

**Investigation into the circumstances surrounding the
death of a man in May 2007 in Sunderland Royal Hospital,
whilst in the custody of HMP Frankland**

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

March 2010

This is the report of an investigation into the death of a man, who died in hospital whilst in the custody of HMP Frankland on 27 May 2007. Although he was terminally ill with cancer, his death was premature due to a serious error in the prescription earlier prepared at the hospital. He was 32 years old.

I would like to offer my sincere personal condolences to his family. My investigation was suspended whilst the police investigated his death, but I must apologise to the family for any added distress caused by the delay in issuing this report.

The investigation was undertaken by one of my senior investigators. Both he and I would like to thank the Governor of HMP Frankland, and his staff for their participation. County Durham Primary Care Trust (PCT) commissioned a review of his clinical care, and I also greatly appreciate their assistance.

As is the case in many of my investigations, I am strongly influenced by what I am told in the clinical review. In this case it concludes that, as cancer treatment is a specialist area of medicine, medical staff at Frankland were unlikely to be familiar with the treatment the man was undergoing.

While I agree that the tragic overdose that was the cause of his death was not something for which the prison can be held responsible, there are issues concerning the procedures for holding medication that I hope have been addressed. I also have concerns about the procedures for compassionate release, and the use of security restraints whilst he was in hospital.

The family have responded to the draft report, and once again I apologise for how long the reporting process has taken. The family expressed concern at the response from the prison's healthcare when he complained of pain and difficulty sleeping. There were also concerns that the family had to arrange hospital appointments for him.

I make eight recommendations. The Prison Service have said that they will respond to the recommendations in due course.

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Prisons and Probation Ombudsman

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SUMMARY

The man was a young man serving an indeterminate prison sentence. Prior to his imprisonment, he had been diagnosed as suffering from Hodgkin's lymphoma. This is a cancer of the lymphatic system, and is sometimes called Hodgkin's disease. He continued to be treated whilst he was in prison.

After a period of remission, his cancer returned in late 2006. He was still under the care of the Sunderland Royal Hospital, and was prescribed a course of chemotherapy which included powerful oral medication.

On 13 March 2007, he returned to prison after a hospital appointment. He had been prescribed another batch of medications, including his chemotherapy drugs. Tragically, an error on the prescription meant that he was given a dosage of a drug called lomustine far in excess of that which he should have received.

Medical staff at the prison did not have specialist knowledge of the cancer treatment, and were unaware that the dosage was too high. He was issued the medication, and took it as directed. Soon afterwards, he started to become seriously unwell and was admitted to hospital. Whilst in hospital his solicitors asked the prison to begin the process to apply for compassionate release, but the request was subsequently refused. The man remained in hospital until his death on 27 May.

I make eight recommendations which cover:

- procedures for dealing with medication coming into the prison
- the process for agreeing that prisoners may hold their own medication
- new procedures for dealing in specialist drugs
- applications for compassionate release
- regular updates on prisoners in outside hospital
- regular security assessments on prisoners in outside hospital
- debriefs and support for staff after a death in custody.

THE INVESTIGATION PROCESS

1. HMP Frankland provided the Ombudsman's investigator with his prison record. The investigator also obtained the man's medical records. He visited the prison and met with the Head of Business Unit. He spoke to staff who knew the man, including the former Head of Healthcare, and visited the previous prison doctor at his surgery.
2. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact my investigator. No further information was received.
3. Northumbria Police conducted an investigation into the circumstances surrounding his death. Prison and hospital staff were interviewed and expert medical opinion sought. No charges were subsequently brought. My investigation was suspended whilst the police completed their enquiries.
4. County Durham Primary Care Trust (PCT) conducted a clinical review of the man's care and treatment. The investigator discussed the report with the clinical reviewer.
5. Both investigator and the clinical reviewer had considerable difficulty in obtaining and interpreting the prison records. The clinical reviewer suspects that the copy of the medical records provided to him was incomplete. I accept that there was a police investigation which might have resulted in the removal of some papers, but nevertheless the man's files were not well maintained.
6. The investigator formally interviewed the prison pharmacist and the former prison doctor, and those interviews were recorded. The interviews were transcribed and interviewees invited to sign and return copies, confirming their accuracy. The investigator provided feedback to the liaison officer at Frankland during the investigation.
7. One of my Family Liaison Officers contacted the man's mother to explain our investigation and offer the opportunity to contribute. The family did not have any specific questions for us but wanted to see the report when it was ready.
8. My investigator wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Throughout the course of the long investigation, the investigator has remained in frequent contact with the Coroner's office. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

HMP FRANKLAND

9. HMP Frankland is a high security prison holding over 700 prisoners serving sentences of four years and over, or category A prisoners on remand. In the prison ratings published by the National Offender Management Service for the first quarter of 2009/10, Frankland is rated as a good performing prison.
10. Frankland has a healthcare centre with 22 in-patient beds, and there is 24-hour medical cover by nursing staff. Surgeries are held by one of two general practitioners between 8.30am and midday on Mondays to Fridays. There is a full-time pharmacist and a full-time pharmacy technician. The prison uses a computer based system called EMIS (Egton Medical Information System) to record prisoners' medical information, but during the man's time in Frankland, prisoner medical records were still mainly handwritten notes.
11. When prisoners are required to attend outside hospital appointments, risk assessments are undertaken. Standard security would be that two members of staff would accompany the prisoner. The prisoner will wear handcuffs, and in addition would be handcuffed to one of the prison officers. This is known as double restraint. When in consultations, the security could be reduced to the prisoner just wearing handcuffs. If a prisoner is staying in hospital overnight, security may be reduced to a longer chain between the prisoner and one of the prison officers, known as an escort chain. The prisoner will remain on double restraint during the day and when moving around the hospital. Management checks are conducted daily by the security senior officer.

