PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man at Sunderland Royal Hospital, while in the custody of HMP Frankland, in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is a report into the death of a man who died in January 2012 at Sunderland Royal Hospital while in the custody of HMP Frankland. The man had been diagnosed with myeloma (bone marrow cancer) shortly before he died. I offer my condolences to his friends for their loss.

The investigation was carried out by one of my senior investigators. A clinical reviewer was commissioned to undertake a review of the man's clinical care. Frankland co-operated fully with the investigation.

The man presented with back pain for most of his time in custody, which increased and was treated with painkillers. It was not until less than a month before he died, that the cause of his pain was more fully investigated. The clinical reviewer expresses concern about the delay in diagnosing the man's myeloma and, while this might not have affected the outcome, earlier diagnosis might have improved his care and pain relief. Once a diagnosis had been made, the man was well supported by the prison.

By all accounts, the man was not an easy patient and he insisted on remaining on an ordinary wing when he might have been better served in the Healthcare Centre. The prison sought to meet his wishes, but the investigation suggests that better care planning could have improved the quality of his care on the wing. Weaknesses are also identified in record keeping and in the speed with which the man's next of kin were identified.

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 **November 2012**

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SUMMARY

1. The man was sentenced to life imprisonment in 2008. He initially served time in custody at HMP Durham, but was transferred to HMP Frankland a year later.

2. At Durham, the man suffered from severe back pain and also complained of pain in his legs. These problems recurred throughout his time at Durham and he was treated with painkillers.

3. On arrival at Frankland, the man continued to see healthcare regarding his physical and mental health. He was dissatisfied with the treatment and medication he received and frequently submitted complaints to healthcare.

4. The man continued to complain of back pain, and sometimes leg and knee pain, but also had recurring chest infections and asthma. He was treated with asthma inhalers and antibiotics.

5. It was not until 24 December 2011, when a nurse persuaded him to agree to blood tests, that the extent of his condition was revealed. The blood tests showed that he was in renal failure and had anaemia. He attended hospital for further assessment and was then diagnosed with bone marrow cancer (myeloma). He was told that this was incurable, but a course of chemotherapy might improve his symptoms. However, the man's health deteriorated rapidly and he died less than a month later, before he could start the chemotherapy.

6. This report makes five recommendations. Three of the recommendations relate to healthcare. These concern an awareness and management of a prisoner's condition rather than it being viewed in isolation, addressing the results of an abnormal blood test in a timely way, and improved record keeping. Another recommendation is made jointly to the Governor and Head of Healthcare and concerns the need for a coordinated care plan for acutely ill prisoners who remain on the wing. The last recommendation, made to the Governor, is to ensure a prisoner's next of kin are informed as soon as possible, that the prisoner is seriously ill in hospital.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death in January 2012. One of my investigators carried out an opening visit on 3 February. During the visit she met with the appointed prison liaison officer, the Head of Healthcare, a member of the Independent Monitoring Board (IMB), a Prison Officer's Association (POA) representative, staff on the man's wing and a prisoner who was anxious to speak to her about concerns he had regarding healthcare at Frankland.

8. The investigator was given all the man's prison records and highlighted those she required. All the relevant records, including the man's medical file, were forwarded to the investigator.

9. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with any relevant information. A number of prisoners from the man's wing asked to speak to her on her next visit. The prisoners all raised concerns about healthcare at Frankland and the man's treatment. They all described the man who was very poorly, but was looked after by other prisoners rather than staff. They were also concerned about the healthcare complaints procedure. This is considered in this report.

10. A clinical reviewer was appointed to undertake a review of the clinical care the man received while at Frankland

11. The investigator conducted five recorded interviews with staff on 20 March (the earliest date the prison could arrange for staff to be available) and three interviews with prisoners. The clinical reviewer was unable to carry out joint interviews for staff and prisoners with the investigator, as a mutually suitable date could not be identified, but he received a copy of all the interview transcripts. The clinical reviewer's review was received on 19 April.

12. Following her interviews with prisoners on 20 March, the investigator met the wing governor to ask him about concerns raised by prisoners that morning. The wing governor arranged for a member of staff (who was not on duty that day) who had a good knowledge of the man, to e-mail her with further information (this was received on 2 April). The investigator also met with the prison's Governor at the end of her visit to provide him with verbal feedback.

13. The investigator wrote to the Governor the next day to confirm the issues they had discussed. These related in the main to healthcare and the man's medical treatment.

14. The investigator also wrote to HM Coroner to inform him of the Ombudsman's investigation. A copy of this report will be sent to the Coroner to assist with their enquiries.

15. One of the Ombudsman's family liaison officers contacted the man's next of kin (family friends) to invite them to be involved in the investigation process.

They said that the man had complained of pain in the previous year but only went to hospital in the last week of December. They said he was carried up flights of stairs at the prison as he could not walk and had complained about his medication, although nursing staff had reassured him that what he was prescribed was appropriate. They added that the man had the impression he had sciatica[1], but that they could see the deterioration in his health during visits, and in his voice when speaking over the telephone.

16. The man's next of kin were forwarded the draft report in June 2012. They did not return any comments on the report.

[1] Pain, weakness or tingling caused by pressure on a nerve

HMP FRANKLAND

17. Frankland is one of eight high security prisons in England and Wales, and can hold up to 844 men. It holds convicted category A and B adult male prisoners, and some high risk remand prisoners. The man was a category B prisoner (those who do not require the maximum security but for whom escape must be made very difficult). All prisoners have single cells.

