucket as a toilet) was officially brought to an end on Friday April 12 1996. The nurse explained that the man would often just need coaxing to do things, and a governor on 15 June 2010, mentioned that the move would be for health and safety reasons. I consider that more determined efforts should have been made to encourage him to move to a more suitable location. In response to this I make the following recommendation:

The Governor should ensure that if a prisoner is unable to easily use the night sanitation system they should not remain on the wing.

123. While I do not make a recommendation on the night sanitation system as a whole, I believe that NOM's should look again at whether the current night sanitation system is appropriate.

The man's care plan

124. An employee of Isle of Wight Social Services completed a very detailed social care plan for the man in April 2010. Although it recommended more proactive management of his health in general, and his respiratory problems in particular, none of her recommendations were acted on. It also recommended that he should be provided with a personal alarm to summon help, this being an important issue for him due to his mobility and breathing problems. This was again not provided.
125. An investigation carried out by one of my investigators at HMP Shepton Mallet in February 2009, showed that certain prisoners had been provided with personal alarms, showing that the provision of such alarms was feasible in the prison environment.
126. After discussion at the review panel on 28 January, the investigator was informed by the healthcare manager that the care plan had been conducted as part of a pilot, with no expectation that the areas identified would be addressed. It was explained to her that the care plan was conducted as part of the 'Isle of Wight Older Prisoners Project', a project to try to develop a framework to meet the health and social care needs of older prisoners. I understand that the man did receive some in-chair exercise therapy, but no other items from this assessment were provided. This care plan identified several areas for improvement in the care being given to him. I find it very disappointing that, despite highlighting these areas, they were not acted on.

The prison should consider whether to provide personal alarms for frail prisoners such as the man.

Emergency response

127. Two Officer Support Grades (OSG) were on duty on F and G wing the night that the man died. Witness statements were received from both OSGs detailing the events before and after his death in the early hours of 12 November 2010.
128. At 12.25am the man pressed his cell bell seeking assistance. It is unclear who responded to the bell and went to his cell as they gave different accounts to the investigator. OSG A advised her that, on hearing the cell bell he attended the cell, whilst OSG B remained in the wing office. The OSG A said

that, after speaking to the man, he returned to the wing office where the other OSG was to contact the SO (Oscar 1). However, OSG B advised the investigator that she went to the cell together with OSG A and stood at the door while he spoke to the man through the observation hatch. OSG B advised the investigator that, on finding that he was unwell, they returned together to the wing office to summon help.

129. Whatever happened, when the SO arrived at the cell at 12.35am, no members of staff had waited with him. The man was slumped in his chair showing no signs of life and must have died alone in the ten minutes since had had rung his bell. Both OSGs were the only two members of staff on duty on F and G wing that night. If they had gone to the cell together, I believe that one of them should have remained at the door to observe him whilst the other returned to the wing office to summon help. If this had occurred, the OSG would have been able to see if his condition deteriorated, and then gone into his cell to help.
130. The SO explained to the investigator that he went into the cell and spoke to the man to try to get a verbal response. After gaining no response, he tried to find a pulse in his neck and checked his eyes. He commented that his pupils were dilated and the tips of his fingers were blue. Because the SO was unable find any sign of life, resuscitation was not attempted.
131. Annex 13A of Prison Service Order (PSO) 2700 gives the following guidance to staff who have discovered a prisoner hanging:
- “If [the prisoner is] not breathing and/or no pulse is present, clear the airway and attempt resuscitation using a face mask with a non-return valve, unless rigor mortis of the limbs has clearly set in.”
132. Whilst the circumstances are different and he was not hanging, I think that this guidance is still appropriate and the principles apply. It is not certain when he stopped breathing, he had last been seen just ten minutes earlier when he rang his bell and OSG A spoke to him.
133. The man had made a DNR request but it was not formalised by completing the necessary paperwork. However, in the event, his rapid deterioration and sudden death meant that that his wishes were inadvertently complied with. Whilst the guidance in PSO 2700 indicates that the SO could have attempted to resuscitate the man, I accept that it was a very difficult decision for him to make. As it happens the SO unwittingly complied with his request. Nevertheless, I think that the Governor should remind staff of the above guidance from PSO 2700 which indicates that prison staff should have started CPR.
134. When the investigator interviewed OSG A she asked him how well he knew the man. He said that he had worked at Albany for three years and had worked on all the wings. He knew him and was aware of his health problems. The investigator asked him to describe what he saw when he looked through the observation hatch into the cell. He explained that when he saw the man

