Investigation into the death of a man at a hospice whilst in the custody of HMP Frankland on 2 June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This is the report of an investigation into the circumstances surrounding the death of a man on 2 June 2006. The man was a prisoner at HMP Frankland and had been diagnosed with terminal cancer of the colon. He spent his last hours in an outside hospice. The man was 44 years old when he died.

I extend my condolences to the man's family and to all those touched by his death.

The investigation was undertaken by one of my colleagues. Both my colleague and I would like to thank the Governor of Frankland, and his staff for their cooperation during the investigation. We are particularly indebted to the prison's liaison officer, who gathered relevant documentation and ensured it was made available in a timely way.

As in previous investigations, I must also thank the clinical reviewer for undertaking a review into the clinical care the man received on behalf of Durham and Chester-le-Street Primary Care Trust.

The man was a high risk prisoner and I am in no doubt that decisions over how best to care for him were at times difficult. I have been impressed by the careful consideration that was given to managing the potential risk he posed outside of a custodial environment, against the rapid decline in his health and pending healthcare needs. The man received a high level of care both at Frankland and when transferred to the hospice where he died.

I make four recommendations and highlight two areas of good practice.

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

CONTENTS **PAGE**

SUMMARY

The man who died was convicted of a very serious offence in 1991. He was sentenced to discretionary life imprisonment, with a minimum tariff of three years. He had spent a total of 16 years in high security prisons before his death.

The man was sent to HMP Wakefield to begin his sentence and remained there for the next five years. In 1997, he was transferred to HMP Whitemoor until his move to HMP Frankland two years later. He returned to Whitemoor in 2001 and, following a psychiatric assessment, was sent back to Frankland where he spent his last few years.

On 18 April 2006, he was diagnosed with cancer of the colon. It had spread to his lungs and liver and, after a number of tests and exploratory procedures, he was diagnosed as terminally ill. Having spent two periods in hospital, the man returned to Frankland for the last time on 27 May.

He spent a further four days back in the healthcare unit before deteriorating so rapidly that he was moved to an outside hospice in his final hours. This was with the agreement with the MacMillan nurse caring for him, the prison, the Directorate of High Security Prisons, and the man himself.

The man died peacefully at 10.30pm on 2 June 2006.

THE INVESTIGATION PROCESS

1. The investigation was opened on 5 June 2006. My investigator began by requesting all relevant prison records relating to the man. These included his medical and core records covering the 16 years he spent in high security prisons.

2. Notices to staff and prisoners were supplied and displayed around the prison. These invited anybody with information to talk to my investigator. In this instance, no staff or prisoners came forward. My investigator examined the records and noted significant events. On the basis of what she found, my investigator judged that it would not be necessary to visit the prison and no formal interviews took place.

3. Durham and Chester-le-Street Primary Care Trust was invited to undertake a review of the clinical care the man received while in custody. The review is included as an annex to this report.

4. The Coroner was informed of the Ombudsman's investigation. In consultation with the family, the Coroner took the view that this was not a case requiring a post mortem examination or toxicology. No such examination took place and the attending physician at the hospice noted the cause of the man's death as metastatic colorectal cancer.

5. The man's brother and sister were contacted by one of my Family Liaison Officers, to ask whether they or other members of the family had any comments or concerns about the man's death. They did not and I sent a draft copy of my report.

HMP FRANKLAND

9. HMP Frankland is one of six maximum security establishments within the Directorate of High Security Prisons. Frankland holds category A and B adult male prisoners in normal location on two residential wings. Vulnerable prisoners are located on four other wings, and all accommodation is single cell. Frankland also holds a small number of category C prisoners and has an operational capacity of 653.

10. The most recent full inspection report by HM Chief Inspector of Prisons, dated March 2003, describes Frankland as offering a safe environment, based upon good relationships between staff and prisoners. The inspection found good staff understanding of individual prisoners and their needs.

11. Following a short unannounced follow up inspection on 25 October 2005, the Chief Inspector recorded that healthcare services at Frankland had improved since the full inspection. Primary care still needed development but staffing shortages had hindered progress. Of the 12 healthcare recommendations made during the full inspection, nine had been fully achieved, one partially achieved, and two had not been achieved.

