# Investigation into the circumstances of the death of a man in hospital in September 2006, whilst a prisoner at HMP Dartmoor

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

**February 2007**

This is a report into the death of a man who died on the morning of 2 September 2006 hospital, whilst a prisoner at HMP Dartmoor. He had been found unconscious on the floor of his cell a few hours earlier. The man was 59 years old and had been suffering from cancer

The man was serving a sentence of life imprisonment imposed in1982 for serious sexual offences. He had served two previous custodial sentences for similar offences.

I extend my sincere condolences to the man's family and friends for their loss.

This investigation was undertaken by a colleague. I would like to thank the Governor of Dartmoor, and her staff for their help and assistance in this investigation. I am also grateful to South Hams and west Devon Primary Care Trust who was commissioned to undertake a clinical review into the man's medical care.

Including the recommendations in the clinical review, I make eight recommendations relating to healthcare issues and commend five areas of good practice. The final report notes that the Devon Primary Care Trust providers of healthcare services in Dartmoor have accepted the recommendations.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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**Prison and Probation Ombudsman** **February 2007**

**CONTENTS**

Summary

The Investigation Process

HMP Dartmoor

Key Events

Issues

Recommendations

## SUMMARY

The man died at 8.55 am on 2 September 2006 in hospital. He had been found unconscious in his cell at HMP Dartmoor some four hours earlier.

He was serving a sentence of life imprisonment imposed in 1982 at Crown Court. In 1999, he transferred to HMP Dartmoor from HMP Maidstone and was resident on the Vulnerable Prisoners Unit (VPU).

In 2004, the man was diagnosed with bowel cancer. He was treated in hospital for his illness. Treatment included surgery and chemotherapy. In April 2006, while being treated for another condition, it emerged that the cancer had returned. His condition then rapidly deteriorated. In June 2006, it was confirmed that the man was suffering from metatasic malignant disease (cancer) and his prognosis was described as poor.

When he was not receiving hospital treatment, the man was cared for, physically and emotionally, on the wing at Dartmoor until the day he died. (Dartmoor does not have a 24 hour healthcare unit.) He remained in his cell and was assisted in his daily and palliative care by prison staff, the wing nurse and fellow prisoners. The man had asked not be transferred to HMP Exeter where there is 24 hour healthcare. It was his wish to remain at Dartmoor with his friends and in a community with which he was familiar.

An application for a compassionate discharge was under consideration when it became obvious that the man's condition was deteriorating very quickly. The collection of reports and evidence to support the application was underway when he died. Given the man's offences, prison security information and psychiatrist's reports, his release on compassionate grounds may not have been appropriate in any event.

## THE INVESTIGATION PROCESS

The investigation into the man's death was opened by a colleague on 18 September 2006 when she visited Dartmoor. She met with the Governor a Senior Manager and a Senior Officer (the latter representing the local branch of the Prison Officers' Association). Notices and terms of reference had already been received at the prison by post.

On 15 September, my colleague had spoken to the chair of the prison's Independent Monitoring Board (IMB).

My investigator reviewed the man's prison file and obtained a copy. A copy of his medical records was also made available.

A review of the healthcare the man received was carried out at the direction of South Hams and West Devon Primary Care Trust (PCT).

On 19 September, my investigator visited the VPU wing where the man had spent his last few years in Dartmoor. She later spoke to healthcare nurse manager, a member of the chaplaincy team and an Officer from the VPU.

One of my Family Liaison Officers, wrote to the man's family informing them of the investigation. The family has not raised any specific issues they wish to be considered.

No matters were raised by any of the man's friends on the VPU at Dartmoor.

## HMP DARTMOOR

Dartmoor is a category C training prison with an operating capacity of 625. The prison was last inspected by HM Chief Inspector of Prisons in February 2003.

Dartmoor works collaboratively with HMP Channings Wood and HMP Exeter as part of the Devon Prisons Health Partnership. There is no in-patient facility within the healthcare unit. A dedicated nurse is based in the VPU on F wing.

South Hams and West Devon PCT have had the commissioning responsibility for Dartmoor's healthcare since April 2003. The prison's healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by Devon Doc, an out of hours service commissioned by the PCT.

