Circumstances surrounding the death of a man at Lincoln County Hospital on 8 February 2006, whilst a resident at Wordsworth House Approved Premises in the Lincolnshire Probation Area

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

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This is a report into the circumstances surrounding the death of a man at Lincoln County Hospital on 8 February 2006. The man, who was aged 60, was a resident at Wordsworth House Approved Premises in Lincoln.

He had been at Wordsworth House since July 2005 when he was released from HMP Bullingdon after serving an eight year prison sentence. He suffered from a multitude of chronic health problems throughout his time in prison and these continued after his release. In January 2006, his physical well-being deteriorated rapidly and he was admitted to Lincoln County Hospital on 2 February. Various tests and scans were conducted which revealed that he was suffering from an advanced form of cancer. He died from natural causes in the early hours of 8 February.

The death of a loved one is always painful and shocking. I would like to offer my sincere condolences to the man's family and loved ones to those already expressed by one of my Family Liaison Officers. Tragically, the family was already mourning the loss of the man's younger brother, just five weeks earlier.

This investigation has been undertaken by a member of my team. I would like to thank the Senior Probation Officer in charge of Wordsworth House and his staff for their co-operation and active participation.

I consider that the staff at Wordsworth House treated the man with dignity and respect throughout his stay, and his supervising officers also took practical steps to assist him. However, I do have concerns that the man was seen by both his General Practitioner and paramedics in the days before he was admitted to hospital, yet no action seems to have followed to explore further his failing health. Indeed, it was only after a public health nurse visited Wordsworth House and expressed her concerns to the man's doctor that he was finally admitted to hospital. My terms of reference preclude me from conducting any sort of investigation into the care provided by those other than the services within my remit. I will therefore be sending a copy of this report to the West Lincolnshire Primary Care Trust, encouraging them to review its findings and consider establishing a local inquiry into the care afforded to the man who died to see if lessons can be learned.

I make one recommendation and draw attention to three examples of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2006**

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Summary

1. The man who is the subject of this report was sentenced to a term of 11 years imprisonment in September 2000. The following year, a successful appeal resulted in the sentence being reduced to eight years. He served time in a variety of prisons before being transferred to HMP Bullingdon, a Category C training prison.

2. He was released from Bullingdon in July 2005, and took up a place at Wordsworth House Approved Premises in Lincoln. He settled in well and enjoyed good relationships with both staff and fellow residents.

3. In early January 2006, the man started complaining of acute pain in his teeth and gums. He saw an emergency dentist and obtained a prescription for antibiotics. However, his pain persisted and he experienced considerable discomfort when attempting to eat. In late January, he went to his General Practitioner and was prescribed more medication.

4. On 31 January, the man who later died was seen by a public health nurse who works specifically with those supervised by the Probation Service. She identified that his pulse was significantly faster than it should have been, that he was experiencing chronic abdominal pain and that his food and fluid intake was extremely poor. She measured the man's weight and found that he had lost three kilograms in the six months he had been at the hostel. She also found that his teeth and gums, which were giving him so much pain, were giving off an unpleasant smell.

5. The combination of these complaints caused significant concern to the nurse, who wrote a detailed letter to the man's doctor in advance of his scheduled appointment on 2 February. On 2 February, the man saw his doctor who immediately recommended that he go to the Accident and Emergency Department at Lincoln County Hospital. He was admitted in the early afternoon and was transferred to a ward later in the day.

6. Between 2 February and 7 February, the man was subject to a range of clinical tests and examinations. By 4 February, it was suspected that he had cancer. Sadly, his condition deteriorated considerably during the afternoon and evening of 7 February and he died in the early hours of 8 February.

The investigation process

7. My investigator considered the man's probation documentation, including records held by Wordsworth House Approved Premises, before formally opening the investigation on 6 April 2006. He met the Senior Probation Officer in charge of the hostel and formally interviewed one member of staff and the visiting nurse practitioner who saw the man on 31 January 2006. He spoke informally with various members of the team at Wordsworth House and one former resident, with whom the man was friendly. My investigator also studied the man's medical record relating to the period he was in prison.

