Investigation into the circumstances surrounding the death of a man, who was a prisoner at HMP Parc, in January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the death of a man who died in hospital from natural causes on 13 January 2006. He was 72 years old.

I would like to add my personal condolences to the man's family to those already expressed by one of my Family Liaison Officers.

This investigation has been undertaken by one of my investigators. I am grateful to the Director of HMP & YOI Parc and his staff for their participation and support. A Nurse was commissioned to undertake a review of the man's clinical care. She worked alongside staff from the Healthcare Inspectorate Wales (HIW). I much appreciate their assistance

As is the case with 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 a number of concerns that the prison and its healthcare supplier will need to consider seriously. I endorse the recommendations made in the clinical review.

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 the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2006**

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SUMMARY

The man was born in 1933. He was 72 years old when he died on 13 January 2006.

The man was received into custody after being sentenced to 11 years imprisonment. He was initially held at HMP Gloucester. The man was then moved to HMP Usk before being transferred to HMP & YOI Parc on 12 December 2003.

On 11 May 2005, the man had an ultrasound scan and a tumour was discovered in the left side of his bladder. Two days later, the prison doctor wrote a letter to the urology department at the local hospital, referring to the discovery of a bladder tumour and requesting an urgent review.

On 25 May, the hospital wrote to the man to inform him that there was a ten week wait for urology appointments.

On 3 August, the man attended a consultation with a Specialist Registrar at the hospital. After the consultation the Registrar arranged for the man to come in for a cystoscopy (examination of the bladder) and trans-urethral resection of bladder tumour, under general anaesthetic. The man was admitted for these procedures on 31 August.

On 5 October, the man was told he had an invasive tumour which would be likely to require radiotherapy or further surgery. A letter from the hospital dated 19 October said that the man's MRI (Magnetic Resonance Imaging) scan showed not only the primary bladder tumour but also lymph duct involvement. The oncologists were recommending chemotherapy and the man was referred for an appointment with the consultant.

The consultant oncologist saw the man on 16 November. In a letter sent the following day the consultant said that she was making arrangements for radical radiotherapy for the man.

On 7 December, the man was taken to hospital. Whilst he was an in patient at the hospital, a bedwatch was carried out by prison staff. The security risk assessment was that a closeting (escort) chain was to be used. However, this was removed on 2 January 2006 after a further security assessment when the man's condition started to deteriorate. The man died in his sleep in the early hours of 13 January 2006.

The clinical review concludes that the man's clinical care in prison was overall of an appropriate standard. However, it was also critical of a number of matters. The review makes four recommendations which I endorse.

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 matters of concern.

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 from prison staff.

2. A nurse who works for my office and staff from the Healthcare Inspectorate Wales (HIW) carried out a review of the man's clinical care. I am grateful both for the contents of their review and for the fact that it was completed 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. They did not raise any specific concerns about his care and treatment whilst he was in custody.

5. My investigator discussed aspects of the man's treatment with staff at Parc and with the clinical reviewer.

HMP & YOI PARC

6. Parc is a modern Category B local prison on the outskirts of Bridgend and 25 miles from Swansea. The prison opened in November 1997 and is the only private prison in Wales. It is managed by Group 4 Securicor (G4S) and employs 391 members of staff, many of whom are recruited from the local area.

7. The prison offers a range of activities that aim to equip offenders with the key skills necessary to reduce the risk of re-offending after release. It currently has space for 1,036 prisoners on different wings.

8. The provision of healthcare within the prison is the responsibility of Primecare Forensic Medical Services. The latest staffing profile describes a team comprising three doctors and 25 nurses. Primary care is delivered by medical staff and registered nurses and the healthcare centre has the opportunity to draw upon the broader expertise of the range of healthcare services within Primecare Forensic Services. The in patient ward has 17 beds, all with integral sanitation.

KEY FINDINGS

The man's time in custody

9. The man arrived at HMP Gloucester on 28 February 2003. During his reception health screen interview, the nurse noted that the man had high blood pressure, gout and stomach ulcers. The man had no history of taking illicit drugs, but he admitted that he drank alcohol to excess. The man had never been in prison before and had no psychiatric history. He expressed no thoughts of self harm. However, the nurse found the man to be excessively anxious and depressed on admission.

10. On 1 March, the man saw a doctor for an initial assessment. The doctor reiterated many of the nurse's findings but noted there were no alcohol or drug problems. The doctor ordered that the man's blood pressure be checked daily and information about his medication obtained from his home General Practitioner (GP).

11. On 17 July, the man was reassessed by a doctor after he was sentenced. The consultation was supportive and noted that the man had expected the sentence.