18. Until April 2011, healthcare services at Frankland were provided by County Durham Primary Care Trust. Since then, Care UK has provided healthcare at Frankland and a number of prisons in the area. There is 24 hour inpatient care

Her Majesty's Inspectorate of Prisons

19. HM Chief Inspector of Prisons carried out an unannounced full follow up inspection in November 2010. The Chief Inspector found that:

> "Nearly half of prisoners said the quality of health services was bad or very bad, although vulnerable prisoners were more positive than others. Significant staff shortages in recent months had had a serious impact on the delivery of care but staffing levels had recently improved and primary care services were being reinstated."
>
> "The large primary care department had undergone some major refurbishment. Clinical rooms were now of a high standard….however some waiting rooms were poor with no health promotion literature and stark facilities. Most treatment rooms on the wings were small but had adequate facilities. A recent infection control audit had identified a good standard of cleanliness and compliance with infection control standards in the main department."
>
> "GP services were provided by a team of GPs who served the four prisons in the cluster. They provided nine sessions a week to the main prison and one session a week to the Westgate Unit. Out of hours medical cover was provided by the local on call service from both emergency nurse practitioners and GPs."
>
> "SystmOne, the clinical information system, had been introduced to the health services department in the previous six months but not all clinical records had been transferred successfully from the previous system. Some entries, particularly those made by the mental health team were good but others were cursory and there was some evidence that required actions had not been completed."

Independent Monitoring Board (IMB) report

20. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, responsible for monitoring the prison and ensuring that proper standards of decency and care

are maintained. The annual report published by the IMB for the period 2010 to 2011 noted with regard to healthcare that:

> "There has been a major change in healthcare within this reporting year, with the switch to a new provider…. Care UK took over responsibility from County Durham and Darlington Community Health Services on April 1st with a three year contract."
>
> "Some areas of performance are causing concern – specifically around waiting times and access."

21. A dedicated senior manager is the "End of Life Champion" for prison staff in healthcare. He works alongside the lead Macmillan and healthcare nurses. The IMB noted that they wished:

> "To congratulate the whole Palliative Care Team for their commitment and collaborative approach to ensure the delivery of equitable dignified care."

22. The IMB also refer to the healthcare complaints procedure. Prisoners who spoke to the investigator expressed concern about this. However, the IMB report:

> "The Care UK procedures are in line with standard NHS directives and the initial local resolution form remains the same. There continues to be a confidential, locked box on all of the wings which is emptied daily by healthcare staff. All relevant forms are available to prisoners on the wings."

Myeloma

23. Myeloma is a type of cancer that develops from cells in the bone marrow called plasma cells. Bone marrow is the spongy tissue found inside the inner part of the body's large bones. It is from bone marrow that different blood cells are produced.

24. Myeloma does not always cause symptoms in its early stages, but possible symptoms can include:
    - pain the bones, especially the back or ribs
    - a fractured bone
    - feeling thirsty
    - feeling or being sick
    - passing a lot of urine
    - tiredness, shortness of breath or weakness
    - repeated infections
    - unusual bleeding or bruising more easily than normal
    - swollen ankles.

Previous deaths at HMP Frankland

25. Two other prisoners died at Frankland in the same month as the man. One death was from natural causes and the other death was self inflicted. The prisoner who died from natural causes died two weeks before the man. There were similarities between the two cases as the prisoner also died shortly after being diagnosed with cancer (two weeks later). However, although the circumstances were similar none of the recommendations made are the same in both cases. Since the man's death, another three prisoners have died of natural causes. None of these investigations have yet been completed.

KEY EVENTS

26. The man received a life sentence for a number of offences and was first imprisoned at HMP Durham in September 2008.

HMP Durham

27. When the man arrived at Durham he underwent a first reception health screening. He told the nurse that he was prescribed medication for back pain as well as diazepam[2] and zopiclone[3]. The man's concerns focussed on his mental health. A referral was made for him to see both the doctor and mental health team.

28. The man's community doctor was contacted who confirmed that the man had a history of back pain, asthma, a personality disorder and anxiety with depression.

29. There is an entry that the man was seen in the psychiatric clinic on 23 September 2008. The doctor confirmed a diagnosis of a personality disorder, with evidence of poor impulse control and emotional instability with an intermittent low mood. The doctor also felt there was evidence that the man was dependent on benzodiazepines.[4]

30. An entry in the man's medical record made on 25 September said that, amongst other problems, he was suffering from severe back pain. A month later the man complained of back pain and pain in his legs. These problems recurred throughout the time he spent at Durham prison.

HMP Frankland

31. The man transferred to Frankland prison on 18 September 2009 and was seen by a nurse (although the entry in the medical record was made by an administrator in healthcare). Although he denied any thoughts of harming himself at that time, an Assessment, Care in Custody and Teamwork document (ACCT)[5] was opened for him the same day because the man had seemed low in mood during the reception process. He was also prescribed diazepam straight away. After an improvement, the ACCT was closed on 22 September.

32. Prison Dr A met the man on 22 September to review his medications. During this consultation the man said he had a history of taking opioid[6] medication for "arthritis pains". The doctor noted that she would change this medication because of its limited effectiveness and prescribed him tramadol[7].

