

**The death of a prisoner on 7 August 2004 while in the custody of HMP
Stafford.**

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

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This is the report of an investigation into the circumstances surrounding the death of a prisoner who died in a hospital on 7 August 2004. At the time of his death, the man was serving a four-year prison sentence at HMP Stafford. The cause of death was myelofibrosis (an impairment of the bone marrow's ability to produce blood cells). A post-mortem was not performed as his death was predicted.

Since 1 April 2004, the Prison and Probation Ombudsman's office (PPO) has been responsible for investigating all deaths in custody, including those due to natural causes. The investigation was conducted on my behalf by one of my colleagues. A clinical review of the prisoner's health care whilst in prison was carried out by a doctor of the South Western Staffordshire Primary Care Trust (PCT).

I offer my sincere condolences to the prisoner's family, friends and others touched by his death. Losing a loved one who is in custody is a painful experience, all the more so when they have been suffering from a terminal illness.

I would like to thank the Governor of HMP Stafford, and her staff for their help and openness during this investigation. The prisoner was clearly well liked by staff and prisoners and remembered with affection. I was particularly impressed with the holistic approach from staff in all departments to caring for the prisoner with compassion and for the dedication of the Health Care department who ensured that the prisoner was treated in accordance with his wishes.

In sad circumstances, this is a report that reflects very well upon Stafford and the Prison Service as a whole. I draw attention in particular to what I have been pleased to write in the Conclusions section of this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

Summary

The prisoner was 65 years old when he died on 7 August 2004 in hospital, while in custody at HMP Stafford. In January 2003 he had been sentenced to four years imprisonment. At the time he was suffering from myelofibrosis.

After being sentenced, the prisoner was first sent to HMP Blakenhurst, and in June 2003 spent a very brief period in HMP Wymott. In July 2003, he was transferred to Stafford. Stafford has no inpatient facilities.

During his period in prison, the prisoner continued to attend regular hospital appointments to manage his condition. By August 2003, he had begun to feel unwell. In January 2004, his prognosis was described as poor and he was given three to five months to live.

Stafford continued to care for the prisoner but, despite regular blood transfusions and medication, his health steadily deteriorated. In April, the prisoner said that he wished to stay at Stafford where he had friends and had been treated well.

In July, Stafford arranged for the prisoner to be released on temporary licence to attend his hospital appointments. He attended hospital appointments in early August, but his condition worsened and he died in hospital on 7 August.

This report commends Stafford for the way they assessed and met the prisoner's needs, and involved him in the process. The care provided was comparable to what he would have received in the wider community, and staff are praised for the quality of care they provided. It identifies several areas of good practice in relation to the multi-disciplinary approach used at Stafford to meet the prisoner's health care needs.

The Prisoner

He had one sister, and worked as a manager in the engineering sector until his retirement in 2001. He was married, had four children. He and his wife separated after he was arrested.

The prisoner was diagnosed with myelofibrosis in 1998 and had been receiving treatment on a regular basis including a blood transfusion every three weeks. He was sentenced to four years imprisonment for sex offences on 31 January 2003. He had no previous convictions and it was his first time in prison.

His prison records described him as quiet, polite, respectful and cheerful despite his illness.

Investigative Process

In cases of apparent death from natural causes, my practice has been to conduct an initial review to determine the extent of the investigation required. My investigator visited HMP Stafford on 13 August 2004 and spoke informally to a number of staff in different areas of the prison including the prisoner's residential unit, the Catering Department, Chaplaincy and Health Care. Staff described their day-to-day contact with the prisoner, his treatment at Stafford and in hospital. My investigator was given access to the prisoner's records, including his medical record.

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

Notices to staff and prisoners about the investigation into the prisoner's death were distributed and displayed around the prison. No responses were received.

The prisoner's son, was contacted by my investigator. He said that he had no concerns at all about the way his father had been treated at Stafford. He accepted that his father was an elderly man suffering from a terminal illness. He expressed his thanks for the exceptional care the staff had provided and the professionalism they had displayed.

The prisoner's sister wrote to the Governor, to thank staff for the compassion and care her brother was shown. She said that she found this comforting, even in the midst of a distressing and painful situation.

A representative from South Western Staffordshire PCT conducted a clinical review.

The prisoner's health prior to arriving at HMP Stafford

On 31 January 2003, the prisoner was sentenced to a total of four years imprisonment. He was sent to HMP Blakenhurst in Redditch. He was seen on reception by a Health Care Worker and stated that he was suffering from myelofibrosis. He said that he was taking long term treatment in the form of aspirin, anagrelide, folic acid, phenoxymenypenicillin and glucosamine. His spleen had been removed 18 months previously. He described himself as a social drinker and a pipe smoker. He was described as generally well.

