Investigation into the circumstances surrounding the death of a man in February 2011 at HMP Isle of Wight - Albany

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report into the death of a man in February 2011, at HMP Albany. He was 65 years old when he died. The post mortem found his death to be due to pneumonia and cancer of the pancreas. I offer my condolences to those affected by the man's death.

The investigation was carried out by my colleague. The Isle of Wight Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review into the man's clinical care and I am grateful for his report. I apologise for the delay in issuing this report.

The man was a life sentenced prisoner who had spent many years in prison. He transferred to Albany shortly before the onset of his symptoms. Staff conducted and arranged appropriate medical investigations and, for the most part, this was timely. Following the diagnosis of terminal cancer, staff at Albany liaised with staff at a local hospital and a hospice and between them provided the treatment and palliative care required.

The clinical review plays an essential part in this report and concludes that the man received care that was equitable to that which he could have expected to receive in the community. The clinical reviewer makes three recommendations, two of which are directly relevant to this investigation and the other is specifically for the Isle of Wight PCT to take forward with HMP Isle of Wight. I endorse the recommendations regarding the need to ensure prompt provision of discharge information from hospitals and steps to be taken to prevent the cancellation of hospital appointments.

I recognise the regular and good quality communication between the prison chaplain, the liaison Governor and the man's family, as well as good practice in facilitating visits to the inpatient healthcare unit from the man's friends on his wing and allowing visits in hospital. This must have been of great comfort to him.

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

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

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SUMMARY

1. The man was a life sentenced prisoner, who had been in prison since 1989. He transferred to Albany in October 2008. He had been diagnosed with high blood pressure and type II diabetes, which were controlled by regular monitoring and medication. He also complained of back pain and was prescribed moderate pain relief. In March 2010, a routine blood test showed a decline in his kidney function and, having lost some weight, he was referred for further tests.

2. Over the next few months, additional tests were carried out, which proved inconclusive and provided no explanation for his symptoms. He continued to experience pain, which had also spread to his abdomen and medical staff referred him for urgent tests under NHS guidelines for suspected cancer. The man's hospital appointments were cancelled twice, on one occasion because no staff were made available to escort him. The second time, escort staff attended from another prison but staff had sent him to work. A recommendation has been made regarding the need to prevent the cancellation of hospital appointments.

3. In December 2010, the man was diagnosed with pancreatic cancer which had spread to his liver and spine. As he was suffering from chronic kidney failure, he could not be treated with chemotherapy and he was therefore referred for palliative care. Clinicians involved him in the decisions regarding his treatment and prognosis. He was able to maintain contact with his family and friends while he was in hospital and with fellow prisoners as an inpatient in the prison's hospital wing. When he returned to the prison in January 2011, following a period as an inpatient in hospital, the hospital did not send a discharge letter outlining his treatment and this does not appear to have been followed up by prison staff. A recommendation has therefore been made on this issue.

4. The investigation has found that the man was well cared for in the inpatient healthcare unit at HMP Albany and appropriately admitted to a hospital and local hospice as the need arose. Healthcare staff managed his symptoms with pain relief and were trained in procedures to ensure they were able to meet his care needs within the establishment. He lived in an end of life cell in the inpatient healthcare unit, with an open door policy. His condition steadily deteriorated and he died at 4.40pm on a day in February 2011, with a nurse and the liaison Governor at his bedside.

5. The clinical reviewer concluded:

> "The care provided to [the man] whilst at HMP Albany met the expected level of care of normal NHS healthcare. The Palliative Care offered to [the man] was of a high standard, and the whole team are to be congratulated on their management of a patient whose malignant disease process resulted in challenging symptoms, particularly the pain from his vertebral body metastasis [tumour in the spine]".

6. In line with the man’s wishes to remain in prison, compassionate release was not considered. Prison staff organised his funeral in accordance with his instructions.

