Investigation into the circumstances surrounding the death of a man in March 2008 at Dorset County Hospital, whilst in the custody of HMP The Verne

Report by the Prisons and Probation Ombudsman for England and Wales

February 2009

This is the report of an investigation into the death of a man who died of natural causes in Dorset County Hospital on 11 March 2008. The man had been taken to the hospital from HMP The Verne on 3 March. He was 71 years old.

One of my Family Liaison Officers contacted the man's niece, who was the nearest member of his family. I would like to add my personal condolences to those expressed by my Family Liaison Officer on behalf of my office.

The investigation was undertaken by my colleague. Both he and I would like to thank the Governor and staff of The Verne for their participation. Dorset Primary Care Trust (PCT) undertook a review of the man's clinical care, and I very much appreciate the clinical reviewer's assistance. The final clinical review was received in my office in November 2008 which has delayed my issuing this report. I must apologise for any distress this may have caused.

When a prisoner dies from natural causes, the clinical review plays a large part in my investigation. In this man's case, the clinical reviewer finds that he was well looked after, and says that staff at The Verne should be commended for the care they offered. I am happy to endorse this, and make no further recommendations to the Governor.

The man had been a prisoner at The Verne for over 20 years and regarded the prison as his home. In effect, he was the artist-in-residence, and had his own studio on the wing. This report demonstrates the high level of care offered by The Verne during the final stages of the man's life.

Stephen Shaw CBE
Prisons and Probation Ombudsman **February 2009**

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SUMMARY

The man had been in prison for a long time. He was sentenced to life imprisonment in 1971 and arrived at The Verne in 1987. A talented artist, the man had his own studio in The Verne, and some of his paintings decorate the prison. He seems to have regarded the prison as his home.

The man had a number of health problems, all of which were being treated with medication. In December 2007, he was reported to be unwell, but assured staff he would seek assistance from healthcare if he felt he needed to. In February 2008, he reported to the prison doctor with pain in his back and abdomen. The doctor found a lump in the man's abdomen, and was concerned that this might indicate cancer. He immediately made a fast track referral to Dorset County Hospital.

The hospital did not automatically confirm the referral, and the prison's healthcare department twice contacted the hospital to ensure that the referral was in place. On 28 February 2008, the man was told that he had cancer that was likely to be untreatable. His health deteriorated rapidly, and on 3 March he was transferred to hospital as an emergency admission.

The prison remained in contact with the hospital to monitor the man's health, and to consider where the best place would be for him. A decision was taken that, in view of his age and health, no security chains were necessary while he was in hospital. The man's family was kept informed of his condition.

The man died in hospital in the afternoon of 11 March. In line with his wishes, his ashes were scattered in the garden in The Verne. He was aged 71.

THE INVESTIGATION PROCESS

1. My investigator visited The Verne and spoke to staff who worked with the man during his imprisonment. Notices were posted to staff and prisoners about the investigation, inviting any contributions. One prisoner initially indicated a wish to speak to my investigator but subsequently withdrew the request. Another prisoner wrote to clarify why the death was being investigated. Another of my investigators visited The Verne and spoke to this prisoner, who was a foreign national and whose first language was not English, explaining our role. He had no further contribution to make.

2. My investigator studied all relevant prison records relating to the man. These included his main prison records and his medical records. My investigator also visited the wing where the man was housed, his cell, and the studio where he worked.

3. Dorset PCT was asked to carry out a review of the man's clinical care. My investigator discussed aspects of the man's treatment with the clinical reviewer and I am grateful to him for undertaking the review.

4. The investigator also 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. On completion, I will send him a copy of this report to help in the Coroner's enquiries.

5. One of my family liaison officers (FLOs) spoke to the man's niece, who was his next of kin. The man's niece told my FLO that she did not think the prison was at fault for her uncle's death. She thought that he had been ill for a while, but he was the sort of person to keep this to himself and not tell anyone. The man's niece thought that her uncle did not seek medical help until it was too late for treatment. She believed that he was moved to the hospital as quickly as possible once the prison were aware that he was unwell, and that they contacted her as soon as they realised the seriousness of his condition. The man was moved to hospital on the Monday (3 March 2008), and she was told two days later. She was able to visit him on the Saturday (8 March), three days before he died.

