Investigation into the circumstances surrounding the death of a man in September 2006 at a hospital on the Isle of Wight whilst a prisoner at HMP Parkhurst

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report of an investigation into the death of a man who was 40 years old, when he died in September 2006, at a hospital whilst a prisoner at HMP Parkhurst.

The man died of acute lymphoblastic leukaemia. He had been diagnosed with leukaemia in March 2006 and, although treated, it did not respond to chemotherapy. My colleagues and I would like to extend our condolences to the man's family for their loss.

This office investigates all deaths of prisoners in custody, including those due to natural causes, and this investigation was carried out on my behalf by one of my investigators. The clinical review was carried out by a doctor, on behalf of the Isle of Wight Primary Care Trust, and I am grateful for his help. Both the doctor and I are satisfied that, apart from health service transport difficulties, the care provided was equivalent to that he would have received in the community.

I commend Parkhurst for their efforts to move the man nearer to his mother's home. It is sad to report that this did not happen, despite their best efforts.

Emma Bradley
Deputy Prisons and Probation Ombudsman **March 2007**

CONTENTS

Annexes

Evidence Considered

Personal prison record and history sheet
Security file
Inmate Medical Record
Bedwatch logs
Family liaison logs
Prison wing observation records
OASys and sentence planning reports
Post Mortem

SUMMARY

The man had been in prison since 1996, and he had transferred to HMP Parkhurst on 21 November 2003. Whilst in prison, he saw medical staff for several complaints, including narcolepsy, urine infections and many instances of back pain.

In March 2006, he was diagnosed with leukaemia, and began a course of chemotherapy treatment at a mainland hospital, with support from an island hospital, and the prison healthcare team.

The man's health began to deteriorate further in August and he was not responding to the chemotherapy. He remained in hospital and was given palliative care. Parkhurst applied for release on compassionate licence, with a view to the man returning to his mother's home. Compassionate release was granted on 6 September, however due to National Health Service transport difficulties, the man could not return to his mother's home and he passed away at the island hospital.

Contact between the prison and the man's family was good and although, the man did not return to his mother's home, his family were able to be near him when he died.

HMP PARKHURST

1. Parkhurst is one of three prisons on the Isle of Wight. It is a Category B prison for long term and life sentence prisoners, and also holds those remanded by the Isle of Wight courts.

2. The healthcare provision for all three prisons is clustered and managed by Parkhurst. Parkhurst has the only in-patient healthcare facility. E3, the allocated healthcare wing and primarily manages prisoners with psychiatric illnesses. It is on the third floor with the only fire exit being the main staircase.

Bedwatch arrangements

3. Bedwatch is the term used by the Prison Service to describe when a prisoner requires in-patient treatment at an external hospital. The procedure includes a risk assessment, to decide on the level of security required for the individual prisoner. In most cases the prisoner is accompanied by two prison officers, and remains attached to one of the officers throughout, by means of an escort chain. The chain can however be removed to administer treatment or when deemed medically necessary.

Compassionate release

4. Early release from prison on compassionate grounds may be considered on the basis of a prisoner's own medical condition or as a result of tragic family circumstances. Prison Service Order 6300, states that the Secretary of State only grants compassionate release in the most exceptional cases.

THE INVESTIGATION PROCESS

5. My investigator requested all the prison records relating to the man, which included his medical records and core prison record. My investigator also visited the prison. Unfortunately the records were not received in the Ombudsman's office until five weeks after the man's death, which has delayed this investigation. The wing history files do not give much information about the man's history in Parkhurst apart from health issues, which is therefore what this report will focus on.

6. A doctor undertook the clinical review on behalf of the Isle of Wight Primary Care Trust and his report is annexed. My investigator met with the doctor to discuss the clinical review process.

7. The Isle of Wight Coroner was informed of the Prisons and Probation Ombudsman's investigation. He kindly provided my office with the post mortem report. The Coroner will receive a copy of this report when it is completed to assist him in the inquest.

8. One of my Family Liaison Officers made contact with different members of the man's family, to offer them the opportunity to raise questions or concerns for our investigation to consider. The man's sister told my Family Liaison Officer that, once the man's condition had been diagnosed, she believes that the prison did all they could to look after him. However, she did question whether his condition might have been diagnosed earlier, as he had been unwell for some time beforehand. The Clinical Review considers this question further. Copies of my report will be made available to the man's family at all stages.

9. Notices to staff and prisoners were supplied and displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters.

KEY FINDINGS

10. During the year preceding the man's diagnosis of leukaemia, he was seen regularly by healthcare staff, primarily for shoulder and back pain. An entry in the wing observation book on 7 November 2005, by his personal officer noted that the man had asked to see a doctor, but does not give a reason why. He noted further that, when the man was told he would not be able to see a doctor for two days, he was unhappy and asked to see a governor and be taken to the island hospital.