THE INVESTIGATION PROCESS

7. My colleague was appointed as the investigator for this case. He opened the investigation on 22 February when he visited HMP Albany. He met the liaison Governor who showed him around the End of Life Suite where the man died. The investigator also visited the chaplaincy department and spoke with chaplains who knew the man well and had attended to him in the period leading up to his death. This report has been delayed because of office workload pressure.

8. Notices were issued to staff and prisoners inviting those who wished to provide information regarding the man's death to make themselves known to the investigator. No one came forward.

9. The investigator was given access to the man's prison record and took copies of documentation relevant to the investigation. He also spoke with senior prison managers to get additional background information about the man and his time in custody. Throughout the investigation, the investigator maintained contact with the liaison Governor, informing him of his initial findings and highlighting any issues as they arose.

10. Isle of Wight Primary Care Trust (PCT) commissioned a clinical review. A clinical reviewer was appointed and he was given copies of relevant medical documentation.

11. On 10 May, the investigator and clinical reviewer attended a meeting, organised by the Isle of Wight Primary Care Trust, to review the healthcare provided to the man while he was imprisoned at HMP Albany. On the same day, the investigator and clinical reviewer interviewed two doctors involved in treating the man.

12. Her Majesty's Coroner for Isle of Wight was informed by the investigator of the nature and scope of the investigation and a copy of the post mortem report was requested. The investigation report will be sent to the Coroner to assist his enquiries into the man's death.

13. One of the family liaison officers wrote to the solicitors representing the man's family to inform them of the investigation and invite them to ask any questions or raise any concerns about the care the man received in custody. A copy of the draft report was made available to the family at the consultation stage and no issues were raised.

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

    a. Whether his diagnosis was made in a timely fashion?
    b. How the man was told about his condition.
    c. The man's medical appointments and treatment.
    d. Whether the liaison with the man's family was appropriate?

e. Whether the man was accommodated in the most appropriate part of the prison?
f. Whether consideration was given to compassionate release from prison?
g. How the prison managed the use of restraints and other security matters when the man was out of the hospital.

HMP ISLE OF WIGHT – ALBANY

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

16. The Albany building is a category B training prison which opened in 1967, on the site of a former military barracks. It offers a varied regime with education and several offending behaviour programmes. There are five wings with single cells and access to electronic night sanitation (the cell door unlocks for a limited time to allow the prisoner to go to the toilet). There are three small areas on each landing with communal recesses containing showers, toilets and wash basins.

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

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

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

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB). IMB members are independent, unpaid and appointed by the Secretary of State. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. Each IMB produces an annual report. The latest report for HMP Isle of Wight, which focuses on all three sites, is from 2010. The report stated in relation to healthcare at the Albany site:

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

chiropodist as prisoners are checked annually. There are approximately 150 supervised medications every day.

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

Her Majesty's Chief Inspector of Prisons

21. The last inspection report on Albany was published following a full, announced inspection conducted in October 2010. The Chief Inspector of Prisons noted that:

> "In our older prisoner surveys at both Parkhurst and Albany, prisoners were generally positive about their experiences: 94% of respondents over 50 at Parkhurst, compared with 78% of those under 50, said that staff treated them with respect and only 12%, compared with 24%, said that they felt unsafe at the moment. At Albany, older prisoners were more equivocal about being treated with respect but only 30%, against 43% of those under 50, said that they had felt unsafe at some point at the prison… Prisoners beyond the retirement age were generally unlocked during the core day but, with the exception of Albany and those on the Phoenix unit at Parkhurst, there was a limited regime. All sites ran gym activities specifically for older prisoners…
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> "In Parkhurst and Albany the primary care environments were poor. Nurse-led clinics varied across the sites, as did waiting times for the GP and other health professionals, which were long. There were numerous problems with medicines management, and dentistry services were not at full strength. There were long delays and cancellations for secondary care appointments. The inpatient unit environment had improved but lacked structured or therapeutic activity for patients."