Two other prisoners have died at Dartmoor since I became responsible for investigations into all deaths in prison custody in April 2004. One death was self inflicted and the other was due to natural causes.

## KEY EVENTS

### Events leading to the death of the man

The man first became unwell in 2003 with pain in his leg and diarrhoea like symptoms. He was seen regularly by the medical officer and prescribed appropriate medication. The man was referred to hospital for an out-patient appointment in the gastroenterology department.

In January 2004, the man saw a consultant enterologist. Further tests and investigations were undertaken. On 23 August that year, a letter to the medical officer at Dartmoor from the consultant indicated that the man had been diagnosed with colorectal cancer in his ascending colon (bowel cancer). A computerised tomography (CT) scan was requested. On 16 September, his (CT) scan confirmed bowel cancer.

On 21 October, the man was admitted to hospital and underwent surgery to remove a small section of his large intestine. He was escorted by two officers and remained under escort during his stay in hospital. He was discharged to Dartmoor on 29 October.

The surgery was followed by chemotherapy which the man received at the hospital on prison escort. On 31 December, he was visited on the VPU wing by a Macmillan nurse who offered advice and support.

The man attended the hospital on 19 February 2005 as an emergency admission with a painful left leg. A deep vein thrombosis (DVT) was diagnosed and he was discharged to Dartmoor on 20 February with appropriate medication.

On 2 April, an entry in the man's medical notes recorded that he had discovered a lump in his thyroid. This was diagnosed as a cyst (a small swelling). A transcutaneous electronic nerve stimulation (TENS) machine was ordered by healthcare to aid his pain relief. (This device relieves pain by providing a distracting electronic stimulation to the surface nerves in the affected region.) On 20 April, a Macmillan nurse reviewed the man's care and offered support.

A bone scan undertaken at the hospital on 26 May indicated no evidence of cancer cells, although it did show features suggestive of degenerative disease in the man's back. On 4 July, a letter from the Macmillan nurse specialist recorded that he did not have any identified palliative care needs at that time.

The man underwent an x-ray on his abdomen on 11 October. The results of this x-ray showed 'no abnormality noted'. In December, he was seen at the hospital in the dermatology department for a swollen and painful finger. This was treated with appropriate medication and the man was referred to a plastic surgeon.

The man attended the hospital on 25 January 2006 with a suspected DVT in his left leg. The condition was diagnosed and he was discharged with medication and a request for healthcare to take regular blood tests from the man to keep a check on his blood clotting.

On 26 April, the man saw the consultant oncologist at the hospital and it was diagnosed that his cancer had returned. He was still receiving treatment for his DVT. The suitability of chemotherapy was discussed by consultants at the hospital. On 9 June, the medical officer started the man on a morphine based medication to help with pain control. When he attended an out patient appointment at the hospital on 26 July, the results of a CT scan showed that the cancer had progressed. The possibility of chemotherapy was again discussed. The man's medical notes record that on 28 July he was advised that chemotherapy might not be appropriate as it would make him ill and might even shorten his life.

On 31 July, the man was appearing very jaundiced (yellow colouring on the skin). A referral for him to attend an Acute Jaundice Clinic was sent to the hospital. On 3 August, healthcare staff contacted Macmillan nurses for support and advice. The following day, the man expressed his wish to remain at Dartmoor although his condition was deteriorating. He felt comfortable with familiar prison staff and friends on the wing. He did not wish to be transferred to HMP Exeter where there was 24-hour healthcare.

On 8 August, the man attended the Acute Jaundice Clinic and his illness was reviewed. Observations and tests were carried out. By 15 August, he was very unwell. He was not eating but taking fluids. The medical officer noted that the man was too unwell to be adequately looked after at Dartmoor and should be transferred to Exeter. The medical officer also recorded in the man's notes that he was refusing to be transferred. Two days later, the medical officer noted that wing staff felt they could manage The man on the wing. The Macmillan nurses would be contacted for further advice and palliative support and care.

On 24 August, the man had a massive oedema (fluid swelling) on his legs. His pain relief of morphine was increased. The man was still refusing to go to Exeter and the medical officer noted that his wishes would be respected. he was visited by a Macmillan nurse later that day.

