Investigation into the circumstances surrounding the death of a man at HMP Frankland In March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the circumstances surrounding the death of a man in March 2008. The man, who was aged 73, died in the healthcare centre at HMP Frankland having been recently diagnosed with gastric cancer at hospital.

He had arrived at Frankland in 2001 after being sentenced to 12 years imprisonment at Court. He was eligible for release on licence in 2006 and again in 2007, but the Parole Board determined that his risk to the public would not be sufficiently reduced until he had done further offending behaviour work. In 2005, he was diagnosed with cancer of his right kidney, which was removed as part of his treatment. At that time it was discovered that he had a small growth on his left kidney, but this was never properly investigated. Some two months later, unrelated to his cancer treatment, he developed problems with his left foot. This led to him having his left leg amputated above the knee.

On 5 March 2008, the man was admitted to hospital following a deterioration in his condition. He had been complaining of stomach problems and vomiting blood for a short time. He was diagnosed with gastric cancer on 7 March, returned to prison on 10 March for palliative care and died six days later. His family circumstances were such that he had no identifiable next of kin, despite the best efforts of the prison to identify someone to fulfil this role.

One of my investigators opened the investigation but ill health prevented him from concluding his work. Another investigator completed the investigation. I am grateful to the clinical reviewer for conducting the clinical review on behalf of the local Primary Care Trust. I would also like to thank the Governor of Frankland and his staff, especially the liaison officer at the prison, for their co-operation.

I must apologise for the severe delay in issuing this draft report.

I make one recommendation.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man was sentenced to 12 years imprisonment on 12 February 2001 at court. He was originally held in HMP Durham, but transferred to HMP Frankland on 7 March 2001. He remained in Frankland for the rest of his time in prison. On his initial reception into prison he reported that he had a false left eye as the result of an accident when he was a child, and he suffered with asthma. He was a smoker.

His asthma developed over time to a more serious breathing problem, known as Chronic Obstructive Airways Disease (COAD). He continued to smoke for some years after the initial diagnosis of COAD.

In October 2005, the man developed kidney cancer and his right kidney had to be removed. Some two months later, because of circulation problems and an infection of the big toe on his left foot, his left leg was amputated above the knee. He recovered from this quite well, using a wheelchair until he was fitted with a prosthesis (false limb). He had a minor operation to repair a hernia in 2006, and a small growth on his left kidney continued to be investigated – although there was a delay in following this up because of a problem between the hospital and the prison, the facts of which I was unable fully to disentangle.

In January 2008, the man began to complain of sickness and stomach pains. Throughout February he continued to deteriorate, with abnormal blood pressure and pulse readings as well as vomiting blood. Following some abnormal blood test results in early March, he was admitted to hospital on 5 March. There he was diagnosed with terminal stomach cancer and sent back to prison on 10 March so that palliative care could be arranged. He died in the prison healthcare centre.

THE INVESTIGATION PROCESS

1. My colleague began this investigation on 16 March 2008. He arranged for statements from staff at Frankland to be sent to him, together with all relevant prison records relating to the man. They included his main prison record, statements from staff about events surrounding his death, and his medical records. Notices were posted to staff and prisoners about the investigation, inviting contributions.

2. The local Primary Care Trust identified a clinical reviewer to carry out a review of the man's clinical care whilst he was at Frankland. The investigator discussed aspects of the man's treatment, including his outpatient appointments, with the clinical reviewer. The clinical review is attached as an annex to this report and I am grateful to him for undertaking it.

3. My office contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, a copy of my report will be sent to the Coroner.

4. Despite efforts by the investigator and the prison's Family Liaison Officer (FLO), no next of kin have been identified to date.

HMP FRANKLAND

5. HMP Frankland is one of eight high security establishments in England and Wales. Frankland holds convicted category A and B adult male prisoners, and also high risk remand prisoners. Four of the six wings hold vulnerable prisoners. The operational capacity of the prison is 734.

6. Healthcare services at Frankland are provided by the local Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two six-bedroom wards and eight furnished rooms. The man lived in one of these rooms for most of his time at Frankland.

7. At the time of the man's death, the most recent published full inspection report by HM Chief Inspector of Prisons was dated March 2003. Her report described Frankland as offering a safe environment based on good relationships between staff and prisoners. The inspectors found good staff understanding of individual prisoners and their needs.