8. Prior to my investigator arriving at Wordsworth House, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to the man's death to make themself known to the investigator. In the event, nobody came forward.

9. One of my Family Liaison Officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation. They raised concerns about how staff at Wordsworth House dealt with the man's deteriorating health and about the quality of care provided by his doctor. I hope this report will go some way towards answering the first question. However, my remit does not extend to passing comment on the quality of care provided by General Practitioners and consequently I am unable to address the family's concerns in this area. (The family has been provided with the details of the appropriate body that looks into such matters.)

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

The man who died

11. The man who died received an 11 year prison sentence on 15 September 2000 for a range of serious offences. He subsequently lodged an appeal against the length of his sentence and succeeded in having it reduced to eight years on 26 March 2001.

12. After initially struggling to come to terms with his imprisonment, he settled into prison life and progressed through the system. He was transferred from HMP Rye Hill to HMP Bullingdon, a Category C training prison, on 30 December 2003 and was released from Bullingdon on 13 July 2005.

Wordsworth House Approved Premises

13. Wordsworth House is an 18-bed Approved Premises for men, run by the Lincolnshire Probation Area. It is staffed 24 hours a day by probation employees who provide support to residents and ensure their compliance with the hostel rules and licence and bail conditions. The resident group comprises a mixture of those on bail and convicted offenders who are at the hostel as a condition of a court order or as a requirement of their release from custody. The overwhelming majority of residents fall into the latter category, and the hostel provides a relatively stable environment as they settle into the community.

14. All residents are registered with a local doctor, although different residents can be allocated to different surgeries. This can create problems for residents with mobility problems who may find that they are registered with a surgery situated further away from the hostel than their more able-bodied counterparts. It also creates difficulties for the hostel itself because some services, such as medication delivery, become logistically difficult. The manager of Wordsworth House has made a representation to the local Primary Care Trust, which currently allocates patients to surgeries, that a better system would be for all hostel residents to be under the care of one surgery. This would help to ensure effective communication and improve the quality and consistency of care given to residents. West Lincolnshire Primary Care Trust's view is that the high turnover of residents would make it impractical for them all to be registered with one surgery, and that the current arrangements are not detrimental to residents' health.

    I recommend that the current system for allocating residents to General Practitioner services be subject to on-going review by West Lincolnshire Primary Care Trust in conjunction with Lincolnshire Probation Area.

15. All offenders supervised by Lincolnshire Probation Area, including those accommodated at Wordsworth House as a requirement of a court order or prison licence, are eligible to receive health services provided by the Healthy Living project. The Healthy Living project is a service unique to Lincolnshire Probation Area and which aims to improve offenders' access to health and welfare services. (It is known that offenders use community-based services far less than the rest of the population.) The project is funded by National Lottery money and employs a total of six staff including qualified nurses. Although the project is run by the local Probation Area, it is entirely independent upon and governed by the same standards as other community-based health services. This extends to 'patient confidentiality', which means that practitioners are not permitted to disclose medical information to anyone else without the

patient’s consent unless there are exceptional circumstances involving the patient’s life or the life of others at risk. I commend this initiative.

Key findings

16. The man who is the subject of this report was given an 11 year prison sentence at Lincoln Crown Court on 15 September 2000, having pleaded guilty to a series of serious offences. Two days prior to being sentenced, he had taken an overdose of temazepam medication which had been prescribed to help him cope with feelings of acute anxiety. He was taken to hospital and placed on a secure ward where medical staff managed to stabilise his condition. As a result of this incident of self-harm, he was placed on an F2052SH document (the Prison Service's system for managing prisoners who pose a danger to themselves). In June 2003, the man harmed himself again when he cut himself with a razor blade.

17. On 25 March 2004, whilst still a prisoner at Bullingdon, the man who died was lancing an infected spot on his chest with a needle when he was momentarily distracted. Apparently the needle disappeared and the man became convinced that he had accidentally inserted it into his body. However, subsequent x-rays failed to corroborate this belief and no foreign body was ever found in his upper abdomen.

