Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Frankland, in March 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the circumstances surrounding the death of a man, a prisoner at HMP Frankland. The man died in March 2009. He was 66 years old. A post mortem showed that the cause of his death was cancer.

I offer my sincere sympathy and condolences to the man's family, as I do to all of his friends and acquaintances who are touched by his passing.

The investigation was carried out on behalf of the Ombudsman by my colleague. Both he and I would like to thank the Governor of HMP Frankland and all his staff for their full and ready co-operation during the course of our enquiries. I also thank the clinical reviewer for the clinical review he led on behalf of the local Primary Care Trust (PCT).

This report recognises that the clinical care and consideration given to the man by the staff was equitable to that he would have received in the community. I make two recommendations concerning improved communication between HMP Frankland and external NHS services and families.

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.

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2009**

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SUMMARY

In May 1986, the man was convicted of murder and sentenced to life imprisonment. He was first sent to HMP Wormwood Scrubs and, over the following 18 years, transferred to different prisons until he arrived at HMP Frankland in January 2004.

Due to experiencing chest problems the man had a computerised tomography (CT) scan of his chest at the University Hospital of North Durham (UHND) in August 2006. It indicated a small shadow on his lung area. He had further x-rays in November and the results showed an abnormality.

The man was told in December that lung cancer had been diagnosed. In February 2007, he had a pneumonectomy (an operation to remove part of the lung). A course of chemotherapy began but the man decided to stop the treatment in July 2007. It was also noted that he continued to smoke.

The man saw the prison doctor in November 2008 as he was coughing more than normal and felt as if his oesophagus (gullet) was squashed. The doctor recorded that air entry could be heard in the upper regions of the left lung and that he had an irregular heart beat. The doctor conducted an electrocardiograph (ECG) (a recording of the electrical acitivity of the heart) which confirmed that he had atrial fibrillation (abnormal heart rhythm that involves the two upper chambers of the heart).

In January, the consultant thoracic surgeon visited Frankland and saw the man. He recorded that there had been a four month history of weight loss with a dry cough and decided to arrange for a CT scan as it had been two years since his operation. The results showed that the man had wide spread cancer. In March, the prognosis was made that his life expectancy would be quite short and that he should be treated with a palliative care.

Healthcare staff tried to speak to the man in March about his prognosis and his wishes for his end of life care but he was too poorly to discuss resuscitation or decide on his preference for his end of life care.

The man's sister was visiting at the prison in March when, at 3.35pm, a nurse recorded that there was no sign of breathing and that her brother had died.

The clinical review highlights that the care the man received at Frankland was equitable with what he would have expected in the community. I make recommendations concerning the co-ordination of referrals to NHS specialists and developing a communication strategy between the prison and the hospital trust and families.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 March 2009 when the investigator issued notices 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. One prisoner came forward as a result and was interviewed.

2. The investigator visited HMP Frankland on 31 March. During his visit he was given copies of all the documentation relating to the man. They included his main prison record and medical records. He also met a member of the Independent Monitoring Board (IMB). During this visit the investigator interviewed one prisoner. He also visited healthcare to see the man's cell. He returned on 27 May when he interviewed three members of staff.

3. The local Primary Care Trust appointed a clinical reviewer to carry out a review of the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment and healthcare whilst he was at Frankland. I am grateful to the clinical reviewer for providing such a thorough and timely review, and for addressing the family's concerns.

4. The investigator contacted HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

5. The senior family liaison officer contacted the man's family to inform them of the investigation. The senior family liaison officer and the investigator later met the family who raised the following concerns:

    - Why were there delays and cancellations of the man's medical appointments?
    - Why had the man not been granted a transfer to a prison closer to the family?
    - Why was the man not considered for compassionate release given his medical condition?
    - Why was the man not moved to a hospice?
    - Why they had not been informed that the man's condition had deteriorated at an earlier stage?
    - Why was it difficult for the family to contact healthcare by phone to enquire about the man?
    - Why was the man not on oxygen, as there were damped bed sheets being used?
    - Why the man's sister had not been prepared for the shock of his physical condition and to find him not clothed on the lower part of his body, with no duvet cover?

