

**Investigation into the circumstances surrounding the
death of a man, who was a prisoner at HMP Preston,
in hospital in May 2006**

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

October 2006

This is the report of an investigation into the death of a man. The man died from apparent natural causes on 13 May 2006 in hospital. He was a prisoner at HMP Preston and had a significant history of chronic diseases including hypertension, angina, diabetes and spondylosis. The man was 69 years old.

I would like to add my personal condolences to those already expressed by one of my Family Liaison Officers on behalf of this office.

This investigation has been undertaken by one of my colleagues. I would like to thank the Governor and staff of HMP Wymott (where the man spent most of his time in custody until the final stages of his illness) for their ready assistance with this investigation.

A doctor was asked by Chorley and South Ribble Primary Care Trust to undertake a review of the man's clinical care, and I also appreciate her assistance.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical review. In the case of the man, the review raises concerns to which both HMP Preston and HMP Wymott and their healthcare provider will need to give careful consideration.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman

October 2006

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SUMMARY

The man was born in March 1937. He was 69 years old when he died on 13 May 2006.

The man had been received into custody on 9 June 2005 after being sentenced to five years imprisonment. He was initially held at HMP Preston and transferred to HMP Wymott on 27 June 2005. During his first reception health screen at Wymott, it was noted that the man had hypertension (high blood pressure), angina, diabetes and spondylosis (arthritis) of the spine.

On 10 February 2006, the man was taken into hospital. He was then transferred to another hospital where he underwent an operation on his bowel and a liver biopsy on 6 March. He was diagnosed with incurable cancer. The man was discharged from hospital on 27 March and transferred to the hospital wing at HMP Preston. He did not return to Wymott.

On 5 May 2006, the man was again taken to hospital. Whilst he was an inpatient at the hospital, a bedwatch was carried out by prison officers.

Around 2:40am on 13 May, an officer noticed that the man did not appear to be breathing. The officer asked the Ward Sister to check and she confirmed that the man appeared to have died while he was asleep. The man was pronounced dead at 3:10am.

The clinical review concludes that the man's clinical care was, overall, of an appropriate standard. The review makes two recommendations which I endorse.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, his medical records and statements made by prison staff.
2. The Chorley and South Ribble Primary Care Trust asked a doctor to carry out a review of the man's clinical care. I am grateful for her review and for the fact it was undertaken in a most timely manner.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's family. This was to give them the opportunity to meet with the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed. In the event, the family raised no specific concerns about the man's care and treatment whilst he was in custody.
5. My investigator discussed aspects of the man's treatment with both staff at Wymott and the clinical reviewer.

HMP WYMOTT

6. Wymott is a Category C training prison for adult male prisoners. Over half of the population are vulnerable prisoners, approximately half of whom are sex offenders. The prison is located on the outskirts of Leyland in Lancashire. The maximum number of prisoners who can be held at Wymott is currently 1,046.
7. Provision of healthcare within the prison is the responsibility of the Chorley and South Ribble Primary Care Trust. The healthcare centre has a doctor available every weekday. Overnight and weekend cover is provided by local GPs, who are on call. There is also a qualified member of healthcare staff on duty at these times. There is no in patient care facility at Wymott and prisoners who require this care are referred either to HMP Preston or to local hospitals.
8. Medication is administered on a weekly and/or monthly basis to those prisoners who have been assessed as capable of holding it in their own possession. It is administered on a daily basis to other prisoners, when they are considered to be at risk or the medication is unsuitable to be held in their possession.

