Circumstances surrounding the death in March 2007 of a man who had been a prisoner at HMP Woodhill

Report by the Prisons and Probation Ombudsman for England and Wales

September 2007

This is the report of an investigation into the death of a man who had been a prisoner at HMP Woodhill. The man died from apparently natural causes on 20 March 2007 at a local hospice. He was 43 years old. At the time of his death, the man had been released on temporary licence (ROTL) and therefore was no longer in custody.

I would like to extend my condolences to all those touched by the man's death.

This investigation was undertaken by one of my investigators. In addition, a doctor was asked by Milton Keynes Primary Care Trust to undertake a review of the man's clinical care. Not for the first time, I must say how much I appreciate her help. Thanks are also due to the Governor of HMP Woodhill and his staff for their assistance.

The clinical reviewer draws attention to a number of issues, and there are clearly lessons to be learned in terms of the clinical management of patients transferred from one prison to another. I endorse all but one of the recommendations made in the clinical review and urge the Primary Care Trusts and prisons to develop an action plan to address these as speedily as can be done.

As well as the family and Coroner, and the other normal recipients of my reports, I am sending a copy to the Governor of HMP Coldingley. This is in view of the significant role played by the man's friend who is currently a prisoner in that establishment.

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 the investigation.

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

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SUMMARY

The man was born in 1964. He was 42 years old when he died on 20 March 2007 at a hospice.

The man had been received into custody on 21 September 2006 as a remand prisoner. He was sentenced to 20 months imprisonment in November 2006 at Lewes Crown Court. The man was initially held at HMP Lewes before being transferred to HMP Woodhill on 8 February 2007.

On 7 March 2007, the man was diagnosed as having cancer of the stomach. His prognosis was poor and he was told that he had less than six months left to live.

On 14 March 2007, the man was transferred to a hospice and it was here that he passed away six days later.

The clinical review finds fault with a number of aspects of the man's clinical care. I have endorsed five of the six recommendations in the clinical review (I believe that the other recommendation may be otiose and have re-worded its terms).

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.

2. The Milton Keynes Primary Care Trust asked a doctor to carry out a review of the man's clinical care. As on a number of previous occasions, I am grateful to her for undertaking the review so speedily.

3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

4. One of my Family Liaison Officers contacted the man's friend, who is in custody at HMP Coldingley. The man had not maintained contact with his family and the prison was unable to locate any family members. Prior to his death, the man had asked for his friend to be the only person who should be informed of his death. The friend was given the opportunity to discuss the purpose of the investigation and indicate any concerns or questions that he would like to be addressed. When my investigator and Family Liaison Officer met with the friend, he raised two main issues relating to the man's care:
   - Why was the man's condition not diagnosed earlier?
   - Why was he transferred from Lewes to Woodhill, a category A prison, given his poor state of health at this time?

   The friend also spoke about the inconsistency in approach from prison staff with regard to the man's wish that he should be treated as next-of-kin. My investigator and the clinical reviewer have explored these points and I hope that this report provides the friend with answers to his questions.

5. My investigator discussed aspects of the man's treatment with staff at both Woodhill and Lewes.

HMP WOODHILL AND LEWES

HMP Woodhill

6. Woodhill is a core local prison located on the outskirts of Milton Keynes. It is one of eight high security prisons holding category A prisoners. Its principal role is to serve the courts in the counties of Northamptonshire, Hertfordshire, Buckinghamshire and Bedfordshire. Woodhill holds a maximum of 807 prisoners in its various units and houseblocks.

7. Woodhill underwent a full inspection by HM Chief Inspector of Prisons, Ms Anne Owers, in February 2002. An unannounced follow-up inspection took place in August 2005. In her report of the follow-up inspection, Ms Owers said the prison had made progress in its induction arrangements. However, she noted that the regime in the healthcare centre had deteriorated (she said this was being addressed by the Primary Care Trust).

8. Healthcare in Woodhill is the responsibility of the Milton Keynes Primary Care Trust. The facilities include a 24 hour in-patient unit and a visiting specialist service. Prisoners have access to a doctor 24 hours a day. Those with more serious conditions or clinical needs are referred to the local hospital.

