Investigation into the circumstances surrounding the death of a man at HMP Parc in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

April 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Parc. The man died in the prison's healthcare centre on 11 June 2006. He was 49 years old. A post mortem recorded the cause of death as bronchopneumonia due to carcinomatosis due to carcinoma of the lung.

I offer my sincere sympathy and condolences to all of the man's family and friends for their sad loss.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by the Healthcare Inspectorate Wales. I am most grateful to the reviewer for her assistance.

I would also like to thank the Director and staff of Parc for their full and ready co-operation during the course of the investigation.

The clinical reviewer commends healthcare staff at Parc for the consideration and support they provided for the man. I concur with her view. This is a report that reflects well on all staff at Parc for the kind and respectful way in which they cared for the man.

I make two recommendations and also highlight one example of good practice.

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Prisons and Probation Ombudsman **April 2007**

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SUMMARY

The man was received into HMP Cardiff on 4 May 1998 as an unconvicted prisoner. He was sentenced to 15 years imprisonment on 16 April 1999.

The man raised no concerns at his reception health screening, other than that he had suffered from inflammation of the vertebrae in the past. On 1 June 2000, he was diagnosed with high blood pressure. He reported various stomach and back pains during his first seven years in custody.

On 5 May 2006, the man attended the healthcare centre at Usk and complained of a lesion to the right side of his neck. He was reviewed on 10 May, and it was noted that the lesion was two to three centimetres in diameter. An appointment was made for a biopsy at the Royal Gwent Hospital, Newport, on 17 May.

At his appointment, the man told the consultant that he had been suffering from stomach and back pains for five weeks and had lost weight. The consultant suspected that the man had cancer of the stomach and discussed this with him. The results of the biopsy, a week later, confirmed an adenocarcinoma (a cancer of a gland or glandular tissue, or in which the cells form gland-like structures).

Following his provisional diagnosis, the man transferred to Parc on 19 May. This meant he would be able to receive 24 hour inpatient care in the prison's healthcare centre. He began to feel nauseous on a regular basis, was eating little and continued to lose weight. His pain was well controlled through adjustments to his analgesia (pain relief) on 19 May whilst still at Usk, and on 29 May when in Parc.

In June, the man's health worsened, although his pain continued to be well controlled. Following discussions with the Probation Service, his children were informed of his illness by a social worker on 9 June. Sadly, the man continued to deteriorate and, at around 7.12am on 11 June, he was found to have stopped breathing by a member of the nursing staff. In accordance with an instruction given four days previously, cardio pulmonary resuscitation (CPR) was not attempted.

The clinical reviewer commends healthcare staff at Parc for the considerate care they provided for the man. She makes a recommendation with regard to a hospital appointment which the man missed due to a breakdown in communication with the hospital following his transfer. I make a further recommendation regarding contact with the man's family.

THE INVESTIGATION PROCESS

The investigation was opened on 13 June 2006 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result. My investigator was given access to the man's prison files, including his medical record.

An independent clinical review of the man's health needs whilst he was in custody was carried out by the Investigations Manager at the Healthcare Inspectorate Wales.

One of my family liaison officers contacted two of the man's children, on 15 June 2006. His daughter expressed concern that, when she was told of her father's illness on 9 June 2006, the seriousness of his condition was not explained to her.

HMP PARC

Parc is a modern category B local prison on the outskirts of Bridgend. The prison opened in November 1997 and is the only private prison in Wales. It is managed by Group 4 Securicor Justice Services (G4S), and has capacity for 839 male prisoners.

The provision of healthcare within the prison is the responsibility of Primecare Forensic Medical Services. They employ a team of three doctors and 25 nurses and provide a 24 hour primary care service. The in-patient ward area has 17 beds, all with integral sanitation. The latest report from HM Chief Inspector of Prisons, dated 9-13 January 2006, describes a good therapeutic and structured environment for in-patients, with a very high level of respectful and constructive contact between staff and patients.

KEY FINDINGS

The man was received as an unconvicted prisoner at HMP Cardiff on 4 May 1998. At his reception health screen (a routine health screen for all new arrivals into prison) on the same day, the man said that he had suffered from spondylitis (inflammation of the vertebrae) but reported no other concerns about his physical or mental health. Following his reception to HMP Maidstone on 28 May 1999, around one month after the man had been sentenced to 15 years imprisonment, he said that he had previously been a very heavy drinker.