18. In December 2004, the man received two injections of depo-medrone, a widely-used treatment for carpal tunnel syndrome, a condition which causes pain in the sufferer's thumb and wrist. It would appear that he reacted badly to the medication. He wrote a letter to his legal representative stating that he thought the prison doctor was trying to kill him. It is outside of my remit to investigate this matter, although the Coroner has been informed that the man made an allegation about the conduct of the medical officer.

19. The man who later died was released from Bullingdon on 13 July 2005. A condition of his release was that he should reside at Wordsworth House Approved Premises in Lincoln until such a time as his supervising probation officer gave him permission to live elsewhere. The conditions of his residence at Wordsworth House, and therefore his release from custody, were that he:
    - comply with the curfew hours (11.00pm until 7.00am)
    - pay his rent
    - keep appointments with his probation officer and keyworker, and
    - maintain acceptable standards of behaviour at all times.

    He arrived at the hostel as directed on 13 July, and received an induction from a Probation Service Officer (PSO). The rules of Wordsworth House were explained, and he was allocated to a keyworker, another PSO. (Each resident is allocated to a keyworker upon their arrival, and this member of staff acts as their primary point of contact for sorting out practical issues, such as claiming benefits.)

20. Due to his history of depression and self-harm, the man was made subject to self-harm prevention procedures as a precautionary measure. He was checked by staff at two-hourly intervals throughout the night and was spoken to regularly throughout the day. This is an example of good practice, and clearly demonstrates that staff at Wordsworth House were sensitive to the potential impact of moving from a prison environment to an Approved Premises after a lengthy custodial sentence. In the event, the man settled in well and the 'Risk Of Self-Harm Form' was closed on 19 July.

21. On 27 July, a 'Health Screening' was undertaken with the man which resulted in a referral to the Healthy Living project. He attended for an assessment with a nurse from the Healthy Living project on 3 August. She identified that he was suffering from a multitude of health problems, including chronic back pain, arthritis, post-traumatic stress disorder, neck problems, breathing difficulties, a history of alcoholism, occasional use of cannabis and mobility problems. He was also a long-term recipient of anti-depressant medication and disclosed that he was one of a number of claimants who had brought a case against Bullingdon for alleged exposure to silicon dust. On the basis of this assessment, the nurse jointly drew up a plan with the man for making his day-to-day life more comfortable. This focussed on maintaining his mobility and pursuing a healthier diet. He was offered vaccinations for Hepatitis B and a programme of bereavement counselling, but he chose not to accept either of these. He was offered further one-to-one sessions with the nurse, but he also declined this intervention and support.

22. The next few months of the man's stay at Wordsworth House were relatively unremarkable, as he established himself in the community. He reliably kept his appointments with both his supervising probation officer and his keyworker. From late August onwards, he was given permission to spend time away from the hostel in order to stay with his family. During the course of these periods of approved leave, he carried out do-it-yourself jobs and re-established his links with his family at the home of one of his siblings.

23. On 6 November, the man once again met the nurse from the Healthy Living project. This appointment was requested by the man so that the nurse could prepare a letter to a local housing provider outlining his various medical conditions. He did not bring any new health issues to the nurse's attention, and therefore the letter she wrote to the housing provider only detailed those complaints that had been identified in their earlier meeting of 3 August. The man who later died saw the nurse again on 6 December when she showed him a draft copy of the letter she had prepared in support of his housing application. He did not mention any new medical issues during this appointment with the nurse.

24. On 20 December, the man had a supervision session with his probation officer, during the course of which he mentioned that he had been to see his doctor and had had his lung capacity tested. He informed his

probation officer that the outcome of this assessment was positive. His doctor had informed him that his lung capacity was equivalent to that of a 52 year old. This was despite the fact that he had been a heavy smoker for many years and was actually 60.

25. The man's younger brother died on 6 January 2006. According to the man's keyworker, the man was "absolutely devastated" when he heard the news and, over the following days and weeks, he lost some of his enthusiasm for life. He went off his food and was visibly more withdrawn.