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[2] anxiety reducing sedative
[3] sleeping tablet
[4] relieves symptoms of anxiety
[5] a process to monitor prisoners at risk of self harm
[6] taken for chronic pain
[7] a pain reliever

33. They discussed a plan the man had begun at Durham to gradually reduce diazepam. They agreed to reduce the dosage by two mg every two weeks. No mention was made of any other medication the man had been taking.

34. The man made several formal complaints during 2009. These regarded medication for his mental health conditions, the reduction of his diazepam, and the attitude of healthcare staff. Each time the healthcare team responding within ten 10 working days in accordance with the healthcare complaints policy. It seems the man thought he should be in a psychiatric hospital, or considered for the Dangerous and Severe Personality Disorder (DSPD) unit at Frankland.

35. In October, it was noted that the man was on a high dose of painkillers for "arthritic pains". He complained of severe pain in his knees and prison Dr A ordered an X-ray. This took place on 5 November.

36. On 12 November, the man met with another doctor at the prison, Dr B. The man said he had suffered pain in his back and knees since a motorbike accident in 1990. He said that the pain relief was not adequate and requested increased painkillers. The doctor noted that the prison were awaiting the results of the X-ray on the man's knees. He examined the man's spine and noted mild tenderness although it was otherwise normal. The doctor also examined the man's knees. He noted some mild soft tissue tenderness on the left knee, but that his movements were normal. The doctor planned to await the results of the X-ray, before deciding whether an increase in medication was necessary.

37. There is no record of the result of the X-ray, although a physiotherapy appointment was scheduled in December, but the man refused to attend despite encouragement.

2010

38. On 13 January 2010, there is a note in the man's medical records that an X-ray had been requested and, on 19 January, he had a lumber X-ray (of his lower back). (Up until this point there was still no record in the medical record of the outcome of his knee X-ray.) The X-ray showed no abnormality. The clinical history on the form requesting an X-ray stated that he had a long history of low lumber pain with moderate restriction of movement. He was diagnosed with probable mechanical lower back pain. There is no record to suggest his medication was reviewed after this diagnosis.

39. Over the next few months, the man continued to be seen regularly by healthcare for mental health reviews and requests to continue with diazepam. The man seemed angry and distressed that he was on a plan to reduce this and was now on a two mg dose that he took four times a day. During a consultation in March he told a member of healthcare that he would contact his solicitor about this. During this time, the man also made complaints about healthcare regarding the reduction of diazepam and a problem with an asthma inhaler. (The prescription for diazepam was due to expire on 10

May.) The man did instruct a solicitor and copies of his medical records were forwarded.

40. On 24 April, the man saw prison Dr B and further complained of back pain. The doctor recorded that the man had no new symptoms at that time and referred him for an orthopaedic[8] review regarding his on-going back problem. There was no record of this review taking place in the medical records.

41. Between May and December, the man saw a number of healthcare professionals, invariably regarding his mental health. He was prescribed anti depressants and reviewed by a psychiatrist. Medical records show that the man continued to be prescribed zopiclone, mirtazapine[9], asthma inhalers and tramadol.

42. Despite a gradual reduction of diazepam, medical records show it was once again prescribed in August, although it is unclear why. Over the next few weeks, the man continued to receive the medication prescribed for him. The man also continued to complain about various aspects of healthcare, including staff and his treatment.

43. The next specific mention of back pain was not till 5 December when a member of staff on the man's wing telephoned healthcare and spoke to Nurse B. The man was complaining of a "bad back". Nurse C went onto the wing to see the man a few minutes later. She saw that he was walking around talking to other prisoners, although when she spoke to him he told her he was in "unbearable pain". The nurse told him to keep mobile, but he was not happy with this and demanded to see a doctor. She telephoned healthcare for advice and was told that the man had already had his pain relief that day.

44. The same day the man submitted a complaint form to healthcare, complaining of "excruciating back pain". He asked to see an "outside GP". It is not clear how healthcare responded on this occasion.

45. Two hours later another Nurse D, noted that healthcare had received a number of telephone calls that morning about the man, and the advice had been the same each time, that he should remain mobile. Four nurses had seen him (it does not say who these were) and the man had no loss of sensation in his limbs and had no urinary or bowel problems. The nurse advised the man that his symptoms did not warrant a call for an emergency doctor's appointment, but that he should ask for an appointment or contact healthcare if his symptoms worsened.

46. The man also saw Nurse B that afternoon, in his cell. He said he was unable to walk. He demanded to see a doctor and became very agitated. The nurse suggested he apply to see a doctor and offered him some paracetamol in addition to his other medication. The man became abusive and dismissed the nurse's suggestion, although he said he had some paracetamol in his own

[8] treatment of knee pain
[9] an anti-depressant

possession. The man subsequently submitted another complaint form to healthcare.

2011

47. The man saw prison Dr A on 25 March, as he complained of feeling thirsty. The doctor ordered blood tests to investigate this. The man underwent a full blood test which included a full blood count[10], and tests for urea and electrolytes[11], liver function[12] and fasting glucose[13]. The results showed that all the tests were within normal limits.

48. The next mention in records of the man experiencing pain (although it does not specify where) was not until 12 September in a consultation with prison Dr A. The man said he still needed tramadol for arthritis. He described sharp muscular pains in his lower back and asked for pain relief gel. The doctor noted that the pain was "clearly postural and not constant". She examined him and could find no tenderness or spinal deviation.[14] The doctor did not prescribe any gel for the man and he did not challenge this.