    The investigator has attempted to address the issues raised by the family within the report. I hope that the report provides the family with a better understanding of the treatment given to the man prior to his death. The family expressed their gratitude to the prison's family liaison officer and the Governing Governor, for their sympathetic dealings with them.

HMP FRANKLAND

6. HMP Frankland is one of eight maximum security establishments in England and Wales. The prison holds convicted category A and B adult male prisoners, and some high risk remand prisoners. The operational capacity of the prison is 734.

7. Healthcare services are provided by the local Primary Care Trust, which is independent of the Prison Service. The healthcare centre provides 24 hour inpatient care in two six-bedroom wards and eight furnished rooms.

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

9. Following a short unannounced follow up inspection on 25 October 2005, the Chief Inspector recorded that healthcare services had improved since the full inspection. However, primary care still needed development and staffing shortages had hindered progress.

10. The latest Independent Monitoring Board (IMB) report (for the year 2006-07) found that healthcare had improved during the course of the year. The IMB reported that morale amongst healthcare staff, which had previously been low, had stabilised and improved. They also reported that all sections of healthcare appeared to be working well.

11. This is the 21st death from natural causes to have occurred at Frankland since April 2004, when I began investigating all deaths in prison custody in England and Wales. One of the reasons for such a high figure is due to the fact that Frankland has in-patient facilities. An earlier investigation concerned another man who suffered from cancer. That report recognised the excellent palliative care co-ordination and management and I am pleased that this which was evident in the man's case as well.

KEY FINDINGS

12. The man was born in November 1942. He predominately lived in the Sussex area. He was not married and had no children. Although he had told the prison and medical authorities that he was a South African citizen, the Ombudsman's investigator contacted the South African consulate but was unable to confirm his status.

13. The man was convicted of murder in May 1986 and sentenced to life imprisonment. His sentence began at HMP Wormwood Scrubs and, over the following 18 years, he transferred to different prisons until he arrived at HMP Frankland in January 2004. Heworked in the food canteen at the prison.

14. Due to chest problems, the man had a computerised tomography (CT) scan of his chest at the University Hospital of North Durham in August 2006. The scan indicated a small shadow on his lung. He was informed by a prison doctor of the result and that further investigations would be made. The man had more chest x-rays in November and the results were abnormal.

15. The man was informed in December that the hospital had diagnosed lung cancer. In February 2007, he had a pneumonectomy (an operation to remove part of the lung) performed by the Consultant Thoracic Surgeon at The Freeman Hospital, Newcastle upon Tyne. After the operation the man began a course of chemotherapy and, in addition, the prison doctor prescribed Ensure drink supplements three times a day.

16. In May, the prison doctor saw the man as he said that he was having difficulty in sleeping due to the chemotherapy. The doctor prescribed Temazepam (a short term treatment for sleeplessness) to be taken for three nights. Four days later the man saw another prison doctor, as he had a chesty cough. The second prison doctor recorded that this was also due to the chemotherapy.

17. The Consultant Thoracic Surgeon reviewed the man in July at Frankland. The consultant recorded that the man was much better following his operation. However he had stopped the chemotherapy treatment at his own request and felt better as a result. The Consultant Thoracic Surgeon also noted that the man was still smoking following surgery. On examining him, the Consultant Thoracic Surgeon noticed a small seroma (swelling caused by a pocket of clear fluid that sometimes develops in the body after surgery) in the wound, which could be removed under sterile conditions at the prison. The procedure was carried out in September by a Consultant Colorectal Surgeon, from University Hospital of North Durham (UHND). The Consultant Colorectal Surgeon saw the man in the healthcare centre at Frankland and removed 35ml of fluid from the seroma which removed the swelling.

