

**Investigation into the circumstances surrounding the death  
of a man in March 2008 at  
Melton Mowbray Hospital while a prisoner at HMP Stocken**

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

**November 2009**

This is the report of an investigation into the circumstances surrounding the death from cancer of a man, a life sentenced prisoner at HMP Stocken, in March 2008. He died in Melton Mowbray Hospital. He had been ill for a little over six months before his death, having first reported sick and complained of a sore throat on 3 September 2007. He was treated regularly throughout the autumn months, both at Stocken and through hospital outpatient appointments. The man was not always a compliant patient. He often refused medical treatment at the prison, declined to attend outpatient appointments and on more than one occasion threatened to discharge himself from hospital if he was not returned to prison.

In January 2008, the man was admitted for three days to Leicester Royal Infirmary. I have found it difficult to piece together precise details relating to subsequent spells in hospital. Prison records show that he was transferred to hospital on several further occasions and continuously from 9 February until he died. Details of transfers between Leicester Royal Infirmary and Melton Mowbray Hospital are not clear. Prison records refer to both hospitals and identify specific events in each, but not the dates of transfers between hospitals.

The man was admitted to Melton Mowbray Hospital for the last time on in March and he died peacefully there. He was 47 years old.

A doctor at Melton Mowbray Hospital issued a death certificate on 20 March, identifying the cause of the man's death as carcinoma of the larynx. There was no post mortem examination.

An investigator carried out the investigation on my behalf. As part of his investigation he commissioned a review of the man's clinical management. I am grateful to the clinical reviewer who carried out the review on behalf of the local NHS Trust. I appreciate also the willing cooperation of the Governor and all staff at Stocken, notably the Governor who acted as liaison officer. The clinical reviewer has found that doctors and nurses in the prison did their best to help the man, notwithstanding his reluctance or refusal to cooperate in his own treatment.

The man had no known family. He gave several different versions of his upbringing and family connections. When asked about his family, although his explanations differed, he said consistently that all contact had long since been lost and he did not want to try to trace anyone who might know him. The visitors and correspondents he had in prison were limited to those who dealt with his case as a life sentenced prisoner. To all intents and purposes, prison staff were his only associates. Many staff from Stocken attended his funeral.

Two prison officers were particularly concerned about the man. They told my investigator that they were his only family and that they felt a need, over and above official and pastoral care, to see that he was treated well, particularly in respect of his deteriorating health. These officers were critical of nursing services at Stocken. They

felt that the man should have been an in-patient at the prison at a much earlier stage in his illness.

I conclude that the care given to the man , both inside and outside Stocken, was appropriate and compassionate, consistent with his worsening illness and his reluctance to allow medical staff to treat him. To all intents and purposes staff and prisoners at Stocken were his only family. As this report makes clear, there was a real sense of loss at his passing.

I make no recommendations.

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 my investigation.

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

**November 2009**

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## **SUMMARY**

The man was sentenced in July 1991 to life imprisonment for the murder of a man he had met at an alcoholics recovery project centre. The judge set the minimum period that he should serve in prison (known as the 'tariff') at 13 years. Although that period had expired, the Parole Board assessed in 2007 (their fourth review of the man's case) that he should address areas of risk and complete further offending behaviour work before they could recommend a transfer to an open prison with a date for release from custody. The man had been at HMP Stocken since 2002.

My report shows that prison staff and prisoners were aware of the man's general problems. Although not difficult to manage, he could be stubborn, particularly in respect of personal hygiene, medical treatment and compliance with voluntary drug testing or offence related work. Refusal was often assessed as stubbornness because, when the man complied with requirements, he was capable of producing good results. For example, on the occasions he took drug tests, the results were always negative. His main reason for refusing medical treatment centred on the fact that, if he were to be admitted to a healthcare centre in prison, or a hospital outside, he would not be allowed to smoke cigarettes.

The clinical reviewer's clinical review shows that the quality of care and clinical records at Stocken and Leicester Hospitals were of a high standard. He expresses surprise, however, that a post mortem examination was not conducted.

Between reporting sick in September 2007 and his death from cancer in March 2008, the man received in-patient treatment at Leicester Royal Infirmary and Melton Mowbray Hospital. From early February 2008 he was in hospital continuously. Never an easy patient and sometimes an acutely disruptive one, he did not make caring for him a straightforward task. Prison healthcare staff and their discipline officer colleagues are to be commended for their patience and kindness during this time. It could not have been

easy for the man either, but staff never lost their sense of compassion or their determination to do their best to care for him.