49. The man also had an inguinal hernia[15] however, he did not want an operation as he had a fear of needles, so the plan was to keep the situation under review. The man also had chesty cough. Prison Dr A found no evidence of wheezing and was reluctant to prescribe any medication (the man was already using asthma inhalers). The man was given advice about stopping smoking. From this time, the issue of back pain became more prevalent.

50. On 29 September, was still experiencing back pain. Although no new symptoms had emerged he was referred to a physiotherapist.

51. Nurse E examined the man on 20 October. He complained of pain radiating from his back to his sternum area, which was worse when he breathed in. The nurse thought it likely he had a chest infection. He was seen by a nurse practitioner later that day and prescribed antibiotics.

52. Eight days later, the man saw a sessional doctor at the prison. The man said he had a pain in his abdomen because of a hernia. He said he had had the pain for weeks but still was not willing to be referred for an operation. He was kept on the same pain relief.

53. On 3 November, prison Dr B prescribed muscle relaxants for the same pain and referred the man to a colorectal[16] surgeon. There is no record that the man received an appointment.

[10] to detect a range of disorders
[11] to confirm normal kidney function
[12] measures chemicals in blood
[13] for detection of diabetes
[14] a spine deformity
[15] in the abdomen
[16] bowel

54. On 9 and 10 November, the man spoke to a healthcare officer and a nurse about worsening sciatica pain and requested further pain relief. At times he was angry. Nurse F encouraged the man to be admitted to healthcare as an inpatient to enable a proper assessment but he wanted to stay on the wing with his friends.

55. By 15 November, the man said the pain was so great in his back and legs, he could not collect his medication from the wing, and instead a nurse took it to him in his cell. He was referred to the doctor again.

56. Prison Dr A assessed him again on 17 November. The man said the pain started nine days earlier when he put up a curtain rail in his cell. The doctor explained that he was already on strong pain relief medication, and the man did not want more muscle relaxants as he said it caused him stomach cramps. The doctor noted that she sympathised and suggested he apply heat to the affected areas. The doctor noted that the man became "irate". Four days later, the man raised another healthcare complaint as he felt his pain relief dosage was inadequate. The man mentioned that he would sue the prison for negligence.

57. On 22 November, the man experienced acute back pain when leaning over a snooker table. He could not straighten up and had to be taken to his cell to lay down by other prisoners. Staff had expressed concern and he was seen in his cell by a member of nursing staff. After consultation with prison Dr A, he was given an intra muscular injection[17] of diclofenac[18] and issued with Heat Rub cream. There is no record of an examination taking place at this point and it does not appear that the man was seen by a doctor. Nurse F advised that he should be admitted to Healthcare for a full assessment, but the man declined.

58. Nurse E took the man's medication to his cell on 24 November, as he was finding difficult to walk down stairs. The nurse noted that the man was in obvious pain and the man felt the injection had not helped him at all.

59. The next day Nurse D went to the wing to see the man. She was told he was unable to leave his cell because of his back pain. The nurse noted that she felt it was inappropriate to see the man in his cell and would schedule another appointment. Although she is a mental health nurse, the nurse did not raise any concerns about the man's physical health or that he was unable to leave his cell.

60. On 29 November, prison Dr A examined the man in his cell. He said he was unable to get out of bed because of lower back pain. The doctor agreed to prescribe extra tramadol. She recorded no red flag symptoms[19] and no diagnosis was recorded. Prisoners told the investigator that the man was using a bottle to urinate in as he struggled to use his toilet by this stage. There is no entry in the medical record referring to this.

[17] an injection into a muscle
[18] a non-steroidal anti-inflammatory pain killer
[19] symptoms that should not be ignored

61. Throughout December, there are numerous occasions where healthcare staff took the man's medication to him in his cell. He continually complained of leg and back pain and asked from pain relief and diazepam. He was concerned he was not on the correct medication and complained about this. Again nursing staff encouraged him to move to healthcare for assessment but he refused. It was thought that this may be in part because smoking is not allowed in part of the healthcare centre and the man wanted to smoke.

62. He was examined by several nurses and doctors. It was regularly recorded that he showed no 'red flag' symptoms and no specific diagnosis was made.

63. On 15 December, the man complained of severe back pain and was unable to get off of his bed. He was seen the next morning by prison Dr C. The man did not co-operate with the doctor's examination, but did ask to be prescribed diazepam to help him sleep. The doctor refused. He diagnosed chronic lower back pain but noted no obvious signs of sciatica in his legs. The doctor prescribed quick release tramadol and promethazine[20] for two nights. It is unclear from medical records, but between this date and 20 December the man appears to have moved to healthcare.

64. A physiotherapist saw the man on 20 December. He advised him to adjust his posture and move around more and would review him in a further two weeks. An entry in the medical records on 21 December noted that, following the man's physiotherapy assessment, healthcare planned to discharge him back to the wing. Before he returned to the wing he was examined by Dr D. On this occasion, the man complained of a tingling sensation in his nipples and a "bad chest". The doctor prescribed antibiotics for his chest and advised that the man should remain in healthcare overnight for observation. Observations were taken every four hours, although the man refused to have his blood pressure checked.