KEY EVENTS

9. The man arrived at Wymott on 27 June 2005. On his arrival, it was decided that he should be given Vulnerable Prisoner status due to the nature of his offences. During his health screen it was noted that he had hypertension (high blood pressure), angina, diabetes and spondylosis (arthritis) of the spine.
10. On 10 February 2006, the man was taken into hospital. He was then transferred to another hospital where he underwent an operation on his bowel and a liver biopsy on 6 March. The man was discharged from hospital on 27 March and transferred to the hospital wing at Preston prison. He did not return again to Wymott.
11. A letter on the file from a Consultant, dated 4 April, reports on his consultation with the man. The Consultant stated that the man had been diagnosed with incurable cancer and confirmed that he had discussed the poor prognosis with him. The Consultant also pointed out in his correspondence that he had discussed chemotherapy and the impact treatment would have on how long the man had to live.
12. On 5 May 2006, when his condition deteriorated, the man was again taken to hospital. Whilst he was an in patient at the hospital, a bedwatch was carried out by prison officers. The security risk assessment identified that a closeting (escort) chain was used. The restraints were removed on 9 May after a further risk assessment and after the man's health had deteriorated.
13. Around 2:40am on 13 May, an officer noticed that the man did not appear to be breathing. The officer asked the Ward Sister to check and she confirmed that the man appeared to have passed away in his sleep. The man was pronounced dead at 3:10am.
14. The Ward Sister contacted the man's family to inform them of his death. The prison also contacted the man's family to offer condolences and support. The prison maintained contact with the family and made arrangements for the funeral. The prison provided financial assistance for the funeral costs.
15. The post mortem report records the cause of death as due to natural causes as a consequence of carcinomatosis (the spread of cancer from the original site of growth to other tissues in the body) which was caused by carcinoma (cancer) of the colon (first part of the large intestine).

16. When contacted by my family liaison officer, the man's family said they were very happy with the way in which the man had been treated by Wymott and the hospital. The family felt that after the man's diagnosis of cancer, and when his health deteriorated, the prison did the best they could under the circumstances. The family also drew attention to some of the positive practices employed by the prison. These included handing back the man's belongings in a timely manner and assisting with the costs for the man's funeral.

THE CLINICAL REVIEW

17. As noted, the clinical review was undertaken by a doctor on behalf of Chorley and South Ribble. She found that the man had suffered from significant long-term chronic diseases (diabetes, hypertension and angina) and had been diagnosed with incurable cancer shortly before his death.
18. The medical records for the man included a report prepared for his solicitors in May 2005 by a Consultant Physician. The report noted that the man had an enlarged and tender liver, abnormal liver function tests and some shadowing on his lung. The report discussed the possibility of a malignant cause of the man's liver problems, which could not be clarified until the results of scans were available.
19. There does not appear to be any record of these investigations into the man's liver pathology being followed up. The first reception health screens at both Wymott and Preston make no reference to the report by the Consultant Physician, and my investigator has been unable to establish whether the report was available to prison staff at the time of either healthscreen. If the report was available, it is regrettable that no mention is made in the healthscreens of the need to chase up the proposed liver scan and blood tests. It is also regrettable that the abnormal liver function tests were not repeated on a regular basis.
20. The reviewer recommended that at each Reception Health Screening health care staff should note any outstanding investigations, out-patient visits etc and ensure that these take place and that the outcomes are reviewed. The reviewer also recommended that, when medical information is received by healthcare at a later date, the date of receipt should be clearly recorded - and again any outstanding investigations or issues should be noted and dealt with promptly.

At each Reception Health Screening, healthcare staff should note any outstanding investigations, out-patient visits etc and ensure that these take place and that the outcomes are reviewed.

If medical information is received by healthcare at a later date, the date of receipt should be clearly recorded and again any outstanding investigations or issues should be noted and dealt with promptly.

21. The reviewer judged that, when the man became very ill, the treatment that he received was appropriate and equivalent to that which would have been available to anyone else in the wider community.

Conclusion

22. The man was received into prison in June 2005. He died from carcinoma (cancer) in May 2006. The man had arrived in prison with a number of health problems. He had a history of heart related disorders, diabetes and spondylosis of the spine. In March 2006, the man was diagnosed with cancer which was widespread and incurable.
23. In reviewing the bedwatch log, it is clear that the staff involved with the man's care behaved with sensitivity. The security arrangements at the hospital seem to have been appropriate, and struck a good balance between public protection and sensitivity to the man's circumstances.
24. In light of the findings of the Clinical Review, and my own investigation, I conclude that while the man's medical care was satisfactory, it is possible that there was a failure to act upon information about his condition and the need for further exploration. I cannot say if earlier action would have affected the outcome of the man's illness. I have endorsed the two recommendations from the clinical review to be addressed by Chorley and South Ribble Primary Care Trust in partnership with the Governors of Preston and Wymott.

RECOMMENDATIONS

Medical

At each Reception Health Screening, healthcare staff should note any outstanding investigations, out-patient visits etc and ensure that these take place and that the outcomes are reviewed.

Accepted by the Prison Service.

If medical information is received by healthcare at a later date, the date of receipt should be clearly recorded and again any outstanding investigations or issues should be noted and dealt with promptly.

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