In-possession (IP) medication

12. Prisoners' medication is stored in one of two ways. If prisoners are assessed as able to follow the administering instructions, pose no risk of suicide or self-harm, and are unlikely to abuse the medication, they are allowed to hold their own medication themselves. This is known as in-possession. If it is judged that allowing the prisoner to hold their own medication is likely to pose a threat to themselves or to others, the pharmacist will prepare the medication and have it taken to the prisoner's wing, where it will be dispensed as required by nursing staff. In addition, controlled drugs such as morphine are administered by staff and are not held in-possession.

Lomustine

13. Lomustine, also known as CCNU, is a cancer drug commonly used to treat brain tumours, Hodgkin's disease, and non-Hodgkin's lymphoma. Lomustine is usually taken as a single dose every six weeks. Possible side-effects of lomustine include a temporary effect on the bone marrow causing an increased risk in infections, tiredness, and being prone to bruising.
14. Lomustine is a specialist cancer drug. Unlike more commonly-used medication, the pharmacy at Frankland would not hold a stock of lomustine. When required,

it would be prescribed by the prisoner's hospital consultant, dispensed by the hospital pharmacy, and brought into the prison.

Previous deaths at Frankland

15. Since I took over responsibility for investigating deaths in prison custody in 2004, 25 prisoners have died at HMP Frankland (13 deaths occurred prior to this man's, and 11 since). I have previously made recommendations about the process for compassionate release. Previous reports also include recommendations about record keeping in healthcare.

Her Majesty's Inspectorate of Prisons' report

16. The last report published on Frankland by HM Chief Inspector of Prisons, followed an announced inspection from 4 - 8 February 2008. The report found that, generally speaking, healthcare provision in Frankland was satisfactory. There were references to high levels of opiate prescription, and staffing levels were noted to be low.

Independent Monitoring Board (IMB) report

17. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The last report published by the IMB for Frankland covered the period 1 December 2007 to 30 November 2008. The Board mentioned that there were some ongoing problems with workloads in the pharmacy department which occasionally led to delays in issuing medication.

KEY FINDINGS

18. The man was in HMP Durham in 2002, serving a previous sentence. He was suffering with Hodgkin's lymphoma, and continued his treatment under the care of a doctor at Sunderland General Hospital (Doctor A). The doctor noted that, although the man's cancer had been in remission, there was a 20 per cent chance of recurrence. If that were to happen, the possibility of a cure would be less likely.
19. Having been released from prison, he was remanded to Durham once more in January 2003. Once again, his lymphoma was noted and his medication continued to be prescribed. The last chemotherapy treatment had been in May 2002, with no signs of recurrence of his illness since then.
20. On 30 April 2004, he was convicted of serious offences and sentenced to life imprisonment. He was returned to Durham.
21. The medical director at Durham (Doctor B) contacted Doctor A on 9 June to request any necessary further information about his illness. Doctor A replied that the man was in remission. Doctor B requested regular updates on the man's progress, to which Doctor A agreed. Doctor A noted that the man was currently well, although the possibility of relapse remained. He agreed that any necessary follow-up could be arranged at any prison that the man was transferred to.
22. With a transfer to HMP Frankland pending, medical staff at Durham contacted healthcare at Frankland on 23 August to give a short summary of his medical history. A brief written synopsis was also sent. On 17 September, the man transferred to Frankland. He was seen on reception, and reported that he was fit and well at that time.
23. Medical staff saw him on the wing on 4 October, then again on 6 October, for cold-type symptoms. It was noted that he was a heavy smoker, but would have to wait for an appointment at the smoking cessation clinic. He saw a prison doctor on 1 December when he complained of not sleeping well.
24. On 7 January 2005, Doctor A reviewed the man. He identified a soft tissue swelling on his right chest wall which might indicate a recurrence of the Hodgkin's lymphoma. He arranged a computed tomography (CT) scan (a specialised X-ray test to give clear pictures of the inside of the body, particularly of the soft tissues), which was undertaken on 3 February. He was subject to standard security restraints during these hospital appointments.
25. Not having received notification of a result of the scan, he complained on 24 March. Healthcare staff told him that his last scan was normal, and the prison doctor, had written to him to that effect. However, by 1 April he had still not received a reply. Healthcare staff contacted the hospital and confirmed that the scan results were normal.