65. The next morning Dr A examined the man. He told her that he felt breathless and his chest felt "tight". The doctor ordered blood tests and was concerned about the possible diagnosis of pneumonia[21]. The man refused to stay in healthcare and signed a disclaimer so he could return to the wing.

66. On 24 December, Nurse E saw the man in his cell. He said he had been unable to sleep all night as lying in bed had become too uncomfortable and he had spent the night sitting in a chair. He told the nurse the pain had increased and he had lost his appetite. The man was worried that he had pneumonia and felt the antibiotics were not working. The nurse assured him that he would be observed closely and that he should tell somebody if he began to feel worse. The man was reluctant to have a blood test and the nurse tried to persuade him to have the tests after the Christmas holiday period. He said he would think about it. The man also mentioned that he was constipated and

[20] for allergy symptoms, nausea and vomiting
[21] inflammation of the lung

the nurse prescribed him lactulose.[22] He was seen the following day and said his appetite had improved slightly.

67. There is an entry in the medical records on 28 December that the man refused "hospital admit" and signed a disclaimer to this effect. It is not clear who recommended that he be admitted to hospital or for what reason. The man also did not attend an appointment with a duty doctor at 10.00am that day, but did see Dr A an hour later. He also had blood tests that day.

68. The man's blood test results were received later that day. They showed that he was anaemic [23] and in renal failure[24]. There was a note in the medical records that Dr D did not have time to see the man that afternoon (the entry is made by a healthcare administrator at 4.49pm). Although again not clear from the records, it appears that the man was back in healthcare as an inpatient.

69. Later that night, at 10.36pm, the man was visited by an out of hours doctor. The doctor advised the man that because of the results of his blood tests, and the abnormal readings, he needed to go to outside hospital for an assessment of potential chronic renal failure[25]. The man refused to go, despite the doctor explaining the seriousness of his condition and that if he did not accept treatment it could be life threatening. Instead, the man signed a disclaimer stating that he would not go to hospital. The doctor again tried to persuade him otherwise, with no effect.

70. Early the next morning, 29 December, the man refused to allow healthcare staff to carry out their observations. He said he was dying. However, during conversation with the clinical team manager, the man said he felt much better. He said he knew the doctor would see him and he would agree to further tests.

71. Dr A ordered repeat blood tests. These tests were reviewed later that day by Dr C and Dr A, who noted clinical information as "renal failure … likely anaemia due to renal failure marrow suppression"[26].

72. Dr A saw the man an hour later. She noted in the medical record that the man was adopted so no family history was available, but he was not aware of any kidney related illnesses in his family. Dr A explained that there were many reasons for kidney failure and that it is often treatable, but if left untreated it could be life threatening. The man said he did not feel that he could attend hospital that day, but would think about going the next day.

73. The next morning, 30 December, Nurse G, spoke to the man at length about the need to admit him to hospital for further tests and treatment. The man

[22] treatment of constipation
[23] iron deficiency
[24] kidneys fail to filter toxins and waste
[25] slow loss of kidney function
[26] suppression of marrow activity – a decrease in cells responsible for carrying oxygen and for normal blood clotting

said he realised this was necessary. Dr C spoke to a renal on call consultant at Sunderland Royal Hospital and agreed that the man should be admitted for further tests and assessment and he was admitted to hospital that afternoon.

74. A Person Escort Record Form (PER) was completed to accompany the man to hospital. Nurse G noted on the PER that the man had a medical problem requiring hospital admission. It is not clear why this visit to hospital was treated as an escort and not a bedwatch, as it was likely that the man would need to stay in hospital. However, the man left Frankland at 1.40pm and a note in the PER said that staff on the escort duty had been fully briefed and security cuffing arrangements had been checked. At 3.00pm it was clear that the man would need to remain in hospital and a note in the PER said a closeting chain had been applied and "cuffs removed" while he remained in hospital. It is not clear whose permission was sought for this. Frankland could not find the paperwork relating to the man's risk assessment and bedwatch.

2012

75. Nurse G telephoned the hospital for updates on 3, 5 and 9 January. She was told that the man's mobility had deteriorated and he would have an MRI[27] scan of his spine. He was also experiencing chest problems and needed to use regular nebulisers. He had also had a renal biopsy[28] and the results of it would help to determine a treatment plan for him. The nurse was told that the man was "poorly" but remained anxious and refused to have an echo-cardiogram (ECG)[29]. Some formal results were awaited but there was early indication of a malignancy[30] and, depending on the results of the MRI scan, the man might require a bone marrow biopsy.

76. Entries in the medical record between 9 January and 13 January give no further information about the man's condition. However, a healthcare support worker visited the man on 12 January and noted that he would be discharged back to prison healthcare the next day and an appointment with a consultant haematologist was arranged for 18 January.

77. The man was discharged with a number of different medications in addition to those he had already been prescribed. These were:

- Lansoprazole[31]
- Buprenorphine[32]
- Codeine[33].

[27] a scan to diagnose conditions affecting bones, organs and tissues
[28] a sample of kidney tissue
[29] measures the electrical activity of the heart
[30] cancerous cells
[31] for gastric problems
[32] for pain relief
[33] for pain relief

78. On 15 January, Nurse H had a discussion with the man about his condition and his understanding of what it meant. The man said the doctor had mentioned a myeloma[34] but did not know what this meant. The nurse encouraged him to speak to a doctor about this at the earliest opportunity. They spoke about acute renal failure and explained that he would require blood tests weekly to monitor his kidney function.

