THE DEATH IN CUSTODY OF A MAN

HMP PARKHURST 24 AUGUST 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

MARCH 2006

This is the report of an investigation into the circumstances of the death of a man in hospital, Isle of Wight, on 24 August 2005. He was aged 63, was serving a sentence at HMP Parkhurst. He had been admitted to hospital on 3 August 2005 in the final stages of a terminal illness.

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

The investigation was led by a registered general nurse, who also reviewed the medical care given to the man whilst he was in prison. She also met with his family and I am grateful for their willingness to discuss his death so soon after their bereavement. A number of questions were raised by the man's family and I hope this report provides them with answers. I understand that the man had a number of medical conditions including a history of angina, which had resulted in heart surgery in November 2003. In the months before his death, he had been investigated for cancer of the mouth and cancer of the lung.

I would like to thank the management and staff at HMP Parkhurst for their assistance and co-operation during the course of this investigation.

My report makes two recommendations which are taken from the clinical review. I hope that one of these will be seen as helpful more generally in the care of terminally ill prisoner-patients.

This version of my report, published on my website, has been amended to remove the names of the deceased and the names of staff and prisoners who were involved in my investigation.

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

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SUMMARY

1. The man was a 63 year old man who was serving a ten-year prison sentence at HMP Parkhurst. He died in hospital, Isle of Wight, on 24 August 2005 of lung cancer. The clinical review, carried out as part of this investigation, does not identify any specific issues regarding the clinical care he received. It says that he had received nursing and medical care comparable to that which would have been available in the community. I conclude that his death was not connected to the fact that he had been in prison, nor to the level of care that he received whilst in prison.

2. The man was received into HMP Cardiff on 24 May 2004 and transferred to Parkhurst on 1 September 2004. On reception he advised the clinical team that he had a history of angina and hypertension and had had heart surgery in November 2003.

3. On 15 March, the man had a biopsy on a 'white patch' in his mouth. On 23 March 2005, a note in his medical records indicates that the man said he was suffering from cancer of the mouth. It is not clear who or when he was advised of this possible diagnosis. The man was appropriately followed up at the local hospital and a subsequent letter from the Consultant Maxillofacial Surgeon in August 2005, notes that "clinically this seems to have resolved and disappeared".

4. On 15 July, the man was admitted to hospital, and reviewed by the doctor who identified a range of problems including hypertension, angina, oesophagitis and gastritis. The man was discharged back to the prison on 3 August with instructions that he would need immediate treatment. It is unclear where this treatment was to take place. On arrival back to the prison it was noted that he was extremely unwell in appearance and supported by the prison doctor, was immediately sent back to hospital.

5. The prison was informed on 11 August, that the man had a tumour and would be remaining in hospital. He passed away during the evening of 24 August with his wife and daughter by his bedside.

6. Some concerns were raised by the man's family regarding the medical care that he had received whilst in prison. They said they felt that staff had not taken his health problems seriously and failed to act quickly enough. The family had not been informed when he had been admitted to hospital and were actually told by another prisoner. There were also concerns that on one occasion the man stated to them that he believed his angina tablets were "poisoning" him. However, the family went on to say that, since the man's death, the prison had treated them with kindness and respect. They mentioned one governor in particular as having been very helpful and supportive.

INVESTIGATION PROCESS

7. My practice in cases of death from apparently natural causes is to conduct an initial review to determine the extent of the investigation required. My colleague, first visited HMP Parkhurst on 15 September 2005 and met with the Security governor. She was given a full briefing about the circumstances surrounding the man's death and was told that his family had been aware of his serious condition and poor prognosis. The family were with him when he died.

8. The prison issued notices to staff and prisoners on behalf of this office, inviting anyone who felt they might have information relating to the man's death, to contact the investigator or my office. My investigator was informed that both the Prison Officers' Association and the Independent Monitoring Board had felt they had nothing specifically to contribute to the investigation.

9. My colleague was given photocopies of all the files and records relating to the man. These included his clinical records. My colleague read all these records and decided to conduct the clinical review separately. This is included as an annex to this report.