Previous deaths in custody at Albany

22. Since the Ombudsman took responsibility for investigating deaths in custody in April 2004, there have been 26 deaths at Albany, of which 23 were due to natural causes. There are no similarities in relation to this investigation and any of the previous deaths at Albany.

ISSUES

23. The man had been in custody since 1989. He was serving a life sentence and had lived in a number of prisons before transferring to HMP Albany on 1 October 2008. He completed a number of offender treatment programmes during his sentence and actively participated in education. Whilst in prison he gained a number of qualifications, including a degree and Master's Degree in Theology.

The diagnosis of the man's terminal illness

24. The man had been diagnosed with type II diabetes (this occurs when the body produces insufficient insulin) and hypertension (high blood pressure). However, he was able to care for himself and collect his medication daily. In December 2008, he complained of abdominal pain and prison doctors referred him for an endoscopy (a procedure where the inside of the body is examined internally with a flexible tube fitted with a camera). Tests showed that he had inflammation of his stomach and he was prescribed medication to treat the symptoms.

25. On 15 April 2009, the man was diagnosed with gastritis and duodenitis (inflammation of the lining of the stomach and duodenum, respectively). (The duodenum is part of the small intestine, connecting the rest of the intestine to the stomach.) A year later, he also reported back pain, which was managed by the prescription of naproxen and tramadol, both pain killers.

26. A routine blood test on 19 March 2010, showed that the man had a reduced kidney function. A note in his medical record on 1 April states that he was in "chronic renal failure", however, as he was still suffering from back pain, he continued to be prescribed pain relief. Further blood tests on 24 April showed that he was also slightly anaemic. Additional tests were carried out to establish whether he had blood in his stools, but these came back negative.

27. The man continued to experience abdominal pain and weight loss and on 5 August, he was referred to outside hospital for a gastroenterology (digestive system) examination. The symptoms were anaemia, poor appetite and persistent tiredness. He was due to attend hospital on 1 September and the prison arranged an escort. Medical staff had signified 'nil by mouth' (a medical instruction for patients who must not take any substances orally) from 7.00 pm on the evening of 31 August. Unfortunately, he was not able to attend hospital on that date as there were no escort staff available due to the prison calling a full staff meeting. His appointment was re-arranged to 22 September.

28. Over the period between 9 September and 21 September, prison staff recorded a number of incidents in the man's core prison record. They noted that he had become aggressive and inappropriate with hospital and prison staff. His risk was re-assessed by prison staff and, on one occasion, a third prison officer attended during bed watch at hospital for added security. Following consideration of his presenting behavioural issues and a review of

his medication, healthcare staff concluded that his behaviour was the result of a recent change of medication which caused him to become uninhibited and unpredictable. An entry in his record on 21 September noted that his behaviour had returned to normal.

29. A doctor reviewed the man on 20 September and noted in his medical record that he had lost a lot of weight in the previous three months and that he should be referred for further blood tests and a chest x-ray. The results of the blood test showed that there was a further reduction in his kidney function; however his liver function and C-reactive protein (CRP) level were normal, as was his chest x-ray. (CRP is produced by the liver and is an inflammatory marker which shows as raised in cases of malignancy.)

30. The man was again unable to attend his planned appointment on 22 September because he was sent to work by wing staff. It is understood escort staff had been sent from another prison on the Isle of Wight to escort him on that occasion. An entry was made in the man's medical record that he was frustrated at having missed appointments with the gastroenterology service.

31. The man's gastroenterology appointment was rescheduled for 20 October, but was brought forward to 14 October as healthcare staff were concerned about his worsening symptoms. He attended his appointment and underwent another endoscopy procedure which failed to identify the cause of his symptoms. A handwritten addition to the endoscopy report, by the consultant, says that the man tested positive for helicobacter pylori, an infection that causes stomach ulcers. This information was recorded in his file; however there is no evidence to suggest that any action was taken to treat the infection.

