A death in custody at

HMP Wymott on 26 July 2004

Report by the Prisons and Probation Ombudsman for England and Wales

January 2005

This is the report of an investigation into the circumstances of the death of a man who died on 19 June 2004 at the Marie Curie Centre, a hospice in Liverpool. At the time of his death the man had been serving a four-year prison sentence at HMP Wymott. His cause of death was disseminated (widespread) cancer.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

The investigation was carried out by one of my colleagues. A clinical review to look into the man's clinical care and treatment has been carried out by the Director of Public Health at Chorley and South Ribble Primary Care Trust.

We would like to extend our condolences to the man's family for their loss. I would like to thank the Governor in charge of HMP Wymott, and his staff for their help.

This report commends a Healthcare nurse for her proactive response when noticing that the man appeared unwell. The prison's involvement in ensuring that he was near to his family during the final days of his life is also noted.

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Summary

The man was born on 6 December 1930 and was 73-years-old when he died on 26 July 2004 from disseminated (widespread) cancer. At the time of his death the man was serving a four-year sentence at HMP Wymott, a category C prison near Preston.

The man had appeared to be in good health up until the middle of June 2004 when he consulted healthcare with symptoms which prompted the Healthcare doctor to refer the man to hospital. At hospital he was diagnosed with cancer, following which he was transferred first to a hospice in Preston and from there was transferred to another hospice in Liverpool. It was at the hospice in Liverpool that the man died.

My investigator spoke by telephone to one of the man's daughters who was his next-of-kin.

HMP Wymott assisted in ensuring that the man was close to his family during his final days. A Healthcare nurse is to be commended for instigating a doctor's consultation for the man.

This report makes two recommendations in relation to Healthcare services at HMP Wymott. These are in connection with the issue of non-prescribed medication and in the provision of Well-man clinics.

Investigation Process

My practice in cases of apparent deaths from natural causes is to conduct an initial review to determine the extent of investigation required.

My investigator visited HMP Wymott on 29 July 2004 when he spoke informally with a number of staff to outline the facts relating to the man's treatment at Wymott, his transfer to hospital, and his subsequent transfers to hospices in Preston and Liverpool. My investigator was given access to the man's records, including his medical records.

The investigator spoke to a representative of the local Prison Officers' Association (POA) and to a representative of the Independent Monitoring Board (IMB). Neither had any issues which they wished to draw to the PPO's attention.

My investigator telephoned the man's daughter. She said that her father's cancer was diagnosed only shortly before his death and she wondered whether the diagnosis could have been made at an earlier stage.

A doctor from Chorley and South Ribble Primary Care Trust carried out a clinical review.

No formal interviews with staff were conducted. This report is based upon a review of all relevant paperwork, including the man's clinical records.

The Man

On 25 October 2002, the man appeared at Liverpool Crown Court where he was convicted on three counts: false imprisonment, indecent assault, and assault occasioning actual bodily harm. He was sentenced to four years in prison. Following his conviction, he was first received into HMP Liverpool where he remained until transferred to HMP Wymott on 20 December 2002. He had been in prison on two earlier occasions, but this had been 50 years previously.

The man was a widower, his wife having died in 1984. He had six children, many grandchildren and a number of great grandchildren.

One of the man's daughters was contacted by my investigator. She said that her father had seemed reasonably well for most of the time that he had been at Wymott, apart from having some problems with his eyes (glaucoma) and with his legs (oedema). He had then suddenly, and obviously, become very unwell and had then gone on to die within a short space of time. She said that her father had smoked in the past and had once been a mineworker. She also acknowledged that her father had been a person who would generally avoid consulting doctors if possible. However, even allowing for her father's reluctance to consult doctors, she did wonder whether he had received appropriate treatment at Wymott given that his cancer had probably been developing for quite some time before being diagnosed.

HMP Wymott

HMP Wymott is a category 'C' training prison which opened in 1979 and which has accommodation for around 1,000 adult males. At the time of the last prison inspection report, 18.5 per cent of prisoners were 50 years-of-age or older. The training regime at Wymott includes provision of farms, gardens and workshops.

The prison's Healthcare unit contains no in-patient beds. When prisoners require in-patient treatment they are referred to outside hospital.

The newly appointed Healthcare manager told the investigator that, at prescription dispensing rounds, prisoners can ask for certain non-prescribed one-off medications, for instance a two day (16 tablets) supply of paracetamol. The only prescription charts available at dispensing rounds would be those relating to prisoners due to receive a prescribed medication. For those prisoners seeking non-prescribed one-off medication, their prescription charts would need to be noted at a later time that non-prescribed medication had been issued. The Healthcare manager acknowledged that this was not a foolproof system for ensuring that all medicines issued to an individual prisoner will always have been recorded. The Healthcare manager went on to say that this system was due to change. In the future, ad-hoc issue of non-prescribed medication will cease.

Events Leading Up To The Man's Death

Upon his conviction on 25 October 2002, the man was taken initially into HMP Liverpool. At his first reception health screen at Liverpool, it was recorded that he had problems with bronchitis and angina. On arrival at HMP Wymott on 20 December 2002, he had a further health screen and then on the following day he was seen by a Healthcare doctor. From these two examinations it was noted that he was known to suffer from angina and asthma, also that he was using eye drops for his known condition of glaucoma, and that he had symptoms indicative of oedema.