10. My colleague also asked one of my family liaison officers to contact the man's family and find out whether they had any specific concerns about the care he received whilst in prison. His family expressed some concerns, mainly regarding the clinical care he received. In particular:

    - they believed that staff were not taking his health problems seriously, and failed to act quickly enough;
    - He mentioned on one occasion that "he was being poisoned by his angina tablets";
    - they were concerned when a fellow prisoner alleged that he was "being abused by the prison";
    - they learned of his admission to hospital from a prisoner, and felt that the prison should have contacted them with this information.

    My colleague telephoned the Governor on 18 October 2005 and discussed the family's general concerns about the man's time in prison.

BACKGROUND

11. The man was born and raised in Cardiff by his natural mother. His father died when he was just three years old, but he enjoyed a generally good relationship with his step-father who moved into the family home soon after the death of his father. The man left school at the age of 15, and began working in the steel industry. He also spent time a period of time working as a receptionist at Mid-Glamorgan County Hall and then as a weighbridge operator. The man married in 1961, and had indicated that his marriage was a happy one, describing his wife as being very supportive. The couple had four daughters, and also looked after their grandson.

12. In 1998, the man suffered a heart attack and was no longer able to work. He advised prison healthcare staff that in November 2003, he required heart surgery, but even after the surgery had continued to be troubled by chest pain.

13. The man had been living with a friend's daughter and her husband following his arrest. Although very grateful for their kind hospitality, he missed his family and became depressed and was prescribed antidepressant medication by his General Practitioner. On conviction, he was sentenced to ten years imprisonment.

14. The man was 63 years old when he died. He had been received into Cardiff Prison on 24 May 2004 and transferred to Parkhurst on 1 September.

15. The man's family remained supportive but were unable to visit frequently, in part because of the distance of Parkhurst from the family home in Wales.

16. HMP Parkhurst is a Category B prison and is one of three prisons situated on the Isle of Wight. It can accommodate just over 500 prisoners who have received sentences of four years or more. It has a type three healthcare centre, providing 24 hour a day on site primary care, and has a small in-patients unit. The fabric of the healthcare centre is far from satisfactory, but it is currently being refurbished and upgraded to make it fit for purpose.

EVENTS LEADING UP TO THE MAN'S DEATH

17. The man was seen and assessed by a prison doctor at Cardiff on 25 May 2004, following his reception screening. The doctor noted that he suffered from angina, hypertension and depression

18. There were a number of occasions, following his transfer to Parkhurst, when the man was referred to and was seen in the oral surgery outpatients department at hospital. He underwent investigative tests, including a biopsy on 15 March on a 'white patch' in his mouth. On 23 March 2005, a note in his medical records indicates that the man said he was suffering from cancer of the mouth. It is not clear from the clinical records who or when he was advised of this possible diagnosis.

19. However, a letter written by the Consultant Maxillofacial Surgeon, and dated 3 August 2005 states, "during a review appointment following a biopsy of the white patch in the floor of the mouth taken in March of 2005, clinically this seems to have resolved and has disappeared". There is no documentation indicating if the man was informed of this finding.

20. Toward the end of 2004, the man began to experience discomfort and pain in the right shoulder and chest. It is documented in the clinical records that he was seen and treated for this problem on a fairly regular basis. Sadly, his symptoms worsened and he began to experience shortness of breath and episodes of nausea and vomiting. Initially, he was treated locally, with antibiotics and analgesia. On 11 July 2005, the man was reviewed by the doctor who increased the strength of his painkillers.

21. He was admitted to hospital and reviewed by a doctor who identified a range of problems, including hypertension, angina, oesophagitis and gastritis. The man was discharged back to Parkhurst on 3 August, with recommendations that he would need immediate treatment. However, it is unclear from the available documentation what treatment was required, or where and when it was to take place.

22. The man was still unwell on his return from the hospital, short of breath and vomiting. He was therefore sent straight back to hospital on the recommendation of the prison doctor. On 11 August, the prison were informed that the man had a tumour and would be remaining in the hospital until further notice.

23. He was released on Temporary Licence, but the prison managers made regular contact visits to the hospital. They were advised that the man had passed away on the evening of 24 August 2005, with his family around him.