32. On 1 November, a prison doctor examined the man and referred him for an urgent outpatient appointment to be tested for possible cancer. In line with the two week rule for referrals in cases of suspected cancer, an appointment was made for 12 November. He attended the appointment and a note was made of the positive test result for helicobacter pylori. He was referred for an urgent colonoscopy (examination of the colon using a thin flexible telescope), which was booked for 30 November. (The two week rule is a NHS target whereby people with suspected cancer are seen by a consultant within two weeks of the GP referral.)

33. The man attended the colonoscopy appointment on 30 November. However as he had not consumed enough water for the procedure to proceed it was not possible to complete the examination fully. A plan was made for him to have an x-ray of his colon, which was to be arranged by a prison doctor.

34. The man's kidney function continued to deteriorate. Prison doctors queried if his primary problem was renal failure and advised that the medication for diabetes be stopped. They also asked for him to be given daily blood tests and it was noted that if his condition deteriorated any further, he should be admitted to hospital. He became increasingly unwell and he was admitted to hospital on 9 December. The following day, he had a computerised

tomography (CT) scan. This showed likely cancer of the head of the pancreas, which had spread to the liver and spine. (A CT scan is a detailed x-ray which produces three-dimensional images of inside the body.) He was kept in hospital while further tests were carried out and also to provide appropriate pain relief.

35. The man's initial diagnostic investigations were negative and did not show any cause for concern. As his condition began to deteriorate, he was appropriately referred for further tests, which resulted in the cancer diagnosis. It is evident that the referrals were made within the specified NHS timescales for suspected cancer. The clinical reviewer found that the diagnosis of the man's illness was timely and appropriate to the symptoms he was presenting.

Informing the man about his condition and treatment

36. The man was informed of the likely diagnosis of cancer by doctors during a hospital ward round on 13 December. Medical staff were then able to explain his test results and answer his questions or concerns. On 16 December, a dietician assessed the man and advised him to take nutrition supplement drinks to try and build up his weight. The following day, the man's radiologist told him that he would not be proceeding with a planned liver biopsy (the process by which tissue samples are obtained) and advised that he should have a biopsy taken from his pancreas instead.

37. On 21 December, the man was discussed at the Upper Gastrointestinal Cancer Multidisciplinary team meeting. It was decided that due to his kidney function, he was unsuitable for chemotherapy and he was referred for palliative care (a specialised area of healthcare that focuses on relieving and preventing the suffering of patients). Nurses from the inpatient healthcare unit at Albany also attended as they were concerned about access to night time pain relief if he was discharged. They were also able to discuss their concerns about his condition and seek support and advice.

38. On 6 January 2011, the man was discharged to the inpatient healthcare unit, however a discharge summary was not sent from the hospital outlining the procedures he had undergone, the medication he had been prescribed or his diagnosis. He was reviewed by the palliative care nurse on 19 January, during which he was involved in decisions regarding his prognosis and made the decision not to be resuscitated. He also decided that any further scans and proposed palliative radiotherapy were to be postponed and he was offered appropriate support from healthcare staff.

39. The oncologist (a doctor who specialises in treating cancer) who had assessed the man prior to his discharge wrote a letter to the inpatient healthcare unit on 20 January. The doctor confirmed that there had been no biopsy diagnosis, but the advanced stage of the cancer was apparent from the CT scan results and blood tests.

40. The investigation has found that the man was made aware of his condition and consulted about treatment. He was informed of his test results by

appropriately qualified professionals. They were able to discuss his prognosis and treatment options with him and he was then able to make informed decisions about his care. He was appropriately supported by a multi-disciplinary team, including staff from HMP Albany and the palliative care team. The clinical review found that information sharing regarding the man's condition and treatment was adequate. The clinical reviewer stated:

> "He was involved in discussions regarding his diagnosis and prognosis, and he made an informed decision regarding his wish to be resuscitated … He was well aware that his prognosis was very poor."