HMP Lewes

9. Lewes is a Victorian local prison built in 1853. It houses trial/remand and sentenced adults and a small number of young offenders committed from local courts in Sussex. Lewes has an operational capacity of over 500 prisoners.

10. Lewes underwent a full inspection by Ms Owers in March 2003, with an unannounced follow-up inspection in August 2005. In her report of the follow-up inspection, Ms Owers said the healthcare centre had been refurbished. The centre now provided a total of 19 bed spaces and there was a large association room. Ms Owers also said that Lewes had sustained the respectful staff–prisoner relationships that she had identified in her full inspection.

11. The provision of healthcare within HMP Lewes is the responsibility of East Sussex Downs and Weald Primary Care Trust. Primary care is delivered by medical staff and registered nurses, and the healthcare centre has the opportunity to draw upon the broader expertise of a range of healthcare services within the local NHS Trust.

KEY EVENTS

12. During the health screening procedure on reception at HMP Lewes, it was noted that the man had an alcohol and drug addiction problem. He undertook an alcohol detoxification programme.

13. On 22 January 2007, the man was examined by a doctor in Lewes as he was suffering from daily vomiting and abdominal pain. A referral was made for an endoscopy (this is where a tube-shaped instrument is inserted into a cavity in the body to investigate and treat disorders). On 31 January, he was deemed fit to transfer to HMP Woodhill.

14. The man transferred to Woodhill on 8 February. When he arrived at the prison a reception health screen was not carried out, but the man did not raise any health concerns

15. On 1 March, the man was seen by a prison doctor, who noted that there was a mass on his abdomen. The prison doctor considered that this could be a gastric tumour and made an urgent Cancer Two Week Wait referral to outside hospital.

16. On 5 March, the man saw another prison doctor. The man complained of having a six month history of upper abdominal pain and vomiting and a two month history of significant weight loss. The man also said he had vomited blood (haematemesis) during the previous two days. An examination revealed an abdominal mass which was tender to touch and which measured approximately ten centimetres. It was decided that the man should be immediately admitted to outside hospital.

17. On 7 March, the man had an endoscopy which revealed that he had cancer (carcinoma) in his stomach. A diagnosis was made of an advanced gastric cancer. The man was told that his prognosis was poor and that he had less than six months to live.

18. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. On 12 March, the man was discharged from hospital back to the healthcare centre at Woodhill.

19. On 13 March, the man requested that family and friends should not be informed of his health problems as he was struggling to come to terms with them. Woodhill made arrangements to transfer the man to a hospice for palliative care. The Head of Healthcare at Woodhill spoke to a doctor at the hospice and gave him an outline of the man's clinical details.

20. On 14 March, the man was granted release on temporary licence (ROTL) and was transferred to the hospice. After the man arrived at the hospice, prison staff withdrew. Subsequently, contact was maintained between the prison and the hospice by telephone. The man passed away at 1:20am on 20 March at the hospice.

21. After the man's death the prison appointed a family liaison officer. In the absence of any family, she maintained contact with the man's friend and assisted with the arrangements for the funeral. The prison chaplain conducted the man's funeral and held a memorial service at Woodhill.

22. A post mortem was not carried out. The man died from a diagnosed condition after being released from custody, and there was no reason to believe untoward circumstances were associated with his death. The inquest into the man's death, held on 29 June 2007, returned a verdict of natural causes.

Concerns raised by the man's friend

23. After the man passed away, Woodhill tried unsuccessfully to locate members of his family. The contact information given by the man was out of date and the prison was unable to locate any of the man's relations. Before his death, the man had asked that his friend be informed that he had died. The prison therefore treated his friend as next of kin and involved him in the arrangements for the man's funeral. My office also informed the friend about the investigation into the circumstances surrounding the man's death and a meeting was arranged with my investigator and Family Liaison Officer.

24. The friend recalled that when he saw the man in the late summer of 2006 he appeared to be very ill. The man was constantly vomiting and his health had noticeably declined since he had previously been at Lewes. The man was seen by one of the prison doctors and received treatment for a stomach bug. The friend questioned why healthcare staff did not pick up on the seriousness of the man's condition at this time.

