Circumstances surrounding the death of a prisoner released on temporary licence to a hospice from HMP Woodhill in November 2005

Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a prisoner at HMP Woodhill. On 13 October 2005, medical tests revealed that the man who died had an inoperable tumour in his chest and that his prognosis was very poor. The next day he was moved to a hospice in Milton Keynes. Having spent five weeks in the hospice, the man died in November 2005 at the age of 38.

The man who died was a known drug user, who sadly had lost contact with his family. When it became apparent that he was seriously ill, the prison encouraged him to re-establish that contact but he refused, saying that he wanted to protect them from the news of his condition. Towards the end of his life, he allowed the hospice to get in touch with his family and he spent his final days with his mother and sister. I offer them and all those who knew him my sincere condolences on their loss.

An investigator from my office led the investigation. His report focuses on the man's time in prison custody, and evaluates the systems in place to establish whether they were (and are) fully effective. I regret the delay in completing this report.

I am grateful for the assistance my investigator received from the staff and management at HMP Woodhill. My thanks also go to Milton Keynes Primary Care Trust who prepared a clinical review. Unfortunately, all copies of that review have gone missing, although all parties are agreed it raised no matters of concern.

The inquest was heard on 24 February 2006, and the jury returned a verdict of death from natural causes. The Coroner raised no issues and was complimentary about the care that the man had received from Woodhill and the Hospice.

I make no recommendations in this report, but have drawn attention to sensitive and professional manner in which Woodhill responded to all aspects of the man's illness and eventual death.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

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SUMMARY

The man who died had been at HMP Woodhill since 19 September 2005. On reception, he disclosed his drug and alcohol misuse. Although he had not previously seen a doctor, he was concerned about pain in his back and legs and said that over recent months he had been losing weight.

The prison doctor wanted to admit the man to the prison's Healthcare Centre, but he refused and was located on House Unit Five. The next day the Substance Misuse Team assessed him. He made it clear that he did not want to stop using drugs, but needed help with his withdrawal symptoms.

Over the next few days it became apparent that the man was short of breath, and so the doctors began to explore the problem. On 4 October, he was admitted to hospital, but discharged himself that evening. He was re-admitted on 5 October for tests.

On 13 October, the man was told that he had an inoperable tumour on his lung. The next day he was admitted to a hospice in Milton Keynes for palliative care. He died in the hospice in November 2005, with his mother and sister at his bedside.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was led by a Senior Investigating Officer. He visited the prison and was shown the areas where the man had lived, including the Healthcare Centre and the wing. The investigator reviewed the man's prison records, and spoke informally to both prison staff and prisoners. He issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known.

2. My investigator also spoke to the chair of the Independent Monitoring Board (IMB), a representative of the local branch of the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff including the Safer Custody Manager. My investigator spoke informally to prison staff and prisoners who knew the man and were involved in the events surrounding his death.

3. The prison gave my investigator full access to all the documentation concerning the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigator obtained further information from probation and court services.

4. One of my Family Liaison Officers, spoke to the man's mother on the telephone and discussed what had happened to her son. There were no issues that she wanted to raise, and she was very complimentary about the prison. She asked that my office should have no further contact with the family, which included not wishing to see this report.

5. Milton Keynes Primary Care Trust (PCT) conducted a clinical audit of the man's care while in prison. The clinical review has been referred to in this report. Regrettably, all copies of the document have been mislaid and are not attached as an annex. However, it is accepted by all parties that it raised no matters of concern.

THE MAN

6. The man was born in December 1967 in Glasgow, Scotland. He was 38 years old when he died. His mother was his next of kin. He was divorced and had three children.

7. Little is known about the man's previous history, except that he had been in prison a number of times and was unemployed. He said that he committed crimes to fund his alcohol and intravenous drug habit.

8. On 19 September 2005, he appeared before Kettering Magistrates' Court, charged with theft and burglary offences. He was convicted and sentenced to nine months imprisonment. The man was then taken to HMP Woodhill, with a release date of 2 February 2006.