41. When the man returned from hospital at the beginning of 2011, no discharged letter accompanied him, albeit that the oncologist later sent an assessment. Although it is the responsibility of the hospital to provide such a letter, there is no evidence from the records that prison staff followed this up or attempted to obtain it from the hospital. The clinical reviewer has made a recommendation to the PCT in respect of the hospital's obligations, but this is outside the remit of this office. Accordingly, the following recommendation is made to the prison:

    The Head of Healthcare should put in place a procedure to ensure that clinical staff check that a discharge letter is provided by outside hospitals when prisoners return following admission. In instances where this is not supplied promptly, staff should follow this up with the hospital and record this in the medical records.

The man's medical appointments and treatment

Appointments

42. The man had a planned appointment to attend hospital on 1 September 2010, for a gastroscopy (an internal examination of the gullet, stomach and small intestine). This did not go ahead because no prison staff were available to escort him, as the prison had called a full staff meeting for the same day. His appointment was re-arranged for 22 September.

43. On 22 September, the man did not attend the postponed appointment because wing officers at Albany had sent him to work despite officers from another prison attending to escort him. The appointment was re-booked for 20 October, some two months after the initial referral, but then brought forward to 14 October. Although the results of the procedure were inconclusive, he was appropriately referred for further investigation.

44. The missed appointments were entirely due to the prison and led to a delay of nearly two months before the man was able to have an important diagnostic test. When the test was eventually carried out no cause was found in respect of his symptoms. Nevertheless, it is unsatisfactory that the cancellations and delays occurred. Rearranging such appointments always leads to more delays than would be the case for other patients. The clinical reviewer makes the following recommendation which we endorse and recast:

The Governor and Head of Healthcare should ensure that when a prisoner has a planned medical intervention at hospital as part of an ongoing treatment plan, his attendance is facilitated. Procedures should be put in place to ensure that such prisoners do not miss their hospital appointments unless there are sound and compelling reasons for doing so.

Treatment

45. Before his diagnosis, the man's symptoms worsened and he was referred to outside hospital for diagnostic tests. In addition to the abandoned colonoscopy mentioned earlier, plans were also made for him to have an x-ray of his colon, which was to be arranged by a prison doctor, however it is not clear from the medical record that this was done.

46. Once the man had been diagnosed with pancreatic cancer, there was a good level of communication and support between prison healthcare and hospital staff and the palliative care team. In particular, the palliative care consultant followed up treatment by visiting the man in prison. Also, clinicians took account of his wishes, including his request for no resuscitation in accordance with standard NHS procedures and documentation. The clinical reviewer concluded in his clinical review that:

> "Though there were minor delays in accessing gastroscopy, the care provided to [the man] whilst at HMP Albany met the expected level of care of normal NHS healthcare."

The man's pain relief and medication

Pain Relief

47. The man's cancer caused him to suffer from chronic spinal pain. Once he was diagnosed, he remained in hospital until his pain relief was optimised and this was followed up by the palliative care consultant in prison. The clinical reviewer comments that the appropriate level of help and advice was sought by healthcare professionals to obtain optimal control of the man's pain.

Medication

48. Prior to his diagnosis, the man's symptoms, including abdominal pain were treated with a number of medications. Towards the end of his life, he required strong opiate-based pain relief. He was prescribed Oromorph, a morphine-based pain killer to be delivered via a syringe driver (a small automated pump used to continually deliver pain relieving medication intravenously to a patient). Initially, staff on the inpatient healthcare unit at HMP Albany could not provide syringe driver medication as they had not been trained to do so. Consequently, the man was admitted to a local hospice in late January 2010. He returned to Albany on 4 February, after his condition had improved and healthcare staff had been trained in the use of the syringe driver.

49. In addition to medication, staff paid attention to comfort aids. For example, he was given a pressure relieving mattress and accommodated in an end of life cell.