26. On 6 May, solicitors acting for the man wrote two separate letters to the prison. The first asked when he would receive his sentence planning review, and for an indication as to what were considered to be his risks of re-offending and therefore the recommended coursework. The second was directed to healthcare, asking about arrangements for his medical care up to and through his eventual release. On 17 May, a member of staff from the prison secretariat telephoned the solicitors to confirm the exact information that was required. The solicitor dealing with the man was not available, so a message was left asking them to return the call. No call was subsequently received. On 26 May a Senior Officer wrote to the solicitors to let them know that his sentence plan was scheduled for September, and the Psychology Department had been asked to assess him for suitability for appropriate courses.
27. Doctor A reported on 8 July that, although the CT scan was normal, the swelling in his chest had grown. A recurrence of his cancer could not be discounted, and a biopsy (a medical test involving the removal of cells or tissues for examination) was taken. On 29 July, the biopsy was also reported to be normal, but the next follow-up appointment was brought forward from six months to two months because of these concerns.
28. On 7 September, the man complained that the large lump in his chest was causing him pain. He was referred urgently to Doctor A who confirmed that the cancer had returned. He was prescribed medication and, on 27 September, was admitted to the Sunderland Royal Hospital to begin further chemotherapy. After suffering from some side effects, including anaemia and a serious rash on his upper arm, his medication was changed. He was no longer prescribed allopurinol tablets (allopurinol is a drug used primarily to treat hyperuricemia, which is excess uric acid in the blood plasma). He remained in hospital for further chemotherapy, and returned to prison on 2 October. He had been subject to standard security restraints during this hospital appointment.
29. Having run out of his medication (which he held in his own possession), the man went to the healthcare on 11 October and asked to see the doctor. It was noted on his record that he usually complied with his medication regime and was unlikely to have abused it. A member of healthcare staff contacted the prison doctor, to ask for a prescription for temazepam to be faxed through but the doctor did not agree to this. The man was advised to see the doctor the following day. He did so, and told the doctor that he had taken extra tablets as he had difficulty sleeping and so had run out of the medication. He was told that his prescription would not be increased.
30. Medical records dated 12 October show that he continued to be allowed to keep his medication in-possession whilst in prison. He was admitted to the Sunderland Royal Hospital on 17 October for further chemotherapy treatment, going back to Frankland on 22 October. He was subject to standard restraints during this hospital appointment. The man's medical records contain another note on 31 October expressing concern about him running out of his medication too quickly.

31. He returned to prison from another course of chemotherapy on 26 November. He was reported to be very anxious about getting his night sedation. A letter from a doctor of the Haematology Department of City Hospital Sunderland shows that, him having completed his third course of chemotherapy, consideration was being given to stem cell treatment. The man's bone marrow would be stimulated to produce stem cells that would be developed and transplanted back into him.
32. On 3 January 2006, wing staff contacted healthcare to say that he was too ill to attend for his scheduled treatment. He said he was okay, but felt "under the weather". On 25 January, kitchen staff rang healthcare to express concern that he was unable to carry out his duties. They suggested he might consider changing his job.
33. Solicitors acting for him wrote to the prison on 20 February. They asked for the man's security category and for a copy of his Offender Assessment System (OASys) report.
34. To assist with his ongoing treatment, he had been fitted with a Hickman line. (This is an intravenous catheter, most often used for the administration of chemotherapy or other medications. Hickman lines may remain in place for extended periods and are used when long-term intravenous access is needed.) On 16 March, he refused to have his Hickman line cleaned and flushed. Staff repeated the request, but once more he declined.
35. A senior officer responded to the man's solicitors on 18 March, informing them that he was security category B. He also sent the requested copy of the OASys report.
36. The man returned to the Sunderland Royal Hospital on 3 April for chemotherapy followed by the stem cell transplant. He remained in hospital until 20 April. He was subject to standard security restraints. On returning to prison, he said that he did not want to be located in the healthcare centre, but would rather remain on the main wing. He further said that he did not want to go to the doctor's surgery the next day as he did not like the crowded waiting room. He said that he would contact healthcare if he needed to see a doctor.
37. His medication had been prescribed for him to hold in his own possession, and on 21 April he reported that he had run out of tramadol. Staff tried to get more from the pharmacy, but no doctors were available to prescribe the drug. The staff waited until a doctor arrived, whereupon more medication was dispensed and taken to the wing. An entry in the man's medical record dated 24 April notes that "[He] ... tells me he ... *illegible* ... out Temazepam and Aciclovir? ... *illegible* ... for non-IP if recurs". This indicates that staff were concerned about his control of his medication, and if there were further problems then he would no longer be allowed to retain his medication in his own possession.
38. When collecting his medications from the pharmacy on 7 July, he said that he felt unwell and asked to see a member of healthcare staff. He had been waking in the night short of breath, with a quickened heartbeat. He was anxious about

his health, but did not want to see the doctor at this stage. He was told that if the symptoms recurred he should alert wing staff and see the doctor.

39. On 12 July, he asked to see the prison doctor as he could feel some lumps in his chest. He was put on the list to see the doctor the following morning. An entry in the medical record the next day notes that a small lump had been found in the man's chest and in the side of his neck, although there is no indication of what action was taken. A separate entry that day shows that he was prescribed his temazepam tablets in-possession. At a hospital review on 10 August, the node in his lower neck was noted. A chest x-ray was taken, and the results were reported to be normal.
40. Another batch of temazepam tablets was prescribed to be held in-possession on 22 September.
41. The prison Doctor C wrote to a doctor at the Sunderland Royal Infirmary on 23 October asking him to see the man in relation to the swelling on the right side of his chest. It was noted that pain was affecting his day-to-day life. A reply was received from Doctor D on 8 November saying that a CT scan had been arranged. On 5 December, results from the scan showed a new lump in the man's chest as well as a growth in his sinuses. He was admitted for further biopsies and ear, nose and throat (ENT) tests on 12 December.
42. The ENT consultant surgeon wrote to the man's consultant haematologist on 14 December. He confirmed that the growth in his nose was not cancerous. However, his medical record notes on 15 December that he was still suffering chest pain and might have had a relapse of his cancer.
43. Concerned at the chest pains the man had been experiencing, and aware of the possibility of a relapse Doctor C wrote to a Consultant in Palliative Care, on 18 December. (Palliative care is provided when patients will not recover from their illness, and are receiving treatment to reduce the severity of their symptoms.) Doctor C requested assessment and advice on palliative care management.
44. A further entry in the man's medical record dated 22 December again queried whether the lymphoma might have returned in his chest wall. The entry referred to the biopsy on the man's nose but is otherwise illegible. A further entry on 29 December indicated that he was anxious about his chest biopsy. It also noted that there was a risk that the tumour was invading the bone of the chest wall. Doctor C discussed his symptoms with the consultant haematologist, and the man was prescribed stronger pain relief.
45. On 4 January 2007, the man was issued tramadol hydrochloride to hold in his possession. The following day, a doctor from Sunderland Royal Infirmary reviewed his care and implemented a new regime to control his symptoms. The man saw the consultant haematologist on 9 January and was told that his cancer could not be cured. Palliative care was explained to him.
46. Medication, including a single day's dosage of five lomustine tablets and approximately 20 tablets of another chemotherapy drug called chlorambucil,