18. The man was reviewed by the Consultant Thoracic Surgeon in December who areviewed the cause of the build up of fluid. The consultant thought that it was likely to be pneumonectomy space fluid (that is space in the chest cavity which is created after the removal of the lung) which was a direct result of a small hernia (protrusion of tissue) in the muscles between the ribs. The Consultant Thoracic

Surgeon had not seen the condition in a patient before. He considered that surgery was an option to rectify the problem. However there was a potential complication of infection which would have disastrous consequences. This was explained to the man, who accepted the potential risk, and the Consultant Thoracic Surgeon proposed to peform the operation in February 2008.

19. In January 2008, the man saw the Consultant Colorectal Surgeon in the colorectal clinic at the healthcare centre at Frankland. The Consultant Colorectal Surgeon removed 60ml of fluid from the swelling, which made the man feel more comfortable.

20. The man had another review with the Consultant Thoracic Surgeon in March. The Consultant Thoracic Surgeon recorded that the Consultant Colorectal Surgeon had removed fluid on two occasions. He commented that, alarmingly, the man carried out the procedure himself with non-sterile utensils, but the situation had remained stable. The Consultant Thoracic Surgeon noted that an operation was planned in April, but was concerned that further operations had two risks. The first risk was that pneumonectomy space fluid infections are difficult to eradicate and can be fatal. The second risk was the possible effect on the chest cavity containing the heart and the vessels of the heart which also could be fatal. The Consultant Thoracic Surgeon recorded that no further removal of fluid was to be performed. In May, the Consultant Thoracic Surgeon reviewed the man and decided that no further treatment would be undertaken on the seroma.

21. In September, the man was seen by a Nurse when she took his Ensure supplement drinks to the wing. The nurse recorded that the man said that he had not felt very well at the beginning of the week, but now felt much better. He said that he received a lot of support from staff and fellow prisoners and had no concerns at that time. He would alert staff straight away if he had any problems.

22. The man saw a third prison doctor in November as he was coughing more than normal and felt as if his oesophagus (gullet) was squashed. The doctor examined him and recorded that he heard air entry in the upper regions of the left lung and he had an irregular heart beat. The third prison doctor conducted an electrocardiograph (ECG) which records the electrical acitivity of the heart. The ECG confirmed that the man had atrial fibrillation (abnormal heart rhythm that involves the two upper chambers of the heart). The third prison doctor referred the man to the UHND for further examination.

23. The man had further tests at the hospital which confirmed the diagnosis of atrial fibrillation. Bisoprolol Fumerate (a beta blocker to control heart rhythm) was prescribed, together with Simvastatin (to treat high cholesterol) and Warfarin (a treatment for atrial fibrillation). The man was sent back to prison and an outpatient appointment arranged with a hospital doctor at the hospital's rapid access clinic the next day. He was kept in healthcare overnight for observation.

24. The following morning the man refused to go to the hospital appointment with the hospital doctor. It was explained that the appointment was important and the consequences of refusing to attend were serious. The man signed a disclaimer

form which stated that he was aware that he would be taken off any waiting list. He also discharged himself from healthcare against medical advice, and signed a separate disclaimer stating that he wished to return to the wing.

25. In December, a second Nurse was called to F wing to see the man who had fallen. The nurse found him lying on his bed. He was fully coherent and not confused. He told the nurse that he had pulled muscles in his left shoulder and arm about three days previously and been resting in bed ever since. He said that he had not been eating very much but had been drinking normally. He told the nurse that he had got out of bed at about 4.00am to go to the toilet. He thought that he passed out for a short while and then got back into bed afterwards. He said he felt much better but did not feel well enough to go to work. The second Nurse recorded that there were no apparent injuries from the fall. She advised him to eat regular healthy meals and try not to smoke. The nurse referred the man for a follow up appointment with the prison doctor later the same day.

26. Later that morning, at 11.55am, two Nurses responded to a call from F wing to see the man, whose condtion had deteriorated. He was experiencing considerable pain to his left ribs and was unable to move. Due to his medical history, an ambulance was called to take him to the emergency department at the local hospital.

27. The man was discharged later from the emergency department and returned to prison. A quantity (100ml of fluid had been drawn from his chest cavity which immediately reduced the pain. He was seen in healthcare by a third Nurse who recorded that his blood pressure was 111/73 and that he was happy to take paracetamol to relieve the pain. The man remained in healthcare overnight for observation.