Liaison with the man's family and friends

50. Prison staff encouraged the man to maintain contact with his family and a close friend to keep them informed of his condition and treatment as and when he wished to. They also offered to facilitate visits from the man's parents, however due to their age, infirmity and distant location they were unable to make the journey. There was also some doubt as to whether they fully appreciated the seriousness of his condition but staff provided information to the solicitor acting on behalf of his parents. His friend visited him in hospital via the prison visits procedure and his friends within the prison were allowed to visit him in the inpatient healthcare unit.

51. At the request of the man, the chaplaincy asked The Salvation Army to help trace other members of his family, however this proved to be unsuccessful. The chaplain and the prison's family liaison officer also kept in regular contact with the man's family and organised his funeral in accordance with his specific wishes. One prisoner wrote to the prison's family liaison officer to thank him for taking the time to speak to him about the man's death.

52. We are satisfied that prison staff did as much as they could to facilitate contact between the man and his friends and family. As his parents were elderly and incapacitated, staff also provided information to their legal representatives.

The man's location

53. The man stayed on his wing while initial diagnostic tests were being carried out. Although he was losing weight and in pain, he was still able to care for himself and was fully mobile. He collected his medication from the treatments hatch and was able to attend medical appointments. He was admitted to hospital on 9 December 2010 for further tests and to establish a cause for the significant deterioration in his health. He was discharged on 6 January 2011 and, although he wished to return to his residential wing, he was admitted as an inpatient in the healthcare unit to enable staff to provide pain relief throughout the night.

54. On 23 January 2011, the man's condition deteriorated further to the point where the prison could not effectively manage his pain. He was re-admitted into hospital, however hospital staff also had difficulty in managing his pain and he was moved to a hospice the following day. By this time, the prison had provided training for healthcare staff in the use of syringe drivers. The man was discharged back to the inpatient healthcare unit on 4 February. He was allocated a room in the end of life suite and staff there managed an open door policy whereby friends from his wing could visit him regularly.

End of life pathway

55. On 10 February, the man was placed on the Liverpool Care Pathway because of his deteriorating health and lack of response to treatment. The aim of the Pathway is to improve the quality of care an individual receives in the last hours, or days, of life and has been formally recommended by the Department of Health (DoH) since 2008. The clinical reviewer comments in his review that the Liverpool Care Pathway was adopted appropriately.

56. The man continued to reside in the inpatient healthcare unit and was closely monitored by staff. However, his condition continued to steadily deteriorate and at 3.00pm on a day in February, the prison's family liaison officer visited the man. As he left the room, the nurse informed him that the man's death was imminent. He returned to the room and they both sat at the man's bedside for several minutes. During this time, the nurse monitored his breathing and at 4.40pm, she told him that the man had died.

57. The man lived in the prison's new end of life suite from 4 February until he died. He was provided with appropriate equipment, such as a pressure relieving mattress, in a suite designed to make his last days as comfortable as possible. The investigator visited the suite and was pleased with the design, facilities and open door policy operated during the man's time in the suite. The clinical reviewer comments that the various locations used to accommodate the man were adequate considering the symptoms he presented and the level of medical care required.

Compassionate release

58. Prisoners who are suffering from a terminal illness and for whom death is thought likely to be imminent (generally a life expectancy of three months or less) can be considered for release from early release on compassionate grounds. On 21 January, the inpatient healthcare unit manager sent an email to prison managers confirming she had discussed compassionate release with the man. He told her that he did not want to be released and wished to stay in custody, where he was receiving adequate care and was familiar with the staff.

Restraints, security and bed watch

59. On each occasion when a prisoner is escorted outside the prison to hospital, a risk assessment is completed. This considers the risk posed to the public by the prisoner in the event of an escape, the potential for escape and likelihood of outside assistance. When the man attended outside hospital for diagnostic tests and consultations, he was escorted by two officers and was restrained using the standard handcuffs, handcuffed to an escort officer, in accordance with prison procedure and risk assessments. When he underwent procedures, such as an endoscopy, restraints were removed for the duration of the procedure to enable appropriate clinical care and manoeuvrability and then reapplied at the end.