12. The healthcare services at Frankland are commissioned by the Durham and Chester-le Street Primary Care Trust. The prison's healthcare centre has 18 beds, all of which are linked to the office with a call bell system. Adjacent to the centre is the Listeners suite which is a large and comfortable two bedded room.

KEY FINDINGS

13. On 18 April 2006, the man was seen by a doctor in the healthcare unit, although his record does not clarify whether he referred himself or was referred by staff. The man had not presented any symptoms prior to that day and the doctor noted in his medical record that he looked anaemic. His blood was taken and sent to an outside hospital for analysis. He was placed under observation by nurses and the observations were recorded.

14. The following day, the prison doctor wrote a referral letter to the consultant colo-rectal surgeon at University Hospital of North Durham. The letter explained that the man had presented symptoms including abdominal pain, nausea and the loss of some blood and that during an examination, the doctor also discovered tenderness of his liver. The letter stated that the man may have hidden his symptoms from healthcare staff. The doctor noted he was concerned that the symptoms were an indication of significant bowel cancer.

15. On 20 April, the man was seen by a doctor during morning rounds and observations were recorded in his medical record. The doctor's entry stated that he 'looks ill and vomits after eating'. The man was admitted to University Hospital North Durham for further tests the same day. My investigator could not locate a bedwatch log or Prisoner Escort Record form (PER) recording the transfer to hospital although the prison has, subsequently, found both documents.

16. The man spent the next week in hospital and underwent a series of tests. His medical record notes the calls made to the hospital for clinical updates on his condition. The record says that, on 21 April, he had a CT scan which indicated cancer and that he would be seen by a bowel specialist in due course. He was also x-rayed and underwent a biopsy that week. He apparently presented as withdrawn after being told of the possible diagnosis.

17. On the morning of 26 April, healthcare staff rang the hospital to determine when the man was likely to be discharged back to Frankland. The hospital said that he would not be discharged immediately as he was receiving medication intravenously.

18. At 5.00pm on 28 April, the man was discharged from the hospital. On his return to Frankland, he was located in the healthcare unit and given a single occupancy room. The hospital summary listed the exploratory procedures he had undergone during his eight days on the surgical ward. The summary also informed healthcare staff that the man had been placed on 15 minute observation, was tolerant of fluids and was in receipt of drugs to manage his pain.

19. The man was made comfortable in his room. The nurse on duty observed that he presented as pale and short of breath. The prison

doctor was notified of his condition and his prescribed medication. In response, the doctor asked to be contacted if any problems arose and confirmed that he would visit the healthcare unit the next morning. The nurse then contacted the hospital to check the correct dosage of morphine to administer as part of the man's pain management care. The advice was noted in his medical record as two doses per day, morning and night. At 10.00pm, he was given his first dose and his abdominal wound was cleaned and dressed. The night duty nurse explained to him that if he felt any pain during the night, he should let staff know.

20. For the next few days, the man's pain was effectively managed and he was made as comfortable as possible. Healthcare staff also made contact with the McMillan nurse at the hospital to find out who would be responsible for his care.

21. On 1 May, another prison doctor saw him. Whilst the doctor found him to be poorly, he was communicating well. He was seen again the following day and the doctor took that opportunity to discuss his condition with him. An entry in the man's medical record notes that he was fully aware he had cancer of the colon and that it had spread to his liver.

22. On 4 May, the man complained of abdominal pain and healthcare staff noticed his loss of appetite. Despite his deterioration, he was able to attend an occupational therapy (OT) session and fully engaged in activities while he was there. The man's OT report for the day said that he had expressed concern to the therapist, over his future, and had been encouraged to enjoy each day as much as possible.