28. The next day, the third prison doctor reviewed the man who said that he felt much better and wanted to return to the wing. The doctor recorded that his pulse was still irregular but deemed him fit to return to the wing.

29. In December, the man had blood samples taken. The reason was to test for his international normalised ratio (INR) which determines the clotting tendency of the blood. The result was that he had a raised INR of five. (A high INR level, such as five, indicates that there is a high chance of bleeding. An INR of 0.5 shows that there is a high chance of a blood clot. The normal range for a healthy person is 0.9 –1.3 and 2.0 – 3.0 for people who are prescribed Warfarin.).

30. A fourth prison doctor saw the man the next day and explained the INR test results. The doctor advised that he should stop taking Warfarin for two days and then resume taking it if the INR result was within the required range. The third prison doctor conducted an INR test on 24 December and the result was 3.5

31. The man saw the fourth prison doctor in January 2009 for a review of his medication. He told the fourth prison doctor that he had stopped taking Warfarin as he felt dizzy and unwell. The doctor explained that it could take up to six to eight weeks to reach the right level and dosage of warfarin. The man agreed to restart taking Warfarin.

32. Healthcare staff received a call in January from F wing staff asking them to go urgently to see the man who was breathless and feeling unwell. A fourth Nurse saw him in his cell. She recorded that the man was not actually breathless, but had difficulty breathing in the night and had been vomiting up to 14 times a day for the previous four days. He was taken to healthcare by wheelchair for continued assessment in quiet surroundings. An ECG was undertaken which produced abnormal results showing that he still had an irregular heart rhythm. He returned to his cell later that day.

33. Three days later the fourth prison doctor saw the man to review his condition. The doctor recorded that his weight was 61.5kg and that a few "scattered crackles" could be heard in his chest. He was advised to continue taking the Warfarin and to contact healthcare straight away if he felt unwell.

34. In January, the Consultant Thoracic Surgeon visited Frankland and saw the man. He recorded that he was "shocked to see the change in him" who had a dry cough and an irregular heart rhythm despite being given treatment. The Consultant Thoracic Surgeon decided to arrange for another CT scan as it had been two years since the man's surgery.

35. Five days later the man saw the third prison doctor who, following examination, advised that he needed to be an inpatient in healthcare. The doctor recorded that the man had pain in his left flank which worsened when he coughed and his blood pressure was 114/78. He also told the third prison doctor that he felt sick after eating. The third prison doctor noted that he was pale and thin and he was taking Ensure drinks.

36. The fourth prison doctor saw the man the following day and recorded that his weight had fallen to 59kg. The doctor also noted that he was coughing a lot and had episodes of shortness of breath. A referral was made, with the man's consent, to the MacMillan Nursing Service for a palliative care nurse to provide advice on pain management and emotional support to him.

37. In February, the man saw the fourth prison doctor as he was experiencing pain in the left side of his chest, was coughing frequently and feeling hot and cold. The doctor prescribed Amoxicillin (an antibiotic used in treatment of bacterial infections) and a Salbutamol inhaler (which is used to treat broncial spasms). Two days later the fourth prison doctor reviewed the man who said that he felt much better, his breathing was better, he was not coughing as much and his appetite had improved. Four days later a MacMillan nurse visited Frankland and provided advice on the man's pain management regime.

38. The third prison doctor saw the man in February as he had refused to take some of his medication. He told the doctor that he had stopped taking Warfarin as it made him vomit and feel unwell. The third prison doctor recorded that he was coughing and producing a light yellow phlegm. The man told the doctor that he felt very despondent about his deteriorating health. The third prison doctor explained the reasons and benefits of his medication. He said that he was taking his Ensure supplement drinks, even though nursing staff told the doctor that he

regularly refused to have them. The third prison doctor removed Warfarin from the man's medication and prescribed Ciprofloxacin (treatment of severe or life threatening bacterial infections) and senna tablets (laxative).

