PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at University Hospital of North Durham, in February 2013, while a prisoner at HMP Frankland

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the investigation report into the death of a man, on February 2013, while in the custody of HMP Frankland. The man died as a result of gastrointestinal cancer. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the man's clinical care at the prison. Staff at Frankland cooperated fully with this investigation.

The man was diagnosed with advanced gastrointestinal cancer which had spread to his liver at the end of January 2013. Active treatment was not possible. At first, the man's life expectancy was expected to be for some months. Staff were arranging appropriate palliative care for him when his condition deteriorated very rapidly. He died less than two weeks after his diagnosis. I am satisfied that he was well looked after and received a standard of care at Frankland that was equivalent to that he could have expected to receive in the community.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2013**

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SUMMARY

1. The man was remanded into custody at HMP Chelmsford, he was convicted and sentenced to life imprisonment on 10 May 2012. On 17 May 2012, he transferred to HMP Frankland.

2. The man told the prison doctor, on 21 December 2012, that he was having difficulty digesting his food. He was immediately referred for hospital tests. On 7 January 2013, he was examined by a consultant at the University Hospital of North Durham, who thought that the man had cancer. A biopsy was taken and, on 30 January, the hospital confirmed that the man had advanced gastrointestinal cancer.

3. In the days that followed, the man was monitored by healthcare staff and was referred to a Macmillan cancer nursing specialist for ongoing support and advice about his treatment and care.

4. The man was fully involved in discussions about his end of life care and treatment. On 2 February, he was admitted to the prison's healthcare unit. On 6 February, a multi- disciplinary meeting discussed the man's on-going care and noted that he was expected to have between ten to 12 months to live. However, on 10 February, the man's condition deteriorated very rapidly and he was admitted to hospital. Hospital doctors diagnosed that the man had peritonitis, abdominal bleeding and kidney failure. He died the next day.

5. Frankland liaised with the man's family throughout his illness and informed them appropriately of his death.

6. We are satisfied that the care and attention the man received at Frankland was equivalent to what he could have expected to receive in the community.

THE INVESTIGATION PROCESS

7. The investigator visited Frankland on 5 March 2013 and obtained copies of all relevant documentation. He met the Governor. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result.

8. NHS County Durham appointed a clinical reviewer to review the man's clinical care. His review is attached to this report.

9. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post mortem report. A copy of this report has been sent to the Coroner.

10. One of our Family Liaison Officers wrote to the man's son to inform him about the investigation. The man's family have not raised any concerns with us about his treatment.

11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP FRANKLAND

12. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 convicted and remand male prisoners. There is 24 hour inpatient care. NHS County Durham commission Care UK to provide the healthcare services at the prison.

HM Inspectorate of Prisons (HMIP)

13. HMIP's most recent inspection of Frankland took place in December 2012. In their report, inspectors said that, although prisoners often waited too long for GP appointments, life-long and chronic conditions were well managed. Inspectors judged that arrangements for palliative care and end of life care for the terminally ill were of a high standard.

Independent Monitoring Board (IMB)

14. Each prison has an IMB made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their latest published annual report, for 2011/2012, the IMB said:

> 'Healthcare is available equally to all prisoners. …Outpatient care is generally provided in a reasonable time but staffing levels do give rise to some problems and there are delays with doctor's appointments. Priority cases are always dealt with promptly. Inpatient care is provided according to clinical need with treatment at outside hospitals where necessary and with appropriate security requirements.'

15. The IMB was very positive about all that was being done at the prison to deliver high quality cancer, palliative and end of life care through a project led by a Macmillan nurse.

Previous deaths at Frankland

16. The man's death was the eighth from natural causes at Frankland since January 2012. There were no significant similarities with any of the previous deaths, although three of those deaths were also the result of cancer.

ISSUES

The diagnosis of the man's terminal illness

17. On 21 December 2012, the man complained that his food was "sticking at the top of his stomach". Dr A, a prison doctor, immediately referred the man to the local hospital, University Hospital of North Durham, for assessment. On 7 January 2013, tests indicated that the man had gastrointestinal cancer and a biopsy operation was undertaken. On 30 January, the hospital confirmed the diagnosis of advanced stomach, gastrointestinal and liver cancer.

18. The clinical reviewer states in his report:

> "At the first mention of the presenting symptom, the man was given an appointment with a doctor. At this appointment a two week referral for endoscopy was sent.
>
> "Gastric cancer with secondaries in the liver was diagnosed on January 7th 2013 - only 7 weeks before the man died. At diagnosis – because of the size of the tumour found, - it was noted that the cancer must have been present for some time. Both smoking and alcohol are known to be risk factors for this condition and the man's history states that both were relevant in his history. Gastric cancer is known to have a poor prognosis as it is a cancer which – just as in the man's case – is found and diagnosed late."

19. We are satisfied that the diagnosis of the man's terminal illness while at Frankland was appropriate and not delayed.

Communication with the man about his condition and treatment

20. Hospital and healthcare staff ensured that the man was fully informed at all times about his condition, from the initial diagnosis and throughout his ongoing treatment and care. The man was told on 7 January that the findings of his gastroscopy indicated that he had cancer.