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

9. However, a report published after the man's death of a full inspection undertaken by HM Chief Inspector of Prisons and her colleagues in February 2008 said that these high standards had slipped disappointingly and that there were worries regarding safety within the prison. In respect of in-patient facilities, the report said:

> 'The in-patient unit was a good environment and patients were well cared for but not all were there for clinical reasons. There were no day care facilities to provide therapeutic activity for inpatients or prisoners from the wings. Liaison with the primary care trust was good and the trust provided good clinical and managerial support.'

Thirty-four healthcare recommendations were made following this inspection.

10. Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The Independent Monitoring Board (IMB) issues an annual report, and the latest report for Frankland covers the year 2007-08. The IMB said they had received no complaints from in-patient prisoners and this was viewed as a positive reflection on their overall feelings of wellbeing. The IMB expressed some concern, however, regarding cancelled outpatient appointments:

> 'Missed appointments to outside hospital are higher than expectations, averaging 25 per month. Main reasons recorded as: prisoner declined

20%, more scheduled appointments than assigned staff available to escort 22%, security reasons 16%, NHS cancellation 12%.'

11. The death of the man was the 16th death to have occurred at Frankland since April 2004, when I began investigating all deaths in prison custody in England and Wales. All but two of these were due to natural causes.

12. Of those deaths that I have previously investigated, two involved elderly men who, like the man, were resident for some time on the in-patient unit. None of these three investigations has raised significant concerns about the care provided by healthcare staff on the in-patient unit to the men concerned.

KEY FINDINGS

13. The man was convicted of serious sexual offences on 15 January 2001 at court. From court he was taken to HMP Durham. He was sentenced to 12 years imprisonment, with five years on extended licence after his release from prison, at the same court on 12 February. He was transferred to HMP Frankland on 7 March.

14. On his arrival at Frankland he underwent a health screening assessment and was diagnosed with Chronic Obstructive Airways Disease (COAD), which is a long-term breathing problem. He had been diagnosed with asthma before he arrived in prison and was receiving treatment from his time at Durham. Apart from his false eye, nothing of note was recorded regarding his health at this time.

15. From 2001 until he became ill in 2005, the man was seen regularly to review his asthma and his COAD. He received medication to help him with his breathing, including an annual flu vaccination. He was also advised to stop smoking.

16. In July 2005, the man complained of a painful toe on his left foot after he had apparently cut his toe nail too short. Tests revealed that he had impaired blood supply to that area. He was admitted to hospital on 16 July. He received intravenous antibiotics whilst he was there, together with further tests to ascertain what the cause of his illness might be. He was discharged back to Frankland on 2 August.

17. Although the clinical records are quite sketchy, it appears that he was diagnosed with cancer of the kidney during the following few months. He was re-admitted to hospital where he had his right kidney removed before returning to Frankland on 7 October.

18. Records indicate that during the operation to remove the man's right kidney, he was found to have an 'indeterminate lesion' on his left kidney. However, this was not followed up by the hospital at the time.

19. In the meantime, the big toe on his left foot continued to be infected and had started to turn black in colour, which indicated that the tissue was dying. He was referred to a vascular surgeon at hospital. He was also prescribed morphine for the pain. On 12 November 2005, an entry in his prison clinical record said that the hospital should be contacted for an urgent review of his case as the affected area of necrotic tissue (dead tissue) was spreading and now extended above the ankle.

20. The man was seen on 2 December by a doctor (the records do not show his/her name clearly) who diagnosed that he was in a 'toxic confessional state' (that is he was confused and delirious because of poisons in his system – probably as a result of infection). He was admitted to hospital.

21. Sometime between 3 and 6 December, the man's left leg was amputated above the knee. He spent the next three weeks recovering from his operation at hospital and returned to prison on 24 December. He was admitted to Frankland's healthcare in-patient unit.

22. The wound from his amputation became infected at the end of January 2006 with multi resistant staphylococcus aurous (MRSA). This became septic and required him to go back to hospital on 10 February 2006 for intravenous antibiotics. He returned to Frankland one week later, on 17 February. He was re-admitted to hospital on 21 February for a planned surgical adjustment to the stump of his amputated left leg and discharged to Frankland once again on 24 February.

23. As far as the man's amputation was concerned, nothing of significance occurred other than physiotherapy and the fitting of a false limb later in 2006. However, he was also being followed up by the urology department (the branch of medicine that deals with the diagnosis and treatment of conditions involving the kidneys, bladder and urinary tract) following the removal of his right kidney in October 2005.