were prescribed to him on 10 January at the hospital. On 12 January, a nurse was working in the healthcare centre distributing the medication. This was not part of his normal duties but he had agreed to do so because of staff shortages. The nurse could see that the man was due to collect a comparatively large number of chlorambucil tablets. Not being familiar with this particular drug, the nurse referred to the British National Formulary (BNF - a dictionary of medicine) to see if the dosage was likely to be correct. The BNF showed that the dosage depended on a person's body mass and would therefore be different for each person. The nurse then dispensed the medication to him as indicated on the prescription.

47. The following day, the nurse contacted a locum pharmacist who sometimes worked at the prison. On this day she was working in HMP Durham. The nurse queried the dosage of chemotherapy drugs the man had been prescribed. The pharmacist told the nurse that she had already identified the dosage and spoken to the issuing body. She assured the nurse that the dosage was correct. The nurse then telephoned the prescribing consultant's medical secretary, who confirmed that the doctor's notes had been checked and that the prescription was correct.
48. On 15 January, the man was brought to the healthcare centre complaining that he had no in-possession medication left. It is not clear if this was due to him over-using his medicine or insufficient medicine being provided. The duty doctor was contacted, and he advised that the man should be given some Zomorph (a morphine-based painkilling drug) from stock. The man was unhappy about the management of his medication and said he would complain the following morning, although the records do not indicate whether he did so.
49. Solicitors acting on behalf of him wrote to the prison on 16 January raising the issue of compassionate release. They requested copies of his medical papers. The same day, they also wrote to his personal officer, asking for a report on his behaviour.
50. Another prescription of tramadol hydrochloride was issued to the man on 27 January. This was also to be held in-possession.
51. The doctor held a review with him on 1 February. The man's symptoms were being controlled better, and some minor adjustments were made to his treatment. He expressed concern about dying in prison without having had the opportunity to spend time with his children.
52. An entry on his medical record on 2 February referred to his review and treatment plan. The entry is largely illegible, but seems to indicate that he was clinically depressed, though reluctant to take anti-depressants. It mentions that he was in the process of applying for early release. The man was again prescribed temazepam on 5 February to hold in-possession.
53. He was prescribed a further dosage of medication on 7 February. Once again, this included lomustine.

54. The Head of Business Unit at Frankland replied to the man's solicitors on 21 February. She asked that they write to the Governor, rather than individual staff members. She explained that any reports on the man would form part of any consideration for release.
55. Different solicitors acting on the man's behalf wrote to the prison on 27 February. They included a letter from his consultant, supporting his release. They asked for clarification of the application process.
56. The man had been undertaking a drug and alcohol rehabilitation programme called FOCUS. On 7 March, the FOCUS Treatment Manager in the psychology department declined to provide a report to his solicitors. She said that he had not completed the course and an interim report might not serve his best interests.
57. The Head of Resettlement replied to the solicitors' letter of 27 February on 13 March. She wrote that she had copied the solicitors' request to the healthcare department as they were considering applying on behalf of the man for compassionate release.
58. After another appointment at Sunderland Royal Hospital, the man returned to Frankland on 13 March. He was subject to standard restraints. The hospital provided quantities of his prescribed medication, which included lomustine and etoposide (another chemotherapy drug). An error in the prescription resulted in him being given more of these two drugs than should have been the case. He was dispensed 35 tablets of 40mg of lomustine, five tablets to be taken per day. This meant that he was given seven days' dosage of lomustine, when the correct dosage should have been five tablets per day, but only for one day per month. He was also given 32 100mg etoposide capsules at a dosage of four per day. This meant that he was given eight days' dosage rather than three.
59. When prisoners return to Frankland from a hospital visit that was not because of a specific incident (such as an operation), they are not routinely seen by a member of healthcare staff. This was the case when he returned to Frankland on this occasion, and he was taken directly to his cell. His medication was taken to the healthcare centre.
60. On 15 March, the prison pharmacist informed the prison doctor (Doctor E), that the medication that had been dispensed to him at the hospital was in the healthcare centre. Doctor E took the bottles and recorded the medication on the computer system. No prescription had accompanied the medication back from the hospital. In interview with the police, Doctor E said that this was not unusual, occurring in perhaps 50 per cent of cases. He therefore read the information on the labels on the bottles and entered them on the system, then passed the bottles to healthcare staff to pass to the man. He printed off and signed a note which confirmed that the man should be allowed to retain the medication in-possession.
61. In interview with the police, the pharmacist said that she did not recall being consulted as to whether the medication should be held in-possession or not. As

far as she could remember he had not had the previous two prescriptions of his chemotherapy drugs in his own possession. It is not clear from the medical records whether this was the case. But the pharmacist told the police and subsequently told my investigator that she did not personally deal with the medication of the man brought back from hospital on 13 March at any time.