Notwithstanding the genuine and heartfelt comments of two officers who felt that medical care for the man was poor, having examined the circumstances from all perspectives, I conclude that care was appropriate during his relatively short terminal illness.

## THE INVESTIGATION

1. My investigation opened in April 2008 when my investigator visited HMP Stocken. He met the Governor and other senior staff and visited the area of the prison where he had lived. He talked to staff and prisoners who had known him. Two prison officers, both on sick leave, asked to see my investigator and he visited them at their homes. They said that the standard of care given to the man was poor; although they added that he would not help himself and usually refused medical treatment.
2. Having regard to the comments made by the two officers, my investigator examined in detail the standard of care the man received from the healthcare centre, together with the level of communication between healthcare staff and those on B wing, where he lived.
3. My investigator examined all documents which shed light on the man's clinical condition, his treatment and the degree to which he cooperated with it. He also scrutinised other more general information relating to the man's demeanour and conditions on the prison wing where he lived.
4. My investigator considered the clinical reviewer's clinical review. This documents not only the difficulty doctors had in diagnosing the man's illness, but also his enduring refusal to engage in treatment. My investigator considered whether or not, given the nature of the man's illness, it would have been possible to have located him in a prison healthcare centre, either in Stocken or at a prison with full time in-patient facilities.

## HMP STOCKEN

5. Stocken opened in 1985 as a young offender establishment, converting later to adult accommodation which holds medium to long-term prisoners, including those serving a life sentence. The prison holds over 800 prisoners and at the time of my investigation was undergoing its fifth stage of expansion.
6. Nurses provide healthcare in the prison between 7.30am and 5.30pm Monday to Friday, and between 8.00am and 5.00pm at weekends. Doctors are available for three hours each day from Monday to Friday.
7. The most recent report published by the Stocken Independent Monitoring Board (IMB) said that healthcare in the prison continued to raise concern. The IMB were particularly worried that a difficulty in finding staff for escort duties meant prisoners were being denied access to the NHS.
8. Two days before the death of the man, another prisoner at Stocken died. There had been three previous deaths at Stocken since I was given responsibility for investigating all deaths in prison custody in 2004. All the deaths at Stocken have been from natural causes. In three of my investigation reports I have praised the prison's sensitive approach to the question of applying restraints to terminally ill prisoners.
9. HM Chief Inspector of Prisons noted in her report of an inspection in 2008 that the prison had been undergoing continuous expansion for a number of years and that the 'extensive building work continued to blight the environment'. She concluded, nevertheless, that there had been significant improvements since her last visit. Stocken remained a safe prison which had made good progress, particularly in the quality and quantity of purposeful activity for prisoners.

## EVENTS IN THE LAST SIX MONTHS BEFORE THE MAN'S DEATH

### Healthcare records

10. The man had been continuously in prison for some 18 years before his death and there is a wealth of information in the files relating to his health. I have examined in depth the last six months of his life and I mention earlier events only where necessary to provide context to my report.
11. The man first reported sick with a sore throat on 3 September 2007 and was prescribed painkillers. A surgery doctor saw him just over two weeks later (19 September) when he complained of a migraine. This consultation did not mention his sore throat.
12. On 12 October, the man had a cold which he said had lasted a few weeks. He said also that his appetite was poor and he had lost weight. He did not go to his next consultation with the surgery doctor on 17 October, but did attend another appointment on 7 November. The surgery doctor recorded a sore throat, difficulty in swallowing and blood stained mucus. He noted that the man had a red and swollen throat. He prescribed erythromycin suspension as the man reported difficulty swallowing. He advised a further review if his condition did not improve.
13. A Nurse recorded weight loss, vomiting and a continuing sore throat on 23 November. She organised a number of blood tests and a review by the doctor. The blood tests revealed normal haemoglobin and acceptable values for renal and liver function. A second surgery doctor, who saw the man the same day, also reported haematuria (blood in urine). The second surgery doctor expressed concern at the spectrum of symptoms, particularly his weight loss.
14. A review by the surgery doctor on 30 November revealed worsening symptoms including cachexia, fetor (smelly breath) and dehydration. He advised emergency admission to an acute hospital. There are separate records recording the man's refusal to go to hospital. The prison's mental health in-reach team became involved to monitor and support him during this episode. A review a week later by a third surgery doctor documented a discussion with the man during which the doctor told him that he should have agreed to go to hospital. An x-ray and sputum sample was sent off.
15. The third surgery doctor reviewed the man's case on 10 December. His chest x-ray was clear and 'watchful waiting' was advised. The in-reach team continued to review his condition. On 21 December, the man was assessed by a fourth surgery doctor who noted poor air entry to the lungs and referred him on a 'two week wait' to chest physicians with a view to a scan and sputum tests.