24. The man developed a swelling in his right groin in March 2006 and was referred to hospital by a prison doctor on 26 March. It was thought he might have a hernia.

25. On 1 June 2006, the man had a computerised tomography (CT) scan (a CT scan involves multiple layered x-rays). The radiographer who reported on this scan wrote regarding the indeterminate lesion on the man's left kidney: 'The lesion in the equatorial region does appear to have grown slightly and has complex features making this very worrying for a small cystic RCC [renal cell carcinoma]'. A consultant urologist at the hospital wrote to doctors at Frankland early in July to tell them the result of the CT scan. He added that he would be arranging discussion of the man's care at a forthcoming multidisciplinary team meeting, and it was possible that he would need an operation in the future.

26. On 5 December the man had his inguinal hernia operated on, but because of the 'poor condition of his chest', the operation was done using a spinal anaesthetic (that is, he was not sedated). He was in hospital for just two days.

27. The man was eligible for parole in 2007 and his Parole Board hearing was on 29 December 2006. The Parole Board panel who considered his application decided that he was not suitable for early release, mainly because he had not completed any offending behaviour courses. The Board judged there was still a risk that he would commit further offences.

28. Partly in response to this, the man began an offending behaviour course early in 2007, but he was removed from the course because he was thought to have an ambivalent attitude towards his offending. It was therefore agreed by the man and the Offending Behaviour Team at Frankland that he should be

enrolled on an Enhanced Thinking Skills course (ETS). This never happened, although the reason is not clear from the prison records.

29. The man was considered for parole once more on 10 December 2007. Again the Board refused early release as he remained at risk of re-offending.

30. He complained of heartburn and coughing at night to a prison doctor on 15 January 2008. The doctor listened to his chest but did not find anything that concerned him. He prescribed an antacid, Ranitidine, to be taken twice a day, and asked that the man be reviewed within 10 days to check if the medication was effective.

31. The medical director at Frankland saw the man on 6 February. He changed the Ranitidine medication to Omeprazole as this type of medication (acid reducing) had been shown to be helping with his heartburn. Omeprazole was thought to be more effective than Ranitidine.

32. On 17 February, a nurse saw the man because he had slight swelling to his right foot and ankle. She examined him and decided that although the foot was warm and she could feel pulses in it (so there was good circulation), he should be seen by a doctor. There is nothing in the notes to indicate he was seen by a doctor until 26 February.

33. A mental health nurse saw the man on 22 February because he was complaining of pain in the upper area of his stomach (she described it as upper gastric pain in the clinical notes). She took his blood pressure, pulse and temperature and found that all these vital signs were within normal limits. He told her that he thought his pain might be due to a pulled muscle, but there is no further explanation of this in the notes. She wanted him to be seen later that day by a doctor.

34. The nurse saw the man again on 25 February because staff working on the healthcare unit had expressed concern about his general deterioration. She arranged for a doctor to see him the following day.

35. A prison doctor saw the man on 26 February. The clinical record indicates that he changed the medication and said he would complete a physical examination at his next clinic (it does not say when that was to be). Later that day, the nurse took his blood pressure and pulse and recorded the results as blood pressure 109/70, pulse 102 (the blood pressure was a little low and the pulse was quite fast).

36. The man was seen by a second nurse on 27 February. She tested a sample of his urine and found it to be very concentrated and reddish brown in colour. The results of this test indicated that he had an infection and that there was blood in his urine. He was referred to the doctor.

37. A prison doctor examined the man and recorded in the clinical notes information from staff that he had vomited earlier. She also wrote that she found his stomach to be ‘soft, non-tender’ and that he should have another

urine test, together with blood tests. He was to be started on antibiotics and seen again in a week unless he became worse in the meantime. The blood test results were reported by telephone that evening and showed that he had a low platelet count, recorded as 35 (normal levels should be between 150 and 400). The second nurse was asked to repeat the blood test, which she did on 28 February.

38. The man vomited a small amount of blood on 29 February and was seen by a prison doctor who prescribed iron tablets and asked that the man's blood pressure and pulse be taken every four hours. A third nurse undertook those observations that day and recorded them as being 100/62, pulse 94 on the first occasion, and 107/70, pulse 97 on the second. Both these results indicated a slightly low blood pressure with a fast pulse.