11. The man was seen the following day and was reported to be complaining of lower back pain, which was apparently travelling down both kidneys and legs. He was taken to the Accident & Emergency Department at the island hospital but, after a full examination, no diagnosis was made and he returned to Parkhurst. The man was prescribed painkillers and a muscle relaxant, in an attempt to manage his pain. He was seen by the medical officer on 9 November. At this consultation his smoking and weight were discussed, the man was considered to be morbidly obese. He was advised about these health risks and received regular medication reviews.

12. On 6 December, he agreed to go on a low fat diet, in an attempt to lose weight. Over the next three months, the man continued to receive advice about his diet and back pain. His wing records show that the back pain was affecting his job as a cleaner and by January the man had to give this job up.

13. On 23 December, the man made a formal complaint about the care he was receiving for his back pain. It is recorded that on one occasion he refused to wait to see the doctor. The nurse later went over to see the man and offered him some paracetamol, which he also refused.

14. By January 2006, the man was managing to lose weight, and had lost 15kg. He continued to be prescribed pain killers for his back pain, although there were some concerns that he was storing his medication. On one occasion the man refused to take any more of a course of treatment.

15. On 4 March, wing staff asked healthcare to see the man. He was asked to produce a sample pot of phlegm, which was noted to contain a small amount of blood. The man's blood pressure was taken and he was given more information about stopping smoking (he had been smoking when healthcare staff entered the cell). The healthcare worker told the man that he would see the doctor on Monday 6 March. The member of staff recorded in his medical record that he did not note any acute change in the man's condition.

16. When the man saw one of the prison doctors on 6 March, he was noted to be very pale and unwell. The man told the doctor that he had noticed blood in his mouth and nose over the past two to three weeks. A subsequent letter sent by the man's solicitors said that the blood loss had in fact continued over a longer period. the man was also noted to have an itchy rash on his abdomen and legs.

17. The prison doctor recommended urgent admission to hospital, and the man was taken to the island hospital, where blood tests revealed the presence of leukaemia cells. Leukaemia was diagnosed, and the man was transferred to a mainland hospital, the following day. An entry in his medical record shows that on 9 March, he had a bone marrow biopsy and ultra sound. It was agreed that depending on the results of these tests, chemotherapy would be started. Chemotherapy began on 11 March. On 15 March he was said to be tolerating it well.

18. As a result of the man's diagnosis, the prison appointed a manager to act as a liaison between the prison and his family. The contact was intermittent at first, but became more frequent as his condition deteriorated.

19. A Senior Primary Care Nurse (SPCN) from the prison visited the man in hospital on 6 April. He noted in the medical records that the man was due to have a lumbar puncture and further bone marrow biopsy. The results of the tests would determine whether he could receive the second course of chemotherapy back at the island hospital. The hospital medical team told the SPCN that it was likely that the man would need ongoing treatment for the next two years.

20. The man went back to Parkhurst on 13 April. He was allocated back on normal location, but as he was vulnerable to infection, he was not allowed contact with anyone with coughs or colds. My investigator asked why the man was not allocated to the healthcare centre; she was told that it was unsuitable. In the event of an emergency, it would have been difficult for someone of the man's size and health to be able to get out quickly. His medical record gave instructions for an immediate transfer to the mainland hospital if he became acutely unwell.

21. A letter from the mainland hospital was circulated to all staff on 14 April, which concerned the man's vulnerability to infection and the need to ensure that any risk was minimised. The same day a dietician was contacted about provision of a neutropenic diet. The diet helps protect individuals with a weak immune system, from some bacteria and harmful organisms found in food. It was readily available as prisoners have several daily menu choices which are pre-ordered and a neutropenic diet can be constructed from these.

22. On 8 May, the man was admitted to the mainland hospital again. Between this date until the day he died, he spent considerable periods of time, in both the mainland hospital and the island hospital and his mother was able to visit him in both. There was an occasion however, on 12 July when the man refused to go from the prison to the island hospital, saying that he would only go to the mainland hospital. He was advised of the consequences of not attending the hospital appointment, and later changed his mind. Healthcare staff believe that he initially refused, because he was unable to smoke at the island hospital, whereas he was occasionally allowed to smoke at the mainland hospital.

23. Throughout July, correspondence between the mainland hospital and the prison shows that the man's white blood count was too low for chemotherapy to take place. He continued to have blood tests, which were unsatisfactory, and on 2 August he was readmitted to the mainland hospital. On 7 August, he was deemed well enough to continue the treatment, although he was in a lot of pain with sciatica. The hospital contacted the prison on 12 August to inform them that the man felt unwell and was to have a blood transfusion, platelets and a course of antibiotics. Chemotherapy was stopped and a morphine pump was put in place, to relieve his pain. The bedwatch logs show that the man was informed on 21 August that his treatment had not been effective and his condition was terminal.

24. The man returned to the prison the next day. His ongoing care was to be given by the island hospital, with weekly blood and platelet transfusions. On this occasion he was located in the healthcare centre.