“he looked like he was breathing badly”. When asked whether he had seen the man look like that before, the OSG replied “no” indicating that his breathing was a concern.

135. The investigator asked the OSG if there was a specific policy about entering cells at night and whether he thought that he should have opened the cell. The OSG confirmed that Albany did have a specific policy, commenting that:

“... it depends which wing you’re on. All the other wings [A to E] are electronically operated, the doors, so for example if I saw a gentleman in a cell on [A wing hanging] I could get on the radio and have that door opened if I deemed it fit for my safety to go into that cell and cut the guy down but on F and G wing, because the doors are not electronically operated, they are solely operated by the key, I can’t do nothing. I can’t enter that cell; I can’t get access to that cell.”

The investigator asked the OSG about his sealed pouch, which contains the key to open the cell doors in an emergency. He responded that he did not hold a sealed pouch with any key, commenting that the only person who had access to the cells was Oscar 1. He said that, even in an emergency such as a fire, he would be unable to open the door to leave the wing.

136. The investigator obtained a copy of the prison’s night orders which were in use at the time of the man’s death. The night orders (night operating procedures section) says that:

“Staff patrolling at night must carry their suite and inundation point keys in a sealed pouch attached to their key chain. Officer Support Grades in F/G Wings must also carry sealed pouches” and under the section detailing the issuing of sealed packets “OSGs working on F/G Wings will draw full sealed packs. You need a full set of keys in case of fire to get out of the wing.”

137. In addition to this the investigator obtained a copy of the prison’s key log which is kept by the gate room to record who has been issued with a particular key at a certain time. The key log shows that key 277 (the key allocated to F/G Wing) was signed out on the evening of 11 November 2010. However, the key log does not show who arrived on duty first, which of the OSGs. It was explained to her that there was one key for F/G wing and the two OSG’s on duty. Whoever arrives on duty first would be the person who would sign the key out. Despite the fact that it is not clear who signed the key out that evening, I find it very concerning that OSG A (a permanent night shift worker) was not aware of its existence.

138. The investigator asked OSG B about her view on entering cells at night. She confirmed that she was aware of the night procedures and the use of the sealed pouch saying:

“We are advised that we shouldn’t enter a cell unless it’s absolutely necessary, especially with one member of staff being on the wing in

case it's a hoax, we could be putting our own lives at risk for instance. We have an emergency key which is sealed in a pouch. Obviously if a prisoner's hanging or if he'd say, for instance, cut his wrists or something that we felt was life-threatening, then we can enter the cell using the key that's in the sealed pouch."

139. I agree that going into a cell alone can be risky and I appreciate that staff have to consider their own safety and the security of the establishment. However, balanced against this, it must be remembered that the man was an older prisoner who was clearly in distress and struggling to breathe. In the circumstances, given that there were two members of staff on duty, I think that it would have been reasonable for them to open his cell to assess and assist him.

140. The night orders say:

"Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the NOO [Night orderly officer] but control must be informed prior to entry and then an individual member of staff may enter the cell on their own. The preservation of life must take precedence over security concerns."

The man's deteriorating health was known to staff. A risk assessment could have been completed when he moved to F and G pre-empting the situation where his cell may have to be opened at night. This could have reduced some of the concerns of the OSGs on duty that night. In my view, risk assessments of every elderly or infirm prisoner on the wing would seem appropriate.