39. Later the same day a full nursing assessment was carried out by a fifth Nurse. The man accepted that, due to his deteriorating condition, he needed more nursing care to assist with all aspects of his daily life. He asked to move into the ward area of the healthcare centre as he would enjoy the company. Following discussions with senior staff, he was moved onto the ward.

40. Over the next 11 days the man was seen every day by nursing staff. He regularly refused food despite the best efforts of staff to encourage him to eat. He also declined blood tests and to have a bath or bed bath.

41. In February, the man went by ambulance to the outpatients department at UHND to have the CT scan arranged by the Consultant Thoracic Surgeon. The third prison doctor reviewed him the following day. The doctor recorded that he was still not eating or taking the senna tablets. The man also continued to refuse to take Warfarin due to the side effects. The third prison doctor prescribed Lactulose solution (laxative), Glycerol Rectal Suppositories (another laxative), and Phenindione (an anticoagulant).

42. The nurse from the MacMillan team, saw the man three days later. The nurse recorded that his condition was clearly deteriorating, but he was comfortable and was being treated sympathetically, including being allowed to dress as he wished. The man told the MacMillan nurse that he was tired but pain free and was happy with his nursing care. The Consultant Thoracic Surgeon had not yet seen the results of the CT scan and the MacMillan nurse said that she would discuss this with him.

43. The Consultant Thoracic Surgeon faxed a letter to the fourth prison doctor in March to confirm the results of the CT scan. The consultant stated that the man had widespread cancer and expressed the opinion that his life expectancy would be quite short. The Consultant Thoracic Surgeon also stated that there was no further treatment that could be offered to the man and that he should be put on a palliative care pathway. (This is an individual care plan used for patients who are reaching the end of their lives.)

44. The Consultant Thoracic Surgeon's letter was shown to a fifth prison doctor. This doctor thought it more appropriate for the fourth prison doctor to tell the man of the results as he had had most dealings with him. However the fourth prison doctor was not available for the next two days (4 March). A palliative care plan was put in place by the fifth Nurse. The man remained on the ward in healthcare at his own request but this would be reviewed if his condition deteriorated further.

45. The MacMillan nurse visited Frankland the next day and discussed the man's care with healthcare staff. They decided that he should be informed of his prognosis. The MacMillan nurse and a sixth Nurse spoke to the man about the tests and the prognosis. He said that he understood that his death was likely to occur in the very near future but was too tired to discuss anything else.

46. In March, a multidisciplinary meeting involving the MacMillan Nurse, healthcare staff and a senior prison manager was held at the prison. The purpose of the meeting was to discuss the man's deteriorating condition and his end of life care. Due to his incurable condition, it was agreed that resuscitation would not be appropriate. The fourth prison doctor and the MacMillan Nurse tried to speak to the man about his wishes but he was too unwell to discuss resuscitation or tell them his preference for his end of life care.

47. Later that same day the man was moved into a single cell in healthcare. The fifth Nurse had commenced the end of life care pathway and recorded that his breathing had deteriorated. A member of healthcare staff sat with him all the time. The Governor had given permission for his cell door to remain open to allow staff to give appropriate care and to maintain his dignity.

48. Healthcare staff attempted to contact the man's sister, who lived in West Sussex, by telephone to inform her of her brother's deteriorating condition. They had no success at first but she was contacted a few hours later at another address in County Durham. The prison arranged for his sister to visit and stay with him in healthcare until 10.00pm that night.

49. The man's sister returned to the prison the following morning at 8.30am and remained for the rest of the day. The prison family liaison officer stayed with her throughout the day, and healthcare staff made sure that she had food and drink.

50. At 3.35pm a seventh Nurse was called to the man's cell by an Officer. The nurse observed that there was no sign of breathing and that the man had died. (His sister was outside the cell at the time talking to the prison family liaison officer and a Governor.) The Nurse informed the man's sister that her brother had died. The prison liaison officer stayed with her at his bedside for some time and a member of the chaplaincy team came to speak to her.

51. The prison made arrangements to allow the man's sister to use the telephone to contact relatives and provided a taxi to return her to the address in County Durham. An on call doctor certified the man's death at 4.50pm.