62. On the same day that Doctor E confirmed that the man should hold his own medication, a palliative care nurse reviewed his care. His pain was under control, but he was unable to tolerate some medication. He suffered feelings of nausea when the medication was administered out of sequence. He had suffered problems from being unable to obtain his chemotherapy medication at the right time in the morning, so it was given to him in the evening for him to take at the correct time the following morning. He was issued the etoposide and lomustine, plus other drugs, in multiple quantities. The outcome of this was that he was given a significantly larger dose of lomustine and etoposide than he should have been. He then proceeded to take this medication as erroneously indicated.
63. The man was scheduled to see a psychologist the following week for assessment as part of his application for early release. He was anxious to be able to spend some time with his children while he was still relatively well. It is not clear from the records whether this appointment subsequently happened. On 18 March, he was issued 28 metoclopramide hydrochloride tablets, which are used to help control nausea.
64. The Acting Healthcare Manager replied to the letter of 27 February from the man's solicitor on 21 March. He wrote that the review to consider early release was underway.
65. The same day, the man's medical record contains the following entry from a healthcare officer (the signature is illegible):

“... spoke to Doctor E and clarified that he could have medication in-possession ... Staff on morning treatments as suggested by the MacMillan [nurse] ... The Chlorambucil to be taken from main treatment room fridge at treatment time. a non-in script to be generated for the chlorumbucil.”
66. On 29 March, having finished the course of chemotherapy some days previously, he saw Doctor E to complain of a sore mouth and throat. Doctor E arranged for blood tests to be undertaken in the healthcare centre. His blood results caused some concern and so he was listed to see the doctor the following morning, with the proviso that his temperature required monitoring overnight. If it became high staff would need to liaise with the out-of-hours doctor and arrange for him to be admitted to hospital. He was asked if he would spend the night in the healthcare centre, but declined. His temperature was monitored in the evening, and he was told to alert wing staff if he felt shivery or hot during the night. When monitored his temperature was 36.9, and he said he felt unwell. His temperature was monitored again at 11.00pm, and was 36.6. (These readings are within the normal range.)

67. The following morning he was seen on the wing by a nurse from healthcare. A Nurse noted that he looked poorly, felt hot and lethargic, was sweating, and was coughing up sputum. He initially said he did not have the energy to go to hospital, but eventually agreed to do so and an ambulance was arranged. He was admitted to the Sunderland Royal Hospital. Following a risk assessment he was, as with previous hospital appointments, subject to standard security restraints.
68. At around this time, the man's mother had written to the prison, explaining how difficult it was for the family not knowing where he would be as he became progressively more ill. The Principal Officer (PO), who is also the Lifer Manager, replied on 2 April. He said that a case conference was being arranged, and that the man's mother should write to a member of staff in healthcare.
69. On 3 April, Doctor E spoke to the man's consultant haematologist. The consultant told him that the man had taken a dose of chemotherapy drugs significantly higher than the correct prescription. This had caused bone marrow suppression. He was being monitored, but had been informed that his condition was terminal. Doctor E said that Frankland had a healthcare unit and was willing to accept him back if and when this became appropriate.
70. Solicitors acting for the man wrote to the prison again on 10 April, about the possibility of compassionate release. They enclosed supporting letters from his family, his consultant haematologist, another doctor, and a report from a psychologist. They also requested that his security restraints should be removed. The Governor who is Head of Operations replied the following day. The Governor said that, as the man was in hospital, he would not be considered for release until there were clearer indications of the effectiveness of his treatment.
71. The consultant haematologist wrote to the man's solicitors on 16 April indicating that the man's condition had deteriorated. There was apparently only a slim chance of him living more than one or two months. She commented that the man's wellbeing, psychological and physical, would be improved if he was not subject to restraints whilst in hospital and the bedwatch officers were not permanently present in his hospital room.
72. The solicitors replied to the prison on 17 April, challenging the decision not to apply for compassionate release as well as the decision not to remove the security restraints. They wrote that they would apply for judicial review if necessary.
73. Treasury Solicitors were acting on behalf of the Prison Service, and on 18 April they requested information from the prison. They asked whether he had been refused a bone marrow transplant, whether he was likely to die in the next weeks, if he was undergoing treatment in hospital, and whether he was handcuffed.

74. On 19 April the Treasury Solicitors replied to the solicitors. They said that, in the light of the new information, the applications for compassionate release and the removal of restraints were under review.
75. The prison carried out a risk assessment that day, and it was agreed that the escort chain could be removed from the man. The escort staff were moved out of his room and outside the door. They were required to make checks twice an hour, and once an hour at night. By this stage he was spending almost all of his time in his bed, and was being administered medication regularly
76. The Lifer Manager completed the compassionate early release forms on 25 April. The recommendation was that the man should be released. A note on his medical record that day shows that his condition was very poor. The Pre-Release Section of the National Offender Management Service replied to the application for early release on 4 May and declined compassionate release. They noted that the man had been convicted of serious offences, and said that the prognosis of life expectancy did not meet the criteria for consideration at that stage. They believed that there remained the possibility that the man's treatment might yield an indeterminate length of remission. The decision would be reconsidered if it were confirmed that the man's condition was terminal.
77. The next entry on the man's medical record was on 27 May, relaying a message from the duty governor that the man had passed away at 1.50pm. His family were with him at the time.

Debrief

78. It is usual in light of the death of a prisoner to hold a debriefing session with staff involved in his or her care. These ensure that staff have an opportunity to discuss any issues arising, and for support to be made available. As the man died in hospital after a period out of the prison, a debrief was not held.