9. He had been released from Woodhill on 4 July 2005, just a few weeks before this latest arrest.

HMP WOODHILL

10. Woodhill was opened in July 1992 and is a local prison within the Prison Service's high security estate. The prison has an operational capacity of 789. On the day of Paul's death, the prison had 757 prisoners in custody.

11. All prisoners received into Woodhill currently undergo an induction process that lasts up to five days. At the time of the man's reception, the induction process available was scheduled to last three days.

12. Woodhill underwent a full inspection by HM Chief Inspector of Prisons in February 2002, with an unannounced follow-up inspection in August 2005. In her report of the follow-up inspection, the Chief Inspector said the prison had made progress in its induction arrangements. However, she noted that the regime in the healthcare had deteriorated, which was being addressed by the PCT.

13. Prior to his death, the establishment was last subject to a Prison Service Standards and Security audit in October 2004 during which it was marked as 91% for standards and 85% for security.

Healthcare Centre

14. Woodhill's healthcare provision includes an inpatient unit and a visiting specialist service. Prisoners have access to a doctor 24 hours a day, and those with more serious conditions or clinical needs are referred to the local hospital.

15. For healthcare emergencies, the prison operates the Hotel One system. If emergency medical assistance is required, the member of staff detailed as Hotel One responds, assesses the situation and commences any treatment before deciding on the next course of action. Hotel One is available 24 hours, a day, and is contactable from the communications room via the prison radio.

Detoxification

16. House Unit 3 at Woodhill is a dedicated drug free unit.

17. Woodhill has a detoxification programme providing help and support for prisoners wishing to stop using drugs and remain drug free. House Unit 3 includes the Detoxification Centre, which uses a variety of methods varying from prescription of suitable medication, auricular acupuncture, yoga, education and group therapy.

KEY FINDINGS

19 September to 13 October 2005

18. On arrival at Woodhill on 19 September 2005, the man told staff that his home address was in Kettering, but refused to name anybody as his next of kin. This was consistent with his response during previous periods of custody.

19. During the reception health screening interview, he said that he had concerns about his sore back and legs. He said that he was a heavy intravenous drug user, a smoker, and also drank heavily on a daily basis. He displayed symptoms associated with drug and alcohol withdrawal. He told the nurse in reception that he had a doctor in the community, but had not been seen in previous months. He said that he had recently lost weight, but had not asked for medical advice.

20. A doctor saw the man in the reception area, and wanted to admit him to the Healthcare Centre for observation, support and management of his detoxification. However, the man refused to go there and, in line with local policy, signed a disclaimer which confirmed that he refused the treatment offered to him. He accepted medication for relief of his symptoms, and was taken to House Unit 5.

21. A nurse who works for the Substance Misuse Team, saw the man the next day. His severe physical withdrawal symptoms were noted, and he was prescribed a Subutex detoxification regime. He made it clear to the nurse that he wanted help with detoxification to relieve his withdrawal symptoms, but did not want help or advice to stop using drugs.

22. The same nurse reviewed the man on 23 September. He had difficulty walking and was described as having “boney pains”, which were not consistent with drug withdrawal symptoms. He was referred to the doctor, and the doctor saw him the same morning. The doctor prescribed medication, and ordered blood tests to be taken. The doctor wanted to admit the man to the Healthcare Centre for observation, but again he refused.

23. The doctor saw the man again on 26 September, when he said that he felt better and had gained a little weight. He was persuaded to move to the Healthcare Centre for observation. The next day, 27 September, the man agreed to further examination and tests on his chest. The doctor saw him again on 29 September, and thought he looked better than when she had seen him earlier in the week.

24. Another doctor reviewed the man on the morning of 4 October. His condition had gradually deteriorated, and the blood test results were available. Shortly after midday, he was referred to hospital and was transferred there by ambulance. He was escorted by two officers and was restrained by hand-cuffs or a closeting chain.

25. He returned to the prison at 9.10pm, having discharged himself against medical advice. He returned to the Healthcare Centre, where staff intended to take regular hourly checks of his pulse and breathing. At 2.40am on 5 October, the man refused to allow staff to make physical observations and signed a further disclaimer to confirm that he refused medical observations.

