Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Frankland, in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

This is the report of an investigation into the death of a man, a prisoner on the Westgate Unit at HMP Frankland. He died in October 2010 at hospital, having been found collapsed in his cell the previous day. He was 52 years of age. The cause of death was a gastrointestinal haemorrhage due to a metastatic adenocarcinoma of the oesophagus. Metastatic adenocarcinoma of the oesophagus is a type of cancer originating from the glandular tissue, speading to the oesophagus, the tube in the throat leading to the stomach.

He arrived at Frankland in September 2006, to be assessed in the dangerous and severe personality disorder unit (DSPD). Staff there described him as a very institutionalised man who was compliant with the prison regime. He was diagnosed with upper gastrointestinal (Upper GI) cancer on 23 October 2009. He tried two different forms of chemotherapy, but due to the unbearable side effects he chose to withdraw from treatment.

The investigation was carried out by colleagues. Both they and I would like to thank the Governor of HMP Frankland and the Governor of the Westgate Unit and his staff for their assistance.

The local PCT commissioned a clinical review from Custodial Care Innovative Solutions who appointed a clinical reviewer to undertake a review of the man's clinical care. I appreciate her help and input.

The man had no known next of kin. However, I would like to offer my sincere sympathy and condolences to all who may have been affected by his death.

There are a number of recommendations that emerge from the investigation, but my overall view is that I was impressed by the attention paid to his care by the staff at the Westgate Unit. The clinical reviewer comments in her report "it is my conclusion that the liaison between Westgate Unit staff and the palliative care team is impressive and should be cited as an example 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.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **August 2011**

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SUMMARY

1. In 1977 the man was sentenced to life imprisonment for manslaughter and sent to HMP Leeds. Between 1977 and 2002 he spent lengthy periods of time in Rampton Hospital and Arnold Lodge Personality Disorder Unit, then in 2002 he was transferred to Grassmere Community House. While there, he was assessed as suitable for a home leave trial.

2. However, on 9 March 2002 whilst on home leave he was arrested and charged with GBH (grievous bodily harm) with intent. He was subsequently sentenced to a second life sentence for a violent attack on a young woman.

3. On 12 September 2006 he was transferred to the Westgate Unit at HMP Frankland to be assessed under the 'dangerous or severe personality disorders' (DSPD) criteria.

4. He asked to see a doctor on 11 February 2009. He reported that for two weeks he had been having trouble keeping food down, and that he had a choking sensation when he ate certain foods.

5. He saw the prison doctor on 16 July, complaining of vomiting and dysphagia (the medical term for the symptom of difficulty in swallowing). Due to continued symptoms a referral letter was sent to the Gastroenterology Department at hospital on 17 July.

6. He attended hospital for an endoscopy on 18 August. On 23 October he was diagnosed with 'upper GI cancer'. He started chemotherapy on 16 November. On 12 December, he (due to the side effects) removed his chemotherapy PICC line and refused to attend hospital for line re-insertion. He insisted that he would not consent to any further chemotherapy treatment until he had discussed alternatives.

7. On 19 January 2010 he underwent an operation in the hope that surgeons could remove his tumour. However, once the surgeons started to operate they realised that the cancer had spread. A decision was made to terminate the operation.

8. Due to the severity of his condition a Macmillan nurse was contacted for expert advice on his palliative care.

9. He attended hospital on 20 May to start oral chemotherapy. However, due to the side effects he decided to stop taking the new form of chemotherapy three days later. He thought he would be "better off letting nature take its course".

10. On 2 June, he discussed his wishes for an 'end of life care plan'. His clear preference was to stay on Westgate until he needed 24 hour nursing care.

11. He completed an Advanced Decision Care Plan on 9 September. He wrote that he did not want to be resuscitated in the event of his heart stopping, and wished that he could 'simply go to sleep one night and not wake up'.

12. At 4.25pm on 9 October, he was found lying on the floor of his cell with a large amount of blood around him. He was transferred to hospital. His condition seemed to improve in the hospital and it was initially believed that he would be well enough to be discharged back to Frankland. However, at around 11.10pm he sat up and began to vomit quantities of blood.

13. Due to his 'do not resuscitate' request (DNR) the medical staff treating him were only able to administer pain relief and try to keep his airways clear.

14. He died in October 2010.

15. I make five recommendations. My investigation has identified that improvements should be made by drawing up an End of Life policy. I consider that the system for conducting regular risk assessments for in-possession medication were not entirely satisfactory and I would recommend that this should be reviewed especially for those who have had a significant clinical diagnosis. The healthcare team in partnership with the Palliative care team should develop a programme of education and protocols to support all prison staff in understanding the management of sudden extreme situations in terminal patients for example haemorrhage seizures, severe pain and severe anxiety. Further to this, the healthcare manager and catering manager should examine the best way of providing meals for prisoners on soft/ liquid diets including consideration of using and outside supplier.

THE INVESTIGATION PROCESS

16. The investigation was opened on 18 October 2010 when the investigators issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known.

17. In response to these notices one prisoner came forward. In his letter he explained that he had been a friend of the man and had helped to care for him whilst he was unwell. He raised issues in relation to the man's diet. He also believed that the staff on the Westgate Unit should receive praise for the way in which they exercise their duty of care towards the prisoners there, and for showing diligence and respect towards him.