25. When the man returned to Lewes in September 2006, he was put on the same wing as his friend. The man's health had not improved and he still looked very unwell. The man had lost a significant amount of weight and was being given nutrient drinks to help stabilise this. The man told his friend that he was really worried about his health. Another friend of the man had recently been diagnosed with cancer which had made him think seriously about his own health. The man was particularly concerned, having been a heavy drinker for 20 years, and he told his friend that he needed to get it sorted.

26. The man transferred to Woodhill shortly after this on 8 February 2007. Both he and his friend were surprised as Woodhill is a high security prison. The friend said the man appeared seriously ill at this time and was in no fit state to be moved. The friend also felt that transferring the man to a high security prison would have caused him undue stress and worry at a time when he was already vulnerable. The friend questioned why the decision was made to transfer the man from Lewes to Woodhill, given his poor state of health at this time.

27. The friend spoke very highly of the help and support he received from the family liaison officer at Woodhill. He felt that he would not have been permitted to attend the man's funeral if it was not for the prison family liaison officer's persistence and assistance. The friend said that this was in direct contrast to the lack of support he had received from Coldingley. He felt that Coldingley chose not to recognise that he was being viewed as next of kin by Woodhill and did not treat him accordingly. The friend told my investigator that he had made a formal complaint about these matters to the Governor of Coldingley.

28. In an interview with my investigator, the Head of Healthcare at Lewes said that the man's medical records gave a different account of what happened whilst he was at Lewes. The Head of Healthcare said she did not recall meeting the man whilst he was a prisoner at Lewes. There was no mention in the records of the issues raised by the friend when the man was examined by the prison doctor. The Head of Healthcare confirmed that the entry by a General Practitioner in the man's medical record on 22 January 2007 stated that a referral should be made for an endoscopy, that an ant-acid preparation should be continued to be administered and that a blood test should be carried out.

29. When she was interviewed, the Head of Healthcare at Lewes was asked why the man had been allowed to transfer when he was awaiting an appointment for an endoscopy. She said that a medical hold on transfer would not have been successful as the man did not have a diagnosed condition, was not displaying serious symptoms and was not receiving treatment. She gave an example of a successful medical hold where a patient was already receiving treatment for liver problems and hepatitis.

30. The Head of Healthcare at Lewes also pointed out that there was a high throughput of prisoners at Lewes due to the nature of the offences committed by prisoners who are referred to the prison.

31. The prison family liaison officer at Lewes told my investigator that her understanding was that the man was transferred due to overcrowding at Lewes. Lewes is currently building a new wing. She added that, although Woodhill does hold category A prisoners, its key function is to be a local prison so the man's transfer would have had no link to the category A aspect of the prison.

32. Prison Service Order (PSO) 3050 on Continuity of Healthcare for Prisoners was issued in February 2006. Chapter 5 of the PSO is devoted to Transfer of Prisoners and says at 5.3:

> ''Current healthcare needs [must be] assessed and continuity of care ensured when prisoners are transferred between establishments.''

Chapter 5.12 of the PSO points out that, ''patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer.'' Chapter 5.25 of the same document sets out the responsibilities of the prison receiving newly transferred prisoners. It is expected that the healthcare team will, ''make such enquiries and undertake such examinations as appear to be appropriate in all the circumstances as set out in the General Medical Service contract.''

CLINICAL REVIEW

33. As noted earlier, a review of the man's medical care was undertaken by a doctor on behalf of Milton Keynes Primary Care Trust. .

34. The clinical reviewer concludes that it is not possible to draw firm conclusions about whether the care received from Lewes contributed to the man's death or not. The clinical reviewer also could not ascertain whether there was a delay in either the diagnosis of the man's condition or his subsequent referral to secondary care services

35. The clinical reviewer notes that, other than a referral letter for an endoscopy from Lewes, there did not appear to be any other clinical records. The clinical reviewer could not find any requests for blood tests which she would have expected to accompany a request for an endoscopy. The clinical reviewer draws attention to the fact that there was no record of a review of the man's symptoms after the referral by Lewes for an endoscopy appointment. She also notes that the endoscopy referral from Lewes was undated. Three recommendations are directed at Lewes:

    Prison healthcare should review their system of record keeping. It may be appropriate to revise the policies on clinical record keeping and to refresh staff knowledge about these policies.

    Prison healthcare may find it a useful Clinical Governance initiative to introduce medical records audits on a regular basis to assure themselves of the quality of record keeping.