23. The man was seen by the doctor the next day and appeared quite settled. He had a quiet night watching television and reported only slight feelings of sickness. At around lunchtime on 7 May, healthcare staff noticed his abdomen was swollen and he was suffering from breathlessness. A nurse ensured he was made more comfortable by moving him to a bed with a backrest so that he could sit up. The nurse noted that the man remained poor in complexion and was still feeling sick. Later that afternoon, he was given a nutritional risk assessment and the results were entered into his medical record. Healthcare staff were made aware that he was to eat small amounts regularly and to replace missed meals with high protein drinks.

24. The man had another bad night and complained of swelling to his left leg. A nurse administered his medication for the night and also elevated both his legs to help reduce the discomfort. On closer examination, his legs were found to be very swollen due to excess lymph fluid. He was advised to keep them in the elevated position and a note was made for the doctor to review his condition.

25. On the morning of 8 May, the man saw the doctor who noticed the bloating. His medication was reviewed and he took both his prescription and his diet for the day. No other concerns were noted and he remained settled but feeling sick.

26. The man was seen again by the doctor on 10 May. He complained of the bloated feeling again, but said that his pain was under control and he did not want to take the morphine. The doctor wrote in his medical record that he seemed to have developed a sore and dry mouth but looked more settled.

27. The man attended another OT session on 11 May and continued with the group activities he had begun during his previous visit. The occupational therapist spoke with him at length and noticed he was in a very low mood. According to the man's medical records, he explained that he wanted to die to relieve himself of the pain of his condition. He also said he felt he had nothing to live for. The OT encouraged him to keep his mind as occupied as possible and prompted him to carry on with the afternoon session. The OT passed on the details of her conversation to the Community Psychiatric Nurse and to the man's psychiatrist.

28. For the next seven days, the man was monitored for pain, sickness and the infection to his throat. He was seen by a MacMillan nurse on 13 May and the nurse carried out an assessment of his symptoms. The man also received treatment for his throat, following confirmation that he had developed an oral infection. He was given a gargle and lozenges and a nurse noted that this seemed to give him some relief from the discomfort he had previously felt. The man continued to appear quite pale, but took a small diet and the rest of his pain management medication.

29. At 11.00am on 18 May, he spoke to the OT again. He explained that his medication had been reviewed to stop his feelings of sickness, but that he had developed the mouth and throat infection instead. He was observed throughout both morning and afternoon sessions as being withdrawn from the group, but still able to participate in the project. An entry in his medical record stated that he told the OT that he was thinking of contacting his estranged family to inform them of his illness.

30. The man spent the weekend of 20 and 21 May in some pain and healthcare staff noticed that the swelling to his stomach and leg had worsened. His daily record of nursing care was updated with an entry that described his complexion as 'yellow'. The man also found it difficult to sleep and healthcare staff arranged for him to use a Parker Knoll chair for more comfort. He slept in his chair for some of the night. A nurse wrote in his medical record that, despite being very ill, he offered no complaints and would be seen by the doctor on Monday 22 May for assessment.

31. Following his assessment on the morning of 22 May, the man deteriorated and was referred to an outside hospital for a review of his condition by the hospital consultant. Before he could be transferred in a category A vehicle, his clothes were x-rayed and he underwent a full search in the reception area of the prison.

32. At approximately 12.15pm, the man left Frankland for University Hospital North Durham. He was escorted by two prison officers using restraints, and arrived at the out patients department at 12.35pm. He was seen by a doctor within 10 minutes of arriving and was cuffed throughout the examination. The doctor decided to admit him as an in patient, and at 1.10pm he was moved to a surgical ward. Escort officers notified the prison of his admission in order for a bedwatch to be arranged. The PER form accompanying him on the visit to hospital showed that he had been risk assessed and restraints would be applied. The form also said that an F2052A booklet had been opened. My investigator found no bedwatch log for the duration of this stay in hospital although the prison has, subsequently, located it.

33. The man remained in hospital for five days. Healthcare staff at Frankland made regular contact with the hospital to obtain updates on his condition, and made entries to his medical record on a daily basis.