16. On 2 January 2008, a worker from the in-reach team recorded worsening personal hygiene and reports from wing staff that the man was giving his food away. He had stopped going to work. Between 3 and 17 January, his physical deterioration was documented including on-going sore throat, altered voice, clinical dehydration and malaise. The in-reach team worker also documented the concerns raised by other prisoners about his physical condition. A review on 24 January by the surgery doctor revealed significant deterioration and he too advised hospital admission. The man initially refused and discussions took place to try and arrange transfer to a prison with 24 hour healthcare facilities, but eventually he consented to go to hospital.
17. The man was admitted to Ward 23 of Leicester Royal Infirmary on 25 January. The only recorded positive finding was H. pylori infection of the stomach. He was started on triple therapy and an Ear Nose and Throat (ENT) referral was advised. From 25 to 27 January, a hospital nurse recorded several conversations with doctors and nurses involved with the man's care. She documented her opinion that his return to Stocken was not appropriate. However, HMP Leicester had refused to take on his care so he had returned to Stocken. Further deterioration was recorded from 27 January to 6 February. During this time, the in-reach team worker recorded several entries about attempts to arrange alternative prison healthcare.
18. There were several medical record entries on 8 February. The man's weight had decreased to 59.4 kg (a loss of 10 kg in seven days). He was unable to swallow and he collapsed later that day. The forensic psychiatrist assessed the extent that his mental state was affecting his physical health and recorded his worsening condition. She sent an email to the local Primary Care Trust urgently seeking care elsewhere. The man again initially refused to go to hospital and said that this was because he would be 'unable to smoke'. He maintained that he would commit suicide if he was forced to go to hospital. However, he eventually consented and was admitted to Leicester Royal Infirmary's Acute Medical Unit via the Accident and Emergency Department.
19. During admission the man was treated with antibiotics for a working diagnosis of tuberculosis. Two quantiferon tests were positive. His refusal to accept intravenous antibiotics and tests including videofluoroscopy (a test which looks closely at a person's swallowing process) and nasopharyngolaryngoscopy (a test examining the person's airways) were recorded. Staff also recorded that his behaviour was disruptive, including urinating next to his bed and spitting onto it bed. He threatened to discharge himself on two occasions.
20. Ongoing dialogue between Stocken, the hospital and other prisons was recorded between 16 and 20 February outlining the fact that healthcare at Stocken thought that his return there was not appropriate. Discussions continued to find suitable accommodation for the man and the prison liaison officer visited him in hospital.

He agreed to move, following discharge from hospital, to HMP Leicester's healthcare centre.

21. The man left Leicester Royal Infirmary on 21 February but, after a night in the healthcare centre at HMP Gartree en route to Leicester prison, he was again admitted to an NHS hospital, this time at Melton Mowbray. Although prison officers were present throughout, he was not handcuffed or placed under any other restraint. A senior manager from Stocken, usually a governor or nursing grade, visited each day, sometimes more than once.
22. Following support and persuasion by the Clinical Manager at Stocken, a flexible laryngoscopy was finally performed at Melton Mowbray Hospital on 27 February 2008. This revealed a 'large' laryngeal tumour, a terminal diagnosis. The man was transferred to Leicester Royal Infirmary on 4 March for a PEG (percutaneous endoscopic gastrostomy) feed, a surgical procedure for inserting a feeding tube without having to perform an open laparotomy (operation on the abdomen).
23. On 17 March, a doctor from the Health Protection Agency confirmed from the sputum specimen that the man had non-infectious tuberculosis. He continued to be disruptive. He spat and urinated inappropriately on the wards and, on one occasion, removed the PEG feed. The ENT specialist, considered that active treatment was no longer possible.
24. Following limited success with his toleration of the PEG feed, he was transferred from Leicester Royal Infirmary to Melton Mowbray Hospital on 18 March. Over the course of the next three days his overall health continued to deteriorate, and he died peacefully from the effects of his cancer in March.

#### **Wing records and information from staff**

25. Wing records show that on 17 October 2007 staff thought that the man was giving away his food in exchange for cigarettes. An officer sent a report to a worker at the healthcare centre expressing her concerns. On 4 December, wing staff again noted their concerns and said that the man should not stay on an ordinary residential wing. On 19 January 2008, the officer yet again recorded her worries about him. She said that he was being cared for by wing staff and other prisoners. The wing records also document the man's refusal to go to hospital and the difficulty persuading him to accept medical treatment.
26. Two officers told my investigator in interview that they were dismayed at what they perceived to be the poor treatment given to the man by healthcare staff at Stocken. They were concerned and distressed at his deteriorating condition, not only for his own sake but also for that of staff who had to manage him and for other prisoners with whom he shared communal eating and hygiene arrangements. It is clear that those two officers thought that not enough was being done for him.