18. During the opening visit both investigators collected copies of the man's prison files, including his medical records. They also visited the Westgate Unit, viewed his cell and introduced themselves to the staff on the wing.

19. They returned to Frankland on 22 and 23 November to interview four members of staff and the prisoner.

20. One investigator visited the hospice on 22 December to gather further information for the purposes of the investigation. During his visit he spoke to the community palliative care consultant and a Community Macmillan nurse, who is the Macmillan Prison Lead for palliative end of life care in the Durham prisons cluster. They were directly involved in aspects of the man's care.

21. A clinical review of the man's health care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust.

22. A family liaison officer was appointed but no next of kin have come forward.

23. This report will be forwarded to the coroner to assist in his enquires.

THE WESTGATE UNIT AT HMP FRANKLAND

24. HMP Frankland is one of eight high security prisons in England and Wales and is located on the northern outskirts of Durham City. Frankland provides a maximum security environment for convicted category A and B adult male prisoners, (and also high risk remand prisoners) serving over four years. The current operational capacity of the prison is 859.

25. The man was held in the Westgate Unit, a self-contained facility within Frankland housing up to 80 prisoners who live in four separate units. The Westgate Unit is one of two prison sites in England and Wales providing specialist assessment and treatment for prisoners with 'dangerous or severe personality disorders' (known as a DSPD unit). The unit works in tandem with Rampton Secure Hospital. The unit has its own facilities which include primary healthcare and on-site provision for education, occupation therapy, gymnasium/sports and horticultural activities. Westgate is staffed by a multi-disciplinary team of prison officers, operational support grades, psychologists and nursing staff. Healthcare is provided by a dedicated team.

26. The then Her Majesty's Chief Inspector of Prisons (HMCIP) inspected Frankland in February 2008. She commented in her report that "the Westgate provided a decent quality environment for long term prisoners with serious personality difficulties who were at high risk from harm. There was an impressive level of developmental and multidisciplinary work, well managed and supported, and officers were able to develop a high level of skill in working with difficult and challenging prisoners". Issues with the standard of the food being provided were highlighted during this inspection. The HMCIP report said "In our main survey, only 12% of prisoners said the food was good and 70% said it was bad. No prisoners on Westgate said the food was good. There were annual food surveys but the response was often poor. The most recent survey, in January 2008, had seen 87 returns, with 17 saying the food was good and 39 that it was poor. The remainder said it was adequate or reasonable.'' The standard of the diet provided to the man is one of the issues highlighted in this report.

27. The most recent Independent Monitoring Board (IMB, a body of local people who independently monitor and report on the prison) report for December 2008 – November 2009 commented that "the whole of this unit and its facilities are of the highest standard and the delivery of individual needs to each prisoner". The report added "the board considers this an outstanding unit in the supportive involvement by all the staff and this is reflected in the very low numbers of applications received by the IMB from this unit".

28. This is the 28th death from natural causes to have occurred at Frankland (or in a nearby hospital when the deceased was a serving prisoner at Frankland) since April 2004, when I began investigating all deaths in prison custody in England and Wales. Since the man's death a further two people have died. Several of these deaths have been as a result of cancer and the high quality of palliative care offered to men at Frankland has been highlighted by a number of my investigators.

29. As long ago as July 2007 my report on the death of a Frankland prisoner at a local hospice referred to the exceptional palliative care he had received at the prison and the good levels of partnership between staff at Frankland and the Community Palliative Care consultant and Macmillan Nurses. More recently, my report on the death of a prisoner at Frankland in May 2010 praised the engagement of the Macmillan palliative care team at the appropriate time.

30. Encouragingly, the quality and frequency of the interaction between clinical staff at the prison (in the Westgate Unit) and their community palliative care colleagues is again a noteworthy feature of the present case.

31. In January 2011 HM Chief Inspector of Prisons published a report on an unannounced full follow-up inspection of Frankland carried out in November 2010. The new Chief Inspector, wrote:

> "Palliative care arrangements were excellent. There were links to local palliative care services and local Macmillan nurses were running a pilot project in Frankland offering drop in sessions for prisoners and structured teaching sessions and work books to give prison officers a greater understanding of the needs of patients with palliative care needs".

KEY EVENTS

32. In 1977 the man was charged with manslaughter, sentenced to life imprisonment and sent to HMP Leeds. In 1983 he transferred to Rampton Hospital under Sections 47/49 of the Mental Health Act 1983. A report at the time said that he was suffering from a psychopathic disorder (within the meaning of the Mental Health Act) and that his mental disorder was of a nature or degree to warrant his detention in a hospital for medical treatment.

33. He was transferred to the Personality Disorder Unit at Arnold Lodge, a Medium Secure Unit in Leicester in 1999, and in 2002, he was considered for a home leave trial and taken to Grassmere Community House. However, on 9 March 2002 (whilst at Grasmere) he attacked a woman and was subsequently arrested and charged with GBH with intent. He was sentenced to a second period of life imprisonment for this offence.

34. The Parole Board refused parole in June 2005 and expressed the view that he was still a risk to the community. Their review letter said: “he remains at a high and undiminished risk of extreme and unpredictable violence in non-secure settings, especially to women”.