Risk assessments should be conducted on all elderly or infirm prisoners accommodated on F and G wing to assess any potential risk of entering their cell at night.

141. The investigator spoke to the SO, who was Oscar 1 on the night when the man died, about the issue of entering his cell. He confirmed that the night orders say that two people must be present before a cell is opened during the night. However, they should assess the risk and, depending on what they see, they should open the emergency pouch and use the key. Staff should not put their lives at risk particularly as officer support grades have less personal protection training than the officers do. He also explained that F and G wings differ from the other wings as they have two OSGs on duty whereas the other wings have one OSG working alone. To my mind this means that F and G wing staff should feel more confident about opening a cell.

142. The then Chief Operating Manager for the National Offender Management Service on 26 January 2010, sent a letter titled "cell access at night/ when in patrol state" to all the Governors/ Directors of prisons detailing concerns raised by death in custody investigations carried out by my office. He commented on the issue of entering cells at night and during patrol state. He detailed concerns regarding prison staff not understanding when they can

enter a cell on their own. He said that staff being unaware that they are able to enter a cell without another member of staff being present, despite the fact that they were in possession of a cell key in a sealed pouch to be unacceptable. He said that all staff must be aware of the establishment's Local Security Strategy (LSS) instruction on entering cells at night or when in patrol state. Further to this he asked all Governors to ensure that procedures are in place to inform all staff of their responsibilities under the LSS.

143. The SO highlighted that the OSGs at Albany do not have the same amount of training as officers. The investigator was informed by both OSGs that they had received no first aid training. Other OSGs are not first aid trained either but OSG B said that she would welcome training. She said that she would feel more comfortable working at night knowing that she had the skills. She commented that:

“There have been several occasions where prisoners have self-harmed on an evening. Although we send them out to hospital so they can be cleaned up and stitched etc, initial first aiding is quite important and if you can help stop bleeding initially it can be a matter of life and death I suppose in some situations.”

The Governor should train OSGs on night procedures, particularly when to open the sealed pouch.

144. The investigator was informed by both OSGs that they had received no first aid training. She asked the SO about the first aid facilities within F/G Wing. He said that he knew that there was a defibrillator in the prison. He had asked the training officer about relevant training as he was to become a permanent night orderly officer. He then hoped to train all the night OSGs to be able to use the equipment.
145. The ambulance was called 14 minutes after the man was found having problems breathing. Whilst I do not suggest that calling an ambulance when he was first discovered could have saved his life, both OSGs commented that they would not decide themselves whether an ambulance should be called. They felt that the decision should only be made by Oscar 1. When the investigator explained this to the SO, he confirmed that OSGs can call an ambulance if “it was a medical emergency”. Both OSGs should have called an ambulance on discovering him in distress. In response to this I make the following recommendation:

“The Governor should ensure that all staff are aware of the procedures to follow when they believe there is a danger to life, whether through natural causes or self-inflicted injuries”

146. The investigator asked the SO if he could think of any areas of improvement, and whether anything should have been done differently on the night when the man died. He remarked that if the staff were confident and trained, then one of them could have stayed at his door. Had they seen him collapse, then they could have gone inside and started CPR straightaway. The SO thought

that the staff felt that his symptoms were a continuation of his long term condition. He surmised that the OSGs thought that it would be enough for him to use his medication until the SO arrived to assess the situation.

147. The need for first aid training for staff has been further highlighted by HM Coroner in February 2011. The coroner's concerns were expressed in a Rule 43 letter after hearing details at an inquest into a death at HMP Isle of Wight at the Camphill site. The coroner said that:

“Evidence was heard at the inquest that Prison Officers at HMP Camphill occasionally encounter potentially life threatening incidents in which prisoners have self harmed (whether ligatures or otherwise). It appears, however that such officers are not systematically trained in appropriate responses to these situations or resuscitation techniques. Prison staff called to give evidence some 21 months after this incident, were not able to give evidence that first aid and resuscitation training was a universal component of their training even now. In particular there seemed some uncertainty as to how they could respond to such situations.”

