

**Investigation into the Death in Custody
of a man in February 2005
at Milton Keynes General Hospital
whilst a serving prisoner at HMP Woodhill**

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

January 2006

This is the report of an investigation into the circumstances surrounding the death on 13 February 2005 of a man at Milton Keynes General Hospital, whilst on temporary licence from custody at HMP Woodhill.

The investigation was lead by one of my colleagues, Tracey Campbell RN ONC. An independent review of the man's medical care in prison was carried out as part of the investigation.

I would like to extend my sincere condolences to the family of the man and to those touched by his death.

We would like to thank the management and staff at HMP Woodhill and Milton Keynes General Hospital for their assistance and co-operation during the course of this investigation. I regret to say I have concluded that the quality of care that the man received was less than optimal in several respects.

Stephen Shaw CBE
Prisons and Probation Ombudsman

January 2006

SUMMARY

The man was an 80 year old man, who was serving a six year sentence at Woodhill prison, Milton Keynes, for indecent assault on a child. He was received into Woodhill on 27 August 2003. He was described as a 'model prisoner' who was calm and had good relationships with other prisoners and staff.

In October 2003, the man was referred by the Medical Officer to the surgical outpatients department at Milton Keynes General Hospital (MKGH), complaining of constipation which was not relieved by medication. He was seen by MKGH following this referral in January 2004, at which time a colonoscopy was recommended. An appointment was received in December 2004 for a colonoscopy on 6 January 2005. This appointment was subsequently cancelled.

In March 2004, he was referred to MKGH regarding an ulcer on his neck which was not healing. The ulcer was removed by the dermatologist at MKGH on 3 August 2004 and diagnosed as malignant.

In December 2003, the man lost his hearing aid. In March 2004, a referral letter was sent to MKGH Audiology Department requesting a new hearing aid. An appointment was never received for him to attend the Audiology Department. However, a subsequent enquiry by MKGH has established that they were never informed that the man was already in possession of a hearing aid and at the time of the referral the waiting list for new patients was 13 months.

In October 2004, the man's dentures were repaired after apparently having been broken for five months, which had resulted in him only being able to manage a soft diet.

The man had been treated in MKGH for a deep vein thrombosis in his right leg in December 2003. On 31 January 2005, he was referred to MKGH's medical on-call doctor in the Radiology Department, with a hot swollen right calf which had worsened over the previous three weeks. A Doppler scan was booked for 1 February 2005.

The man was admitted to MKGH on 1 February 2005 and died there on 13 February 2005. The post mortem report gives the cause of death as primary carcinoma of the liver and widespread peritoneal carcinomatosis.

INVESTIGATION PROCESS

All the indications were that the man's death was from natural causes. In these circumstances, it may be sufficient for a clinical review to be carried out by an independent health care professional rather than a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In the man's case, I decided that the circumstances did not require a full investigation, but appointed a clinician to undertake the review of his care.

My Deputy Ombudsman, Emma Bradley, visited Woodhill and met with the Head of Healthcare and the liaison Governor. Ms Bradley spoke informally with staff and reviewed the prison records. My investigator, Ms Tracey Campbell RN ONC, conducted a review of the health and social care the man received whilst in custody.

One of my family liaison officers the man's half brother and sister. The man's half sister was visited on 16 May 2005, by the Family Liaison Officer and Investigator, also present was the partner of his half sister.

Following the issue of the draft report an investigation into the issues raised with regard to Milton Keynes General Hospital was carried out and their response has been included in this final report.

KEY EVENTS

The events leading up to the death

On reception into prison the man was seen by a healthcare worker and the First Reception Health Screen was completed.

The man stated that he was on medication, but there is no documentation as to what this was for and what the medication actually was. The man also stated that he had chest pain. Despite signing a consent form allowing information to be requested from his GP, there is no evidence to indicate that his past medical history and records were requested. The First Reception Health Screen form was incomplete and the man's weight not documented. Furthermore, the lack of available documentary evidence indicates a failure to follow up on positive responses to questions on the form.

The First Reception Health Screen notes that an F2052SH (self-harm at risk form) had been opened by a doctor. This was appropriately completed and, as a result of the healthcare assessment, the man was subsequently admitted to healthcare.

On 5 September 2003, a decision was taken to close the F2052SH. There is no documentary evidence that a multi-disciplinary case review, in accordance with national procedures, was carried out to support this decision.

On 27 October a referral was made to MKGH by Woodhill's locum medical officer, requesting an investigation to rule out a possible non-benign obstructive lesion as the man was suffering from chronic severe constipation which was not relieved by medication.

In December 2003, the man attended MKGH. The man was diagnosed with right leg thrombophlebitis and a deep vein thrombosis. He was prescribed Warfarin to commence depending on INR result. The A&E discharge summary notes that the man had chronic constipation and a smoothly enlarged prostate.

