

**Circumstances surrounding the death of  
a man who was a prisoner at HMP Woodhill  
in February 2007**

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

**November 2007**

This is the report of an investigation into the death of a man. The man had been a prisoner at HMP Woodhill and died from natural causes on 9 February 2007 at a local hospice. He was 46 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 add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. She and I would like to thank the Governor of HMP Woodhill and his staff for their assistance. A doctor was asked by Milton Keynes Primary Care Trust to undertake a review of the man's clinical care, and we also much appreciate her help.

As is the case in many of my investigations following a death from natural causes, I am much influenced by the findings of the clinical review. I have noted the issues highlighted by the clinical reviewer and there are clearly lessons to be learned in terms of the clinical management of patients at Woodhill. I endorse the recommendations made in the clinical review and urge the Primary Care Trust and Woodhill to develop an action plan to address these in a timely manner.

In addition to my recommendations, I have been pleased to draw attention to two examples of good practice.

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 my investigation.

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

**November 2007**

## **CONTENTS**

Summary	3
The investigation process	4
HMP Woodhill	5
Key events	6
Concerns raised by the family	9
Clinical review	10
Conclusion	11
Recommendations	12

## **SUMMARY**

The man was born in 1960. He was 46 years old when he died on 9 February 2007 in a local hospice.

The man had been sentenced to one year's imprisonment at Northampton Crown Court in 2004, and he was originally released on licence later that same year. His licence was revoked and he returned to custody in May 2005. The man was released a second time on January 2006, but his licence was revoked again in August 2006. The man returned to custody at HMP Woodhill in August 2006.

On 28 November 2006, the man was diagnosed as having cancer of the rectum. His prognosis was poor and he was told that he had less than six months left to live.

On 18 January 2007, the man was transferred to a local hospice. Whilst he was at the hospice, the man was accompanied by one member of prison staff and was not restrained. He passed away at the hospice at 3.40am on 9 February 2007.

The clinical review concludes that the man's clinical care was not entirely appropriate. I have endorsed the two recommendations in the clinical review.

## **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 identified a doctor to carry out a review of the man's clinical care. I am grateful to her for undertaking the review.
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 him in his enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. Members of the family said they were frustrated by the lack of communication they experienced regarding the man before his death. They felt that they should have been told sooner that the man was terminally ill, thus allowing them to spend more time with him.
5. My investigator discussed aspects of the man's treatment with staff at Woodhill and with the clinical reviewer.

## **HMP WOODHILL**

6. HMP 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, and it serves courts in Northamptonshire, Hertfordshire, Buckinghamshire and Bedfordshire. Woodhill holds a maximum of 807 prisoners in several units comprising both remand and convicted adults, young offenders, juveniles and vulnerable prisoners.
7. Woodhill underwent a full inspection by Ms Anne Owers, HM Chief Inspector of Prisons, in February 2002, with an unannounced follow-up inspection 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, though this was being addressed by the Primary Care Trust.
8. Provision of healthcare within Woodhill is the responsibility of the Milton Keynes Primary Care Trust. Healthcare facilities include a 24 hour in-patient unit and a visiting specialist service. Prisoners have access to a doctor 24 hours a day and those with more serious conditions or clinical needs are referred to the local hospital.
9. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are judged to be at risk or the medication is considered unsuitable to be held in their possession.

## KEY EVENTS

10. The man arrived at Woodhill on 21 August 2006 after his licence had been revoked a second time. During the health screening procedure at the prison, he complained about his haemorrhoids. He was advised to make an appointment to see the prison doctor. It is not clear if this took place.
11. On 2 September, the man reported he was experiencing problems with passing urine and opening his bowels. He was examined by a prison doctor who found that the man had an enlarged prostate gland and no evidence of internal haemorrhoids. The doctor diagnosed that the man had prostatitis (inflammation of the prostate).
12. On 21 September, the man complained of rectal pain and bleeding. An urgent referral was made to a local hospital on the following day. On 23 September, the man was admitted to hospital with acute urinary retention. He was started on antibiotics and given an out-patients appointment for 10 November. The man was discharged from hospital on 24 September and returned to Woodhill. After they received the draft report of this investigation, the family pointed out that they had not been informed by the prison of the man's admission to hospital. The family said that they were contacted by a nurse at the hospital who informed them of his whereabouts. The family feared that the man could have died in hospital and they would not have known that he was there.
13. On 5 October, another prison doctor noted that the man had symptoms of prolapsed internal haemorrhoids. The following day, the prison doctor requested an urgent follow up appointment at the local hospital because the man was suffering again with acute urinary retention. Woodhill contacted the hospital again on 9 October to follow up the referral. The hospital confirmed that they had received the urgent referral and that it was with their Consultant Surgeon.
14. On 10 October, a letter was received from the Consultant Urologist at the local hospital. The Consultant Urologist suggested a trial of Tamsulosin (a tablet) to relieve the urinary retention.
15. On 23 October, Woodhill contacted the hospital again to chase the appointment for the man's rectal bleeding problem. The hospital said that an appointment had already been booked for 10 November with the Consultant Urologist. The prison informed the hospital that the Consultant Urologist was dealing with the man's urine retention, not his rectal bleeding.
16. On 10 November, the man attended an out-patient's appointment and was listed for a cystoscopy on 27 November. (This is where a visual examination of the urinary tract is carried out with a cystoscope. The latter is an instrument that allows a doctor to see inside the bladder and to remove tissue samples or small tumours.)