35. On 12 September 2006, he transferred to the Westgate Unit at Frankland to be assessed under the ‘dangerous or severe personality disorders’ (DSPD) criteria.

36. At his first reception health screen, no serious underlying health conditions were noted and he was assessed as fit for normal labour/ gym. There were no significant interactions with healthcare staff until 2009.

37. On 11 February 2009, he asked to see a doctor. He said that been having trouble keeping food down, having a choking sensation when he ate certain foods over the previous two weeks. It felt as though his food was getting ‘stuck’ half way down. He saw the triage nurse the next day.

38. Six days later, he requested to cancel any doctor’s appointment that may have been made for him, saying that he no longer wished to see the doctor. He thought that the problem had been caused by eating his food too quickly.

39. On 26 May, he made another request to see the doctor as he was still having problems with his food. He also said that he had a pain in his chest, on the left side just below his nipple.

40. In response, Prison Doctor A saw him and prescribed Omeprazole gastro-resistant capsules (heartburn medication) and Nefopam (pain relief medication), undertaking to review his symptoms in two weeks. The clinical reviewer notes that “at this point there was no record on his medical notes to indicate any symptoms being identified at this stage which would have triggered an urgent suspected cancer two week wait referral”.

41. It is unclear when or if this two week review happened as there is no further mention of this review in his medical records. On 14 July he asked to see the doctor because he was still suffering with swallowing problems.

42. On 30 June, it was found that he did not meet the DSPD criteria. Ordinarily at this point he should have been transferred back to his referring establishment. It is unclear why he was not transferred out of the Westgate . When interviewed the Lead Nurse at Westgate said that closer to his diagnosis he was kept at Westgate due to his referral to the Gastroenterologist in relation to his swallowing problems, so that his treatment would not be disrupted

43. On 16 July, he saw the prison doctor to complain of new symptoms, these being vomiting and difficulty in swallowing. A referral letter was sent to the Gastroenterology Department at the hospital the following day.

44. He was diagnosed with kidney disease stage 2 (early stages of kidney disease with a mildly reduced kidney function) on 17 July. The Lead Nurse confirmed at interview that no treatment was required at that stage.

45. On 18 August, he attended hospital for an endoscopy. He was advised that he would need to await the results of the procedure, but was warned that he might have a cancerous growth or ulcer. Further to the referral letter being sent on 17 July it is unclear why the 'two week rule' for suspected cancer patients was not adhered to by the local Primary Care Trust. The two week rule is based on national targets which state that a person with suspected cancer should be seen by a consultant within two weeks.

46. His endoscopy results came back showing abnormalities and on 25 August a referral for a second endoscopy was made.

47. On 4 September, after a review with the Lead Nurse, he was prescribed 'build-up' drinks twice a day and advised that he could use the kitchen's blender to soften his food.

48. He attended hospital for further tests on 10 September and a diet of soft food was prescribed. Form F35 was sent to the prison Kitchen notifying them of his new dietary requirements. A F35 form is filled in by the prison doctor detailing a person's (medical) dietary requirements.

49. Further to a gastroscopy (examination of the inside of the gullet and stomach) and a second endoscopy on 14 September the results came back indicating that he might have 'upper GI cancer'. The biopsy results issued on 1 October were inconclusive so the procedure had to be repeated on 13 October.

50. On 23 October, he was diagnosed with 'upper GI cancer'. Upper GI cancer is cancer of the gastrointestinal tract which consists of the esophagus, stomach, and duodenum He was advised by his specialist that he would be offered chemotherapy. He would then be re-scanned and offered surgery if the tumour had shrunk.

51. He was scheduled to attend his next oncology appointment on 26 October. However this appointment was cancelled by the prison and had to be rescheduled due to lack of escort staff. His medical notes read “Escort staff unavailable for escort - no record of being informed of appointment. Appointment has been rescheduled”.

52. Despite being prescribed a soft food diet, on 2 November he requested to see the doctor. He complained that, although they had been told he needed soft food, the kitchen would send him a cold banana milk shake, no matter what meal time it was. Further to this request, on 5 November the Lead Nurse spoke to him. He told her that he was having difficulty with his food in that the kitchen would only give him food when they could liquidize it, not providing him with a nutritious meal. He explained to her that he had tried to use the blender on the wing but had found that it did not chop the food up sufficiently. He added that someone had spoken to the kitchen for him but that they had been told that if the food on the menu could not be liquidised then he would only receive a yoghurt or smoothie.

53. He was seen at the oncology clinic on 6 November and the different types of chemotherapy available were discussed. He was advised that he would have a ‘hickman line’ (an intravenous catheter most often used for the administration of chemotherapy) fitted on day one at the hospital, allowing him to return to the prison, and then this would be removed on day four. In between, he would have a pump fitted that would need to be flushed by healthcare staff.

54. After his oncology appointment on 10 November, the Bed Manager at the hospital contacted Frankland. The Bed Manager wanted to admit him on Thursday 12 November to start his chemotherapy. However, it was noted in the medical records that, because of lack of escorts, Monday – Friday of the following week would be the earliest day an escort could be arranged. A new appointment was made for him to start his chemotherapy on 16 November.