Bloods were taken for INR and, as a result of the level no treatment with Warfarin was required.

In January 2004, the man was seen by a Locum Consultant Surgeon at MKGH, following the referral in October for his chronic constipation. By the time he attended the OPD on 20 January, he had lost two stone in weight and was experiencing constant abdominal pain. It was decided by the attending Consultant that the man should have a colonoscopy and made this referral, but did not note any urgency.

In March 2004, the man was referred to MKGH Dermatology Department with a suspected rodent ulcer on the left side of his neck. He was seen by a Consultant Dermatologist on 2 June 2004 and had an operation on 3 August 2004. The man had a follow up appointment arranged for October, but this was rescheduled by Woodhill due to a lack of staff available to escort him. He had his follow up appointment in November, when he was discharged from the care of the dermatology department.

On 26 March 2004, a referral was made by the I medical officer to the Audiology Department at MKGH for the man to have a new hearing aid supplied. An appointment was never received for him to attend the Audiology Department. However, a subsequent enquiry by MKGH has established that they were never informed that he was already in possession of a hearing aid and at the time of the referral the waiting list for new patients was 13 months.

An entry in the medical records shows that, on 23 September 2004, he had blood tests to investigate the dizzy spells that he was experiencing. The blood tests requested included a request for liver function tests (LFT) amongst others. The Bilirubin result was abnormally high and the Creatinine very slightly raised. There is no documentary evidence to support any investigations into the possible cause of these abnormal results.

On 29 October 2004, it appears that the man was seen by the Dentist in the Healthcare Centre and his dentures were repaired. I can see no evidence in the medical record regarding when they broke, however his relatives informed us that it took some 5 months for them to be repaired. This meant that the man could only manage a diet of soup, custard and biscuits dipped in tea.

In December 2004, an appointment was received for the colonoscopy, which was scheduled to take place on 6 January 2005, a year after the initial referral by the Consultant. At that time the waiting list for non-urgent colonoscopies was 12 months. This appointment was subsequently cancelled by Woodhill, apparently due to a lack of prison staff available to carry out the escort.

The medical record indicates that the man weighed 86 kgs on 6 January 2005.

The next entry in the medical records is dated 27 January 2005, when he was complaining of a hot, swollen calf. The man's presenting symptoms were discussed with MKGH and a plan of care arranged. The man was scheduled to have a Doppler scan on 2 February and to commence Tinzaparin. The man's weight was noted to be 58 kgs.

On 31 January, the man was complaining of a dull ache in his abdomen and said he had not had his bowels opened for two weeks. The prison locum medical officer wrote a detailed urgent referral letter to the radiology physician at MKGH, outlining concerns about his health. The man had lost two stones in the previous year, he also had a one month history of loss of appetite, malaise and a two week history of abdominal distension. They questioned whether the man was suffering from a DVT, which was secondary to abdominal cancer. The man's weight was recorded as being 60 kgs at this time. The man was subsequently admitted to MKGH on 1 February 2005.

An entry in the medical records on 2 February states that ward 2 at MKGH was contacted regarding the man's progress. They were informed that he would be having an ultra-sound that afternoon and to ring back at 3.30pm. The next entry is on 13 February which states that they had been contacted by duty Governor to say the man had passed away at 7.30am that morning.

The prison response following the admission to hospital and the death

On 1 February, The man was admitted to MKGH. A letter was sent by MKGH on 9 February to the Governor following the man's CT scan. The letter states that the man's prognosis was very poor and that he had probably only days/weeks to live.

There is an undated risk assessment signed by an officer and a governor grade stating that all restraints be removed but that two officers should remain with the man at all times. On 10 February 2005, a release on temporary licence was applied for using form ROTL6. An accompanied release was approved due to risk factors being greatly reduced as a result of the man's illness. At this stage the bed watch was reduced to a single supervising officer.

The bed watch log indicates that the restraints were removed on 9 February 2005. These were not reapplied.

The man died at 7.35am on 13 February 2005, in ward 2 at MKGH according to the bed watch log.

The post mortem identified the cause of death as: primary carcinoma of the liver with widespread peritoneal carcinomatosis.

Following his death, it was found that the man had no recorded next of kin. However, Woodhill established that the man had a half brother whom the chaplaincy subsequently contacted. I believe this to have been well and sensitively handled. They did not however contact the man's half sister and her partner whom had visited and written to the man on a regular basis. They stated that they were unaware that the man was so ill, let alone dying. They feel they were robbed of the opportunity to be with him and to say goodbye. They would have also liked to find out whether he wished them to do anything for him once he had died (regarding possessions etc). The man's possessions were never returned to his half sister as his half brother had apparently told the prison to 'get rid of them'.