148. As I say, OSGs at Albany are not first aid trained. They are asked at night to patrol the wings without direct access to medically trained staff. I agree with the HM Coroner that every case should be dealt with as an emergency, and assumptions should not be made about someone's condition. I agree that all members of staff in contact with prisoners, especially those working at night, should be first aid trained.

The Governor should review first aid training to ensure that all duty senior officers are trained. The Governor should roll out the training to other staff including OSG, particularly those who work at night.

149. Further to this, the investigator was informed by prison staff that F and G (due to the in-cell sanitation) housed a large number of elderly or infirm prisoners. Being aware of the people residing in this wing, risk assessments could be done to assess any potential risk of entering their cell at night.
150. A previous investigation at the Parkhurst site carried out by one of my investigators raised the issue of entering cells at night. A recommendation was made to say "The Governor should ensure that all staff working at night, including operational support grades, are aware of the prison's policy regarding entering cells in an emergency". I understand that, as a result of this recommendation, all staff watched a video about the actions to take when entering cells.

Provision of oxygen

151. During the investigation the investigator spoke to the man's friends. They were both concerned about the lack of oxygen for him. On occasion he required oxygen when his nebuliser failed to ease his symptoms. The

prisoner said that the man spoke about feeling as though he would die because the oxygen was not easily accessible. His 'buddy', remembered a time when oxygen was brought over from the IHU as he had trouble breathing. He commented that an officer was especially helpful that day and the man had bought her a thank you card to show his appreciation.

152. The investigator asked the officer about the incident. The officer confirmed the details and spoke about another prisoner who has now left the prison. This prisoner did not smoke and the officer thought that he was allowed to have oxygen in his cell for a period of time. The investigator was informed that, as the man smoked, health and safety reasons meant that he could not have oxygen in his cell. In fact the nurse explained that the circumstances were not as the prisoner and the officer thought as the other prisoner did not have his own oxygen supply.

153. Nevertheless the matter was discussed at the clinical review panel. The clinical lead for HMP Isle of Wight did not think that having oxygen on the wing would have helped the man during his last moments. However, in interview with the officer, the clinical reviewer commented:

“In people who have severe lung disease they can be effectively breathing on their low oxygen and if you give them oxygen it can stop them breathing but in an emergency situation there’s much more potential for harm withholding it than giving it.”

I understand that oxygen (being in a pressurised container) could be dangerous in the wrong hands. However, considering the prisoners accommodated on F/G wing are of age, or suffer from ill health, I feel it would be beneficial to consider carrying out a risk assessment on having oxygen kept in a secure location on the wing.

The Governor and Head of Healthcare should assess whether oxygen could be kept in a secure location on F/G wing for prisoners with breathing difficulties.

CONCLUSION

154. The man was sentenced to 21 years for serious offences. He was unwell even before he was imprisoned. During his time at Albany, he declined to take action which might have improved his wellbeing. He was given stop smoking treatment in hospital, but discontinued it on return to prison, and chose not to have flu jabs in some winters. He delayed his transfer from A wing (which was not conducive to his health needs or to the risk of accidents) to F and G wing (which provided more suitable accommodation due to having in-cell sanitation). He also refused to transfer to the inpatient healthcare unit on several occasions; even though it was clear to staff that he was too unwell to remain on the wing. He discontinued various medical treatments, and declined outpatient's appointments for his cataracts and his heart failure. He declined or delayed admission to hospital during some of his breathless episodes, and discharged himself against medical advice in his final admission.
155. Despite the man having refused many initiatives which could have made his last months more comfortable, I also consider that there was more that the staff could have done for him. In particular more thought should be given to looking after prisoners who are in poor health. The Governor should consider providing more first aid training and re-emphasise when it is safe to go into a cell at night.