55. On 20 November, he suffered from breathlessness and pains in his chest. Nursing staff at Westgate spoke to the oncology department because they were concerned it could be a possible side effect of his recent chemotherapy treatment. The oncology department recommended that he be admitted to hospital in order to establish the reasons for his breathing troubles. The clinical reviewer comments that “the records show that a good liaison occurred between the Westgate and the oncology service at the hospital”.

56. He told medical staff on 25 November that he was unable to sleep due to constant thoughts about his illness. On 4 December, he reported that he was still unable to sleep. He was suffering from daily panic attacks and because of this he decided to withdraw from education. He was placed on the psychiatrist list to have his medication reviewed.

57. On 12 December, he (due to side effects) removed his chemotherapy PICC line (peripherally inserted central catheter is a form of intravenous access that can be used for a prolonged period of time) and refused to attend hospital for

line re-insertion. He insisted that he would not consent to any further chemotherapy treatment until he had discussed alternatives. Due to concerns for his mental health (he had said 'I'm feeling like I did when I was in Rampton' and I'm 'going mad') an 'out of hours' doctor was consulted. As a result, sleeping pills were prescribed.

58. After he removed his PICC line, his medical notes show that he wanted to look into alternatives to chemotherapy, and this was then again discussed during a mental health review on 18 December. The next time a change of treatment, to oral chemotherapy, was mentioned was on 26 April 2010 when he attended an oncology appointment. It is unclear why it took four months for him to be referred back to see the oncologists.

59. On 19 January 2010, he attended hospital and underwent an operation in the hope that his tumour could be removed. However, a note on his medical records shows that once they started to operate they realised that the cancer had spread. A decision was made to proceed no further with the operation. The clinical reviewer observes that in response to this operation "the records refer to the fact that the hospital team were going to discuss his case at a multidisciplinary team meeting the following day. This is in line with best practice". She also comments that "he was given full information about his condition and treatment and supported to make informed choices".

60. Due to the severity of his condition the Macmillan nurse was contacted. On 28 January after consultation with him, the nurse and medical staff a 'stent' (an artificial tube/ scaffolding for the throat to assist in swallowing food) was fitted as a way to try and help with his swallowing.

61. After the insertion of the 'stent' the oncologist said that drinking soda water would be beneficial to clean his throat after eating. However due to his imprisonment obtaining soda water was not very easy. Healthcare staff purchased bottles of soda water for his consumption.

62. As a consequence of his condition he frequently suffered from feeling cold. Both the man's prisoner friend and the Lead Nurse recalled that even when his room was warm he would be found shivering under his blanket. Healthcare and prison staff arranged for the purchase of a dressing gown to help try and keep him warm.

63. In early March 2010, a community consultant in palliative medicine based at a hospice reviewed him at the Lead Nurse's request. On 11 March, the consultant wrote to the prison doctor at Frankland. In her letter she refers to the "inoperable adenocarcinoma (cancer) of the oesophagus with peritoneal metastases" discovered at hospital on 19 January. She added that he received palliative treatment with oesophageal stenting and palliative chemotherapy, but developed thrombophlebitus (vein inflammation causing pain and swelling in the effected area) and diarrhoea after two cycles and declined further treatment. She advised on alterations to his medication and remarks that "over recent weeks he has found it more difficult to swallow. Food does not stick, but he becomes anxious about the thoughts of eating".

She ends her letter to the prison doctor by indicating that she would be happy to see him again. She concludes in her letter that he had decided that he would now like to be considered for oral chemotherapy, and was awaiting an appointment to see the medical oncologists. She confirmed that he understood that he had an incurable illness with a lifespan measured in months rather than years, wishing to be cared for on the Westgate Unit for as long as possible.

64. On 23 March, he was moved into a cell on the same wing, with facilities to cater for someone disabled. He was provided with a 'Nimbus' mattress for pressure area care. This cell was considerably larger in size and had in-cell shower facilities, unlike standard cells on Westgate .

65. He attended an oncology appointment at the hospital on 26 April. He was notified on 4 May that he was due to have a parole hearing but this hearing was postponed to obtain extra information on his condition.

66. Further to the 26 April appointment, a call was received on 11 May from the hospital to discuss dates for his impending oral chemotherapy. He attended the hospital on 20 May to begin his course of treatment. It is unclear why it took three weeks (from his decision to try this on 26 April) to start oral chemotherapy.

67. Due to the severity of the side effects, he decided to stop taking the new dose of chemotherapy on 23 May. In his opinion, he was "better off letting nature take its course".

68. After a discussion with the Macmillan nurse, he contacted solicitors requesting advice on how to apply for early release on compassionate grounds. On 1 June, a solicitor contacted the Governor at Frankland informing him that they intended to make an application for compassionate release. In this letter the she asked for information on his condition, requesting a clear prognosis of the time he had remaining.

69. Upon receiving this letter the palliative care consultant wrote to the solicitor. She explained that he had inoperable metastatic oesophageal cancer. She added that "there is no further active treatment planned, his physical condition is likely to continue to deteriorate with a need for increased nursing support and his outline prognosis is now measured in months. Whilst I suspect a realistic estimate would be 3 – 6 months, he may survive longer".