34. On the evening of 23 May, a nurse contacted the ward and was informed that the man had received two litres of blood and further pain relief. The same nurse was contacted three days later by a Macmillan nurse who confirmed that he had been placed on a Palliative Care Plan and was very poorly. The entry in his medical record explained that he wanted to return to Frankland as soon as possible and had been given a syringe driver to administer his pain relief. MacMillan nurses would provide follow up input to help manage his condition, and a nurse would arrange to visit him back at the prison on 31 May.

35. At approximately 4.15pm on 26 May, the Healthcare Manager was informed of the man's condition and his wish to return to Frankland. The healthcare manager held a meeting with healthcare staff to discuss the man's needs and to prepare the healthcare unit for his return. According to his medical record, the prison chaplain and a probation officer liaised with his next of kin to inform them of the deterioration in his health. The daily record of nursing care confirmed that a Palliative Care Plan was in place.

36. At 9.30am on 27 May, healthcare staff at Frankland contacted the hospital. The staff nurse on the ward explained that the precise discharge details had not been confirmed, but that the registrar would review the man's condition that afternoon. The hospital would contact the prison once the decision had been made to return him to the prison's healthcare unit.

37. At 3.00pm, the hospital confirmed that the man would be discharged later that day and that arrangements were put in place for his transfer. The Discharge Notification Letter contained full pharmacy instructions to dispense seven days worth of medication to Frankland on his discharge. The letter explained that this would give healthcare staff enough time to plan ahead and order a full supply for the following week. The letter also stated that he would be placed in the care of the community cancer nurse, with no further hospital appointments required.

38. At 6.45pm, the man was discharged by the hospital consultant and prepared for his return to Frankland. His summary discharge plan from the hospital said that he was alert and could dress himself, was able to take fluids, and was not in any pain. The care plan also informed healthcare staff at Frankland that he was to continue with his pain management following a pain control assessment made in hospital. The form stressed that he was in an advanced stage of cancer and could no longer take oral medicine. A syringe driver would therefore commence once he had settled back in the healthcare unit.

39. At 7.00pm, the man was transferred back to Frankland under restraints. He arrived at 7.15pm and was strip searched before being located straight into the healthcare unit. A PER form, originally completed on 22 May to record his transfer from Frankland to the hospital, was re-used to record his return journey.

40. In the early hours of the morning of 28 May, a night nurse noticed that his syringe driver was empty. It had been full on his return from the hospital at 7.00pm the previous evening. His nursing care record notes that a nurse contacted the hospital for advice and was told to refill the driver. The nurse then contacted the on call prison doctor, and was advised to leave the syringe driver for his attention the following morning.

41. At 9.25am on 28 May, a prison doctor saw the man as part of his morning rounds. At 10.00am, his syringe driver was re-sited and replenished and he was made comfortable by healthcare staff. He ate a small breakfast and told staff he was pleased to be back at Frankland. The Palliative Care Plan, devised by the MacMillan nurse, instructed healthcare staff to keep his wounds infection free and to look for signs of inflammation. The plan also instructed nursing staff to encourage the man to report any feelings of pain, and to support him emotionally now that he was in an advanced stage of illness.

42. At 1.30pm, one of Frankland's Governors spoke to a nurse and told her that the man's brother had been informed of his poor physical health. An entry in his medical record notes that his brother had been contacted via the police.

43. By late afternoon, the man was made aware of the terminal nature of his illness and his religious needs were determined in order to provide him with some emotional support. The Palliative Care Plan was also discussed and agreed with him. He was made comfortable for the evening and saw the prison chaplain. Unfortunately, he had a restless night.

44. At 10.30 am on 30 May, a prison doctor saw the man and approved the 'no resuscitation' policy. The doctor noted that he remained pain free and took diet and fluids. Later that afternoon, the healthcare manager came to see him to discuss hospice care and the man asked him to explore the possibility of a move. The healthcare manager made a note in his medical record for the MacMillan nurse to look into the option of transferring him to a local hospice.

45. The man had another bad night and deteriorated throughout the morning of 31 May. At approximately 7.50am, the MacMillan nurse assessed his condition and became concerned about his deterioration. The nurse asked for arrangements to be put in place for his move to hospice care, and for nurses to monitor his pain levels in the meantime.