    Prison healthcare should review their use of blood tests to aid diagnosis with particular focus on any blocks there may be in the system.

36. The clinical reviewer notes that a health screening did not take place when the man transferred to Woodhill. The clinical reviewer draws attention to the fact that the medical records do not make it clear when he moved.

    Prison healthcare (at Woodhill) should review their systems to ensure that all new prisoners receive a health screen.

37. The clinical reviewer judges that the transfer arrangements between the two prisons were not robust as the transfer of care did not include reference to the ongoing endoscopy referral. However, the clinical reviewer says that Woodhill acted promptly once the seriousness of the man's problem was recognised.

38. The clinical reviewer recommends that there should be a national review of transfer of care arrangements between prisons to ensure continuity of care, particularly when a referral to hospital has been made. (For the reasons I give at paragraph 43, I think this recommendation may have been overtaken by events. I offer an alternative recommendation on p.14 of this report.) The clinical reviewer also recommends a review of medical record keeping, in particular to ensure that the national Continuous Clinical Record sheets are fully completed.

    There should be a review of medical record keeping. There is a box on the national Continuous Clinical Record sheets headed 'Establishment and date'. This box is often used to record the date and rarely used to record the establishment. It would be helpful if, at the top of each sheet, the establishment was recorded.

39. The clinical reviewer also commends Woodhill for their awareness and use of the NHS Cancer Two Week Wait referral system for suspected cancers. I too am pleased to note that Woodhill has embraced this approach.

CONCLUSION

40. The man arrived at Woodhill in February 2007 and died from natural causes just over a month later. After his transfer to Woodhill, the man was diagnosed with cancer and was told that his prognosis was very poor.

41. The man was transferred from Lewes before his condition was diagnosed. However, a health screen interview was not carried out by Woodhill after he transferred. Moreover, the outstanding investigations into his health issues were not highlighted by Lewes before he transferred and were not initially discovered by Woodhill. I appreciate that in this case earlier diagnosis may not have delayed the man's death. Nevertheless, I do feel that action to identify what was wrong with him should have taken place sooner.

42. In the light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was not entirely satisfactory. I have endorsed five of the six recommendations from the clinical review. These need to be addressed by both East Sussex Downs and Weald and Milton Keynes Primary Care Trusts in partnership with the Governors of Lewes and Woodhill respectively.

43. In her review, the clinical reviewer makes a recommendation that there should be a national review of transfer of care arrangements to ensure continuity of care, particularly when a referral to a hospital has been made. In my view this is already covered in chapter 5 of PSO 3050 and therefore I make an alternative recommendation:

    I recommend that the two Primary Care Trusts and the Governors of Lewes and Woodhill review their current compliance with chapter 5 of PSO 3050.

RECOMMENDATIONS

For HMP Lewes

1. **Prison healthcare should review their system of record keeping. It may be appropriate to revise the policies on clinical record keeping and to refresh staff knowledge about these policies.**

2. **Prison healthcare may find it a useful Clinical Governance initiative to introduce medical records audits on a regular basis to assure themselves of the quality of record keeping.**

3. **Prison healthcare should review their use of blood tests to aid diagnosis with particular focus on any blocks there may be in the system.**

   Recommendations 1 – 3, directed at HMP Lewes, have been accepted subject to the agreement of the PCT.

For HMP Woodhill

4. **Prison healthcare should review their systems to ensure all new prisoners receive a reception health screen.**

   This recommendation has been partially accepted on the grounds that the man was not a new reception prisoner, but had been transferred in from another establishment. The current procedure is for all new prisoners into reception to receive a full health screening.

For the Governors of Lewes and Woodhill

5. **I recommend that the two Primary Care Trusts and the Governors of Lewes and Woodhill review their current compliance with chapter 5 of PSO 3050.**

   Accepted by both establishments. The Governor of Woodhill and the local PCT will review current compliance with PSO 3050 (Continuity of Healthcare for Prisoners).

For the Prison Service nationally

6. **There should be a review of medical record keeping. There is a box on the national Continuous Clinical Record sheets headed 'Establishment and date'. This box is often used to record the date and rarely used to record the establishment. It would be helpful if, at the top of each sheet, the establishment was recorded**