After that initial contact with Healthcare staff on 20 and 21 December 2002, no further entries were made in the man's health record for over 18 months. On 14 June 2004, a Healthcare nurse was on the man's landing on other business when she noticed the man's jaundiced complexion. The Healthcare nurse arranged a doctor's consultation for 16 June. However on 15 June the man's appearance indicated a deterioration over the previous 24 hours, so he was seen by a doctor that same day.

At the consultation on 15 June, the Healthcare doctor noted that the man had symptoms of one week's duration of loss of appetite and lower back pain, a discolouration of his skin (jaundice) for an unknown period of time, and mild constipation during the previous fortnight. Blood tests showed, among other things, that his haemoglobin (Hb) level was 7.2, a level which for a man is indicative of severe anaemia. The doctor referred the man to Chorley Hospital that same day requesting further investigations.

Following these investigations, a hospital consultant wrote to the Governor at Wymott on 7 July to advise him that the man had been diagnosed with terminal cancer, that he was deteriorating rapidly and was too unwell at that time to be moved out of hospital. The consultant added that it would be inappropriate for the man to return to prison. Instead, he should either remain in Chorley Hospital or move to a hospice when well enough.

On 10 July the man was transferred to a hospice in Preston. However, at the request of his family, HMP Wymott arranged for him to be further transferred to a hospice in Liverpool where all the family are based. The transfer took place on 20 July and HMP Liverpool agreed to supply bed-watch officers. The man remained in the hospice in Liverpool until his death on the early morning of 26 July.

After The Man's Death

The man died at 6.05am on the morning of 26 July. Hospice staff contacted the man's family to break the news to them and the bed-watch officer from HMP Liverpool notified HMP Wymott. The man's family came to the hospice at 8.00am that morning. HMP Liverpool arranged for both the principal bed-watch officer, and a Governor grade officer, to be present at the hospice to speak with the family.

When my investigator visited the prison, all the necessary information had been gathered together for the purposes of the investigation. Arrangements had been made for the investigator to speak to relevant members of staff.

Level of Compliance

Standards of clinical care in prison are intended to mirror those available in the outside community. The man's records indicate that while at Wymott his health care needs were dealt with adequately. In particular, there was no delay in his transfer to hospital once the severity of his condition was recognised.

The post incident response by HMP Wymott was fully compliant with Prison Service instructions and policies on managing a death in custody.

Findings

The man's daughter has said that her father was a person who was reluctant to seek medical advice and his health care records amply confirm that. Following his obligatory health screen on arrival at HMP Wymott in December 2002, almost 19 months elapsed before the man next consulted a Healthcare doctor. It had been a Healthcare nurse who instigated the consultation for 15 June 2004 when she noticed the man's jaundiced complexion. At that consultation, his symptoms and blood test results led to him being referred to hospital that day for further tests, resulting in a diagnosis of terminal cancer. The man's condition deteriorated rapidly and he died on 26 July 2004, a mere six weeks after his Healthcare consultation.

The question that the man's daughter has understandably asked is whether her father's cancer could reasonably have been diagnosed at an earlier stage. We know from the man's health records that he did not consult a doctor between the time of his arrival at Wymott in December 2002 and the consultation of 15 June 2004. The notes made by the doctor that day indicate that most of the man's symptoms had been of brief duration and so it seems that he was largely symptom free during the time his cancer was developing. Having said that, I am very conscious of the daughter's assessment of her father's response to illness and it might well be that he chose to ignore, or diminish in his mind, the potential significance of certain symptoms. We shall never know the answer to this. We do know, though, that when the man did consult Healthcare the response was to refer him to hospital without delay.

Although there is nothing to suggest any deficiencies in the care and treatment provided to the man, two matters have arisen in this case that are of concern to me. The first matter is the practice of ad-hoc issue of non-prescribed medication. The concern here is that a prisoner who prefers to avoid consulting doctors might choose to deal with his symptoms by taking paracetamol tablets. A breakdown in recording systems might then result in a failure to record issue of the drug in the prisoner's prescription chart possibly masking the onset of a serious clinical condition.

The second matter of concern relates to Wymott's ageing prisoner population. The man was a 73-year-old man who had not had a clinical consultation for 18 months between arriving at Wymott in December 2002 and the consultation in June 2004.

Conclusions

The man was well cared for in Wymott, the healthcare he received there was probably at least as good as it would have been outside in the community. There were no indications that the man had a developing condition that ultimately proved to be fatal.

Good Practice

I commend the Healthcare nurse, for her diligence in first making, and then bringing forward, a doctor's consultation for the man when she noticed his jaundiced complexion.

The prison's assistance with the man's transfer to a hospice close to his family was an example of good practice.

A full investigation might have revealed other aspects of the man's treatment that amounted to good practice, but in this case, where the death was clearly due to natural causes, the more limited type of investigation that has been conducted has not brought these to light.

Local Recommendations

1. If the system has not already been changed, I recommend that ad-hoc issue of non-prescribed medication should cease.

2. Healthcare should establish a Well-man clinic and actively encourage all prisoners, especially older prisoners, to have a periodic check-up.

3. I recommend that Healthcare nurse, receive a letter of commendation.