39. Over the weekend of 1 and 2 March, the man continued to have his blood pressure and pulse monitored. The pattern remained that of relatively low blood pressure readings with high pulse rates. He continued to look and feel unwell with occasional bouts of vomiting. The first nurse recorded in the clinical notes that he should be seen by a doctor on Monday 3 March because of his general deterioration. She also wrote: 'The man is reluctant to discuss symptoms as he does not want any bad news. He is concerned that he will deteriorate before his release date next year.'

40. The man was not seen by a doctor on 3 March, even though he continued vomiting. On 4 March he brought up 'coffee ground' vomit (a description used when a patient vomits blood). He was seen by a prison doctor who recorded that the man did not look unwell. The doctor asked that he be sent for a chest x-ray and given medication to help stop his vomiting. His repeat blood test results came back and confirmed his low platelet count (properly described as thrombocytopenia). The doctor was informed of these results.

41. After the man again vomited blood on 5 March, the prison doctor arranged his admission to hospital.

42. On 7 March, the man was diagnosed with gastric cancer. The local Macmillan team were informed and he was sent back to prison on 10 March for palliative care at Frankland.

43. The man had some swelling in his scrotal area on 11 March, and the prison doctor prescribed Furosimide, a diuretic (diuretics are medicines that remove water from the body by increasing the amount of urine the kidneys produce). He also asked that a fluid balance chart (a chart which is used to measure the amount of fluid someone takes in and passes out of the body) be started.

44. A Macmillan nurse visited the man on 13 March to explain his diagnosis and what he might expect to happen over the time he had left to live.

45. Apart from some entries in his clinical record about his fluid balance and being made comfortable, the man does not appear to have had any significant further health interventions over the next few days. However, one morning

when staff went in to his room at 9.15am, they found that he had died in his sleep. The first nurse and a Healthcare Support Worker found him unresponsive in bed when they answered a cell call bell request from another prisoner. The prisoner had pressed the call bell when he became concerned about the man.

46. Both nurses left the ward, taking the prisoner with them. They telephoned the duty governor, the uniformed officer in charge of the prison (Oscar 1), the Healthcare Manager and the duty doctor, to inform them that the man had died. The Healthcare Manager, together with two nurses, re-entered the ward to check his pulse and breathing. The nurses decided that no resuscitation efforts should be made. The duty doctor arrived at 10.05am and confirmed at 10.10am that the man had indeed passed away.

47. Despite efforts by the prison's FLO to establish contact with family members, no next of kin were identified. Care and support opportunities were offered to those staff and prisoners affected by the man's death, in accordance with the prison's contingency plans following a death in custody.

ISSUES

48. The man arrived at HMP Durham in January 2001 and was sentenced to 12 years imprisonment the following month. His only medical issues at that time were that he had asthma and a false left eye. He was a smoker. Over the following four years there were no remarkable clinical developments, but in 2005 he became unwell with a tumour to his right kidney which resulted in the removal of that kidney in October 2005. In December 2005, he had an above knee amputation of his left leg and in December 2006 he had a hernia operation.

49. During this time his asthma steadily worsened and he developed Chronic Obstructive Airway Disease (COAD). This compromised his breathing, but he continued to smoke.

50. When the man had the operation to remove his right kidney, it was discovered that he had a worrying lesion (growth) attached to his left kidney. This discovery was not followed up promptly by doctors at hospital. It was not until March 2007, when a doctor at Frankland sent a letter to the hospital to ask about the matter, that further investigation and follow up at the hospital were eventually organised. Even then, it was not until December 2007 that he was actually reviewed in clinic at the hospital.

51. Unfortunately, poor record keeping prevents me from being certain about what went wrong with the care afforded to the man. The clinical reviewer says a number of times in his report that he cannot be certain what occurred because he does not even know if he has all the relevant records. Those he does possess are incomplete and change from being handwritten one minute to computer-generated the next. They were difficult to follow because of the way they had been copied or, more likely, filed in the first place. The clinical reviewer writes that he is unsure at various points as to whether the appropriate examinations were carried out and not recorded properly, or not in fact undertaken in the first place. I therefore recommend that:

    The PCT should undertake an immediate review and audit of the clinical records system within HMP Frankland to satisfy themselves that entries are complete, accurate and comply with the professional standards of GPs and Nurses in the United Kingdom.