79. The next day, a member of the mental health team met with the man. They discussed his fear of injections and his dislike of hospitals, but he said he was getting used to them now.

80. On 18 January, the man returned to Sunderland Royal Hospital for the appointment with the consultant haematologist and returned later that same day. At 5.42pm, Dr E went to see the man in healthcare. He told the man that he had been diagnosed with myeloma and renal failure and that he needed to begin a course of chemotherapy[35]. There is no other entry that day noting any other interactions with the man.

81. The next day, Nurse G spoke to the man. She explained she would be his 'key worker' and would be there to discuss any concerns he might have. The man said he was having trouble sleeping and had an uncomfortable mattress on his bed. The nurse asked whether he would like to move into another cell that had an electric bed[36] and a comfortable mattress, but he declined as he was aware that another prisoner had recently died in that cell. He said Nurse G had been insensitive. The nurse apologised and said she had only been thinking of ways to try to improve his comfort.

82. On 20 January, Nurse E became aware through other staff that the man was struggling with his illness and anxious about how to tell his friends. The nurse asked the man if he would like her to contact the prison's Macmillan nurse specialist[37] . He said he did not, as they only see people who are dying and he did not want to be written off. The nurse tried to explain the role of the specialist nurse and that they do not just care for people who are dying. The man said that he just wanted a doctor to prescribe him something for his anxiety and "sort out" his pain relief.

83. Dr C saw the man later that day. They discussed his level of pain and the man said it did not feel that bad but he could not relax in healthcare and wanted to return to the wing. The doctor said he would discuss this with a governor. Later it was noted that the man was able to eat and that he had been taken to his wing during the association period to see his friends.

84. On 21 January, the man told Nurse E he was worried about the side effects of chemotherapy treatment. The nurse tried to reassure him. He asked to return to the wing and the nurse said they could discuss that once he had begun the treatment.

[34] cancer found in bone marrow
[35] treatment of cancer with drugs
[36] a bed that can be adjusted electronically
[37] a specialist in cancer and palliative care

85. On 24 January, the man requested oxygen as he was having difficulty breathing. He was very chesty and unable to speak in full sentences. He was given a nebuliser, but this had little effect. He was given six litres of oxygen and referred to the doctor.

86. Less than an hour later, Dr A examined the man, who was breathless, coughing and anxious. The doctor wrote that she would check with the hospital to see whether he could be prescribed steroid treatment ahead of him starting chemotherapy. However, at 9.24am the doctor saw the man again and he appeared to be worsening. In view of the renal failure and the complicated clinical picture the man was presenting, she advised he be re-admitted to hospital.

87. The man did not want to go back into hospital and is noted as being "non compliant". Nurse G spoke to him and reiterated the importance of going to hospital for a full assessment and he eventually agreed. An ambulance was called and the man transferred to hospital at 12.20pm. That afternoon the man asked for his next of kin details to be updated and recorded as his close friends

Bedwatch arrangements on 24 January

88. Another risk assessment for the man's transfer to hospital was carried out by the Security department. It considered the man's behaviour in prison and the risk of him escaping from hospital. The risk assessment noted that the man should not receive any visitors, just treatment, and that he remained a high risk to the public and to hospital staff and there was a risk that he would attempt to take a hostage (because he had threatened to take a doctor hostage in 2009). The man was also assessed as being a high risk to members of the public. However, they assessed his potential to escape as low, as was the likelihood that he would receive outside assistance to do so. It was decided that restraints would be appropriate and that two officers should escort him. It was also noted that handcuffs were not to be removed when he was being transferred to hospital.

89. The handcuff arrangements noted that restraints must be applied at all times, using an escorting chain when the man required the toilet. Permission needed to be sought from the duty governor if any changes to these arrangements were needed.

90. If the escort to prison became a bedwatch (meaning the man needed to stay in hospital, which he did) then restraints must be applied at all times. This was specified to be no less than a single cuff and an escorting chain and that the man should remain in at least partial view at all times.

91. Once the man arrived at hospital, a physical security checklist was carried out by staff. The purpose was to check the security of where the man was and to ascertain any escape risk.

92. Later that morning a review of the man's security arrangements was made. A doctor at the hospital requested that his restraints be removed as his condition had deteriorated. Permission was sought from the duty governor and all the man's restraints were removed.

93. At 2.15pm the man was transferred to the Intensive Care Unit (ICU) and placed on a ventilator[38].

94. On the morning of the man's death, the prison telephoned the hospital for an update. The man remained in ICU on a ventilator and his condition continued to deteriorate. The man was being treated for pneumonia, but his prognosis was poor.

95. That afternoon, the man's condition deteriorated further and a clinical decision was made by the hospital to withdraw his treatment. There is a note that the acting Deputy Governor and two senior staff members, were told of this development.

96. An officer on bedwatch duty rang the prison at 2.33pm to inform them that the man had died. This information does not appear to have been relayed to healthcare as they received notification at 3.13pm from the hospital that the man had died.