6. The man's niece also told my FLO how the prison had been helpful with arranging the funeral and organising for her uncle's ashes to be scattered within the prison grounds. She did not have any further concerns to raise at the time but expressed a wish to see my report when completed.

HMP THE VERNE

7. The Verne is a category C training prison for adult men. It opened in 1949 on the site of a former military barracks dating from the end of the nineteenth century. About 60 per cent of the prisoners are foreign nationals from over 50 different countries.

Security for hospital visits

8. All prisoners travelling outside the prison to attend hospital are subject to security arrangements. Each is individually risk assessed, and the standard entails two members of staff acting as escorts. The prisoner is handcuffed during transit to and from the hospital. The handcuffs should be removed, and a security chain applied securing the prisoner to one of the escorting officers, following admission to a ward.

Her Majesty's Inspectorate of Prisons

9. The most recent report by HM Chief Inspector of Prisons followed a full, announced inspection in August 2007. The report does not raise any issues relevant to this investigation.

Independent Monitoring Board (IMB)

10. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life and to ensure that proper standards of care and decency are maintained. The most recent report published by the IMB at The Verne does not raise any issues to be noted here.

KEY FINDINGS

11. The man was sentenced to life imprisonment in 1971. He moved through the prison system and, on 2 February 1987, transferred from HMP Kingston to The Verne.

12. The man settled at The Verne. He went on three town visits in 1994, another in 1996, and then again in 2000 and 2004. He also attended his brother's funeral in 2002. But other than such visits and general medical appointments, the man showed no inclination to move on from The Verne. On one occasion he threatened to take his own life if he were transferred out. As recently as October 2007, he returned his parole dossier unread, indicating his lack of interest in possible release.

13. The man was elderly and was not in the best of health. As a result, he was in regular contact with healthcare. In September 2005, he refused to attend an outside hospital appointment, saying that he did not want to go out of the prison in handcuffs and chains as security procedures required. In October 2007, after reporting some pain in his hips, he was advised to have an x-ray. Once again, he declined as he did not want to go to outside hospital in security cuffs.

14. In December 2007, the man was reported to be unwell. By this time he was attending the healthcare centre daily to collect his medication. On 22 December, he was told that he would be checked on his daily visit. The man said that if he felt ill at any point he would return to healthcare. He did, however, again express an unwillingness to go to outside hospital on a security chain.

15. Medical records show that on 23 January 2008, the man reported to the prison doctor that he was suffering from pain in his leg and frequent migraines. On 5 February, he reported that he thought he was suffering the symptoms of a slipped disc.

16. The man told the prison doctor on 12 February that his back pain had worsened. He also reported pain in the top of his abdomen, and the doctor thought he might have detected a lump. He made a fast track referral to the Dorset County Hospital that day. This was the first occasion that there was any suggestion that the man might have cancer.

17. No response had been received by 15 February, the healthcare department contacted the hospital and confirmed that the referral had been received. The prison doctor contacted the hospital on 19 February, and was told that an appointment had been made for the man for 27 February.

18. Over the next few weeks the man's health deteriorated rapidly. He had difficulty in using stairs, and the prison provided a wheelchair to improve his mobility between his cell and the healthcare centre.

19. On 27 February, the man attended hospital for an out-patient appointment. A prison officer volunteered to accompany him on outside hospital appointments as she felt she had a good relationship with him. The following day, the prison doctor told the man that he almost certainly had cancer and that treatment would be unlikely to be able to provide a cure.

20. The prison doctor saw the man on the wing on 3 March. He was very unwell, not eating properly, and was short of breath. It was felt that he ought to be admitted to Dorset County Hospital in order to better control his pain. In view of the man's age and the nature of his illness, it was agreed that no security restraints would be required while he was in hospital. He was taken to hospital as an emergency admission. The following day, results of a computed tomography (CT) scan (a specialised x-ray test to give clear pictures of the inside of the body, particularly of the soft tissues) confirmed that the man had cancer in his left lung.

21. Records dated 5 March 2008 indicate that the man's prognosis was poor. Discussions were held as to what would be the best place for him to be, and options included a return to The Verne or a possible move to HMP Dorchester which has a 24 hour healthcare facility.