70. In a letter to Prison Doctor A at Frankland written at the same time the consultant observed that "he has clearly deteriorated in the last three months with significant weight loss and profound lethargy". She said that he spent most of his time alone in his cell with little or no interest in any of his usual recreational activities. She detailed that during her consultation he was clearly in pain, frequently rubbing his sternum (breastbone). She added that "he does not think he would cope outside the prison environment and is unsure whether or not he would wish to be considered for transfer to a hospice at the end of life".

71. On 2 June, he discussed his wishes for an 'end of life care plan' with the consultant and the Macmillan nurse. He said that he wished to stay on Westgate until he needed 24 hour nursing care, then he would transfer to the main Frankland healthcare unit and consider hospice transfer at the end of his life. He added that he did not want his 'stent' to be replaced if he developed a total obstruction. He was made aware that if the 'stent' was not replaced this could lead to deterioration and then death. He was assessed as competent to make this decision.

72. He was diagnosed with Gastro-oesophageal disease on 12 June. His medical notes reveal that his health was visibly deteriorating and some days he was unable to sleep, even with sleeping pills. His mood was low and pain relief was becoming problematic.

73. The Macmillan nurse wrote a letter to his solicitor on 21 June. She informed her that she and the consultant had been asked to attend Westgate to review him. She explained in her letter that after speaking to him, he no longer wished to pursue compassionate release. She wrote "He has given me permission to contact you regarding his recent anxiety, to identify some contributing factors to the problem. Since the process to consider release on compassionate grounds began he has been feeling increasingly anxious, and at times is experiencing frustration and panic. Although he is very grateful for your advice, his frustration seems to be related to the anticipation of coping with letters and decisions related to the application for release. Further discussion with him reinforces his preference is to remain on the Westgate Unit until he requires 24 hour nursing care when he would be transferred to the healthcare wing".

74. In interview, the Lead Nurse commented that due to his lengthy sentence he had become institutionalised and he had spoken to her about his increased anxiety and concerns on how he would cope outside of prison. She said that he had indicated his wish to die on Westgate, with his reason being "at the end of the day I've been in prison for many, many, many years, this is what I know. I don't deserve to die in a hospice; I deserve to die in prison".

75. She sent an email to the Parole Board on 1 July, detailing his decision to withdraw his request for compassionate release. Her email said "He has expressed that he has withdrawn his request to be considered for compassionate release. This has been causing him some increased anxiety and he has stated that "he wished that he had never done it" as he dreads every day thinking that a solicitor's letter is coming to him. This has been discussed with the palliative care consultant and Macmillan nurse and a letter was drafted and sent to his solicitors outlining his request".

76. Problems with his diet had been highlighted in November 2009. In August 2010, one of his prisoner friends made a complaint about the food being provided. He said "for many months I have been privy to see the dietary laid on by the kitchen in HMP Frankland. It's disgraceful and inadequate". He told the investigator in interview that the food the man received was the same food

issued to all the other prisoners, just having had a whisk put through it. He said that the man was unable to eat the food and would simply throw it away. He recalled that he would make him alternative food such as cuppa soups or rice pudding watered down with milk so that he was able to have something to eat.

77. In response to his complaint, the SO, catering manager at Frankland, visited the man to discuss solutions to the issues raised about his diet.

78. On 9 September, he completed an Advanced Decision Care Plan. He wrote that he did not want to be resuscitated in the event of his heart stopping, and wished that he could 'simply go to sleep one night and not wake up'. He confirmed that he had no family and that he did not want anyone to be contacted at that time or following his death. He requested that he should be cremated. Prison Doctor B, one of the prison doctors, completed the requisite documentation on 16 September.

79. The clinical reviewer comments that "the records for the period between this date and 8 October show that his condition continued to deteriorate in line with the palliative nature of his disease. It appears that each change was noted and managed appropriately including liaison with the medical staff and palliative care team".

80. It was noted in his medical records on 27 September that he was in constant pain. He was now unable to keep any food down apart from the 'build-up drinks' and milk and said that he 'just wanted to die'. At this point he requested to cancel all future appointments with the Macmillan Nurse, saying that he felt that he was just repeating himself talking about his symptoms. He asked the Lead Nurse to liaise with the Macmillan nurse from now on, rather than her coming over to the prison.

81. At 4.25pm on 9 October, he was found lying on the floor of his cell with a large amount of blood around him. It was noted that he was barely conscious, sweating and had vomited blood. First on the scene were two officers. They were later joined by a nurse, who called a code Red. A code red is phrase that would be used in emergency situations indicating that a person is bleeding. This code would allow the medical staff to respond to the situation with appropriate equipment.

82. An ambulance was called and the paramedics who attended were made aware of his DNR request. Two officers accompanied him to hospital. At this time an escorting chain was used. (An escort chain is used when a prisoner is confined to bed or if they require the use of a toilet while on escort. A single handcuff is attached to the prisoner and a length of chain connects this to another worn by an officer. The escort chain is designed to allow some freedom of movement for the prisoner and to make it possible for nursing staff to administer treatment.)

83. At 7.40pm another two officers took over the bedwatch escorting duties. (A bedwatch is where a prisoner has been admitted to outside hospital.