26. When the man met his supervising probation officer on 11 January, he disclosed that, in addition to his feelings of grief, he was experiencing acute pain in his teeth. He said that he was going to see a dentist for an emergency appointment. It is known that the man saw the dentist at some point between 11 January and 13 January, because during the morning of 14 January he complained to his keyworker that the medication he had been prescribed by the dentist was making him feel unwell. The man was assured by his keyworker that this was a known side-effect of this particular medication, a fact that the keyworker found out from reading the information leaflet that came with the tablets.

27. Over the next couple of weeks, the man's intake of food continued to be poor, which hostel staff attributed to the unfortunate combination of his bereavement and on-going dental problems. On 27 January, the man had his first supervision session with his new probation officer. During this meeting, he expressed a view that the antibiotics he had been prescribed did not seem to be having any effect on his gum infection. The probation officer telephoned NHS Direct during the session to seek medical advice as to the most appropriate course of action. The outcome was that the man was advised to go and see his doctor, which he did the same day. He was prescribed more medication for his gum infection.

28. Due to the concerns of staff at Wordsworth House about the man's failing health, they agreed with him that staff would enter his room periodically to check on his well-being. This is not normal practice for Approved Premises and reflects positively on the professionalism of the staff involved who clearly had the man's best interests at heart. The only comment I have to make on this arrangement, which was informal in nature, is that the details of these interactions were not routinely recorded in the hostel log. For this reason, my investigator has not been able to establish how frequently the man was seen throughout the nights in question. The only exception to this is an entry made at around 3.00am on 28 January, when the man was seen by a member of staff who engaged him in conversation and found him to be feeling a lot better than he had during the previous evening.

29. At curfew (11.00pm) on 29 January, the man who is the subject of this report once again informed the night staff that he was feeling better.

However, he was still not eating and the next day he was visited in his room by the in-house chef at Wordsworth House to see whether he wanted soft or pureed food specially prepared. The man agreed to this, but his food consumption continued to be negligible.

30. On 31 January, the man's condition appeared to be deteriorating and the nurse from the Healthy Living project, who was visiting the hostel to see other residents for pre-arranged appointments, was asked by the man's keyworker, to examine him. The health screening, which lasted for over an hour, revealed that the man's pulse was very high (100 beats per minute compared to a normal rate of 70) and he was three kilograms lighter than when he was measured in August 2005. His breath was noted to be extremely unpleasant. The man described to the nurse a sensation of abdominal pain which started low down and worked its way up to his chest.

31. The nurse took into consideration the man's extremely poor appetite, his low fluid intake and his general state of weakness. She suspected that he might be suffering from blood poisoning. However, due to patient confidentiality the nurse was not able to inform Wordsworth House staff of her specific concerns, although she felt able to dispel the notion that his physical presentation was related to underlying feelings of depression. After seeing the man, she prepared a letter to his doctor, in advance of his scheduled appointment on 2 February, outlining her findings.

32. On 1 February, the man continued to look unwell and was still suffering from pain. Due to his concerns about the man's condition, the hostel manager contacted the nurse to seek medical advice. The manager then telephoned the man's General Practitioner and asked the doctor to visit the hostel and examine the man. Apparently the doctor was unable to visit him, but instead arranged for a paramedic unit to come to Wordsworth House and conduct an assessment.

33. The paramedics from Lincolnshire Ambulance Service arrived at 9.42am and spent over an hour with the man, before recommending that he take Ibuprofen painkillers, that he attend his scheduled doctor's appointment on 2 February and make another appointment to see the dentist. According to the Patient Report Form completed by one of the paramedics, the man's presenting complaint was a "dental infection".

34. Around 7.50pm on 1 February, the nurse from the Healthy Living project returned to Wordsworth House where she showed the man a copy of the letter she had prepared for his doctor. He agreed that he was happy for the letter to be sent on his behalf. According to the nurse, he looked slightly less distressed than when she saw him on 31 January.

35. At 9.00am on 2 February, the man had a discussion with hostel staff and disclosed that he had had a bad night. His doctor's appointment was scheduled for 9.30am and, at 9.15am, he was driven to the surgery by a

member of staff, accompanied by one of his friends. It not normal practice for the staff of Approved Premises to drive residents to appointments of any sort. However, given the state of the man's health at this point, this should be recognised as another example of good practice.