22. The man had a further scan on 6 March. That day, with his consent, a Governor contacted the man's niece to inform her of her uncle's condition. By this stage, the man was able to move to go to the toilet but was otherwise largely immobile. On 7 March, the man improved slightly. Security arrangements were altered so only one prison officer was required as an escort. Again, the man's niece was updated about her uncle's condition.

23. The following day (Saturday 8 March), the man moved to Ilchester ward. The man's niece and other members of the man's family went to visit him. During this time staff from The Verne assessed the man's situation, and his medical records show that consideration was being given to a possible move to a hospice.

24. A member of the IMB visited him on 9 March, and records show that on 10 March, hospital staff were still considering whether a move to a hospice was viable. The prison doctor telephoned the hospital and said that The Verne would be happy for the man to return to the prison if the hospital were content that they could provide the necessary care.

25. Two officers were each detailed for shifts on bedwatch duty with the man on Tuesday 11 March. At 10.15am, staff at the hospital told the prison that the man's condition had seriously deteriorated. The prison in turn contacted the man's niece. At 2.10pm, the man died. The man's niece was informed by hospital staff, and spoke to the prison's family liaison officer at 3.30pm. Notices were posted to staff and prisoners informing them of the man's death, and showing where support could be found if needed.

26. Having lived there for over 20 years, the man had regarded The Verne as his home. He had asked if his ashes could be scattered in the garden there. The

prison liaised with the man's niece to arrange this, and assisted with the man's funeral arrangements including offering financial assistance. They also showed his family his artist's studio, and allowed them to take one of his paintings away with them. The cremation service was held in the prison, so the man's fellow prisoners could attend and pay their respects.

ISSUES

Healthcare

27. The man was elderly and had been a heavy smoker for a number of years. He had high blood pressure, raised blood fats, and diabetes. These conditions were all exacerbated by his smoking, though ultimately none of them played a direct part in his death.

28. The man did not seek assistance from healthcare until his cancer was at an advanced stage, by which time there was no possibility of curative treatment. In those circumstances, staff at The Verne did everything they could for the man. He was given a fast track referral to the hospital. Healthcare staff contacted the hospital almost daily to monitor his progress. Consideration was given to where he would be best located given the nature of his illness, including the possibility of returning to The Verne. There seems little that anyone could have done to prevent the man dying.

29. The clinical reviewer says that the prison did not receive automatic confirmation of the fast track referral when it was first suspected that the man might have cancer. The prison had to seek confirmation that the referral had been received. Again, it is to the prison's credit that they pursued this. I understand from the Primary Care Trust that, since the man's death, they have changed their processes and all fast track referrals are now automatically confirmed.

HMP The Verne

30. The clinical reviewer writes that everyone in The Verne involved in the man's care should be congratulated for their care, compassion and consideration of his wishes. One particular officer should be commended for volunteering to accompany the man to hospital, despite the possibility of the man receiving bad news whilst there. Security restraints were removed while he was in hospital, and only one member of prison staff was required to remain with him. In view of his age and health, these were humane and proper decisions.

31. The man regarded The Verne as his home. He was employed as the prison artist and was given a studio in which to work. After he died, the prison liaised with his family in carrying out the man's wishes to have his ashes scattered in the prison grounds.

The Governor should commend the officer and the other staff involved in the care of the man in the last weeks of his life.

CONCLUSION

32. The man was elderly and had various health problems. He seemed to enjoy living in The Verne, and was employed there as a prison artist. He was given a studio to work in.

33. The man did not seek assistance from healthcare for his cancer until it was at too advanced a stage to be treated. As soon as he was diagnosed, I believe that the prison did all they could to ensure he was properly looked after.

34. Through the latter stages of his illness and after his death, the prison also liaised well with the man's family. They arranged for his ashes to be scattered in the prison, as was his wish.

35. The care shown to the man by The Verne in the last stages of his life was of a very high standard. I do not make any recommendations to the Governor beyond endorsing the commendation of staff for their care and compassion.

COMMENDATION

The Governor should commend the officer and the other staff involved in the care of the man in the last weeks of his life.