21. On 30 January, Nurse A accompanied the man to his hospital appointment, when a hospital consultant, informed the man he had stomach and gastrointestinal cancer which had also spread to his liver. Active treatment was not possible but the possibility of having a stent fitted to ease the symptoms of food sticking was discussed as was palliative chemotherapy.

22. When he returned to the prison, the man said that "he may as well end his life rather than die of cancer" and suicide monitoring procedures were begun to support him. The monitoring was ended on February as he was living in the healthcare unit and observed frequently.

23. A multi-disciplinary meeting was held on 6 February to discuss the man's ongoing care. It was recorded that the prognosis was that he had 10 to 12

months to live. At the meeting, he man said he did not want to talk about his diagnosis or prognosis. No treatment was begun before his sudden death.

24. In his report the clinical reviewer comments:

> "The man was given in full the findings of his diagnostic endoscopy and histology. This information was given by the secondary care specialists at a review appointment booked by them. In addition, the man was able to discuss this with prison healthcare staff.
>
> Discussion took place between the man and the hospital specialists that he had a terminal illness and that any treatment offered would be for palliative care of symptoms only. He was told that he had a likely survival time of seven months."

25. We are satisfied the man was kept appropriately informed about his condition and treatment options.

The man's medical appointments and treatment

26. After being diagnosed with cancer, the man was under the care of the hospital consultant. Prison healthcare staff liaised with the Macmillan palliative nursing care specialist to ensure the man received appropriate treatment. After his hospital appointment on 30 January the man had no further hospital treatment until his admission to hospital on 10 February, when prison healthcare staff were concerned about the speed of his deterioration. Hospital records indicate that he had peritonitis, abdominal bleeding and kidney failure. His treatment included blood transfusion and antibiotics. Just before 6.00pm active treatment was withdrawn and the treatment changed to active pain relief. The man died at 3.10 in the morning in February.

27. The opinion of the clinical reviewer is:

> "NHS set the schedule for the clinical review of the man and all of these appointments were kept. The recommendations made by the specialists were acted upon by the prison healthcare. The man received – by virtue of being a prisoner – more checks and observations than he would have if he had been a patient in the community."

28. We agree with the clinical reviewer's comments and consider that the treatment the man received was equivalent to what he could have expected in the community.

Restraints, security and bed watch

29. The man was accompanied to his hospital appointments by a member of healthcare staff. When he was admitted to hospital on 10 February, the man was accompanied by prison officers and no restraints were used. We consider that this was appropriate and allowed the man to die with dignity.

The man's pain relief and medication

30. The man was prescribed medication as directed by doctors and a Macmillan nursing specialist. In relation to the man's pain relief and medication, the clinical reviewer said:

> "As would have happened in the community, a schedule for titrating [steadily increasing] the doses of medication for pain relief was established in addition to additional nutritional support. Communications between outside agencies and both the prison and healthcare (within the prison) as revealed by the documentation in the notes were good."

31. In light of the clinical reviewer's comments, we are satisfied that the man was offered appropriate medication and pain relief.

Palliative care plans

32. After tests indicated the man had cancer a palliative care plan was put in place on 8 January and referral made to a Macmillan cancer nursing specialist. Nurse A saw him regularly to review his palliative care plan. On 1 February he was placed on the end of life care register. On 4 February, Nurse B, a Macmillan specialist, saw the man.

33. On 7 February following the multi-disciplinary meeting the day before, the formal Gold Standard Framework protocol for end of life care was worked through and completed. Staff had begun to discuss end of life care with the man. However, his condition rapidly deteriorated before plans had been finalised.

34. We consider that Frankland's handling of the man's end of life care was appropriate.

Liaison with the man's family

35. The man kept in contact with his father by telephone throughout his time in custody. The man had kept his father informed about his diagnosis, although the decline in his health was very rapid. On 10 February, Frankland notified the man's father that he had been admitted to hospital.

36. Frankland appropriately followed national guidance on breaking the news of the man's death to his family, which they did that morning. The prison family liaison officer maintained contact with the man's family to provide continuing

support and, in line with Prison Service policy, arranged and met the costs of the man's funeral.

The man's living arrangements

37. The man wanted to remain on his wing with his friends for as long as possible. Healthcare staff advised the man on 23 January that he would benefit from being admitted to healthcare but he declined. While he remained on the wing, healthcare staff maintained regular contact with him to monitor his condition and health needs. The man finally agreed to be admitted to healthcare as an inpatient on 2 February. On 10 February, his condition rapidly deteriorated and he was taken to hospital. He died in the early hours of 11 February.

38. We are satisfied that Frankland responded appropriately and sympathetically to the man's wish to continue to live on his wing, where he had the support and company of friends, as long as possible.

Compassionate release

39. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

40. On 6 February, the prognosis was that the man had between ten to 12 months to live and, the next day, the man said he intended to apply for compassionate release. The man's condition rapidly deteriorated on 10 February and he was admitted as an emergency to hospital where he died the next day. There was no indication at that time that his death was imminent.

41. We are satisfied that Frankland acted appropriately in relation to the consideration of compassionate release and that the man's rapid deterioration and death was not anticipated or predicted.