27. However, wing records also show that healthcare staff arranged many consultations and clinical tests. Staff tried to persuade him to go to an outside hospital and actively sought a transfer, as an alternative, to a prison hospital with appropriate facilities. The B wing occurrence book shows that healthcare centre staff were doing their best in the face of the man's refusal to go to hospital. They also communicated well with the wing staff. A note made on 23 November 2007 in the occurrence book reads, 'Healthcare Centre would like us to continue to monitor the man as we have been. They appreciate the input from the wing and agree that he seems to have deteriorated. He will see the doctor again this week.'
28. Other notes from the occurrence book and from the man's wing file record his 'point blank' refusals to go to hospital, and the many attempts made by prison officers and healthcare staff to get him to change his mind. Entries also show that healthcare and wing staff worked together to try to arrange the best possible care. An entry on 5 December shows that 'a care plan has been put in place'. On 11 December, an entry shows that healthcare staff arranged extra food for him. A further entry on 24 January 2008 shows that the man was too ill to attend his healthcare appointment. A doctor came to see him on B wing but 'he told her he would not go to outside hospital' and swore at her.

#### **Events following the man's death**

29. The man died peacefully in March. Following his death, the Governor published notices for the information of staff and prisoners. He also made the funeral arrangements and paid the costs. In the absence of any family, the Governor, Head of Residence, Family Liaison Officer, Head of Healthcare and members of staff from the wings attended the funeral, held at Gilrose Crematorium in Leicester. At the same time as the funeral service, the prison chaplain held a service at the prison which was attended by both prisoners and staff. Those who had attended the funeral brought the flowers, paid for by prisoners and staff, from the service and arranged them in Stocken's chapel. The chaplain later held a memorial service at the prison.

## **ISSUES CONSIDERED**

### **Clinical care**

30. The clinical reviewer conducted a clinical review of the man's treatment in Stocken and in outside NHS facilities. The clinical reviewer has wide experience as a general practitioner and as a prison medical officer. His review appears in full as Annex 1 to my report.
31. In brief, the clinical reviewer's comments particularly concern the availability of prison healthcare units and wing staff assessments of whether they are able to care for seriously ill prisoners. He believes that wing staff could influence the transfer of prisoners from a prison which is unable to provide care to one which has better facilities. He says, however, that in this case 'access to healthcare was made by appropriate clinicians. For this reason I do not feel there are any issues relating to the process of health care at HMP Stocken.'
32. The clinical reviewer emphasises the importance of communication between healthcare professionals and their prison officer colleagues. He considers that it would have been beneficial for a decision about the man's mental capacity to have been clearly communicated to the prison officers on the wing. Having said that, the clinical reviewer is satisfied that the man was capable of refusing active consent to medical intervention, however unwise his decisions may have been.
33. The clinical reviewer concludes that the quality of medical care and record keeping was consistent with the standards provided within a typical doctor's surgery. He also judges that earlier investigation of the man's illness did not occur because of his refusal to consent to treatment and does not reflect on the level of care provided at Stocken.

### **Compassionate release**

34. HMP Stocken did not consider recommending that the man be released from custody on compassionate grounds during the later stage of his illness. I think that this was appropriate. The terminal diagnosis was only made in February and he was in hospital until his death, some 22 days later. He had nowhere to go outside prison and I am satisfied that the care given to him by both NHS and prison staff was what he needed in the circumstances.

## CONCLUSIONS

35. In the six months between the onset of the man's illness and his death, prison wing staff, healthcare staff and professionals in the wider NHS did all that they could to get him to cooperate fully with his treatment. He usually refused and, on the occasions he accepted treatment, did so on his own terms, making it difficult for those administering care to do so comprehensively. He often disrupted the process or made threats to harm himself if he could not have his own way.
36. I cannot say whether, by the time symptoms of his illness were manifest, earlier admission to hospital, together with his full cooperation, would have prolonged or even saved the man's life. No doubt he had his reasons, and those who treated his condition had to do the best with how he presented as a patient.
37. This investigation draws attention to the extent to which prison staff and fellow prisoners become a surrogate family for those prisoners who have lost touch with any blood relatives. Aside from this sad but revealing insight, I have no other conclusions or recommendations to make.