RESPONSE TO THE DRAFT REPORT FROM THE MAN'S WIFE

156. Written representations were made by solicitors on behalf of the man's wife, on 2 September 2011. This letter detailed several areas of concern raised by her about the care he received. The main areas of concern are as below.

Do Not Resuscitate (DNR) procedures

157. The solicitors said that they felt that insufficient attention had been given (in this report) in respect to the contents of the man's letter to the healthcare team at HMP Albany, in particular his comments about his confusion surrounding his treatment and illnesses. They commented that, had someone taken the time to discuss with him what was happening with his treatment he may have been less willing to put in a DNR. In addition to this they said that they were concerned that the Prison Officer did not take the time to talk to him about his wish to have a DNR in place.

In response to this, the investigator detailed in a letter to the solicitors that,

“On 27 May 2010, the man sent a letter to the healthcare department informing them that he did not want any further medication, that he was confused seeing different doctors, and that he wanted a DNR order in place. On more than one occasion he either cancelled or failed to show for medical appointments. On 16 April 2010, he failed to show for a doctor's appointment. When a nurse visited him, he confirmed that he did not want to see the prison doctor as “all I hear is bad news”. On 27 May (the same day he wrote his letter to healthcare), he asked for his hospital appointment at the cardiac clinic to be cancelled. In response to his letter to healthcare on 27 May, an appointment was made for him on 1 June to see the prison doctor. However, he failed to attend this appointment”.

158. The investigator explained that this investigation looked at whether the care received by the man was equitable to that he would have received in the wider community. If he had lived within the community, it is unlikely that he would have been chased had he failed to attend medical appointments.
159. In response to the solicitors' concerns about the officer it was explained that without wanting to give incorrect information (as she has not had formal healthcare training), she advised the man's friend that she would look for further guidance and then come and speak with the man. I believe that, in the circumstance, this was a reasonable course of action.
160. The solicitors explained that they were concerned about the lack of resuscitation attempts. Advice was sought from the clinical reviewer and in a reply to their concerns the investigator said that (as detailed in the earlier report) that the decision not to attempt resuscitation was surprising, and that a recommendation, that OSGs should be trained in resuscitation skills had already been made. In addition to this the clinical reviewer commented that,

“I think the chances of successful resuscitation were very low, given the findings at post mortem of the extent of his heart disease, even if he had been in a hospital setting with a full resus team. Out in the community, survival after cardiac arrest is very rare, but it is attempted in all such cases in the hope that the individual has had an acute rhythm disturbance (ventricular fibrillation or ventricular tachycardia) in the presence of a structurally normal heart. Sadly, that was not the case here. If the staff had been suitably trained, I would hope that in the future, they would attempt CPR in this situation”.

161. The reviewer further commented that he believed that the lack of action by staff did not affect the outcome.

Inconsistencies in interviews regarding emergency response.

162. The solicitors commented that the interviews with the OSGs contained inconsistencies. They said that it was not clear whether OSG B was in attendance at the cell, and to whether it was conveyed to the SO that the situation was an emergency or not. They said that staff involved in the emergency response should have been re-interviewed to try and resolve inconsistencies. In response to this the investigator explained that prior to the interviews she was provided with witness statements made by the staff concerned. She advised the solicitors that she was aware of the inconsistencies in the statements of both OSGs and challenged them at interview. It is the view that re-interviewing members of staff would not have changed their recollection of events.

Care Plan

163. The solicitors said that they felt that the issue of the man’s care plan was not sufficiently explored by the Ombudsman. The investigator referred them back to paragraph 123- 125 of the report, where it explained the reasons for the care plan trial, the areas highlighted by the person carrying out the assessment, and her (the investigator’s) disappointment that the deficiencies highlighted were not acted on by the prison. The investigator reminded them that, in response to her findings a recommendation about the provision of personal alarms had been made.

Delays

164. The solicitors said that they were concerned that the man declined a move to IHU on the basis that he was not made aware that he could smoke on the premises. The investigator explained to them that the issue of not being able to smoke was not the only reason as to why he chose not to move. They were referred back to paragraph 114 where she mentioned that he declined

the move to IHU because he didn't want to leave behind the friends he had on the wing.