46. The next day, at approximately 11.45am, a Senior Officer sent a fax to the Directorate of the High Security Prisons and attached an application and risk assessment for the man to be cared for at a hospice without restraints. The application listed the medical reasons for the request and said that the man, still a category A prisoner, would be accompanied by at least two plain clothed officers assigned 24 hour bedwatch duties. The request also stated that bedwatch officers would contact Frankland if his mobility improved, and that visitors to his bedside would be agreed by the duty governor in advance.

47. The application was granted and, following a thorough search, the man was discharged from the healthcare unit. At 5.25pm, he left Frankland for the hospice. The PER from accompanying him clearly stated that any risk he posed had been reduced to 'virtually nil' due to his terminal illness.

48. On arrival at the hospice, the officers on bedwatch duty carried out a physical security checklist of the man's room and noted that it was a low risk environment. Within a few minutes of arrival, a Senior Officer began a bedwatch log. The log said that officers were in possession of restraints and that the man had been examined and spoken to by the doctor. Before handing over bedwatch duty to another member of staff, the SO also confirmed that the hospice exit points would be secured at night.

49. On the morning of 2 June, officers carried out a bedwatch check and re-checked the policy of no restraints to be used whilst the man remained in hospice care. The checklist also stated that officers had

all emergency contact numbers and were to provide Frankland with updates every three hours.

50. At 9.30am, the man's father visited his bedside unannounced. The man confirmed to officers that the visitor was his father and that he had not seen him for many years. An unofficial visits form was completed and recorded that his father left the hospice at 9.40am, visibly upset. The document recorded that his father was offered support from staff and thanked them for doing so. An SO made an entry in the man's log that full details of the unofficial visit by his father would be entered in his history sheet.

51. At around 2.15pm, the prison chaplain arrived to see him. There was no record of when the chaplain left the hospice. The log recorded a change in shift at 7.25pm; three officers arrived to relieve the daytime officers of their duties.

52. At 10.30pm, the man died peacefully in his room. All three officers were at his bedside. Hospice nurses confirmed the time of death and an SO informed the prison that he had passed away. He recorded the time on his escort record.

53. Shortly after the man's death, the prison's liaison officer (PLO) contacted his next of kin to break the news of his death. Over the next few days, the PLO also spoke to his father and discussed funeral arrangements with him. The PLO explained that Frankland would arrange the funeral and meet the costs. The prison chaplain attended on behalf of the prison.

ISSUES CONSIDERED DURING THE INVESTIGATION

54. The man had remained a potential high risk to himself and others throughout his 16 years in the high security estate. There were times when he made a concerted effort to participate in the regime and, when he attended workshops, education and occupational therapy sessions, he did make some progress. However, the man presented with challenging behaviour throughout his time at Frankland. This resulted in a disproportionately high number of adjudications, and several moves to other wings including the segregation unit.

55. Bearing in mind his challenging behaviour and category A status, I have been impressed by the extent to which healthcare and discipline staff responded to the man's illness and made his life as comfortable and dignified possible. He was encouraged to participate in a limited regime, and received 24 hour inpatient care. When he deteriorated rapidly, he was compassionately managed and transferred to an outside hospice in a timely way.

56. That said, although there would have been no effect on the ultimate outcome for him, the investigation highlighted a number of areas where practice could be improved.

Record keeping

57. The Prison Service expects a high standard of individual prisoner record keeping. Prison officers are required to make regular and considered entries on a prisoner's demeanour, and interaction with staff and others, and to record any other noteworthy events in all records. In this man's case, there were examples of good record keeping from some individual members of staff, but in general the record keeping fell short of the expected standard. Records were disorganised, difficult to read and not presented in chronological order. I make the following recommendation:

The Governor should develop a self-audit programme for monitoring standards of record keeping and provide appropriate training to staff as necessary.