THE PRISON'S RESPONSE FOLLOWING THE DEATH

24. My investigator considered Prison Service Order 2710: Follow up to deaths in custody, which provides detailed instructions of the actions required following any death in custody. Parkhurst's local death in custody contingency plan contained a detailed checklist of the actions to be taken following such an event. My colleague noted that the instructions had been followed appropriately.

25. Notices informing members of staff and prisoners of the man's death were displayed throughout the prison and published on the local prison Intranet. A member of the chaplaincy conducted a memorial service on 12 September which was well attended, with prayers being offered for the man and his family.

26. Parkhurst contributed to and helped arrange his funeral, which also took place on 12 September in Cardiff. Unfortunately, due to the distances involved there was no representative from the prison in attendance.

27. The man's family have specifically mentioned the Governor as having been helpful and supportive to them. I am pleased to offer this public commendation of his actions.

28. The post mortem was carried out locally at the request of Her Majesty's Assistant Deputy Coroner for Isle of Wight on 2 September 2005. The cause of death was given as:

    1A Carcinoma of lung [small cell type].

ISSUES CONSIDERED DURING THE INVESTIGATION

Compassionate release

29. When prisoners have been diagnosed with a terminal disease, I always consider if there was a case for early release on compassionate grounds under section 10 of the Crime (Sentences) Act 1997. However, I am conscious that such decisions cannot be made lightly if the intentions of the sentencing court are not to be undermined and public confidence in the criminal justice system is to be maintained.

30. Given that the man had in fact been granted Release on Temporary Licence (ROTL), I understand the prison felt there was little point in pursuing the possibility of an early compassionate release on medical grounds. I think this was entirely reasonable in the circumstances. Given the relatively short time he had been in custody, his sentence and the nature of his offence, I think it unlikely that compassionate release would have been agreed.

Transfer to a prison, hospital or hospice closer to the family home

31. The man's serious medical condition was not diagnosed until the latter stages of his illness, but there is no evidence that consideration was given to transferring him to a prison, hospital or hospice nearer his home in South Wales. The transfer of prisoners nearer their home enables family and friends to visit with ease and to spend some quality time with them in their final days. I endorse the following recommendation from the clinical review:

    The Primary Care Trust and prison should develop a protocol allowing for the timely transfer of prisoners who are terminally ill to a more appropriate location nearer to their families.

Informing the family of the man's admission to hospital

32. When the man was admitted to hospital, there was initially no communication with his family by the prison. In fact, the family learned from another prisoner that he had been admitted to hospital. I consider it good practice for next of kin to be informed of a prisoner's admission to hospital in a timely and sensitive manner. I make no formal recommendation on this point, but the Governor of Parkhurst will wish to consider if there is new advice he can offer to his staff.

Records and record keeping

33. Recognised standards for clinical record keeping were not always met. Written documentation in the man's clinical records was less than satisfactory. Entries were not always informative and at times very difficult to read. It is unclear from the records as to how much information and insight he had about his medical condition, or if and when he had any counselling to help him cope with the emotional and

psychological impact of a terminal illness. Again, I endorse the recommendation in the clinical review:

Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

34. More generally, healthcare staff need also to be aware that patients may not have full insight into their own medical conditions. Accordingly, steps may need to be taken to offer support to help them deal and come to terms with their illness.

CONCLUSIONS

35. I consider that Parkhurst cared for the man entirely appropriately given the confines of a secure environment. Management and staff were sensitive to his needs and took all reasonable steps to accommodate them. The care given to him was proper and timely, and continued until his transfer to hospital on 3 August. On 11 August, the man was discharged back to the prison by the hospital. Healthcare staff were so concerned about his physical condition that they arranged for him to be re-admitted to hospital immediately.

36. The man was a 63 and had a number of medical conditions, mainly cardiac in nature. He was referred to hospital on a number of occasions for tests and investigations, before he was given a diagnosis of lung cancer. The treatment and prescribed medication that he received was timely and appropriate.

RECOMMENDATIONS

1. The Primary Care Trust and prison should develop a protocol allowing for the timely transfer of prisoners who are terminally ill to a more appropriate location nearer to their families.

2. Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.