Next of kin liaison

97. At 6.00pm on the day of the man's death bedwatch staff contacted the prison to request the man's next of kin details. There is no reason given why this took so long given that the man had been in ICU for almost four hours. The details of next of kin (close friends) were received at 6.54pm. It is not clear who contacted the next of kin but it appears they were telephoned just after 7.00pm. They arrived at the hospital at 10.11pm, after travelling from Carlisle and stayed at the hospital until he died.

98. A prison's family liaison officer was appointed shortly before the man died (as she had been informed that his prognosis was poor). The prison's family liaison officer attended the hospital and met with the prison's chaplain, who had been with the man's next of kin at the hospital for a significant time before he died. The man died as the prison's family liaison officer arrived and she went to meet the man's next of kin and the prison's chaplain in the relatives room. The prison's family liaison officer introduced herself, offered her condolences and explained her role. The man's friends expressed shock at how quickly he had died, as he had only told them a few days before that he had cancer. The prison's family liaison officer explained to them the processes that would follow, the post mortem, the inquest and the Ombudsman's investigation. She also said the prison would help organise and pay for the man's funeral.

[38] a machine to mechanically move air into lungs

99. The prison's family liaison officer subsequently telephoned the man's friends. They once again discussed the speed at which the man had died and that he had not been in touch with any of his family. They spoke about funeral arrangements, contributing towards funeral expenses, and the prison's family liaison officer invited them to visit the prison if they wished. The man's friends said they would like to do so and arranged to visit on 30 January.

100. On 30 January, the man's friends visited Frankland as planned. They saw where he had lived on G wing and the healthcare department. They spoke to a nurse who had cared for the man and explained the man's health issues to them. At the end of their visit, the prison's family liaison officer gave them the man's possessions and a condolence letter from the Governor. She also spoke about attempts she had made to trace the man's family, which had been unsuccessful.

Support for prisoners

101. Members of the chaplaincy and the IMB attended the man's wing to advise prisoners of the help and support available if they felt affected by his death. They were reminded of the services of the Samaritans and Listeners and all ACCT documentation was reviewed. A memorial service was held and prisoners on the wing had a collection for flowers for the funeral.

Support for staff

102. A hot debrief was held at 5.05pm on the day the man died. Staff who had been on bedwatch duties attended. They were offered the services of the staff Care Team. Staff were reminded of the support mechanisms available to them and were sent off duty immediately after the debrief ended. A critical incident debrief was not held.

Post mortem

103. The post mortem was carried out on 26 January at Sunderland Royal hospital. The cause of the man's death was attributed to multiple organ failure and multiple myeloma.

ISSUES

Clinical care

104. The man regularly saw healthcare staff for a number of conditions. He was asthmatic and suffered frequent chest infections. He was a smoker and was offered advice and support to give up smoking, which he declined.

105. Throughout his time in custody the man experienced back pain. At first he attributed this to a road traffic accident in 1990. He also mentioned hurting his back putting up curtains and playing snooker. The clinical reviewer notes that the man was potentially difficult to assess and it was initially reasonable to treat his back pain as an exacerbation of an on-going back problem sustained during an accident. However, the clinical reviewer says once the pain was severe enough to merit an intra-muscular injection of diclofenac, he would have expected a more robust plan.

106. The clinical reviewer notes that, as the man's symptoms persisted, he was regularly seen and assessed and he judges that the individual consultations and examinations were adequate. Healthcare staff regularly recorded that he had no 'red flag' symptoms. However, as the man's symptoms persisted there is no indication that any member of healthcare took an overall view of the problem, but only took into account the issue they were dealing with at the time. No consideration appears to be given that the man's symptoms were worsening and that the treatment he was given was not helping. The clinical reviewer also notes that there were two recorded observations which, if acted upon, may have suggested other causes of the man's problems. These were the reported weight loss and the recorded observation that he appeared pale.

107. It is also a concern that the man became so unwell that healthcare staff took his medication to him in his cell. Despite this, no particular concerns were raised for them and in fact, one nurse decided not to carry out a mental health assessment because she did not want to conduct it in his cell, but did not appear to raise as an issue that the man was too unwell to leave his cell. Healthcare staff appear to have found the man difficult to deal with at times.

108. It was not until a doctor ordered blood tests on 28 December, that the true extent of the man's condition was discovered.

109. The clinical reviewer is of the opinion that if someone had taken a wider view of his symptoms it might have indicated the need for further investigation at an earlier date. Although this might not have altered the course of the man's illness and changed the outcome, it might have enabled an earlier diagnosis and allowed better decision making around his pain relief.

110. The clinical reviewer makes a recommendation which we endorse:

The Head of Healthcare should ensure that a member of healthcare takes lead responsibility for reviewing prisoners who do not respond to

treatment as expected. This review should be completed by September 2012.

111. It is also of concern that, when the man was told of his condition on 18 January, there is no record of him being offered any support or counselling about what this meant and how he was feeling. It may be that this did happen but, if so, it should have been recorded in the medical record. As it stands, it appears that the man was given the news and then left to deal with it on his own. However, the next day a nurse did spend time talking to the man about his illness and the clinical reviewer notes that once the diagnosis had been made, staff interaction was ”supportive, responsive to clinical need and of good quality.”

112. It is clear that from 19 January, the man was supported by two nurses in particular and was also offered the opportunity to meet with a McMillan specialist care nurse.