165. The solicitors also commented that it is not clear why it took so long for an ambulance to be called. Paragraph 144 of this report explains that both OSGs thought that the ambulance should only be called by Oscar 1, the officer in charge of the prison. The SO Sheen (Oscar 1) did not wait until he had established that the man had died before calling for an ambulance as you have suggested. The SO asked for an ambulance to be called at 12:38, three minutes after he unlocked the door to the cell. He said in his interview that he was told that the man was not in extreme distress and was sitting in his room using his nebuliser. He knew him and was aware of his illness. He acted on the information given to him by OSG A and decided to wait until he arrived at the wing to assess his condition before calling an ambulance.

Training Needs

166. The solicitors said that prison staff should be made more aware of issues regarding the health of prisoners, commenting that, "they should have briefings regarding people who have been in hospital, this could also include the types of problems these people may have and what might be considered a medical emergency".
167. It was explained to the solicitors that due to issues of confidentiality ('medical in confidence'), healthcare staff were not permitted to discuss details of a prisoner's health with staff without prior consent. In addition to this the investigator reminded them, that as a result of the investigation a recommendation had been made to say, "Risk assessments should be conducted on all elderly or infirm prisoners accommodated on F and G wing to assess any potential risk of entering their cell at night".
168. The solicitors commented in their letter that they felt that the OSGs should have called an ambulance, believing that staff had an overly prescriptive idea of what constituted an emergency. The investigator explained that she agreed that an ambulance should have been called, commenting that this had already been commented on in her report. After consideration, it was decided to make an additional recommendation to the Governor to say, "The Governor should ensure that all staff are aware of the procedures to follow when they believe there is a danger to life, whether through natural causes or self-inflicted injuries". The draft report was re-issued reflecting this additional recommendation.

Degrading Treatment.

169. The solicitors were critical of the night sanitation system, saying that it was unclear as to why it was permitted for the man to remain on the wing being unable to use toileting facilities. The investigator explained that she was aware that the night sanitation system was an issue for him, commenting that

this had already been highlighted in her report. The investigator wrote in her letter to them that

“The report details that due to the issue with the night sanitation system a transfer to F and G wing was discussed with the man. He declined this move, and whilst they tried to find a solution to this problem he had no other option but to use a bucket at night”.

170. The solicitors suggested that criticism should have been made of the sanitation facilities, as did the HMCIP reports of 2008 and 2011. The investigator referred them to paragraphs 120 and 121 of my report where it was explained that it was undignified for the man to use a bucket at night, and that more determined efforts should have been made to encourage him to move to F and G.
171. After consideration an additional recommendation was made to say that prisoners who were unable to easily access the night sanitation system should no longer be housed on the wing. In addition to this a line was added to the report suggesting that NOM's should look for a solution to this issue of night sanitation at Albany.

Prescriptions

172. The solicitors raised a concern with the man being prescribed tramadol. They explained that,

“The toxicologist [in his report] notes that tramadol is a CNS Depressant and its major toxic effect is respiratory depression which can ultimately result in respiratory arrest. As a result it can exacerbate any underlying respiratory complaints such as asthma and COPD. Whilst the toxicologist goes on to mention that if taken regularly one can become tolerant to such side effects, and the man had been prescribed it for several months and was therefore likely to be less susceptible to its effects, providing it had been taken regularly.”
173. They commented that it was unclear why it would be considered appropriate to prescribe such a drug in the first place given his underlying health problems. They highlighted that he had previously returned all of his medication and therefore it would not be possible to say whether tramadol could be considered a drug he was taking regularly.
174. In response to the solicitors' concerns the toxicology report was reviewed and advice was sought from the clinical reviewer. The toxicologist stated in his report that:

“The concentration of tramadol was not accurately determined; the trace amount present in the blood is consistent with therapeutic use and does not indicate excessive ingestion or an overdose of this drug prior to death. Given that tramadol is a central nervous system

depressant, its major toxic effect is respiratory depression, which ultimately results in respiratory arrest. Such an effect can exacerbate any underlying respiratory complaint, such as asthma and COPD. However, persons who are prescribed tramadol and take it regularly become tolerant to such side effects. In this case, given that the deceased had been prescribed tramadol for several months prior to his death, it is likely that he would have been less susceptible to such effects, providing that he had been taking regularly.”