Over the next seven days, the man was visited regularly by the medical officer and the Macmillan nurse. The wing nurse, assisted in basic care and the man was supported by prison staff and prisoners.

On 2 September at 4.45am, the man was discovered lying on the floor of his cell by night staff. At 4.50am, the night orderly officer entered the cell and immediately called for an ambulance as the man was obviously very unwell. He appeared to be bleeding and was unrousable although he was still breathing.

At 6.00am, the man was taken to hospital by ambulance. The ambulance had arrived at the prison at 5.10am. The delay in transporting the man to hospital was due to the need to find two members of staff to escort him in the ambulance.

He died at 8.55am. A member of the chaplaincy team started a death in custody log. The man's brother was contacted at 9.10am and his sister at 11.30am. Both had had little contact with their brother. The man's brother asked that the prison make the funeral arrangements. He would send a letter to the prison giving his consent.

The two officers on bed watch and the night orderly officer were contacted by the member of chaplaincy for support in his role as a Care Team member. A critical incident debrief for those involved with the man was held on 21 September.

After quotes were obtained for the man's funeral, a funeral director was commissioned. His funeral took place on 28 September at the prison. His relatives were unable to attend due to ill health and distance to travel. The service was open to staff and prisoners.

A post mortem confirmed that the man died of natural causes with contributing factors of metastatic colorectal carcinoma and bilateral basal pneumonia.

## ISSUES

### Clinical Review – the man's medical care

A review of the man's medical care, from the onset of his illness to his death, was carried out by a review panel. The panel was led by the Commissioning and Development Manager for South Hams and West Devon Primary Care Trust (PCT).

The panel took into account:

- The appropriateness of the care and treatment provided for the man.
- The identification of any specific strengths or weaknesses in his care.
- Whether the NHS and Prison Service policies were followed.
- The examination of factors that may have contributed to the man's untimely death.
- Any recommendations and learning for the improvement of care for other prisoners.

The panel noted that the man died as a consequence of metastatic bowel cancer. This condition had been jointly monitored and appropriately treated pallatively, by his oncologist, pain management specialist and doctor, during the time leading to his death. He was also supported by Macmillan Nurses who visited the prison.

The Clincial Reviewer offers the following observation from his clinical review:

> "During the early stages of his illness, there may have been some delay in the patient presenting his condition being fully investigated and diagnosed. This was not due to his clinical management within the prison, but likely due to unremarkable earlier results to investigations at out-patients and the delayed colonoscopy investigation. It would be speculative to determine whether this would have had a material effect on his prognosis. However, the two week wait standard for referrals of suspected cancers was in place within the prison and would expedite referral and full investigation today."

The Clinical Reviewer comments that:

> "Communication between those involved in the man's care was assessed as excellent. The man was unable to be considered for compassionate release given the rapid progression of his illness. He refused to be transferred to Exeter where he could have received 24 hour nursing care. However, the healthcare staff attended the man daily, monitored his condition and took appropriate action during his last stages of life."

The clinical review identified eight recommendations for service improvement and three areas of good practice, all of which I accept in full.

- The chronologies of the medical notes were poorly maintained and would have benefited from a summary sheet. Notes, investigations and letters should be kept in specific sections allowing easier reference.

- Medical record entries should be legible, with a legible signature and designation recorded.

- Evidence of multi-disciplinary review and care planning of patients with terminal illness should be maintained in the patient record, especially determining a planned and prepared response when the patient is dying.

- Equipment for supporting a dying patient within the community should be immediately available to prisoners from the joint loan store and not be subject of delay through local purchasing.

- Where appropriate, consideration should be given (and documented as early as possible) to a compassionate release as part of a considered multi-disciplinary plan to manage a prisoner with terminal illness.

- For completeness, visiting practitioners should either make an entry or have their visit recorded in the prison patient record.

- A review should be undertaken of the protocol/policy for the administration and monitoring of anti-coagulant therapy.

Good Practice:

- Excellent and timely telephone communication was maintained between the prison medical officer, the oncologist and pain management specialist supporting the management of the man’s care in the latter stages.

- The involvement of Macmillan Nurses should be regarded as a positive support for both the patient and healthcare staff, providing equity with what may be experienced in the community.

