The death in custody of a prisoner

HMP Whatton – 24 April 2004

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

July 2004

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Whatton on 24 April 2004.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to the Prisons and Probation Ombudsman (PPO) to bring independence and greater consistency to the task.

In this case a member of the PPO's staff has carried out the investigation. An independent clinical review was commissioned from the Director of Public Health at Rushcliffe Primary Care Trust.

The prisoner died in Queens Medical Centre (QMC), Nottingham, during his treatment for an inoperable aggressive pancreatic tumour. He was serving a five-year prison sentence at Whatton Prison at the time of his death.

My colleagues and I would like to extend our condolences to the prisoner's family for their loss. I would also like to thank the acting Governor in charge of Whatton Prison at the time of my investigator's visit, and the other members of his staff who assisted us. My investigator found staff especially helpful. In particular, all the documentation he required had already been gathered together for him.

Stephen Shaw
Prisons and Probation Ombudsman

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Summary

The prisoner died at the age of 58 at Queens Medical Centre (QMC), Nottingham, while undergoing treatment for an aggressive pancreatic cancer. He was serving a five-year prison sentence at Whatton Prison. His death was not connected to the fact that he was in prison or to the level of care that he received there.

The prisoner was a person with multiple medical problems, including jaundice, DVT, multiple pulmonary emboli, pneumonia and pancreatic cancer.

This was the prisoner's first conviction and, though he was not familiar with prison life, he appeared to settle well. The prison describes him as a quiet but determined man, with good custodial behaviour.

The report includes one recommendation.

Background

The prisoner was born in December 1945 and was 58 years old when he died on 5 April 2004.

He served as a Paratrooper in the British Army, but was discharged in 1971 following an accident in which he sustained serious burns.

The prisoner had been married three times, but was living with another partner at the time of his arrest. He was the father of seven children – two girls and five boys. On reception to prison the prisoner gave his next of kin as his second wife.

This was the prisoner's first conviction and was imposed on 16 October 2002 at York Crown Court. He was given a five-year prison sentence for rape.

At the time of his death, he had been in Whatton Prison since 19 December 2002.

The prisoner was well known to the staff at Whatton Prison, and particularly to the healthcare staff who had dealt with many of his physical problems.

The prisoner was admitted to the QMC on 16 January 2004, following complaints of abdominal pains, indigestion and jaundice.

In the meantime the QMC treated the prisoner for two episodes of chest infection. He was subsequently re-admitted to hospital in late February with a further chest infection and then developed a blood clot on the lung.

During this time, he was found to be suffering from pancreatic cancer that was ultimately deemed inoperable. He remained in hospital until his death on 24 April 2004.

Investigation process

All the indications were that this was a death from natural causes. The Ombudsman's Terms of Reference permit in these circumstances, that it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than a full investigation. My approach in cases of apparent natural cause deaths has been to conduct an initial review to determine if a full investigation is justified. In this prisoner's case, I decided that the circumstances did not require a full investigation.

I did so after the investigator visited Whatton Prison and had a very helpful discussion with the Deputy Governor[1] as well as the Healthcare Manager. The investigator recommended that a full investigation was not warranted and I agreed that this procedure should apply in this case.

The investigator visited the Unit where the prisoner spent much of his time in prison. He met the Chairman of the local Prison Officer's Association (POA), and the Chair of the Independent Monitoring board (IMB). Neither the POA nor the IMB had any issues they wished to draw to the investigator's attention.

The investigator was given access to all the prisoner's prison records, including his medical records, and was given copies of everything that was required.

The Deputy Governor had spoken to his ex-wife[2] the recorded next of kin, and explained that there would be an investigation. His ex-wife was sent a letter by the investigator inviting her to get in touch to make any comments or ask questions if she wished. She wrote to me, with copies of entries in her husband's diary. This is a record kept by the prisoner regarding his medical treatment.

The Director of Public Health, of the Rushcliffe Primary Care Trust carried out the clinical review. A medical report sent to him, from the person who was in charge of the prisoner's care at QMC, is also available.

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[1] The Governor was absent from the establishment at the time of the visit.

[2] The second of the prisoner's three wives.