12. On 4 August, the man transferred to Usk. The healthcare worker who assessed him noted, in addition to his known chronic conditions, that he had blood in his urine of unknown cause. The doctor's assessment noted that he had had recurrent episodes of haematuria (blood in the urine) since 1964. The doctor ordered a series of blood and urine tests and certified the man fit for work.

13. When the man transferred to Parc on 12 December, it was noted that he suffered from high blood pressure, gout and a lack of calcium. The doctor continued the man's prescribed medication and noted his recent history of anaemia (inadequate red blood cells and/or low levels of haemoglobin) and haematuria.

14. At the well man clinic on 3 February 2004, the man was found to have blood in his urine. The nurse performed an electrocardiogram (ECG) examination, but noted no findings. A 'full check of bloods' was conducted by the nurse and the man was referred to the doctor. There was nothing significant found in the blood tests. Prescribing records show that the man was given a course of trimethoprim (an antibiotic used to treat urinary tract infections).

15. On 28 September, the man complained of 'burning' when passing urine. He was again prescribed trimethoprim and further investigations were ordered. There was blood and protein present in the urine, but no evidence of an infection was found.

16. On 4 October, the doctor noted that he wanted the man to come to clinic to discuss his test results. On 12 October, a doctor noted the man had mild anaemia and his blood tests would be repeated in three months. However, it is evident from the records that this did not happen.

17. On 14 February 2005, the man complained of being light headed and a further ECG was performed. A diagnosis of sinus bradycardia (slow heart beat) was reached.

18. On 16 February, the man's pulse was still very slow and his blood pressure was low. He was referred to the medical registrar at the local hospital. He was admitted and commenced on warfarin (to prevent blood clots) and further tests were conducted, including a step test (to test heart rate response to exertion) and a 24-hour ECG.

19. The man returned to Parc on 23 February. From later correspondence, it was established that he had been diagnosed with atrial fibrillation (a fast and irregular heartbeat).

20. On 25 February, the man was passing fresh blood in his urine. Blood and urine investigations were ordered and an appointment made to see the prison doctor.

21. On 1 March, the man was again complaining of pain on passing urine. There was no doctor available, so the nurse sent off a urine specimen to the laboratory. The laboratory report asked for a repeat specimen, but no relevant further report was found and it is therefore difficult to establish if in fact the test was repeated.

22. On 15 March, the prison doctor referred the man for an ultrasound scan of his bladder at the local hospital. The referral request does not indicate that it was an urgent request or a referral under the NHS Cancer Plan which would have necessitated an appointment within two weeks.

23. On 11 May, the ultrasound report for the man stated, "... fronded polypodial tumour in the left side of bladder … Urgent urological referral is advised."

24. On 13 May, the prison doctor made a referral to the Urology Department at the local hospital. The referral letter did note that an urgent appointment was required.

25. On 25 May, the man had a diagnostic coronary angiogram at the local hospital. A letter was also sent to him by the hospital the same day to say that there was a 10 week wait for urology appointments.

26. A letter on the file from a Specialist Registrar, dated 3 August, reports on his consultation with the man that day. The man had waited 82 days for this appointment instead of the 14 days required by the cancer standard. Due to his findings and the ultrasound result in May, the Specialist Registrar arranged for the man to come in for a cystoscopy (examination of the bladder) and trans-urethral resection of bladder tumour under general anaesthetic on an urgent basis. The man was admitted for these procedures on 31 August.

27. On 3 September, the man returned from hospital after the surgery for the removal of the growth in his bladder. The doctor's letter confirmed he was arranging a two week review in out patients as well as a kidney x-ray. The man was offered a bed in the healthcare centre, but preferred to go back to the wing.

28. On 20 September, the man complained to the nurses about his bladder problems. The prison doctor started the man on a trial dose of doxazosine to improve his urinary flow. On 4 October, the prison doctor prescribed paracetamol to be kept in possession. Blood tests were taken and the results showed increasing anaemia. In response, a doctor increased the dose of ferrous sulphate.

29. Despite the Specialist Registrar's reference to a review in two weeks, correspondence showed that the man was not seen again for four weeks - on 5 October. However, records show that on 7 September the man had declined to go into the healthcare centre for preparation for his hospital appointment, which had therefore been postponed.

30. At his hospital appointment on 5 October, the man was told he had an invasive tumour which would be likely to require radiotherapy or further surgery. He was to have an urgent CT (Computed Tomography) scan and be seen again once they had discussed the results. A letter from the Specialist Registrar dated 5 October was stamped as received at Parc on 10 October. In the letter, the Registrar told the prison doctor what the man had been told. There was no reference to the diagnosis in the man's continuous medical record.