60. When the man’s condition worsened, staff reassessed the risk posed and restraints were authorised to be removed while he was in hospital and in the hospice. The escort officers are required to record a history of time and events which take place while a prisoner is out of the prison as an inpatient at hospital. This is known as a bed watch log. The logs during the time that the man was in hospital were completed appropriately and indicated that staff acted sensitively. Recordings were made regularly and all relevant information was included. Writing was legible and it was clear to see who had made the entries and at what time.

CONCLUSION

61. The man had been in prison for many years before transferring to Albany at the beginning of October 2008. Soon after he arrived at the prison, he reported abdominal pain which was investigated appropriately over a period of time. During this time, he had regular appointments with doctors and healthcare staff, which were documented in his medical record, as were his treatments and diagnosis.

62. Following abnormal blood test results, the man was referred for tests to establish the cause. Unfortunately, following an initial referral for an appointment with the gastroenterology services, due to staff shortages and poor communication, he missed two appointments and it was almost two months before the procedure was done. Subsequent hospital appointments and tests were timely. A good level of communication was held between staff at the hospital, at Albany and with outside agencies. Once diagnosed with cancer, his treatment and pain relief was managed appropriately according to his symptoms and his needs were met as his condition began to deteriorate.

63. The man's family were fully aware of his condition at all times. Prison staff liaised regularly with them and made every effort to respect the man's wishes, especially during the end stages of his life. His close friend was able to visit him at Albany as well as in hospital and visits were facilitated to the inpatient healthcare unit for his friends on the wing. This is good practice.

64. The clinical reviewer concludes that:

> "The Palliative care offered to [the man] was of a high standard, and the whole team are to be congratulated on their management of a patient whose malignant disease process resulted in challenging symptoms, particularly the pain from his vertebral body metastasis.".

65. We concur with this view as well as his judgement that, overall, the care received by the man was equivalent to that which he could have expected in the community.

66. There are two recommendations, based on the findings of the clinical review. They relate to obtaining discharge letters from hospital and preventing the cancellation of appointments.

RECOMMENDATIONS AND GOOD PRACTICE

Recommendations

1. The Head of Healthcare should put in place a procedure to ensure that clinical staff check that a discharge letter is provided by outside hospitals when prisoners return following admission. In instances where this is not supplied promptly, staff should follow this up with the hospital and record this in the medical records.

   The National Offender Management Service accepted this recommendation and commented;

   In addition to the pre existing discharge checklist agreed for discharging wards and departments at the nearby [outside hospital}, Prison Healthcare staff have been given an additional instruction that, in the event of a discharge summary/letter not being supplied promptly, this will be:

   1. Followed up with the discharging ward/department.
   2. If felt necessary reported the organisations Datixweb incident reporting system as a clinical incident.

2. The Governor and Head of Healthcare should ensure that when a prisoner has a planned medical intervention at hospital as part of an ongoing treatment plan, his attendance is facilitated. Procedures should be put in place to ensure that such prisoners do not miss their hospital appointments unless there are sound and compelling reasons for doing so.

   The National Offender Management Services accepted this recommendation and commented;

   Robust systems are now in place that ensure effective liaison between:
   - *Prison Healthcare*
   - *Prison Detail office*
   - *External hospitals*

   Cancellations are monitored and reported monthly to inform further remedial action. February 2012 figures show a 70% achievement against the maximum number of appointments it would be possible to escort within normal escort officer allocation.

Good practice

We commend managers at HMP Albany for facilitating good communication with the man's elderly and infirm parents during his illness and for allowing visits during both his admission to hospital and his stay as an inpatient in the healthcare unit.