The Events Leading up to the prisoner's Death

The prisoner was admitted to QMC on 16 January 2004, following complaints of abdominal pains, indigestion and jaundice. At the time, it was thought that the jaundice could be caused by an obstruction due to cancer, but further tests were required.

In the meantime, the QMC treated the prisoner for two episodes of chest infection. He was not happy about his treatment at the QMC, as he felt he needed further hospital treatment. However this would have been for his chest and not for the troubles in his stomach.

The prisoner was subsequently re-admitted to hospital in late February with a further chest infection and then developed a blood clot on the lung.

During this time, the prisoner was found to be suffering from pancreatic cancer, which at first was thought to be operable and was admitted in early April to the QMC for surgery. Shortly after this, the prisoner's cancer was deemed inoperable and he remained in hospital until his death on 24 April 2004.

Throughout these periods at the QMC, the prisoner was still in prison custody. Due to the nature his offence, he was not eligible for Release on Temporary Licence. However at the time of his death, the prison were attempting to secure a compassionate release, possibly to a hospice.

Regrettably he died before a decision was reached.

Post Incident Response

All the necessary information was gathered together for the purposes of the investigation, and arrangements were made for the investigator to see the relevant members of staff so that we could satisfy ourselves as to the way the prisoner had been cared for.

The Duty Governor of the prison broke the news of the prisoner's death to his ex-wife, whom he had named as his next of kin. This seems to have been appropriately and sensitively handled.

As the prisoner died in hospital of cancer, the hospital did not appreciate the significance of informing the Coroner that he was in prison custody. This was an oversight from the Hospital that the Coroner has addressed.

An autopsy was not carried out for the same reason.

The prison informed the Coroner by letter on 26 April 2004. This letter was returned some weeks later as undelivered on 26 May 2004 and a copy was immediately re-sent. The Coroner's Office then contacted the prison on 1 June 2004 and an explanation was given. The coroner then contacted the prison on 3 June 2004 indicating that he was not intending to hold an inquest. This was for the sake of the

family. The funeral had taken place, and the Coroner was satisfied with the hospital's opinion on the cause of death.

Level of Compliance

Standards of healthcare in prison are intended to mirror those available in the outside community.

The prisoner's prison records indicate that, while in custody he was being given an appropriate level of care, and his medical and social needs were recognised and adequately dealt with. The medical aspects of his care are described in the independent clinical review. The Director of Public Health concludes that due care was given to the prisoner in the diagnosis and treatment of what turned out to be a terminal illness.

The prison was compliant with the current version of PSO 2710 – Follow Up to Deaths in Custody, as it does not specify that establishments telephone Coroner's offices when prisoners die in outside Hospitals. However, despite an early attempt to inform the Coroner by letter, the Coroner was not aware that the deceased was a prisoner at the time of his death for about six weeks.

Apart from the communication breakdown between the Prison and the Coroner, the post-incident response was fully compliant with Prison Service instructions and policies.

Findings

The prisoner died of natural causes as a result of an aggressive cancer of the pancreas. The decline was rapid, with 3 months from diagnosis to death. This appears to be entirely consistent with this type of cancer.

The prisoner was not happy about his treatment at the QMC, as he felt he needed further hospital treatment. However, the independent clinical review concludes that this would have made no difference to the outcome, as this centred on his chest, and not the stomach.

The Coroner was not aware that he was a prisoner at the time of his death. This clearly compromised the Coroner's position regarding a post mortem and an inquest.

Conclusions

The prisoner was well cared for in Whatton Prison, and in my judgement received an equivalent level of healthcare when he was there as he would when he was outside in the community.

The prison attempted to confirm details with the coroner by letter. Unfortunately this letter was returned, but a second letter did reach the Coroner. Good practice would be to report such a death by telephone, and confirm by letter.

Recommendations

I recommend that, at an appropriate time, PSO 2710 be amended to remind governors of the need to inform Coroners of the deaths of prisoners who die in outside hospitals.

Good Practice

A full investigation might have revealed aspects of the prisoner's treatment that amounted to good practice. In this case, where the death was clearly due to natural causes, the more limited type of investigation that has been conducted has not brought these to light.