During his first seven years in prison, the man complained of various back aches, stomach pains and infections, each of which was dealt with at the time. On 1 June 2000, he was diagnosed with hypertension (high blood pressure) and subsequently prescribed bendroflumethiazide to treat this. The man received monthly checks on his blood pressure following this diagnosis. In the spring of 2002, he began one to one sessions with a psychologist, in a bid to address his offending behaviour.

On 24 May 2005, the man transferred to Usk, having spent time at HMP Wandsworth and HMP Parc in the previous two years. His history of hypertension was recorded at his reception health screening. At a hypertension clinic on 3 January 2006, the man's blood pressure was noted to be rising. He was prescribed lisinopril, in addition to bendroflumethiazide, to control this.

On 20 March 2006, the man attended the healthcare centre complaining of shortness of breath and pain in his lower back. He also complained of coughing up frothy sputum. The man's blood pressure and pulse were taken, and he was escorted back to his cell. He was reviewed 15 minutes later, when it was noted that he was less short of breath. However, later that day the man's shortness of breath increased. He was sent to the Accident and Emergency Unit at a local hospital for a review. The man returned to Usk the same day, having been diagnosed with a chest infection. He was prescribed amoxicillin (an antibiotic) by the prison doctor.

On 5 May, the man attended healthcare and complained of a lesion on the right side of his neck. He was prescribed a course of erythromycin (another antibiotic) and advised to return for a review if it did not settle. At a review on 10 May, it was noted that the lesion was now two to three centimetres in diameter. The man was subsequently referred to a larger hospital on 12 May, and an appointment was made for him to return on 17 May for a biopsy.

The man was seen in Usk's healthcare on 15 May. The lesions were now reported to have spread to both sides of his neck, his back and his right arm. He attended the hospital for his biopsy on 17 May and was seen by the Consultant ENT and Head and Neck Surgeon. As well as the lesions, the man told the consultant that he had had stomach and back pains for the last five weeks and was losing weight. The consultant suspected a stomach malignancy (cancer of the stomach), and discussed this with the man. The man then returned to Usk. The results of the biopsy, a week later, showed a moderately differentiated adenocarcinoma (a cancer of a gland or glandular tissue, or in which the cells form gland-like structures).

The man was reviewed in healthcare on the morning of 18 May. He was very upset about the thought of having cancer. He said that he was not eating, as he felt nauseous and was vomiting after eating solids. As a result, he was encouraged to take Fortisip (a dietary supplement drink). The man was also having difficulty walking due to his pain, which was noted to be uncontrolled. He saw a prison doctor the following day and was prescribed MST continus (a morphine based slow release painkiller).

Usk is a small prison with no in-patient wing and only a part-time doctor. As a result, healthcare staff decided that they would be unable to provide the level of care and assistance required by the man following his diagnosis and increasing pain. A transfer to Parc was therefore arranged following the review on 18 May, and the man transferred on 19 May. On arrival at Parc, he was located in the healthcare centre as an in-patient and a full care plan was written by the healthcare team. The care plan contained five objectives: to maintain the man's hygiene standards; to maintain intact pressure areas of skin; to reduce sickness; to reintroduce diet; and to control pain.

The man's pain was quite severe on 20 May, although he was able to walk around the wing unaided during association. His pain had reduced the following day, and he became more settled and talkative over the next couple of days. On 24 May, he attended the hospital for a CT scan, but missed an out-patient appointment on the same day because the hospital had sent the notification to Usk rather than to Parc. That appointment was re-scheduled for 31 May.

The man's pain began to increase again over the next few days. He was also feeling nauseous and not eating very much. By 29 May, his pain was severe and he was vomiting frequently. A prison doctor, was contacted in the evening and gave a verbal instruction for diamorphine to be administered.

Following a further biopsy on 31 May, the man was diagnosed with an advanced malignancy. In a telephone conversation on 1 June, a Consultant in Gastroenterology advised about palliative care (symptom control was the only possible way forward given his diagnosis). A referral to the Palliative Care Consultant at a nearby hospital was made on 5 June by the prison doctor.

The man's pain was well controlled during the first days of June, although he was eating very little and often feeling nauseous. After a review on 4 June, he was put down to see the doctor every day due to deterioration in his general health. He was having difficulty taking his medication on account of his nausea and, on 6 June, all of his medication was stopped apart from his painkiller and an antiemitic (a drug used to control nausea).

On 7 June, following a review, the prison doctor noted that the man's health had clearly deteriorated. The doctor considered that the man was no longer mentally competent to contribute to decisions with regard to his management. He recommended that the man be seen more by the palliative care specialist, and that cardiopulmonary resuscitation (CPR) should not be attempted were he to suffer a collapse. The doctor noted that the man did not appear to be in any pain.