Depending on the risk assessment carried out by the prison, they will generally be escorted by two officers who stay beside their bed at all times.)

84. About an hour later, due to the extent of his blood loss he was given a blood transfusion to counteract his extensive loss of blood.

85. In view of apparent improvements in his health, it was initially believed after a review by a doctor that he would be well enough to be moved to a different ward later that night, with discharge back to Frankland in a further day or two. However, at around 11.10pm he sat up saying that he felt unwell and began to vomit quantities of blood. The escorting chain was removed due to the deterioration in his condition and to assist medical staff

86. Due to his DNR request the medical staff treating him were only able to administer pain relief and try to keep his airways clear. He died at 12.50am.

87. He had no known next of kin. Before he died he told staff that he did not wish anyone to be notified of his death. A memorial service was held at the prison chapel for staff and prisoners to attend.

ISSUES

Diagnosis

88. On 11 February 2009, he asked to see a doctor, complaining of a choking sensation when he ate certain foods. He saw the triage nurse the next day. On 17 February, he requested that any appointment made for him should be cancelled as he believed that his discomfort had been caused by eating too quickly.

89. Examination of his medical notes showed an entry stating “an application was logged however no appointment was made”. It is clear from this note that the appointment requested on 11 February 2009 was never made.

90. When the investigator interviewed the Lead Nurse she asked her to confirm the procedures followed when a prisoner requested to see a doctor. The nurse said that once a request was made the prisoner would be seen by the triage nurse, and then by the doctor the same day or the day after.

91. He next saw the doctor on 26 May, complaining of increased symptoms, these being pains in his chest just below his nipple.

92. The clinical reviewer noted that at this point there was no record on his medical notes to indicate any symptoms being identified at this stage which would have triggered an urgent suspected cancer two week referral. However, it is unclear if his cancer could have been diagnosed at an early stage if he had been seen by the doctor when he made his request three months prior.

Two week referral target

93. On 16 July 2009, he saw Prison Doctor A complaining of new symptoms, these being vomiting and problems swallowing. Due to continued symptoms an urgent referral letter was sent to the Gastroenterology Department at hospital the next day.

94. He received an appointment to be seen at the Gastroenterology Department for 18 August. However, the appointment given to him did not meet the expected target date set for cancer patients, this being two weeks. It is unclear why the two week cancer referral target was not met by the hospital.

I draw the apparent departure from the target period to the PCT’s attention.

In-cell medication

95. On 2 November 2009, he was issued with a repeat prescription of his current medication. Included in this medication was a prescription for 84 Paracetamol (500mg) tablets. Previous to this he was issued with similar amounts ranging from 42 – 112 tablets. He at this time had just been diagnosed with cancer and was notably shocked.

96. On 25 November, he said that he was unable to sleep due to constant thoughts about his illness, had withdrawn from education due to panic attacks and on 12 December 2009 an 'out of hours doctor' was consulted in relation to his mental health. When he saw the doctor he said that he felt "like he did when in Rampton' and was 'going mad'.

97. His medical notes show that between 2 February and 22 April 2010, he had been prescribed a combined total of 672 Paracetomal, 168 Tramadol (a month's supply) and 112 Oxycodone (2 weeks supply). Whilst I understand the need for healthcare professionals to try and give him that responsibility to allow him to take some autonomy for his own independence in managing his pain, my concern is if things had become too much to cope with he could have taken his own life.

98. On investigation the only 'in-possession medication' risk assessment form that my investigator could find was dated 19 September 2006 when he first arrived at Frankland. Further to the risk of self harm, being provided with large quantities of in-possession medication could have left him open to potential harassment and bullying from other prisoners.

99. The Community Palliative Care Consultant working with him visited him on occasion and at interview commented that she became aware of an issue with one of his pain relief medications. This particular medication had to be given every 12 hours to avoid break through pain. She commented that the prison regime could inhibit the best care because of staffing and timing issues such as being in lock down. (Lockdown is when all prisoners are locked in their cells for a roll call, or as part of a security alert or other incident. She said that if the person (on normal prison location as he was) was on lock down there would be difficulty in them obtaining medication due to the doors remaining locked. Because of this she said that she felt that he should have had all of his medication 'in possession'. Whilst I do not disagree with this view, the absence of a recent risk assessment is of concern, and therefore I make the following recommendation.

Regular risk assessments should be conducted on all prisoners holding in-possession medication, especially for those who have had a significant clinical diagnosis. These risk assessments should not only concentrate on the risk of harm to themselves but also to the potential risks around them i.e. to prevent any instances of bullying or harassment.

Chemotherapy

100. On 16 November 2009, he started his chemotherapy. On 12 December, (due to side effects) he removed his chemotherapy PICC line and refused to attend hospital for line re-insertion. He said that he would not consent to any further chemotherapy treatment until he had discussed alternatives.

101. On 18 December, during a mental health review he discussed the possibility of obtaining oral chemotherapy rather than through the previous IV method (Intravenously – administered into the vein). The next time a change of chemotherapy was mentioned in his medical notes was on 26 April 2010 when he attended an oncology appointment to discuss alternative treatment. It is unclear as to why it took over four months for him to be referred back to his oncologists to discuss the change of chemotherapy. I am unable to find any mention for the delay in his medical notes.