52. Perhaps more worrying is the clinical reviewer's observation that there is nothing to indicate that the man had any physical examination of his abdomen in the last few months of his life. The man was seen by a prison doctor on 15 January 2008 for heartburn and coughing at night. The doctor recorded that he had listened to the man's chest, but there is no record of any abdominal examination. The doctor prescribed the man an antacid and he was due to be seen within the following 10 days.

53. A second prison doctor saw the man on 6 February and prescribed medication that was more suitable for his heartburn. There is no evidence to suggest that any abdominal examination took place.

54. On 22 February, the man was seen by a mental health nurse after complaining of pain in the upper gastric area. She wanted him seen by a doctor that day, but this did not happen for another four days. A third prison doctor saw him on 26 February but did not examine his abdomen, saying he would complete a full physical examination at his next clinic.

55. The man started vomiting the following day and, according to the first nurse, appeared to become more unwell. His urine sample had shown signs of having blood in it. His pulse and blood pressure readings were abnormal, with low blood pressure and fast pulse. These are indicators of possible internal bleeding. On 27 February, a fourth prison doctor examined the man's abdomen and found it to be 'soft, non-tender'. This seems to be the only evidence of any clinician undertaking an abdominal examination at all during the six times he was seen between 15 January and 16 March. This is also the date when blood results for him showed extraordinarily low levels of platelets. The tests were redone the next day to establish whether a mistake had been made in the way the blood sample was collected (one possible explanation for such low platelet level results).

56. After vomiting a small amount of blood on 29 February, the man was seen by the third prison doctor. He prescribed iron tablets but there is no indication that he conducted any abdominal examination. Again, his blood pressure and pulse readings were not normal.

57. The man continued to vomit blood and his blood pressure and pulse readings over the weekend of 1 and 2 March were abnormal. He was seen by the third prison doctor on 3 and 4 March, but it was not until 5 March that he was transferred to hospital. After his admission to hospital he was diagnosed with advanced gastric cancer and discharged back to prison on 10 March for palliative care. He died six days later.

58. I do not suggest that the man's illness could have been prevented nor that the outcome would have been different if his condition had been recognised sooner. However, I am concerned that warning signs were not fully and properly investigated with a view to his earlier transfer to hospital. This might have afforded him and the prison a few more days in which to implement a Care of the Dying care package. It is perhaps a consequence of the man's personality that he chose to play down many of his signs and symptoms. I note that he was reported to have told the nurse that he was 'reluctant to discuss symptoms as he does not want any bad news.' This may indicate that he did not want to know what was wrong with him, especially since he had undergone cancer treatment in 2005.

CONCLUSION

59. When the man was first received at HMP Durham in 2001 he was 66 years old but had relatively few ailments, other than asthma. He developed cancer of the kidney in 2005 and his right kidney was surgically removed. A few months later, unrelated to that cancer, he had an above knee amputation of his left leg. In December 2006, he required a hernia operation, again unrelated to either his cancer or his amputation.

60. Late in 2007 and early in 2008, the man began to show signs of being unwell again but without any specific cause. He slowly deteriorated during February, with episodes of vomiting blood and low blood pressure coupled with accompanying fast pulse readings. Eventually, following abnormal blood test results, he was admitted to hospital on 5 March 2008. He was diagnosed with gastric cancer on 7 March, discharged back to Frankland on 10 March and died there. Even if his gastric cancer had been diagnosed sooner, my investigation does not suggest that the eventual outcome would have been any different. He was being followed up for a suspicious growth on his remaining kidney by doctors at hospital from July 2007, but there were no other indicators that he might be developing cancer until his blood test results in March 2008.

61. Throughout January and February 2008, the man complained of stomach problems and vomiting blood. The failure to conduct a physical examination of his abdomen during that period appears to have deprived doctors of the opportunity to diagnose his cancer sooner. Although earlier diagnosis is unlikely to have saved his life, it might have made a difference to the care afforded him in his last few weeks.

RECOMMENDATION

The PCT should undertake an immediate review and audit of the clinical records system within HMP Frankland to satisfy themselves that entries are complete, accurate and comply with the professional standards of GPs and nurses in the United Kingdom.

This recommendation has been accepted. The Head of Healthcare has contacted appropriate personnel in order to conduct a review and audit of the clinical record system. No date has been set as of yet, but this is expected to be completed by August 2010. In addition, nursing staff attended the Trusts Documentation and Record Keeping study day in 2009.