31. By 10 October, the man's pain was much worse and he was again referred to the doctor. He was seen in the pain clinic next day and started on co-dydramol three tablets twice daily. He was given a diary to record his pain and an appointment for one month.

32. A letter from the hospital dated 19 October stated that the man had had an MRI (Magnetic Resonance Imaging) scan which showed not only the primary bladder tumour but also lymph duct involvement. The oncologists were recommending chemotherapy and referred the man for an appointment with the consultant.

33. There was no correspondence relating to an appointment with the oncologist in the period up to 10 November, when the man showed the nurse at the medicines hatch that he had a large lump on the left side of his neck. An appointment was made for him to see the doctor. On 15 November, the doctor thought the lump might be a secondary tumour and made a further urgent referral.

34. A letter dated 17 November from the consultant oncologist confirmed she had seen the man on 16 November. She referred to a CT scan and its results. She also noted that she had not been able to find any evidence that he had had an MRI scan. She was making arrangements for the man to receive radical radiotherapy.

35. On 23 November, healthcare staff informed the security department at Parc that the man would be attending another hospital for an extensive course of medical treatment. They emphasised how essential these appointments would be and warned that he might have side effects such as tiredness and nausea.

36. On 27 November, the prison doctor prescribed dihydrocodeine for the man's worsening pain. On 30 November, the man was seen by the night nurse because he had vomited twice in the night.

37. On 5 December, the man's left calf was swollen, hot and red. A doctor saw him and wondered if it was lymphoedema (swelling due to an obstruction of the lymph vessels) caused by secondary disease in the pelvic glands. The doctor ordered a blood test, but the result indicated that the blood collected the next day had not been collected according to the necessary protocol.

38. When the prison doctor saw the man on 6 December, he thought he had deep vein thrombosis (DVT) and sent him to the local hospital. The man returned to prison after treatment with an appointment to return next day for an ultrasound.

39. On 7 December, the man returned to hospital for this agreed appointment and was admitted. Whilst he was an in patient at the hospital, a bedwatch was carried out by prison staff. The security risk assessment was that a closeting (escort) chain be used. Nursing staff from Parc kept in touch with the local hospital and learned that the man was being referred to another hospital. They correctly pointed out he was already under the care of the other hospital.

40. The man was described as 'rather unwell' on 15 December. The following day, he was reported to be having a blood transfusion in preparation for transfer to the other hospital once stable.

41. On 19 December, the man was still in the local hospital. He was having further CT scans before going to the other hospital. The man was at this stage walking with a Zimmer frame. The nurse informed the security department of this, in case it affected their risk assessment. Due to the nature of his conviction, the man was not considered suitable for release on temporary licence (ROTL) on compassionate grounds. However, in order to be as sensitive as possible, the prison arranged for him to be escorted by just one officer whilst he was in hospital.

42. The nursing staff continued to keep in regular contact with the ward staff at the local hospital over the coming weeks. On 2 January 2006, following a security risk assessment, it was decided to remove the mechanical restraints. While in he was an in patient, the man was visited on a number of occasions by his daughter and staff from the prison.

43. The man did not improve sufficiently to be transferred to another hospital for radiotherapy. The man died in his sleep at 2:25am on 13 January 2006.

Liaison with the man's family

44. The prison immediately tried to inform the man's family of his death. Unfortunately, the man was estranged from his sons and the prison was unable to contact his daughter as she was in hospital herself.

45. The Head of Drug Strategy and Resettlement Manager, was appointed as the prison's family liaison officer. He made arrangements for the funeral and provided financial help. The prison chaplain later conducted the funeral service. There was also a service held on the wing of the prison, where the man was housed.

Post Mortem and Clinical Review

46. The post mortem states that the cause of death was due to natural causes as a consequence of metastatic bladder carcinoma (cancer).

47. The clinical review concludes that the man's overall clinical care in the three prisons was of a good standard, although instructions for monitoring or investigations were occasionally missed. This included the man's very longstanding history of haematuria which was not apparently investigated in depth at an early stage. His condition might also have been made worse by being prescribed warfarin, as doctors might not have known about his pre-existing health problems.

48. The reviewers note that the prison doctor acted expediently in referring the man for a bladder ultrasound examination. However, it is a great

concern that the man had to wait for nearly two months for that ultrasound appointment, and the question is raised of whether this was the norm at the local hospital at that time.

49. The reviewers say that it was particularly regrettable that the prison did not question the letter from the urology department which stated that the average wait for an appointment was 10 weeks. The man was being referred because the ultrasound scan had showed a tumour and recommended an urgent urology referral. National standards require all referrals for suspected cancer to be seen within two weeks. In the event, the man waited 82 days for his first appointment with the urologist and another four weeks for surgery on a known cancer.