The local investigation by MKGH notes that hospital staff were concerned that no family members knew of his admission or his clinical condition. With persuasion the man finally consented, on 7 February, to a letter being written to his half sister advising her that he was very ill. The hospital staff understood from the man that his family had wanted nothing to do with him.

KEY FINDINGS AND CONCLUSIONS

The First Reception Health Screen notes that the man was on medication, but no note was made as to what it was. He stated that he was suffering from cervical spondylosis, helicobacter Pylori, haemorrhoids and chest pain. It appears that no medical records were requested from the man's GP. A healthcare worker completed the Health Screen and referred the man to the doctor regarding his physical health.

The man complained of the symptoms of a DVT in December 2003, which was treated quickly and appropriately by healthcare and hospital staff.

In August 2003, it was noted in the medical record that the man was deaf. In December 2003, he lost his hearing aid. Despite several notes in the medical record regarding this and an eventual referral in March 2004 to the Audiology Department at MKGH, it appears that he never received a new one. However, a subsequent enquiry by MKGH has established that they were never informed that the man was already in possession of a hearing aid and at the time of the referral the waiting list for new patients was 13 months.

In October 2003, the man was referred to MKGH with the suggestion that the cause of his chronic constipation be investigated in order to rule out a non-benign obstructive lesion. Having been seen by a consultant at MKGH in January 2004, the man did not receive an appointment for his colonoscopy until January 2005. This appointment was subsequently cancelled, apparently due to a lack of staff to facilitate the escort. The handwritten note on the referral letter regarding the cancellation is unsigned and undated. Whilst it is apparent the man had waited a year for the colonoscopy, the referral by the locum consultant surgeon was not marked as urgent and at that time the waiting list for non-urgent referrals was 12 months.

The man had a history of four or five rodent ulcers, which he had had removed from various parts of his body in the past. It appears that this was not discovered until he attended MKGH in June 2004, for the removal of a further rodent ulcer. The man was referred in March 2004 by Woodhill and had the ulcer removed on 3 August 2004.

A liver function blood test result in September 2004 showed a raised Bilirubin level. It appears from the lack of documentary evidence that this was never acted upon by the prison healthcare team.

Despite the man suffering from chronic constipation since at least October 2003, and his continuous weight loss, there are no regular records in the medical record of his bowel action or weight.

The man is described by the prison as 'a very private man who kept himself to himself'. The man's relatives informed us that he was unable to hear most of what was said to him which left him very isolated and unable to socialise. This apparently affected him from December 2003 until his death. The delay in repairing the man's dentures and the effect this had on the diet he was able to manage will have contributed to his weight loss.

Overall, the quality of care that the man received was less than optimal. However, given his age and illness, I do not believe this contributed to the fact or timing of his death.

The man was released on temporary licence on 10 February 2005, due to the terminal nature of his illness. The arrangements regarding use of restraints and the level of bedwatch, were handled appropriately and sensitively.

The prison failed to thoroughly check visitor and communication records to establish whom to contact when it became apparent that the man's prognosis was so poor. This meant that they only contacted a half brother who had practically 'disowned' the man when he was sentenced and not the relatives who cared about him. The investigation by MKGH notes that hospital staff were concerned that no family members knew of his admission or his clinical condition. With persuasion the man finally consented, on 7 February, to a letter being written to his half sister advising her that he was very ill. The hospital staff understood from the man that his family had wanted nothing to do with him.

RECOMMENDATIONS

There are five recommendations for the attention of the Governor, Healthcare Manager and Milton Keynes PCT.

- 1. I recommend that healthcare professionals are reminded of the importance of First Reception Health Screen procedures. This includes thorough completion of the First Reception Health Screen form and obtaining previous medical records if appropriate.**
- 2. I recommend that as far as possible the prisoner's next of kin should be documented as soon as possible. It is acknowledged that sometimes prisoners are reluctant to divulge this information initially but they may be willing later on in their sentence. On the death of a prisoner for whom no Next of Kin is recorded, careful attention should be paid to visitors and written correspondence in order to establish who should be contacted.**
- 3. I recommend that healthcare professionals be reminded of the importance of legible, accurate and thorough documentation, particularly in relation to record keeping. Clinical tests carried out should be noted in the medical record, coupled with the result. The result should be brought to the attention of the relevant healthcare professional and acted upon if required.**
- 4. I recommend that healthcare professionals are reminded of the importance of regular monitoring of patients' conditions, with accurate and thorough documentation of their findings.**
- 5. I recommend that a copy of this report is sent to Milton Keynes General Hospital with a view to their reviewing the man's case. In particular, they may wish to establish why it took so long from his appointment with the Consultant to receiving the colonoscopy appointment, and why, when its purpose was to investigate a possible malignancy, the appointment was then cancelled.**

Milton Keynes General Hospital carried out an internal investigation into the issues raised by the draft report and the findings have been incorporated into this report.