26. A doctor saw the man early in the morning of 5 October. Following a conversation with the doctor at the hospital, he persuaded the man to return to the hospital for observation and further tests. He was escorted by two staff, and again remained in hand-cuffs or on a closeting chain. Although he was not told, the doctor suspected a diagnosis of lung cancer.

27. During the next eight days, the man underwent further tests including a biopsy on his lung. He spent an uneventful time in the hospital, with the only concern being his smoking habit. He was advised to stop smoking on medical grounds, but refused even though it was clearly exacerbating his condition. I understand that he was very vocal about his need to smoke, but staff facilitated smoking breaks as regularly as possible.

28. Prison staff and managers attempted to persuade the man to name and contact his next of kin, but he refused as he said that he did not want to worry them.

29. On 13 October, he was told that he had an inoperable tumour in his lung. His prognosis was very poor, and the hospital was making arrangements to transfer him to a hospice for palliative care. He coped with this news relatively well, but still refused to name a next of kin as he did not want to worry them.

14 October to the day he died

30. On 14 October, the man was transferred to the hospice. The prison completed a risk assessment, and decided that it was appropriate to release him on temporary licence on compassionate grounds.

31. The exact date is unclear, but some time around 11 November, he told staff at the hospice that they could contact his mother at an address in Scotland. The prison arranged and financed travel and accommodation to enable his mother and sister to visit the hospice.

32. On 16 October, a bed was identified at a hospice in Glasgow, nearer to his mother's home, and arrangements were coordinated between the prison and both hospices for him to transfer there within the following days.

33. Sadly, he continued to deteriorate, and at 11.00am in early November he died still in the hospice. His mother and sister were at at the bedside.

34. The post mortem report has confirmed that he died of a tumour on the lung.

ISSUES

Clinical care

35. The clinical review concluded that the man was cared for appropriately by the prison. The detoxification programme was appropriate, as was the referral to the hospital for further tests when it became apparent that his respiratory function was impaired.

Conclusion

36. The man had a long history of intravenous substance misuse. This inevitably has serious effects on the body, and it was apparent when he arrived at Woodhill that he was in a poor condition. Healthcare staff took prompt action to assess his clinical needs and to refer him for specialist attention.

37. On two occasions, he refused to be admitted to the Healthcare Centre, and twice he refused medical attention. Nevertheless, each of these circumstances was handled well. Nursing staff and doctors were vigilant and supportive, and ultimately successful in persuading him to accept medical intervention. Even when he wished to remain on the wing, healthcare staff attended promptly and treated his symptoms.

38. When he was admitted to hospital, it appears that the man was difficult for prison and nursing staff, as he was demanding and vocal about his need to smoke. From the entries in the bed watch logs and from conversations between my investigator and the staff concerned, it seems that the situation was handled well, and his needs were balanced against the medical advice. Staff acted professionally whilst working in a public setting.

39. The speed with which the prison acted to release the man from prison on compassionate grounds, when he was diagnosed with cancer is to be commended. The decision provided him with a degree of independence, privacy and dignity in his final days. The decision to agree temporary release also enabled his family to have more privacy.

40. Finally, I judge that the liaison between the prison and the family was sensitive and appropriate. The prison was persistent in attempting to persuade the man to name his next of kin. When they were contacted, the prison was quick to arrange transport and accommodation so his mother and sister could spend precious time with him. This must have made a difficult situation slightly easier for his family.

41. I make no recommendations in this report, but I hope the Governor of Woodhill will share my comments in para 37-40 with his senior managers and with the staff concerned. Everything in this brief report reflects well upon Woodhill.

EVIDENCE CONSIDERED

1. Bedwatch Log
2. Cell Sharing Risk Assessment
3. Clinical Record
4. Clinical Review
5. F2050 – Core Record
6. F2050A – History Sheet
7. Pre-Sentence Report
8. Prisoner Escort Record
9. Release on Temporary Licence – Risk Assessment
10. Release on Temporary Licence – Licences
11. Sentence Calculation
12. Warrants