Post Mortem

79. A doctor conducted a post mortem. He noted a reference in the man's medical record on 23 March 2007 that chemotherapy is to be administered by treatment staff. The doctor concluded that the pancytopenia (all three elements of the blood - red cells, white cells and platelets - are reduced) observed in the man was outside normal limits and, in his opinion, could be directly attributed to the over-prescription. The doctor pointed out that he did not have specialist knowledge of this area and advised that an expert opinion should be sought from a clinical pharmacologist (a specialist in drugs and their clinical use) and an oncologist (a specialist in tumours). The doctor concluded that the man's death was due to:
- 1a multi-organ failure
 - 1b Hodgkin's disease and overdose of chemotherapy
80. It was the doctor's opinion that both the Hodgkin's disease and the increased dose of medication directly contributed to the acquisition of an infection and the

development of multi-organ failure. He wrote that while the Hodgkin's contributed to the man's death, he would not have died then had it not been for the excess medication.

81. A second post mortem was carried out by another doctor, who concluded that the man's pancytopenia was caused by bone marrow damage which was a consequence of the chemotherapy he received.

82. The cause of death was given as:

- 1a multi-organ failure due to
- 1b sepsis due to
- 1c pancytopenia

City Hospitals Sunderland NHS Trust Investigation

83. City Hospitals Sunderland NHS Trust carried out an investigation into the over-prescription of medication to him at the hospital. The report concluded that the clinical checking procedures appear to have been appropriate. Nevertheless, a number of contributory factors meant that an error was made. The report made a number of recommendations which aimed to reduce the likelihood of further errors being made. They largely related to procedural matters within the hospital, but were shared with the prison to allow them to review their procedures in a similar way. The recommendations included ensuring that all patients in receipt of such drugs are personally counselled by professional staff, ensuring that helplines are available to patients, and to review the training needs of all staff involved in the dispensing process.

Police investigation

84. Northumbria Police conducted an investigation into the circumstances of the man's death, and the Ombudsman's investigator was in regular contact throughout. He attended the police headquarters and was given access to police papers relevant to the man's care in prison, including copies of statements and interviews with prison staff. No criminal charges were brought against any member of Frankland prison staff.

ISSUES

Clinical care

85. The clinical reviewer says that, after reception into prison, the man's ongoing health and medication needs were addressed. When he transferred to another establishment, the decision to transfer him to Frankland was helpful as it ensured continuity of care by the same PCT, and he was able to remain under the same hospital. Furthermore, staff at Durham took the time to contact healthcare staff at Frankland by telephone and by letter in advance of the man's transfer to apprise them of his medical history.
86. I am also impressed, and the clinical reviewer makes a similar comment, that Doctor C took the initiative to seek guidance and input from a palliative care specialist when it was thought possible that the man's cancer was returning in late 2006. This helped to reduce the man's suffering, and I hope that provides some comfort for his family.

Incorrect prescription

87. One of the main areas of concern in looking at the man's care is obviously the incorrect dosage of lomustine. The drug was prescribed by the hospital consultant and the error on the prescription was made at the hospital, and did not involve prison staff.
88. There does seem to have been some confusion about the process for dealing with medication when it was brought back to the prison from outside hospital. In interview with the investigator, the prison pharmacist said that there was no set way for it to be dealt with. It might go to the healthcare department, or it might go straight back to the wing with the prisoner. The prison doctor told the investigator in interview that as far as he was aware medication would always be referred to the prison doctor to enter onto the prison medical computer system (EMIS). This would generate a paper document for the prisoner to sign, confirming that he had received his medication, and create a paper trail for audit purposes. It would also ensure that drugs were entered on the system to confirm they were in the prison.
89. In the light of the man's death, the PCT have drafted guidance for the re-use of patients' own drugs (that is medication coming into the prison from outside sources), but they remain at the draft stage. I recommend to the Head of Healthcare that procedures for dealing with medication coming into the prison from outside are clear and give readily understood lines of responsibility.

The Head of Healthcare should ensure that procedures for dealing with medication coming into the prison are clear, with unambiguous lines of responsibility

90. This man was allowed to hold his own medication and this arrangement needs to be considered. In interview with my investigator, the pharmacist said that the risk assessment forms allowing prisoners to hold their own medication were not always used as fully as they have been since. She said that the aim is, wherever possible, to allow medications to be held by prisoners, mirroring what would be standard for patients in the community.
91. There were a number of occasions where there were concerns about the man's care of his own medication. An entry on his medical record on 24 April even states that if there were further problems he was not to be allowed to hold it himself. But he was described by Doctor E in interview with the police as an intelligent man. He was aware of the complexity of his illness, and was judged unlikely to abuse his medication. On balance, it appears reasonable that he was allowed to hold his medication himself. However, the process by which he was allowed to do so appears to have been rather haphazard. I recommend as follows:

The Head of Healthcare should ensure that the process for prescribing in-possession medication is clear and decisions are properly documented.