175. The solicitors commented that (due to the man previously returning medication) it was unclear whether tramadol could be considered a drug he was taking regularly. His prescription chart showed that, after he stopped taking his medication in May, tramadol was re-prescribed on 8 July, and was taken on a regular basis up until he died on 12 November.

The clinical reviewer said that:

“In the man’s case, he was tried on milder tablets, but got constipation from the codeine. So tramadol was tried as an appropriate alternative.

I am certain that it was reasonable to prescribe him this medication despite his COPD. The findings in this case are indicative of therapeutic use rather than excessive ingestion or an overdose, hence, it is unlikely that the concentration of tramadol in the blood would have been associated with toxic effects, particularly in a person who had been taking the drug regularly and had acquired some tolerance to its effects.”

Clinical Review

176. The solicitors detailed in their letter that, “Within the Clinical Review we feel that some exploration of whether the man could have been revived or helped if Paramedics had been called earlier would have been of assistance, however note that no healthcare staff were involved in this decision”.
177. The concerns raised about the clinical review have been discussed above in the section about the Do Not Resuscitate notice.

Other Issues

178. The solicitors said that the man’s wife had said that he had found it very uncomfortable in hospital as he was treated differently by the hospital staff as a result of his escort, and this may have contributed to his desire to self discharge himself. The investigator explained to them that the behaviour of hospital staff was not within the Ombudsman’s terms of reference and was therefore unable to comment further. However, the investigator had been informed by a prison nurse that the man had told him that, as he was unable to smoke in hospital, he found it very hard being an inpatient in hospital.

RECOMMENDATIONS

For Healthcare

1. The healthcare manager should improve the quality of care provided to prisoners with long-term conditions such as chronic obstructive pulmonary disease.

National Offender Management Service responded with,

Accepted - These services are already under review and are the focus of further work with our Lead Clinician to develop improved chronic disease registers, Quality and Outcomes Framework compliant services and an increased range of nurse led clinics.

2. The doctors at HMP Isle of Wight should review their antibiotic and general prescribing, and adopt an antibiotic formulary and ensure prescribing is in line with best practice.

National Offender Management Service responded with,

Accepted - Copies of the Hampshire and Isle of Wight antibiotic guidelines have been made available to all GPs with a copy in each site. Regular meetings have been set up with pharmacists to support best practice, evidence based prescribing.

3. I encourage the Primary Care Trust to consider the advantages of allowing staff to attend medical emergencies within Albany during the out of hour's period.

National Offender Management Service responded with,

Accepted - Consideration of this is already part of a range of options being explored as part of a wider review of the IHU post 18 months since opening.

4. The Head of Healthcare should adopt an End of Life policy; to include the use of the South Central Do Not Actively Resuscitate forms.

National Offender Management Service responded with,

Accepted - As an integral part of NHS Isle of Wight, we implemented the procedures and documentation for the "Liverpool Care Pathway for the Dying Patient (LCP) supporting care in the last hours or days of life" within Prison Healthcare Services in HMP Isle of Wight in February 2011 as part of work already identified and underway in 2010, that included training of staff. The South Central Do Not Attempt Resuscitation documentation is integral to this and is now in use

For the Governor

5. The prison should consider whether to provide personal alarms for frail prisoners such as the man.

National Offender Management Service responded with,

Accepted - The Disability Liaison Officer has identified a company that provides a 'Personal Alarm' kit. It is hoped that this system would be sufficient to provide an appropriate level of care for a number of prisoners on F & G Wing. A Business Plan has been produced and is at this time awaiting a response in respect of financing the project.