52. The prison offered financial assistance towards the funeral expenses which included transporting the man's body to West Sussex where the family wished the funeral to take place.

ISSUES

Clinical care

53. The clinical review examined in depth the care the man received from both the healthcare staff at Frankland and external medical professionals. The review concludes that, overall, he received equitable care from the healthcare team at Frankland as he would in the community. The clinical reviewer specifically said:

> "It is my opinion that the care he received leading up to his death, by the nursing and medical team, was common and acceptable medical practice."

54. The review did highlight one aspect of the man's care that gave rise to concern.

> "On 4th February 2005 he was referred for investigation of a possible stroke. Somehow this referral letter was never sent and it was not until 16th February 2006 that the referral was sent. On this aspect his standard of medical care had fallen below common and acceptable medical practice."

The clinical reviewer made the comment that this situation can occur in any busy general practice and was satisfied that the omission had no bearing on the circumstances of the man's death. I make no recommendation here but the Head of Healthcare will wish to review the co-ordination of referrals to NHS specialists and ensure that they are timely and a follow up process is in place.

55. The review also recognised that there was an issue regarding the communication between the healthcare centre at Frankland and external NHS services. The clinical reviewer said:

> "Throughout the medical records it is abundantly clear that the doctors and administration staff of NHS hospital based care cannot appreciate the inherent difficulties and problems for the medical and administrative team based in a high security prison."

56. Their lack of awareness resulted in Frankland not being able to meet every request for outside hospital consultations. (This was one of the concerns raised by the man's family.) An example from his medical records showed that on 2 November 2006, a doctor's team requested that another bronchoscopy be performed the following day. It is clear to both the clinical reviewer and myself that this was insufficient notice for the prison to put the necessary procedures in place. The man subsequently had the bronchoscopy on 17 November 2006.

The Head of Healthcare should engage with the hospital trust to put into place a robust communication strategy so that the requirements of all stakeholders can be met and issues, when identified, can be addressed.

Family issues

Transfer to a prison closer to family

57. Compassionate transfers within the high security estate may be granted for a temporary period for various reasons One example would be to facilitate easier access for family visits. The request for a temporary transfer has to be made by the prisoner themselves. A family member or other individual may write to an establishment to ask for a prisoner to be transferred, but the prisoner has to agree and request to be transferred.

58. In December 2006, the man's sister made a written request to the prison for him to be moved closer to her home in West Sussex. The investigator found no evidence that he wished, or had requested, a transfer from Frankland.

Consideration given for compassionate release

59. There is a formal process which has to be followed for a prisoner to be granted compassionate release. This includes a recommendation by the Parole Board and the approval of the Secretary of State for Justice.

60. In the man's case the definite diagnosis of his illness was only received by the prison in March and he died four days later. This was a very limited amount of time within which compassionate release could have been arranged, subject to it being approved.

Transfer to a hospice

61. The clinical reviewer has considered whether the man should have moved to a hospice and makes comments that there are several factors which are relevant. The points that would be considered include the nature of the disease and the diagnosis for the patient and the place where the most suitable care can be provided.

62. Many patients can spend their remaining days in a hospital, a hospice or at home depending on their own wishes and the place where the best possible care can be provided. The clinical reviewer comments that:

> "It is my opinion that from the time the prison authorities received the definitive diagnosis from the Consultant Thoracic Surgeon on 02/03/2009 there was an accelerated and rapid deterioration in the man's condition.
>
> "It is my opinion that the care he received leading up to his death, by the nursing and medical team, was common and acceptable medical practice."

63. The investigator interviewed the fifth Nurse and asked about the efforts to secure a hospice place for the man. The nurse said that she had personally asked the MacMillan Nurse whether a hospice place was available but regretfully there were no places at that time.

Contacting healthcare and keeping the family updated on the man's deteriorating condition

64. The man's family asked why they were not informed when his condition deteriorated and commented that they found it difficult to obtain information from healthcare staff. From the interviews conducted, the investigator was able to establish that there are clear differences between how prison records and medical records are recorded and how information, if any, is shared. Healthcare records do not include next of kin details. They contain confidential medical information about a prisoner. Any contact with the family is made by the family liaison officer from the prison, rather than by healthcare staff.