92. When the man was given his medication to hold in January 2007, a nurse thought that the amount being prescribed seemed high. I am pleased to learn that he checked the drugs in the BNF, sought the advice of a pharmacist, and confirmed the dosage with the hospital.
93. In interview, both Doctor E and the pharmacist said they did not have any specialist training in cancer treatment, and did not know anything about lomustine. The pharmacist said that she would not consider it necessary to query a prescription issued by the specialists at the hospital, which included pharmacists used to prescribing chemotherapy medication.
94. Doctor E told the investigator that, although he entered the lomustine onto the computer system, this was only because prison procedure required that this be done by a doctor. The doctor said that it was not the case that he was confirming the prescription but simply recording it. If, as in the man's case, the drugs were ones that the doctor was not familiar with and had been prescribed by a specialist, there would be no reason for the doctor to query the prescription or the dosage.
95. Doctor E confirmed that in his role as the prison doctor he was in effect the prisoners' GP. The investigator asked the doctor whether, having responsibility for a cancer patient, he felt that he should have taken the opportunity to learn a little more about the cancer and treatment being given. The doctor said that in the community he would leave specialist medicine to the specialists, and there was no reason to do differently in prison. Patients with specific illnesses require specialist knowledge. Furthermore, consultants change drugs and dosages frequently, and so any knowledge the GP would acquire could quickly become out of date.

96. The clinical reviewer confirms that chemotherapy is a very specialised area. He says that it is very unlikely that the clinical team at the prison had any expertise in this area, and would not recognise that the dosage was too high. Although the nurse showed great initiative by checking the dosage of the man's chemotherapy drugs in January, I consider it reasonable for both Doctor E and the pharmacist to have accepted the dosage the man brought back with him from the specialists at the hospital.
97. The clinical reviewer recommends that the outcomes of the NHS Trust investigation are considered and procedures within the prison are reviewed. I note that in January 2008, the National Patient Safety Agency issued an alert after a number of incidents whereby patients across the country receiving oral chemotherapy had been given incorrect dosages. One of the recommendations they made was:
- “Staff dispensing oral anti-cancer medicines should be able to confirm that the prescribed dose is appropriate for the patient, and that the patient is aware of the required monitoring arrangements, by having access to information in the written protocol and treatment plan from the hospital where treatment is initiated and advice from a pharmacist with experience in cancer treatment in that hospital.”
98. The pharmacist said in interview that in the light of the man's death, Standard Operating Procedures had been introduced to tighten up safety over any specialised drugs. Procedures are now in place to ensure that the prescription is correct by checking with the prescribers and dispensers at the outside hospital. There are risk assessment forms, and prison pharmacy staff have named contacts in the hospital pharmacies with whom they can check prescriptions.
99. I am pleased to learn that procedures have been strengthened, and I hope that sufficient checks are in place to ensure the effectiveness of the new procedures.

The Head of Healthcare should ensure that new procedures for dealing with specialist drugs introduced in the light of the man's experience are working effectively.

Considering compassionate release

100. Procedures for applying for compassionate release for prisoners serving indeterminate sentences are contained in Prison Service Order (PSO) 4700. The criteria are as follows:
- “the prisoner is suffering from a terminal illness and death is likely to occur very shortly (**although there are no set time limits 3 months may be considered to be an appropriate period for an application to be made to Lifer Review & Recall Section**), or the lifer is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and

- The risk of re-offending (particularly of a sexual or violent nature) is minimal; and
- further imprisonment would reduce the prisoner's life expectancy; and
- there are adequate arrangements for the prisoner's care and treatment outside prison; and
- early release will bring some significant benefit to the prisoner or his/her family."

101. Frankland does not have separate local instructions for applying for compassionate release for prisoners.

102. The man's mother wrote to the prison in late March or early April 2007 to say that it was hard for the family not knowing where her son was going to be as his illness deteriorated. The response from the Lifer Manager was merely that she should write to the Head of Healthcare.

103. The man had been told that his cancer could not be cured when he saw his consultant haematologist on 9 January 2007. Solicitors acting for him wrote to the prison on 16 January to raise the issue of compassionate release. They also wrote to the man's personal officer requesting a report. The Head of Business Unit replied on 21 February saying that reports would form part of the consideration and asking the solicitors to channel all requests to the Governor. Solicitors acting for the man wrote to the prison on 27 February, including a letter from his consultant supporting release. They asked for clarification of the application process. The Head of Resettlement replied on 13 March saying that an application on behalf of the man for compassionate release was being considered. The letter was also copied to healthcare for an interim reply. The Acting Healthcare Manager replied on 21 March saying that the review to consider early release was underway. He hoped to have some news in the very near future.

104. Solicitors again wrote to the prison on 10 April, enclosing letters from the man's family, his consultant haematologist, his consultant in palliative medicine, and a psychiatric report, all requesting his release as well as the removal of the security restraints. The Head of Operations replied on 11 April saying that, as the man was in hospital, he would not be considered for release until there were clearer indications of the effectiveness of his treatment. The consultant haematologist wrote to the man's solicitors on 16 April to say that his condition had deteriorated and he was unlikely to live longer than two months. The solicitors wrote to the prison on 17 April, challenging the decision of the prison not to apply for compassionate release plus the refusal to remove security restraints. On 19 April, Treasury Solicitors acting for the Prison Service replied to the man's solicitors that the applications for compassionate release and removal of restraints were under review. The Lifer Manager completed the compassionate release forms on 25 April, recommending the man's release. The Pre-Release Section of the National Offender Management Service

declined the request on 4 May, stating that the prognosis of life expectancy did not meet the criteria at that stage.

105. At each stage, a different member of prison staff – five in all – dealt with the correspondence. The prison's response to such an important issue gives the impression of being very uncoordinated. Moreover, the initial response from the Lifer Manager, advising the man's mother to write to the Head of Healthcare, strikes me as a poor response to a mother whose son was seriously ill. In any event, prisoners being treated in hospital are eminently suitable for consideration for compassionate release. A co-ordinated response would have been much more sympathetic. I recommend that the process for dealing with applications for compassionate release is clearly laid out, and responsibility is given in each case to a single member of staff to oversee and co-ordinate.
106. As mentioned above, I have previously made recommendations that all prisoners who are diagnosed with a terminal illness should be regularly reviewed by a multi-disciplinary team and considered for early compassionate release in a timely manner. I initially made such a recommendation in 2004, and repeated it again in May 2009. Once more, I repeat the recommendation.