The man was visited and reviewed by a Consultant in Palliative Medicine on 8 June. The consultant praised the nursing staff at Parc for dealing with the man's needs "very appropriately". She went on to say that his deterioration might be consistent with him entering the terminal phase of his illness, but that this was not necessarily the case. Later that day, the man fell out of his bed. He was disoriented but did not suffer any injuries.

On 9 June, the man's daughter was contacted and informed of his illness by Social Services. Prison staff had been advised not to break the news themselves because of the nature of the man's offence. Blood tests taken on 9 June were reviewed the following day. They showed that the cancer had spread to the man's liver, his kidneys were starting to fail and he had a raised white blood cell count as a result of his chest infection. His condition was deteriorating and he was confined to his bed. Nursing staff continued to check on him regularly through the night.

At around 7.12am on 11 June, a nurse checked on the man and found that he was not breathing and had no pulse. In accordance with the prison doctor's instructions four days previously, CPR was not attempted. The duty doctor was called and pronounced death at 8.26am. A post mortem carried out on 14 June showed the cause of death to be bronchopneumonia due to carcinomatosis due to carcinoma of the lung.

One of the prison chaplains spoke to the man's daughter on 11 June to break the news of her father's death. The chaplain had previously spoken to her on 9 June after she had been told of his illness. Two of the man's sons and two of his sisters visited the prison on 13 June. The funeral was organised by members of the chaplaincy team, and all of the costs were met by the prison.

ISSUES

Issues raised in the clinical review

The man transferred to Parc on 19 May 2006, shortly after he was diagnosed with cancer. A full care plan was written on his arrival, and his pain appears to have been well controlled. The clinical reviewer commends the healthcare staff at Parc for their "considerate care" of the man.

The clinical reviewer notes that, on 2 June 2004 and 18 February 2005, blood test results indicated that the man had raised blood lipids (fats) which, if abnormally high, have been associated with heart disease. This was not picked up on by medical staff at Usk. A further blood test on 3 January 2006 again showed high blood fat levels, as well as a chronic iron deficiency. Anaemia is sometimes a sign of chronic disease, and could have been caused by the man's lung cancer. Again, these results were not noted by medical staff at Usk. The reviewer considers that, whilst these failures would not have affected the progression of the man's cancer, "prison medical teams should be alert when results come back from laboratories".

On 24 May 2006, the man attended hospital for a CT scan. However, he missed an out-patients appointment on the same day, apparently because the hospital had sent the notification to Usk rather than to Parc. The hospital did not appear to have been informed of the man's transfer to Parc five days earlier. Given that it is the sending prison that holds details of the prisoner's contacts and appointments, I consider it to be their responsibility to inform the hospital of any transfer. The clinical reviewer makes the following recommendation, which I endorse:

Healthcare staff at the sending prison need to inform the relevant NHS hospital if a prisoner's location changes, so that communication is not delayed and appointments are kept wherever possible.

Contact with the man's family

Following his transfer to Parc on 19 May 2006, the man expressed the wish that his children be told of his illness. Staff from the Probation Service met with him on 7 June and discussed his wishes. It does not appear that the man had had any contact with his family following his imprisonment. A chaplain at Parc told my investigator that chaplaincy staff were prepared to break the news to the man's family, but were asked not to do so by the Probation Service due to the nature of his offence. As a result, one of the man's daughters was informed of his illness by a social worker on 9 June.

Given the seriousness of the man's offences, and the lack of contact with his children following his reception to custody, I consider it appropriate that a social worker rather than prison staff broke the news of his illness to them. However, the man's daughter felt that the seriousness of her father's illness was not explained. It might have been helpful if she had been given the contact details of a healthcare professional at the prison with whom she could discuss the nature of her father's illness in more detail, and possibly even arrange a visit.

The Director should ensure that, when next of kin are given news of a relative's serious illness, a telephone number of a member of healthcare staff is provided so that they have the opportunity to discuss the circumstances in detail.

RECOMMENDATIONS

Healthcare staff at the sending prison need to inform the relevant NHS hospital if a prisoner's location changes, so that communication is not delayed and appointments are kept.

Fully accepted – All nurses will be informed of the required action and the relevant hospitals informed if a patient move to another prison.

The Director should ensure that, when next of kin are given news of a relative's serious illness, a telephone number of a member of healthcare staff is provided so that they have the opportunity to discuss the circumstances in detail.

GOOD PRACTICE

Healthcare staff at Parc should be commended for the care provided for the man in the last few weeks of his life.