6. Risk assessments should be conducted on all elderly or infirm prisoners accommodated on F and G wing to assess any potential risk of entering their cell at night.

National Offender Management Service responded with,

Accepted - Prisoners have in place Personal Emergency Evacuation Plans. Risk assessments will be completed on prisoners who are considered to require access at night. Any prisoner requiring access at night should be located in the Inpatient Healthcare Unit. Staff are advised of the correct procedure for entering a cell at in a routine or emergency

7. The Governor should train OSGs on night procedures, particularly when to open the sealed pouch.

National Offender Management Service responded with,

Accepted - A review of the 'Night Orders' has taken place and the updated version has been issued to staff. A Notice to Staff has been issued regarding entering a cell during State 'A' to re-iterate our responsibility to the LSS procedures. The LSS clearly states what staff should do if faced with a potentially life-threatening situation when there are no other staff in the immediate vicinity and contains sufficient guidance for staff on the appropriate action to take when there is a need to enter a cell at night or when the establishment is in patrol state.

All staff have received a personal copy of the national training video on how to enter a cell and use of the anti-ligature knife. The Training Department have organised the viewing of this video by all staff as a rolling programme.

Night Orderly Officers are now permanent Senior Officers and they are responsible for training regular night staff in all aspects of decency and safety whilst on nights i.e. ACCT documentation, entering cells and dealing appropriately with incidents of self-harm.

8. The Governor should review first aid training to ensure that all duty senior officers are trained. The Governor should roll out the training to other staff including OSG, particularly those who work at night.

National Offender Management Service responded with,

Accepted - At the end of 2010, HM Prison Isle of Wight reviewed the importance of having effective first aid arrangements in place to respond to prisoner related incidents that result in injury or self-harm. Our first aid provision is continually being reviewed and amended to suit identified areas of need.

HM Prison Isle of Wight has provided training and we now have an additional 35 staff trained in the use of Defibrillator, 19 additional staff trained to First Aid at Work level and an additional 7 staff trained to Emergency First Aid at Work level.

A series of first aid courses has also been arranged for August and September 2011. Operational Support Grade night staff has again been identified for attendance. The course will also cover the use of defibrillators. The notion of all Senior Officers being trained by the Ambulance Service as "First Responders" (as in HMP Cardiff) has already been raised and NHS Isle of Wight and HM Prison Isle of Wight will explore this idea further.

9. The Governor and Head of Healthcare should assess whether oxygen could be kept in a secure location on F/G wing for prisoners with breathing difficulties.

National Offender Management Service responded with,

Partially Accepted - Advice has been sought from the NHS Isle of Wight BLF (British Lung Foundation) Respiratory Nurse Specialist and there are a number of aspects that would require consideration on assessing whether this would be appropriate. There are the recognised statutory requirements relating to the safe storage and use of this potentially hazardous gas (particularly where smoking is allowed within cells). There are also clinical risks associated with the use of oxygen by untrained staff or those without an informed awareness of the cause/nature of an individual's difficulty with breathing.

There are other potential solutions that may include the use/location of oxygen concentrators that deliver lower amounts per minute that are more in keeping with maintenance than emergency use.

The NHS Isle of Wight Oxygen Service is currently under review and any discussions that take place regarding the use/further deployment of oxygen within HMP Isle of Wight need to involve the relevant stakeholders within NHS Isle of Wight. This issue will be discussed at the Prison/PCT Management meeting.

10. The Governor should ensure that if a prisoner is unable to easily use the night sanitation system they should not remain on the wing.

National Offender Management Service responded with,

Accepted - This will now form part of the local policy.

11. The Governor should ensure that all staff are aware of the procedures to follow when they believe there is a danger to life, whether through natural causes or self-inflicted injuries.

National Offender Management Service responded with,

Accepted - All staff will be reminded of their responsibility in this area.