17. On 19 November, the man expressed concern about his bowel problems. The following day, a prison doctor wrote to the colo-rectal surgeons at the local hospital and asked them to see the man when he attended the hospital on 27 November.
18. On 27 November, the man had a cystoscopy performed during which a possible rectal tumour was discovered. On 28 November, a colonoscopy revealed a large inoperable infiltrating rectal tumour. An operation was carried out two days later to relieve obstructions to the man's bowels. The man was told that his prognosis was poor and that he had less than six months to live. Whilst the man was in hospital in November and December, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. He was discharged from hospital on 9 December and returned to the healthcare centre at Woodhill.
19. On 19 December, the man started chemotherapy treatment in the local hospital. He returned to the healthcare centre at Woodhill two days later.
20. On 10 January 2007, it was noted at the palliative care multi-disciplinary meeting that the man was experiencing difficulty accepting his diagnosis and prognosis. After receipt of the draft report, the family disputed this. They felt strongly that the man had accepted his diagnosis and prognosis and that he had felt frustrated that he was unable to go anywhere or see his friends and family until the end.
21. On 11 January, the man was granted release on temporary licence (ROTL) on compassionate grounds due to his terminal prognosis. (ROTL permits prisoners to be released for temporary purposes, although there is no right to this. A security risk assessment must be carried out before a licence can be issued. The risk assessment for the man said that he should be accompanied by one member of staff and that restraints should not be used.)
22. The man attended the local hospital for further chemotherapy treatment on 16 January. On 18 January, he was admitted to hospital with acute urinary retention and widespread vein thrombosis. After treatment, the man transferred to a local hospice later that day.
23. Following his transfer, contact was maintained between the prison and the hospice by both staff visits and by telephone. A Healthcare Officer (HCO) visited the hospice during the afternoon on 18 January. The HCO gave staff at the hospice copies of the man's medical records, care plan and treatment chart, as well as his cancer medication.
24. The HCO visited the man on 19 January. The man asked the HCO if both his sister and partner could be kept informed about his condition. During his visit the HCO noted that the man was in a lot of pain which was being treated by the nursing staff at the hospice.

25. On 23 January, the HCO visited the hospice again. He was told by the man that the doctor at the hospice had stopped his cancer medication and was making him comfortable with pain relief. The man also now spoke about the possibility of his death occurring. When the HCO spoke with the doctor after this third visit, the doctor was pleased that the man was accepting his prognosis as up to that point he had only talked about getting better.
26. When the HCO visited the man on 25 January, the doctor at the hospice told him that the man was not well and his condition was deteriorating. The doctor also said that the man was now in denial once more regarding the final outcome of his condition. The doctor thought it might be possible that the man was aware of his prognosis but did not want to admit it.
27. On 30 January, the HCO visited the man but did not speak to him as he was asleep. The prison officer who was on duty at the hospice told the HCO that blood tests had identified that the man's calcium levels were high and were causing him to be sleepy. On the following day, Woodhill were informed that the man had deteriorated overnight and was now difficult to manage. He had pulled out his drips and was acting erratically. The man had calmed down by the late afternoon but was then very sleepy and withdrawn.
28. On 5 February, the hospice told Woodhill that the man was now under sedation to control his pain. It was likely he would remain sedated until he passed away. The man remained stable but was very poorly. His family was with him. The man died at 3:40am on 9 February at the hospice.
29. The prison's family liaison officer made contact with the man's family shortly before his death. He maintained contact with the family and assisted with the arrangements and some of the expenses for the funeral.
30. A post mortem was not carried out as the man had died from a diagnosed condition after being released from custody, and there was no reason to believe untoward circumstances were associated with his death.