102. In response to his oncology appointment on 26 April 2010, he attended hospital on 20 May, to start oral chemotherapy. Further to the delay in referring him back to see his oncologist, I am also unable to find any mention in his medical notes as to why (after oral chemotherapy was discussed with his oncologist) there was a further three week delay in starting his treatment.

The healthcare manager should work with the local hospital to ensure that there are no long delays in the referral/ continued treatment of prisoners.

The man's Diet

103. Due to eating/ swallowing difficulties he was prescribed a soft food diet. Despite this request, on 2 November 2009, he spoke to the Lead Nurse reporting that he was having difficulties with his food. He detailed that at meal times he was only being provided with a cold banana milk shake no matter what meal time it was.

104. My Investigator spoke to the SO, the catering manager. He agreed that there had been a few issues in relation to providing him with a suitable diet. He said that the first dietary request he received in relation to him asked that he be provided with a soft food diet. The SO told the investigator that a soft food diet would normally consist of things already on the menu (being slightly adapted) like mashed potato and beans or something similar. However, it was found out at a later date that he actually needed a liquidised diet rather than the soft food diet earlier prescribed. The SO commented that before this was brought to their attention, food was being provided but due to him being unable to eat it, or him not liking what had been selected for him he was just having the smoothie/ yoghurt provided. As an example, he explained that minced beef was listed as being suitable for a soft food diet. However due to his 'stent' he was not able to have this as it would catch on his tube. After this issue was highlighted the SO and Lead Nurse visited him to ask him to detail what food he could/would eat. As a result of the meeting a four weekly

preference sheet was filled out by him to enable the kitchen to provide meals suitable for him.

105. The SO discussed with the investigator the issues around providing a specialised diet. He explained that due to the weekly preference sheet system providing a nutritious diet for the general prison population wasn't a problem. As an example, on a daily basis he may have to provide 300 curries and 400 pasta dishes. He also explained that to cope with Halal meals they had a specific Halal cooking area and that all kosher meals were provided by an external supplier and were not cooked on site. However, he commented that if he had to cook just one specialised meal (i.e. soft food diet like the man's) this could easily be missed due to the other orders. To prevent such problems being encountered by other people in the future, I make the following recommendation.

The healthcare manager and catering manager should examine the best way of providing meals for prisoners on soft/ liquid diets including consideration of using and outside supplier.

Anticipatory prescribing

106. In relation to his collapse (due to the major bleed) and subsequent transfer to hospital the clinical reviewer raises the issue of anticipatory prescribing for terminally ill prisoners. She comments that bleeding had not been a previous problem for him and even outside the prison environment such events are not easy to anticipate or contain at home. She says that there is likely to be future demand for terminal care in prison and she has identified an area for improvement, this being "preparing staff for the possible implications of enabling fulfilment of a person's do not resuscitate order and express wish to not die in hospital".

End of life care at Frankland

107. An earlier section of my report, on HMP Frankland, observes that the quality of the palliative care for men dying at the prison has been praised in a number of my previous reports. Again, it is pleasing to note in this case that, in the conclusions section of her clinical review of the care the man received, the clinical reviewer finds that the liaison between Westgate staff and the palliative care team was impressive and should be cited as an example of good practice.

108. I do not underestimate the practical and ethical difficulties of providing high quality palliative care in conditions of maximum security, such as those experienced by him. I note that on some previous occasions at Frankland the prisoner learned only days or weeks before his death that his condition was incurable. In his case, however, he was aware of that fact several months before his death. A letter of 11 March 2010 from the Community Consultant in Palliative Medicine, to Prison Doctor A, refers to him understanding that he

had an incurable illness with a life span measured in months rather than years.

109. One of the central questions to be addressed in each of my reports is whether the prisoner who died received the same quality of clinical care as she/ he could have reasonably expected were they not in prison. I appreciate that in this case there were some practical limitations imposed by his confinement in a cell on a unit expressly designed and staffed to hold some very dangerous men. However, in most respects, it is abundantly clear that he received compassion care and support of a high order once it became clear in early 2010 that his condition was grave and terminal.

110. An important yardstick for establishing whether he received equitable care is the access he had to specialist services and people. A striking and recurring feature of my reports on natural causes deaths at Frankland stretching back over a number of years is the level of contact the prisoner had with the palliative care consultant and Macmillan nurse. It is most heartening to see that both of them are able and willing to place their experience and expertise at the service of both the prison and individual prisoners on such a regular basis. This is exactly what happened again in this case and it is noteworthy that he received these high quality interventions. He had no relatives whatsoever outside the prison walls, there was no media concentration on him or his crimes and he did not have a well known firm of solicitors championing his cause at regular intervals.

111. I understand that the Macmillan nurse is presently seconded from her normal duties with Macmillan Cancer Support to work on a short term project designed to improve the standards of cancer palliative and end of life care in prisons in the Durham Prison Cluster (Durham, Deerbolt, Frankland and Low Newton).