58. The man stayed in hospital twice before being moved to the hospice in his final hours. On all three occasions, escort officers were deployed to remain at his bedside and to maintain a bedwatch log. In this man's case, the only bedwatch log made available to my investigator at the time of the investigation was the hospice log. Subsequently, the bedwatch logs for the period 20 to 28 April and 22 to 27 May were found by the prison. Whilst the bedwatch logs were completed for all three periods, it is disappointing that it took approximately three months for the prison to notify my investigator that the remaining bedwatch logs had been found.

The Governor should review and revise the record storage system to ensure that bedwatch and escort information about particular prisoners is filed correctly.

Healthcare records

59. Healthcare staff at Frankland showed great determination and commitment in caring for the man during the last six weeks of his life. It is clear from his medical record that nurses overcame difficulties quickly to ensure he was made as comfortable as possible. When unsure of how to administer certain medication, nurses sought the advice of medical practitioners in a timely way. What is not clear from the record is whether handover meetings took place regularly during the change from night to day shift, and who his primary carers were for the duration of his stay in the healthcare unit. The man's medical records were often difficult to read, incorrectly initialled and signed, and below the expected standard.

The Healthcare Manager should remind staff that, in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order.

CLINICAL REVIEW

60. The clinical review conducted on behalf of Durham and Chester-le-Street PCT comments that the man's deterioration was relatively rapid. The reviewer is satisfied that all that could be done for him was done. The review notes that, whilst the man might have had some symptoms that would have suggested the need for investigation, it would appear that he either ignored them or chose not to report them. The clinical reviewer stresses that the man's diagnosis of anaemia resulted from observations made by staff.

61. The clinical reviewer also highlights the good standard of symptom control the man received, especially latterly following the use of the syringe driver, and the further advice sought from the MacMillan Nurse.

62. The clinical review does comment adversely on the presentation and content of the man's medical records. It says of his transfer to the hospice that, "He must therefore have been transferred on 1 or 2 June, but the clinical record had no details of the transfer."

63. The clinical reviewer makes the following additional comments regarding clinical records, and I urge the PCT in partnership with Frankland to consider them carefully and look for a way forward to improve records and record keeping:

    Prison manual clinical records remain of poor quality and the filing in this case was quite chaotic. This not only makes them extremely difficult to review but also must be problematic for clinical staff in finding the information that they require. I regard this as a potential clinical risk.

    It is frequently stated that the introduction of the electronic patient record will rectify this problem, but, without initial work to tidy up the manual records, the new electronic system will suffer from "rubbish in, rubbish out".

    I have commented on this before and fear that little is currently being done to address this concern. It is an issue for the service as a whole and not just HMP Frankland. I believe this issue should be raised with Primary Care Trusts with prisons as an issue of clinical governance.

    The PCT in partnership with the prison should consider the points raised in the clinical review with regard to records and record keeping and develop an action plan to address these in a timely way.

RECOMMENDATIONS

OPERATIONAL

1. **The Governor should develop a self-audit programme for monitoring standards of record keeping and provide appropriate training to staff as necessary.**

   The Prison Service accepted this recommendation.

2. **The Governor should review and revise the record storage system to ensure that bedwatch and escort information about particular prisoners is filed correctly.**

   The Prison Service accepted this recommendation.

CLINICAL

3. **The Healthcare Manager should remind staff that in accordance with the Nursing and Midwifery Council's guidelines for records and record keeping, all medical records should be legible, up to date and in chronological order.**

4. **The PCT in partnership with the prison should consider the points raised in the clinical review with regard to records and record keeping and develop an action plan to address these in a timely way.**

GOOD PRACTICE

5. **Senior management and staff should be commended for arrangements they made for the man to be treated with dignity during his final hours in the hospice. Compassionate management of a category A prisoner was shown in implementing a 'no restraints' policy and by ensuring that escort staff remained in civilian clothes whilst he was in the hospice. A careful balance was struck between the man's potential high risk and the need for dignified care due to his terminal illness. This was done in a sensitive and timely way.**

6. **I commend the occupational therapist, for the attempts she made to keep the man's spirits high in light of his terminal condition. The occupational therapist provided him with additional emotional support and encouraged him to remain as active as possible in the final weeks of his life.**