## CONCERNS RAISED BY THE FAMILY

31. When contacted by my Family Liaison Officer, the man's family said they were frustrated by the lack of communication they experienced before his death. They felt that they should have been told sooner that the man was terminally ill, allowing them to spend more time with him. The family also said that the man had complained to them that when he told staff that he was in pain they had not been helpful or assisted him.
32. My investigator has discovered that the family was informed on 30 November 2006 that the man was in hospital. They were also told of his terminal diagnosis on 1 December. The Head of Healthcare at Woodhill wrote to the family on 16 January 2007. In her letter, the Head of Healthcare apologised on behalf of the prison for any undue distress caused by the lack of communication concerning the man's illness. The Head of Healthcare went on to say that permission to make contact had only just been given by the man, and that prior to this the man himself was contacting his family members. The Head of Healthcare added that, without his prior consent, the prison was not permitted to make this contact themselves.
33. When my investigator contacted the Head of Healthcare, she said that healthcare staff were aware that the man was in contact with members of his family, but it was not clear if he was discussing his illness in the early stages. The Head of Healthcare added that they would not be able to release information without the man's consent. After the family received the draft report, they said that the man had asked them to speak to the person in charge and request a disclosure form. The family did contact the prison to request this and were told they would be called back, however, this did not happen.
34. Although the prison says that every effort was made to respect patient confidentiality, the family feel strongly that the man had actively advised them regarding disclosure and that the prison had failed to assist them with this. I appreciate that efforts should always be made to ensure that relatives are made aware of serious health concerns. However, this is not always possible. Healthcare staff need to respect patient confidentiality as well as the patient's own wishes. Not everyone wants their loved ones to know about the state of their health. In this case an additional factor was the man's alleged denial of his prognosis, although this is something the family strongly deny. It would appear that all these issues conspired to delay notification to the family of the seriousness of the man's condition. I commend the efforts that Woodhill made after the diagnosis and the support given to the man's family after his death. After receipt of the draft report, the family wanted to draw attention to the positive support given by staff at the hospice to the man. I am happy to reflect their views in this report.

## **CLINICAL REVIEW**

35. As I have reported, a review of the man's medical care was undertaken by a doctor on behalf of Milton Keynes Primary Care Trust.
36. The clinical review concludes that "it is unlikely that the care received by the man in Woodhill contributed to his death."
37. However, the reviewer also says that, although attempts were made by Woodhill to access rapid clinical care for the man, there was a delay of several weeks before he was seen for the problem of rectal bleeding. The reviewer suggests that the man's care could have been expedited if the Cancer Two Week Wait referral system had been used instead. The reviewer judges that it is not clear whether healthcare staff at Woodhill are aware of the standardised routine Two Week Wait system for possible cancer referrals.

**Prison healthcare should review their system of record keeping. It may be timely to examine the merits of introducing a computer based system in line with current NHS practice to facilitate exchange of information and improve healthcare information storage.**

**Prison healthcare should refresh the knowledge of all staff about the cancer Two Week Wait system and the national guidance supporting it.**

38. The reviewer also commends the co-operative working between the healthcare staff at Woodhill and the Milton Keynes Palliative Care Team who between them provided terminal care for the man.

## **CONCLUSION**

39. The man arrived at Woodhill in August 2006 and died from natural causes in February 2007. Following his arrival at Woodhill, the man was diagnosed with cancer and told that his prognosis was poor.
40. In light of the findings of the clinical review and my own investigation, I conclude that the man's medical care was not entirely satisfactory. However, I have noted in a subsequent investigation into a death in March 2007 that Woodhill was then using the Two Week Wait system. I commend Woodhill for moving forward on that issue so rapidly.
41. I have endorsed the two recommendations from the clinical review. These need to be addressed by Milton Keynes Primary Care Trust in partnership with the Governor of Woodhill.

## RECOMMENDATIONS

- 1. Prison healthcare should review their system of record keeping. It may be timely to examine the merits of introducing a computer based system in line with current NHS practice to facilitate exchange of information and improve healthcare information storage.**

Recommendation 1 was partially accepted. The Prison Service agree that a computer based medical records system would be beneficial, but this needs to be as part of a national system. The Primary Care Trust have received budgetary allocation to introduce a nationally agreed system.

- 2. Prison healthcare should refresh the knowledge of all staff about the cancer Two Week Wait system and the national guidance supporting it.**

Recommendation 2 was partially accepted. Prison healthcare currently use the two week cancer referral system, however the man's preliminary diagnosis was unclear because of ongoing medical problems. The GP services at Woodhill are under a new contract and are aware of the referral system. All relevant healthcare staff will be made aware of this new system

### *Good Practice*

- 1. I commend the co-operative working between the healthcare staff at Woodhill and the Milton Keynes Palliative Care Team who between them provided terminal care for the man.**
- 2. Healthcare staff at Woodhill neither forgot nor abandoned the man when he was admitted to the hospice. A Healthcare Officer visited the man on five separate occasions during the 12 days between 18 and 30 January. The Governor should consider whether the Healthcare Officer's actions should be formally recognised.**