112. Her project is an example of a good local initiative but I consider it would be sensible and helpful if more detailed national guidance were available on end of life care issues in the Prison Service. The man signed an Advanced Care Plan on 10 September 2010, a month before his death, and the plan was countersigned by the Nurse Manager on Westgate and a very familiar and reassuring presence in his life. His recorded thoughts about what should happen to him in the future included an instruction that he would not like to be resuscitated in the event of his heart stopping and a further instruction that Westgate Unit was his preferred place of care if his condition should deteriorate.

113. An Advanced Care Plan is only likely to be successful if staff have the knowledge and confidence to implement it and an unusual feature of this case is that he remained in his own cell, being cared for by a combination of prison officers, nurses and prisoners (especially his prisoner friend) until just a few hours before his death.

114. I am aware that the Prison Service is presently reconsidering the value of issuing a detailed and prescriptive set of national instructions from

headquarters. I am surprised that the National Offender Management Service has not yet published a policy on end of life care. I consider that the need is great and growing, with the man's Advanced Care Plan providing an example of the value of clearer guidance. He decided that he would not like to be resuscitated if his heart stopped but the existing guidance on reviving prisoners contained in PSO 2700 is based on the assumption that almost all dead or dying prisoners encountered by prison officers will be found hanging in their cells. My view is that there is a clear need for equivalent guidance on how staff (both medical and non-medical) should proceed in a situation where the prisoner's death, like his, is entirely or substantially predictable. I am aware that the NHS has current guidance on End of Life Care. However, this guidance is for clinical staff, and I believe it would be helpful to publish guidance for non-clinical staff, especially prison officers. I therefore make the following recommendation.

I recommend that the National Offender Management Service publishes an End of Life Care policy.

CONCLUSION

115. He arrived at Frankland in September 2006. Staff on the Westgate Unit described him as a very institutionalised man who was compliant with the prison regime.

116. He was diagnosed with upper-gastrointestinal (Upper GI) cancer on 23 October 2009. I understand that prior to his diagnosis he had a job working in the prison gardens. However, due to the side effects of his illness he had to give this up, having little or no energy for this.

117. He tried two different forms of chemotherapy, but he found the side effects unbearable so he chose to withdraw from treatment. He said that he wanted to "simply go to sleep one night and not wake up".

118. Compassionate release was considered but he subsequently withdrew the request for compassionate release initiated by his solicitor because he was concerned that he would be unable to cope outside prison. After suffering from cancer for just under 12 months, he died at hospital from a gastric haemorrhage.

119. The clinical reviewer comments in her report, "It is my conclusion that the liaison between Westgate Unit staff and the palliative care team is impressive and should be cited as an example of good practice".

RECOMMENDATIONS

For the National Offender Management Service:

1. I recommend that the National Offender Management Service publishes an End of Life Care policy for use by prison staff.

   Accepted - The National End of Life Care Programme (NEoLCP) is the NHS organisation responsible for promoting good practice and training, for 2.5 million health and social care staff involved in end of life care. As part of its work, it is developing a series of guides for professionals who work in different settings or disciplines. The team is currently working in close consultation with its partners in the Department of Health and the National Offender management Service on a new guide for those held in prison to offer guidance and direction on the establishment of policies and procedures around end of life care, as well as practical tips, suggestions and questions for staff who may be involved in caring for someone nearing the end of their life. The new guidance is expected to be published this summer.

For HMP Frankland and the Prison Healthcare Partnership Board

<u>Healthcare</u>

2. Regular risk assessments should be conducted on all prisoners holding in-possession medication, especially for those who have had a significant clinical diagnosis. These risk assessments should not only concentrate on the risk of harm to themselves but also to the potential risks around them i.e. to prevent any instances of bullying or harassment.

   Accepted - The full role out of IP Risk assessments will include the Westgate Unit.

3. The healthcare manager should work with the local hospital to ensure there are no long delays in the referral/ continued treatment of the prisoner.

   Accepted - A review of the current process and role out to the Westgate Unit to be completed.

4. The healthcare team in partnership with the Palliative care team should develop a programme of education and protocols to support all staff in understanding the management of sudden extreme situations in terminal patients for example haemorrhage seizures, severe pain and severe anxiety.

   Accepted - A programme is currently in progress and Work Book from Teesside University is currently being completed. This includes discipline staff also. The project team have a full education programme developed.

Catering

5. The healthcare manager and catering manager should examine the best way of providing meals for prisoners on soft/ liquid diets including consideration of using and outside supplier.

   Accepted - This process will be reviewed by Palliative Care Clinical Lead and the Catering Manager.

GOOD PRACTICE

Staff on the Westgate Unit

1. On 28 January 2010 a ‘stent’ was fitted as a way to try and help with the man’s swallowing. After the insertion of the ‘stent’ his doctor stated that drinking soda water would be beneficial to clean his throat after eating. However due to his incarceration obtaining soda water proved difficult. Healthcare staff took it upon themselves and purchased bottles of soda water for his consumption.

2. Due to his condition he frequently suffered from the chills. Even when his room was warm he would often be found shivering under his blanket. Healthcare/Prison staff arranged for the purchase of a dressing gown to help try and keep him warm.

3. When the man’s prisoner friend wrote to my investigator he made a number of recommendations. He stated that he felt that the staff on the Westgate Unit should receive praise for their duty of care towards the prisoners, and for showing diligence and respect towards the man.