- The man’s wishes to remain in prison were totally respected, and appropriate care was provided under difficult circumstances and constraints.

**The man’s care at Dartmoor**

I judge that the man was well looked after by staff at Dartmoor, especially by healthcare and prison staff on the wing. The support, care and assistance they offered allowed him to remain at Dartmoor, in accordance with his wishes.

When she spoke to my investigator by telephone, the chair of the IMB commended the officers on the wing for the way in which they cared for the man. My investigator came to a similar view.

**The way in which prison staff and healthcare staff on F wing cared for and supported the man was a model of good practice.**

An application for compassionate discharge was in the process of being put together when the man died. The application was ready on 23 August but not submitted as the prison was still waiting for Probation Service contact. The application noted that

his offences and medical and psychiatric reports indicated that a discharge might not have been appropriate even though he was so ill. Information received by the security department at Dartmoor in August 2006 underpinned the need for an in depth review of the man's eligibility for compassionate discharge. In addition, a Parole Board Review held on 6 June 2006 recorded that the man was not suitable for release or for a transfer to open conditions. The panel was aware of his illness at the time of the Review.

A member of the chaplaincy team visited the man during the last few months of his illness. He offered him spiritual support and comfort. The Chaplaincy member produced an excellent log of events following the man's death. It chronologically recorded contact details and events up to the final arrangements for his funeral. The chaplaincy member officiated with the chaplain at the man's funeral.

**The support the member of chaplaincy gave to the man during his illness and his actions following his death demonstrate good practice.**

## RECOMMENDATIONS

1. **The chronologies of the medical notes were poorly maintained and would benefit from a summary sheet. Notes, investigations and letters should be kept in specific sections allowing easier reference.**

**Accepted -** Some prisoners have been in the system for a long while and are still using old style medical records. These records to be identified and updated to new versions.

2. **Medical record entries should be legible, with a legible signature and designation recorded.**

**Accepted –** Re-enforce the need for clear signed entries. Internal memo to be sent to all nursing staff. Regular reminder via staff briefings, minutes to be noted. Review commissioned to look at writing and legibility of records for cluster care.

3. **Evidence of multi-disciplinary review and care planning of patients with terminal illness should be maintained in the patient record, especially determining a planned and prepared response when the patient is dying.**

**Accepted –** Prisoners identified with a serious or terminal illness will be monitored and their care pathways identified via the creation of a new proforma held and kept within the prisoner IMR. This form will be up-dated by Healthcare and other medical professionals in light of new treatment or information. This proforma will remain in place until it is replaced by NHS IT software.

4. **Equipment for supporting a dying patient within the community should be immediately available to prisoners from the joint loan store and not be subject of delay through local purchasing.**

**Accepted –** Single point reference document listing agencies/departments that carry equipment (to form part of the Action Care Pathway form)

5. **Where appropriate, consideration should be given (and documented as early as possible) to a compassionate release as part of a considered multi-disciplinary plan to manage a prisoner with terminal illness.**

**Accepted –** This recommendation was actually being used, but it was no evident in the IMR. Outcome of Risk Assessment from Security file to action care pathway form.

6. **For completeness, visiting practitioners should either make an entry or have their visit recorded in the prison patient record.**

**Accepted** – All agencies visiting any prisoner will document IMR. Internal memo to all nursing staff.

7. **A review should be undertaken of the protocol/policy for the administration and monitoring of anti-coagulant therapy.**

**Accepted –** Clinical Review to be carried out and policy/protocol renewed.

**Good Practice**

1. **Excellent and timely telephone communication was maintained between the prison medical officer, the oncologist and pain management specialist supporting the management of the man’s care in the latter stages**

2. **The involvement of Macmillan Nurses should be regarded as a positive support for both the patient and healthcare staff, providing equity with what may be experienced in the community.**

3. **The man’s wishes to remain in prison were totally respected, and appropriate care was provided under difficult circumstances and constraints.**

4. **The way in which staff and healthcare staff on the wing cared for and supported the man was a model of good practice.**

5. **The support the member of chaplaincy gave to the man during his illness and his actions following his death demonstrate good practice.**