A note dated 3 February 2003 in the prisoner's medical record said that the prison was awaiting confirmation of his medication from his General Practitioner as some of it was not licensed for use. Blakenhurst's Senior Medical Officer (SMO) wrote to the Consultant Haematologist who was treating the prisoner when he was in the community, to say that he did not feel competent to prescribe anagrelide as it was an unlicensed treatment for myelofibrosis, as was glucosamine. He asked for the consultant haematologist to remain the responsible prescriber for the prisoner. The senior medical officer maintained contact to seek advice concerning the prisoner's continuing treatment until the prisoner was transferred to HMP Wymott on 17 June 2003.

An entry in his medical record on 17 June said that the prisoner felt he needed to go to Wymott as he wanted to be in a more settled environment and he was happy to be referred to a local hospital there. Once at Wymott, however, his Record of Events (a record of occurrences completed by staff on each prisoner) states on 20 June that he was too far away to receive visits and he was hoping to be nearer to his family.

The prisoner was transferred back to Blakenhurst on 23 June 2003 due to concerns expressed at Wymott about prescribing Agrylin (anagrelide) and the fact that they did not have an SMO and used locum doctors as medical cover. The prisoner was feeling under stress, having travelled to and from Wymott in a short space of time. A hospital appointment had been arranged for the next day but it was too short notice for the prison to arrange for him to attend, so it was rescheduled for 27 June. The prisoner was seen at the prison's Well-Man clinic on 26 June.

The care given to the prisoner while at Stafford

The prisoner was transferred to Stafford on 25 July 2003. It is a category C (medium security) prison for adult males. It was described in its last inspection report by Her Majesty's Chief Inspector of Prisons (21-23 May 2003) as a safe and calm prison whose Health Care department "was well-integrated into all departments of the prison". There is a no in-patient facility so prisoners requiring such care may be transferred to other prisons. There is also no medical cover after 8.45pm but staff can contact the Senior Medical Officer if necessary.

The prisoner was prescribed a 28 day supply of his usual medications on 29 July 2003. On 25 August, the IMR states that he was "feeling rough". Two more entries that day detail the concerns of his residential unit staff i that he appeared to be very unwell and exhausted following minimal effort. As a result, the duty doctor was contacted for advice. The duty doctor saw the prisoner that day, and arranged for him to be admitted to hospital the next day. Following a blood transfusion, he returned to the prison. His medical record contains regular detailed entries about his health and medical checks. It also records contact with the prisoner's son concerning his father's health.

On 8 January 2004, the prisoner was told by his consultant that his life expectancy was limited as the prognosis for his condition was poor. He understood that he would only have between three to five months left. His health declined steadily over the next three months and he suffered from internal bleeding, and a grossly enlarged liver. According to his records, he remained in an optimistic mood despite realising that his illness was becoming more aggressive. He continued to keep weekly appointments with the hospital for transfusions and other scheduled appointments with his consultant. On 6 February, a Macmillan nurse was contacted to take part in the prisoner's case review.

On 15 April, the prisoner met with a Nurse from Stafford's Health Care Centre as part of regular support sessions. She talked through pain relief issues with him and asked the prison kitchen to alter his diet accordingly. The nurse felt that a case meeting should be convened to create an action plan for supporting the prisoner whilst in Stafford. Together, they discussed which staff should attend the meeting, including the Disabilities Liaison Officer, Wing Manager, Head of Health Care and his personal officer.

The case meeting took place on 26 April. The prisoner said that he wished to stay at Stafford on a residential unit rather than be moved to a prison hospital as he felt he had been treated well by staff and he had friends at Stafford. The Head of Health Care agreed to contact Macmillan nurses to arrange palliative care. It would also be ensured that contact was kept with his family by the staff responsible for the prisoner's care, that he would be provided with appropriate pain relief and that a wheelchair or any other equipment would be available when he felt it was needed. In addition, the nurse was to draw up a staff protocol so staff would know what to do when the prisoner's condition deteriorated. The Deputy Governor was to consult the Home Office Sentence

Enforcement Unit to find out their position on possible early release. The Security department was to arrange for his visits to take place in the multi-faith room or his residential wing should he be unable to access the visits room due to ill-health. Similarly, the Chaplaincy was to be asked to make arrangements for pastoral support should he be unable to attend church services.

Other arrangements involved ensuring that the prisoner did not suffer a loss in pay simply because he was ill. The Kitchen agreed to adjust his meals as required and his wing manager agreed to discuss with the Governor the possibility of him being given a personal alarm if he was unable to reach his cell call bell, and for a portable stereo system with relaxation tapes or compact discs to be provided. In addition, it was agreed that a Critical Incident Debrief would be held for staff and prisoners after the prisoner's death and bereavement counselling would be available to anyone who desired it.

On 13 May, the Head of Health Care met with the prisoner to discuss his health and his "will-of-life". The prisoner chose to move to G Wing as he could have his own room with an en-suite shower. A Macmillan nurse visited him on 18 June for assessment, and she asked for a special supporting mattress and chair cushion to be provided.

On 12 July, the prisoner discussed pain relief with a member of Health Care staff. He said that he had been resistant to taking it as he felt that he was "giving in" to his illness. As a result of the discussion, however, he accepted that analgesia was there to improve his quality of life and was not a weakness.