50. The reviewers could find no evidence that the man received care of a lower overall standard whilst in prison than he would have received had he been living in the community. However, they say that the delay in processing his referral for an urgent urology appointment was unacceptable.

51. The reviewers also point out that records and recordkeeping left something to be desired. It is noted that there were no prescription cards from Gloucester or Usk prisons, and entries in the continuous medical record were not in chronological order. The reviewers also note that tests and correspondence were filed rather at random, and no record was made in the continuous medical record of significant correspondence received.

Conclusions

52. The man was first imprisoned in February 2003. He died of cancer of the bladder in January 2006.

53. The man had arrived in prison with a number of heath problems. He had a history of gastro-intestinal disorders which were explored, with a focus on his upper abdomen. Nothing abnormal was found. His anaemia was also diagnosed and treated.

54. In August 2003, the prison doctor noted that the man had blood in his urine (haematuria) of an unknown cause, and that he had had recurrent episodes of this since 1964. The clinical review notes that the doctor requested a series of clinical investigations.

55. When the man transferred to Parc in December 2003, doctors again noted his history of haematuria. At a check up in February 2004, it is recorded that the man had blood in his urine. Nothing significant was found in blood tests and he was subsequently treated for a urinary tract infection.

56. In September 2004, the man was again treated for a urinary tract infection after various investigations which showed blood and protein present in his urine.

57. In October 2004, the man was noted to have mild anaemia following a blood test. The test was to be repeated in three months, but this was not done.

58. On 25 February 2005, the man was passing fresh blood and was referred to see the prison doctor but no appointment occurred until 15 March. Meanwhile, the man complained of pain when passing urine, and tests arranged by the nurse showed a quantity of blood and protein present.

59. On 15 March, the prison doctor referred the man for an ultrasound scan of his bladder. The referral request did not indicate that it was an urgent request.

60. It was not until 11 May, a delay of about eight weeks, that the ultrasound scan was carried out. It is very regrettable that it took so long to obtain an appointment, but the hospital was not notified of any urgency or suspected cancer diagnosis. Prison healthcare staff noted a number of times that the scan was awaited, but do not appear to have pursued the appointment. The scan found that the man had a tumour in his bladder and an urgent urological referral was advised. The prison doctor made the referral on 13 May, clearly noting the

bladder tumour found on the ultrasound and requesting an urgent referral.

61. On 25 May, the local hospital sent a letter to the man saying there would be a ten week wait for an appointment. I agree with the clinical reviewers that it is a matter of regret that the prison did not question this wait. The man had a provisional diagnosis of cancer, and the matter was therefore urgent and he should have been seen within two weeks as laid down by the NHS Cancer Plan.

62. The man eventually saw a consultant on 3 August, and was admitted to hospital on 31 August for the tumour to be removed. A two week follow up appointment was not kept, but this may have been because the man declined to go to healthcare to prepare for the original appointment.

63. On 5 October, the man was told the tumour was invasive and further tests showed that the cancer had spread.

64. In reviewing the bed watch log, it is clear that the staff involved with the man's care behaved with sensitivity. The decision to remove mechanical restraints, following a risk assessment, was entirely appropriate given the circumstances. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.

65. The view of the clinical reviewers is that the man received care akin to that he would have received had he been living in the community. However, the delays in processing his referral for an urgent urology appointment were unacceptable. I make four recommendations.

RECOMMENDATIONS

Medical

1. **Primecare Forensic Health Services should consider why their staff did not question the letter indicating that the man would wait at least 10 weeks for an appointment in response to their urgent referral.**

   Accepted by prison – The Primecare Manager will implement a system whereby urgent referrals to any Department are chased if the waiting time is deemed to be excessive.

2. **Primecare Forensic Health Services should bring to the attention of the Local Health Board the delay in the man's urgent urology referral to establish whether this was the norm at that time and what action is being taken to ensure cancer referrals are processed within two weeks.**

   Accepted by prison – Letter sent to Local Health Board by Primecare Manager.

3. **Primecare Forensic Health Services should bring to the attention of the Local Health Board the eight week delay in the man's ultrasound referral to establish whether this was the norm at that time.**

   Accepted by prison – Letter sent to Local Health Board by Primecare Manager.

4. **Prison Health and the Welsh Assembly should take steps to ensure their clinical staff working in prisons adhere to the guidance on records and recordkeeping issued variously by the General Medical Council, the Nursing and Midwifery Council and the Royal Pharmaceutical Society of Great Britain.**

   Accepted by prison – Letter sent to Prison Healthcare Project Co-ordinator in the Welsh Assembly.