Each application for compassionate release should be allocated to a single member of staff, with that person responsible for co-ordinating the whole process.

Prisoners who are suffering from terminal illnesses should be regularly reviewed by a multi-disciplinary team and considered for early compassionate release in a timely manner.

107. The clinical reviewer notes that it was unfortunate that the application for compassionate release seems to have been partly based on a hospital assessment that preceded the man's admission on 30 March 2007. However, no correspondence between the hospital and the prison at that time gave a prognosis of the time he might have to live. The only document that does indicate a specific short life expectancy for the man is the letter from the consultant haematologist to the man's solicitors dated 18 April. This being the case, going by the criteria in PSO 4700, the prison was reasonable in the way it handled the application for compassionate release. But I agree with the clinical reviewer in saying that, when documentation is prepared for consideration of compassionate release, it must be accurate and up to date. The prison medical files do not show that there was frequent contact with the hospital after the man's admission. From 30 March to 27 May there are only four entries in his continuous medical record, two of which are single-line entries and the last is the record that he had died.
108. The Head of Healthcare should ensure that procedures are in place to ensure regular, good quality updates are obtained on any prisoners admitted to outside hospital. If there is a possibility that the prisoner's illness is terminal, when his condition shows signs of serious deterioration the prison should regularly obtain medical opinion on life expectancy.

The Head of Healthcare should ensure regular, good quality updates are obtained on any prisoner in outside hospital, especially those who are terminally ill.

Use of restraints

109. One of the issues the man's solicitors sought to address was the use of security restraints whilst he was in hospital. He remained subject to security restraints from his arrival in hospital on 30 March until 19 April 2007. There is no evidence of any risk assessment between those times. The solicitors forwarded a letter from his consultant advising that removal of restraints would be beneficial and it was only at this point that the man's security restraints were re-assessed. I have to say that I do not think it reasonable that a terminally ill man was subject to double restraints until this was challenged by his solicitors.
110. I understand the pressures prisons are under when considering the level of risk presented by prisoners who are held in outside hospital. But the records do not show how regularly the man was risk assessed whilst in hospital. I recommend that the Governor ensures that risk assessments are made and documented regularly.

The Governor should ensure that security risk assessments are regularly made and updated for prisoners who are seriously ill in hospital.

Support for staff

111. After the man had died, members of prison staff were interviewed by the police. They included the prison pharmacist. She was distressed by what had happened, and felt that the support available to her was inadequate. The lack of a debrief removed one opportunity to offer staff support, and there seems to have been minimal follow-up. Debriefs can also give staff an opportunity to discuss what has happened and to highlight any areas of practice that need to be reviewed. I recommend that the Governor consider this.

The Governor should ensure that debriefs are held after the death of every prisoner, and that staff who may be affected are offered ongoing support.

CONCLUSION

112. The man was a relatively young man serving an indeterminate prison sentence. He had been diagnosed with cancer before his admission to prison, and continued to receive treatment throughout his sentence.
113. He seems to have been well cared for in prison, including continuity of care when transferred between establishments. Although he regularly attended hospital, he preferred to remain on the wings in prison rather than be in healthcare. When there was a possibility that his cancer might have returned late in 2006, the prison doctor made arrangements for palliative care.
114. On 13 March 2007, he was erroneously prescribed a large dosage of his chemotherapy drug, lomustine, in hospital. He brought it back to prison, but medical staff in the prison were not familiar with this drug and its standard dosages, and did not know that he had been overprescribed. Procedures within the prison for managing medication were not clear, although in this instance it is unlikely that more clarity would have protected him from the hospital's error. When he took the drugs, he overdosed and became seriously ill from the effects. He was transferred to hospital.
115. Solicitors acting for him remained in contact with the prison, asking for him to be released on compassionate grounds. They also asked for the physical restraints to be removed. The prison made an application for compassionate release, which was subsequently refused. The procedures for making the application appear to have been a little confused, though once again it is unlikely that any more clarity would have made a difference in this instance.
116. Although the man was terminally ill, his death was premature due to a serious error in the prescription prepared at the hospital. Whilst I am satisfied that prison staff played no part in this mistake, his situation might have been alleviated had prison staff looked more sympathetically at his application for compassionate release and their use of restraints.

RECOMMENDATIONS

The Head of Healthcare should ensure that procedures for dealing with medication coming into the prison are clear, with unambiguous lines of responsibility

The Head of Healthcare should ensure that the process for prescribing in-possession medication is clear and decisions are properly documented.

The Head of Healthcare should ensure that new procedures for dealing with specialist drugs introduced in the light of the man's experience are working effectively

Each application for compassionate release should be allocated to a single member of staff, with that person responsible for co-ordinating the whole process.

Prisoners who are suffering from terminal illnesses should be regularly reviewed by a multi-disciplinary team and considered for early compassionate release in a timely manner.

The Head of Healthcare should ensure regular, good quality updates are obtained on any prisoner in outside hospital, especially those who are terminally ill.

The Governor should ensure that security risk assessments are regularly made and updated for prisoners who are seriously ill in hospital.

The Governor should ensure that debriefs are held after the death of every prisoner, and that staff who may be affected are offered ongoing support.

The Prison Service have indicated that they will respond to the recommendations in due course.