65. Frankland has a dedicated business unit which receives, logs and processes all incoming written correspondence. There is also a dedicated safer custody hot line for families and friends to contact with concerns over a prisoner's well being. My investigator has not been able to establish why the man's sister had difficulty in contacting the prison by telephone.

66. In the man's case the definitive diagnosis was only received from the hospital four days before his death. However the clinical reviewer said:

> "By 29 January 2009 it was abundantly clear that his condition was further deteriorating. Accordingly his case was referred to the MacMillan nurses (who specialise in palliative care). Anticipatory palliative drugs were considered and a care plan was drawn up."

67. Provided that the man had given his permission, I believe that it was reasonable for his family to have been informed of his worsening condition, certainly from 29 January. This would have provided the family with the opportunity to co-ordinate visits and maintain dialogue with the prison. The end of life care pathway makes specific reference to support for the family and no exception should be made for the families of prisoners.

The Governor and Head of Healthcare should develop a proactive communication strategy to ensure a prisoner's next of kin are informed of critical health matters, particularly when the prisoner is terminally ill.

68. I acknowledge the efforts of healthcare and prison staff in their attempts to contact the man's sister in West Sussex on 5 March. I also commend the work of Governor Wales to put in place the authorisation for open visiting and allow his family to remain in the prison until late at night.

Use of oxygen and the use of dampened bed sheets

69. The man's family also asked why he was not given oxygen and the purpose of the damp bed sheets. These issues have been specifically addressed by the clinical reviewer who said:

> "With regard to the use of oxygen, as to whether or not this was used would be a medical decision at that moment in time. However, I would draw the reader's attention to the consultations on 4 March 2009, where a pulse oximeter was being used on him. Basically this measures how well oxygenated a person is. The man's result was 91% showing that with

breathing the air in the room he was adequately oxygenated and did not, at that stage require additional oxygen.

"Finally, with reference to the use of dampened bed sheets on his radiator. This may be a reference to an attempt to humidify the air, but this is pure speculation on my part."

The man's physical condition and use of bedding

70. At interview the fifth Nurse said that duvets are not routinely available in the prison, however a new one was obtained in the last few days before his death in an attempt to increase the man's comfort. The fifth Nurse apologised that the duvet came without a cover, and that sadly the cover arrived after the man's death.

71. The fifth Nurse said that Frankland healthcare followed the end of life care pathway. She explained that this focused on making the patient as comfortable as possible and adhering to their wishes as far as possible. The man was nursed in the ward area of healthcare as he enjoyed the company of fellow prisoners. However, in the final few days of his life, he was moved to a single cell where he was provided with a multi positional bed and a pressure relieving mattress. He was allowed to be dressed as he wished and to have his own personal blanket.

72. The end of life pathway provides guidance on comfort measures which include moving the patient for comfort only and use of a syringe driver (to administer pain relieving medication) when appropriate. The fifth Nurse said that a syringe driver was put in place on the day he died. It continuously administered small amounts of very strong pain relief until his death.

CONCLUSION

73. I am pleased to endorse the clinical reviewer's comments that the care and treatment received by the man from staff at HMP Frankland was equitable to that which he would have received in the community. Care and support was also provided by hospital specialists and the visiting MacMillan cancer nursing specialist. However the prison should ensure that it has robust communication strategies in place to meet the needs of all healthcare stakeholders. This should include the prisoners' family and friends as well as the healthcare professionals inside and outside the prison.

RECOMMENDATIONS

1. The Head of Healthcare should engage with the hospital trust to put into place a robust communication strategy so that the requirements of all stakeholders can be met and issues, when identified, can be addressed.

2. The Governor and Head of Healthcare should develop a proactive communication strategy to ensure a prisoner's next of kin are informed of critical health matters, particularly when prisoners are terminally ill.

At the time of issuing this report no response to the recommendations had been received.