Events leading up to the prisoner's death

On 14 July, Stafford began the process to risk assess the prisoner for Release on Temporary Licence (ROTL) due to his terminal illness. A Board was held that day to consider whether it was appropriate to grant ROTL. As the prisoner had been convicted of sexual offences, it was important that his risk to the public be considered. The Board noted that he had no history of violent response to confrontation and had no previous convictions. The risk assessment form also noted that he had expressed regret and remorse for his offences. The Board recommended that he should be released on temporary licence to attend his hospital appointments (provided he was accompanied by an officer) as he was extremely poorly, was at low risk of re-offending, had received good reports from staff and had complied with prison discipline.

The prisoner attended hospital accompanied by one prison officer on 3, 4, and 5 August as part of his regular treatment. He was not handcuffed. On 6 August, he went to the hospital for a blood transfusion which started at 11.45am. At 4.30pm the hospital decided to keep him overnight for observation. At 9.50am on 7 August, he was told by a doctor that he would be remaining there for a few days.

At 7.50pm the prisoner was given oxygen. At 8.20pm, the escorting officer contacted Stafford to say that the prisoner's condition was deteriorating rapidly. Health Care staff contacted the prisoner's son, who set out for the hospital but his father died peacefully at 9.30pm.

Issues considered during the investigation

My investigator obtained the prisoner's records and spoke to a number of staff informally at Stafford. She also visited the last residential wing where the prisoner had lived with a view to assessing whether the prison had met the prisoner's needs and wishes before his death.

The prisoner had moved to G wing when it opened and benefited from being in a cell by himself with his own shower. As noted, he had a special supportive mattress and use of a wheelchair when he wanted one. Wing staff spoke to my investigator about taking him outside in his wheelchair when he was unable to walk and being familiar with his condition both through working on his wing and also from having accompanied him on hospital appointments. The prisoner had been provided with a small fridge to keep his protein health drinks. Staff appeared to be responsive to his needs and spoke knowledgeably about his life at Stafford.

Staff from other non-residential areas of the prison commented favourably on the quality of care that officers showed the prisoner. This was evidenced by his records which indicated that the departments whose work had an impact on him were pro-active and adaptable in tailoring their work as appropriate, without compromising on aspects of security or quality.

Catering department records showed that the prisoner had been treated as an individual. Staff had discussed with the prisoner what foods he was able to eat and in what quantity. He was given packed lunches rather than a hot meal at a set time so that he could eat at a time that was convenient for him, bearing in mind his frequent appointments out of the prison and his physical discomfort. For example, he was given small meals and more digestible items like packet soups and soft fruit.

As the prisoner had chosen to remain at Stafford, it is understandable that the prison did not pursue the issue of release on compassionate grounds. However, they did consider and grant ROTL when it became clear that the prisoner was approaching the end of his life. This showed appropriate and well-balanced judgement.

A clinical review was commissioned from South Western Staffordshire PCT which concluded that the prisoner appeared to have received medical care equivalent to that found in the wider community and that prison staff should be commended for the quality of care they provided.

The prisoner's medical record was informative and updated regularly to an excellent standard. The quality and frequency of the entries, particularly by the Nurse and Head of Health Care were high and reflected care and compassion in their dealings with the prisoner. Residential unit staff had forged effective links with Health Care, who in turn consulted other departments so that decisions affecting the prisoner were not made in isolation. The prisoner himself was actively involved in decisions affecting his

own health care. This no doubt made him feel valued and that staff were considerate of his wishes.

Conclusions

The prisoner's family are in no doubt that he was treated with sensitivity and that Stafford did all they could for him bearing in mind that he was suffering from a terminal illness. I concur with their views. It is clear that Stafford's care for the prisoner embraced the spirit of treating prisoners and their families with respect, dignity and, above all, with humanity as individuals. Staff demonstrated a true multi-disciplinary approach which did not depend on financial resources but, rather, a willingness to work effectively. They have provided a model example of the care terminally ill prisoners should be able to expect no matter the type of prison they are in, or the offence they have committed. These are facts of which the Governor and her staff can be proud. I hope the knowledge that he could not have received more considerate care will bring comfort to the prisoner's family as they come to terms with his death.

Examples of Good Practice at Stafford

The prisoner was able to contribute towards the agenda of care meetings and suggest which staff he wanted to attend. He was also able to become involved in planning his own care when he was physically able to rather than being a passive recipient. Moreover, staff respected and acted on his decisions where appropriate.

Health Care staff maintained regular contact with his son so that he was aware of developments in his father's condition.

Staff in all departments liaised to provide a comprehensive and holistic approach to the prisoner's care and this was reflected in the quality of information recorded about the prisoner and items he was allowed to have to improve his quality of life.

Contingency plans were in place so that staff would know what to do should the prisoner's condition deteriorate, especially when there was no night medical cover.

The Disability Liaison Officer was involved in meetings concerning the prisoner.