25. After just two days back in the prison, the man returned to the island hospital, but this was not noted in the medical records. There is an entry on 30 August, which notes that the man's mother wanted to discuss his care plan with her own doctor. The entry also records that she hoped her son could be discharged into her care, at her home. The following day, the doctor at the island hospital gave a prognosis that the man had two weeks to live, and said that he too wanted to discharge him to his mother's home or to a nearby hospital.

26. The SPCN noted in the medical records on 4 September 2007, that the man was receiving palliative care. Parkhurst applied for his early release on compassionate grounds, which was to be considered by National Offender Management Service (NOMS) on behalf of the Secretary of State. Pending this decision, it was decided by the hospital and prison, that the man should remain in hospital. This would facilitate an easier transfer to a hospital or hospice closer to his mother's home. This was explained to the man.

27. There is conflicting evidence about the man's early release. It is clear that NOMS approved his compassionate early release on 6 September, but the bedwatch officers believed that it was refused and he was to be released on temporary licence. They informed the man to this effect. There are no entries in the man's medical records regarding the arrangements being made for his release. The information has had to be gathered from various other sources. However, there is a release pack amongst the man's prison documentation, which included information on benefits and community care.

28. On 7 September, it was recorded that the man was due to transfer to his mother's home that day. When the prison telephoned the hospital to find out the time of transfer, they were told that the ambulance service refused to transport him as he was not going to another hospital. However, other evidence, including a summary from the hospital consultant and discussion with the head of prison healthcare,

suggests that the relevant health authorities in Wales were unhappy to take responsibility for the man's care.

29. An entry in the man's prison medical record makes it clear that the prison did not think that the ambulance service responded compassionately. Enquiries were made about other arrangements. The St John's Ambulance Service in Newport was approached, but was unable to help for four days. The prison also tried to arrange transport by a private car, accompanied by two members of staff and a trained nurse. However, as the man was very weak, it was agreed that he would not be able to manage such a long journey in a car. The prison also liaised with the local hospice, who were prepared to admit the with a view to transferring him to the area where his mother lived when his health stabilised. However, the man and his mother wanted him to return straight to her home.

30. On 8 September, plans were made for a private ambulance to transfer the man to his mother's home, where the family doctor was to meet him. The medical records do not show why this did not happen, but an entry in the bedwatch log indicates that the relevant health authority could not provide the necessary support at her home over the weekend. It remained unlikely that the man would return to his mother's home until 11 September.

31. The Prison Family Liaison Officer, contacted the man's family to inform them of the difficulties and suggested that, in the light of his deteriorating health, they may wish to be with him at the hospital. Permission was given by senior managers at the prison to assist the family with some of the costs associated with their travel and accommodation. The man's family arrived at the hospital late that evening. Although they were not at his side, they were nearby when the man passed away at 1.00am on 10 September.

32. Parkhurst contributed to the cost of the man's funeral and held a memorial service locally for those staff and prisoners unable to attend.

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical Care

33. The man developed a terminal illness and, after initial treatment with chemotherapy, palliative care was all that could be provided for him. After he was diagnosed with the lymphoblastic leukaemia, he was mainly cared for in outside hospitals, until he died on 10 September 2006.

34. The clinical reviewer has noted that had a more robust care plan between the specialist health providers and the prison been put in place, it might have meant that they could have planned more effectively to enable the man to return to or near his mother's home as per their wishes. This apparent lack of effective and timely care planning meant that when they wanted to transfer the man to his mother's home, they were unable to secure transport before he died.

    Healthcare providers should ensure that a robust multi-disciplinary care plan is in place for all terminally ill prisoners.

Communication

35. Throughout the man's hospital stays the communication between the hospitals and the prison was generally good. The prison's Family Liaison Officer worked well to keep the family informed and listen to their concerns. However, the records about early release and the man's move to his mother's home are poor. The information is held in different places and confusing, with different staff given and passing on different information. A detailed multi-disciplinary care plan, as proposed by the clinical reviewer, would help to address this issue.

    All staff should be reminded of the need to keep accurate and contemporaneous records to ensure effective communication.

GOOD PRACTICE

The following were considered to be areas of good practice.

1. When the man was initially diagnosed with leukaemia, the prison appointed a Family Liaison Officer and the records indicate that the family were very grateful for the support and assistance they received.

2. The prison provided further support for the man's family by meeting some of their travel and accommodation expenses, and the funeral costs.

3. Prison and Healthcare staff made several attempts to ensure that the man was able to die close to his family and with dignity. It is sad that, despite their extensive efforts, he was not able to return to his mother's home.

4. A release pack including information on benefits and community care was prepared for the man.

5. RECOMMENDATIONS

1. **Healthcare providers should ensure that a robust multi-disciplinary care plan is in place for all terminally ill prisoners.**

   Parkhurst have accepted this recommendation and a protocol is being drawn up in conjunction with the PCT and implemented on an individual basis.

2. **All staff should be reminded of the need to keep accurate and contemporaneous records to ensure effective communication.**

   Parkhurst have accepted this recommendation and staff will be reminded and trained in appropriate recording systems.