36. The man saw his doctor as planned. After reading the nurse's letter and conducting his own examination, the doctor immediately recommended that the man should go to the Accident and Emergency Department at Lincoln County Hospital. He was driven to the hospital by the member of hostel staff and admitted at some point between 12.45pm and 3.10pm. His relatives were informed of his admission to hospital and, in subsequent days, they would regularly call the hostel to inform them of any changes in his condition.

37. From 2 February onwards, the man was subject to a number of tests and examinations in order to find out what was wrong with him. Wordsworth House maintained contact with the hospital by telephone but, because the staff are neither family members nor next of kin, they were not able to obtain much information from the medical staff. On 4 February, the man was visited by a member of his family, who contacted Wordsworth House and disclosed that the hospital was exploring the possibility that he had cancer.

38. On 6 February, the man was visited in hospital by his keyworker. He says that he found the man to be quite chirpy, but that he was obviously unwell. He was still undergoing scans and various tests at this time and was moved to the Oncology Ward, the specialist cancer treatment unit.

39. On 7 February, residents and staff at Wordsworth House signed a 'Get Well' card for the man and, at 8.15pm, it was taken to him at the hospital by a member of staff. Sadly the man had taken a turn for the worse since the previous day and his prospects for recovery were bleak. He died in the early hours of 8 February.

40. After news of the man's death was received at Wordsworth House later in the morning, staff made sure that his fellow residents were informed. Four members of staff attended his funeral, as did one resident and one former resident.

Issues arising from the investigation

The man's care by staff at Wordsworth House

41. The man's family expressed two main areas of concern that they wanted considered as part of the investigation into his death. The first related to how staff at Wordsworth House attempted to deal with his deteriorating health. My findings in relation to this reflect positively on the staff team at Wordsworth House. I consider they acted with great professionalism and dedication throughout the last few weeks of the man's period of residency, when his health was obviously failing.

42. For the record, it needs to be stated that Approved Premises staff are not clinically trained and, over recent years in particular, their roles have changed from helping and directly assisting residents to monitoring their behaviour and enforcing the rules. Given this significant shift in ethos, it is encouraging that staff felt confident enough to use their initiative and apply commonsense and compassion whilst attempting to make the man as comfortable as possible.

43. One of the rules of Wordsworth House is that visitors are prohibited from going into residents' rooms. The primary purpose of this rule is to ensure that behaviour cannot take place in areas which are not routinely monitored by staff which could potentially compromise the safety of staff and residents. On this occasion, permission was given to a former resident, to whom the man was particularly close, to go into his room and sit with him, ensuring he was provided with support and company.

44. There is no doubt in my mind that this gesture, relatively minor in itself, will have afforded the man a degree of comfort at what must have been a time of great distress and alleviated some of his feelings of isolation. When the in-house chef went to speak to the man on 30 January to discuss ways of making his meals more palatable, this illustrated that the whole team, not just his keyworker or allocated probation officer, were sensitive to his changing needs and growing vulnerability.

Quality of care provided by the medical professionals involved

45. My terms of reference preclude me from looking into the quality of clinical care provided by the doctor, dentist and paramedics who saw the man prior to his admission to hospital. However, a copy of this report will be sent in due course to the Primary Care Trust responsible for providing General Practitioner services to the residents of Wordsworth House.

Recommendation

46. I recommend that the current system for allocating residents to General Practitioner services be subject to on-going review by West Lincolnshire Primary Care Trust in conjunction with Lincolnshire Probation Area.

Good practice

47. My investigation has highlighted three examples of good practice by the Lincolnshire Probation Area. I would be grateful if the first two and my comments thereupon are drawn to the attention of all staff at Wordsworth House:

    1. Opening a ‘Risk Of Self-Harm Form’ on a resident with a history of self-harm but whose current emotional state is unknown and whose circumstances have changed significantly is an example of good practice.

    2. Arranging for the man to be driven to his appointment with his doctor and relaxing the rules regarding visitors entering his bedroom are two examples of staff being sensitive to his increasing frailty and his changing needs.

    3. Providing health services directly to those subject to probation supervision, in this case under the auspices of the Healthy Living project, is an example of best practice.