Blood test results

113. The clinical reviewer also expressed concern about procedures for dealing with a prisoner who has an abnormal blood test. This is in response to the blood test results received for the man on 28 December. Dr D was too busy to see him when asked to during the afternoon. Instead, an out of hours doctor visited the prison at 10.30pm to speak to the man and explain the seriousness of his condition and to try to persuade him (unsuccessfully) to go to hospital. It is hard to imagine how the man was not prioritised that afternoon, given that the test results indicated renal failure and anaemia. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure that abnormal blood test results are dealt with by the prison doctor. Where this is not possible there should be a clear handover to the out of hours doctor. This review should be completed by September 2012.

Prisoners concerns

114. My investigator met with four prisoners during the course of the investigation. She was told that the man was clearly unwell but they felt he received little help or support from healthcare or wing staff. They said it was left to prisoners to collect meals for the man and even to empty his urine bottle.

115. The prisoners told the investigator that they spoke to wing staff about how unwell the man seemed but were told they could not force him to go to healthcare as an inpatient. In the medical record, there are entries to confirm that staff had advised him to go to healthcare for a full assessment but he declined twice. Prisoners said anecdotally that this was because the man could not smoke in healthcare.

116. Officer A confirmed that when the man became confined to his cell, prisoners had assisted by taking his meals to him. He said that he had emptied his urine bottle, but was not aware whether prisoners had.

117. It is clear the man needed to be an inpatient in the healthcare centre by this stage. Staff cannot force a prisoner to attend or stay in healthcare and it seems that staff were trying to balance the man's wishes with his treatment. Healthcare staff were clearly aware of his needs as they were visiting him in his cell. However, it was a month between the first time the benefits of him being in healthcare were raised with the man, and him agreeing. It cannot be acceptable that prisoners are emptying his urine bottle. There is no evidence in either clinical or wing records of arrangements being made for the man's use of toilet facilities, provision of food, or hygiene needs. If a prisoner is to stay on a wing that cannot cater fully for his needs, a care plan should be established to make reasonable adjustments where necessary.

The Governor and Head of Healthcare should ensure that multi disciplinary care plans are established for acutely ill or disabled prisoners who remain on the wing

Delay informing next of kin

118. The man was admitted to ICU at 2.15pm on 24 January, but there appears to have been a delay in notifying the next of kin who were not telephoned until approximately 6.00pm. Prison Rule 22 requires the governor to inform the prisoner's next of kin when a prisoner becomes seriously ill.

119. We consider that there was an unreasonable delay in informing the man's next of kin that he was in seriously ill and in ICU.

The Governor should ensure that, when a prisoner becomes seriously ill, the designated next of kin is informed without undue delay.

Record keeping

120. The clinical reviewer concludes that the man's medical record was comprehensive (in terms of recording in detail healthcare's interactions with him) but a number of omissions have been identified which make it difficult to judge the quality of his care. There is often no explanation about what the outcome of a referral or consultation was. Medication is reviewed and amended but there is not always a record, and the result of an X-ray is not recorded. Nor is there mention of the man's apparent need for assistance with using the toilet.

121. In is clearly important to record a patient's diagnosis, care needs and follow up appointments so that all other healthcare colleagues involved in a patient's care are suitably informed.

The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and timely record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

CONCLUSION

122. The man frequently raised concern about back pain. He complained of this intermittently throughout his time in custody. He attributed it to an injury he sustained during a road traffic accident. He was prescribed painkillers, but it is evident that over time, his requirement for pain relief increased. Despite this, broader investigations into the cause of his pain were not made until a very late stage. The clinical reviewer concludes that a more robust investigation of the man's complaints should have been made at an earlier stage, and while this might not have made a difference to his life expectancy, it might have informed better decisions about his pain relief.

123. The man was not an easy patient. At times he needed to be persuaded to receive some tests and treatment. He also needed encouragement to move to the healthcare centre, possibly because of restrictions on smoking. However, given the limitation of facilities on an ordinary wing to cater for his needs, there was a need for a more coordinated care planning approach to his care.

124. Once the man had received a diagnosis, the clinical reviewer concludes that staff interaction was supportive, responsive to clinical need and of good quality. However, the man's health rapidly declined and he died less than a month later.

RECOMMENDATIONS

To the Head of Healthcare

1. The Head of Healthcare should ensure that a member of healthcare takes lead responsibility for reviewing prisoners who do not respond to treatment as expected. This review should be completed by September 2012.

The prison accepted this recommendation.

2. The Head of Healthcare should ensure that abnormal blood test results are dealt with by the prison doctor. Where this is not possible there should be a clear handover to the out of hours doctor. This review should be completed by September 2012.

The prison accepted this recommendation.

3. The Head of Healthcare should ensure that all healthcare staff follow the requirements for accurate and timely record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

The prison accepted this recommendation.

To the Governor

4. The Governor and Head of Healthcare should ensure that multi disciplinary care plans are established for acutely ill or disabled prisoners who remain on the wing

The prison partially accepted this recommendation. They said "Whilst multi disciplinary care plans are established and in working progress, this depends on the prisoner consenting for their medical information to be shared with other staff. It is important to recognise that not all individuals will consent to this and healthcare professionals have to respect these decisions and manage accordingly.
There is work ongoing with the commissioner about social work and palliative care needs, and linking this into Safer Custody so that relevant information is shared appropriately. "

5. The Governor should ensure that, when a prisoner becomes seriously ill, the designated next of kin is informed without undue delay.

This prison accepted this recommendation.