Investigation into the circumstances surrounding the death of a man at HMP Frankland in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

This is the report of an investigation into the death from natural causes of a man at HMP Frankland in February 2010. He was 56 years of age.

We extend our sincere condolences to the man's family and friends and all those affected by his loss. We apologise for the delay in issuing this report and for any additional distress that this may have caused.

We would like to thank the Governor of Frankland and his staff for their co-operation. A clinical review of the man's care and treatment has been carried out on behalf of the local PCT.

The man was a life-sentenced prisoner who had been continuously in custody since 1992 and in Frankland since August 2007. In April 2009, the man was diagnosed with cancer of the oesophagus. The following month, the disease was confirmed to be both advanced and incurable. The man began a course of chemotherapy aimed at reducing his symptoms and extending his life, but he discontinued treatment due to the side effects. By early January 2010, it was found that the cancer had spread to his brain.

On the morning of 31 January the man complained of severe chest pain. He was taken to hospital later that day where he was diagnosed as having pneumonia and a blood clot in the lung. He remained in hospital until early February when he was discharged back to Frankland but died just a few hours later. At post mortem, the immediate cause of death was given as bronchopneumonia and pulmonary thromboembolism (blood clots on the lung). The underlying problem that brought on these fatal conditions was the oesophageal cancer with widespread metastases (secondary growths).

We make nine recommendations. These relate to liaison with the man's next of kin, provision of medication, response to medical emergencies, arrangements for attendance at external medical appointments, provision of wheelchairs and local policy on resuscitation. It is concerning to note that two of these recommendations are very similar to ones which have been made to Frankland following previous deaths (these are the recommendations on dealing with potential medical emergencies and on arrangements for prisoners attending outside hospital appointments).

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.

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Prisons and Probation Ombudsman **April 2012**

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SUMMARY

1. The man was a life-sentenced prisoner who arrived at HMP Frankland in August 2007. At that point he was more than 16 years into his sentence. During initial health screening he disclosed a number of on-going health problems including heart disease, high blood pressure and asthma.

2. From early 2009 the man began reporting difficulties with swallowing food and vomiting after eating. He was referred to a consultant gastroenterologist for examinations and in May was diagnosed with oesophageal cancer. Further tests showed that the cancer was advanced and incurable.

3. Healthcare staff at Frankland liaised with other health specialists, including palliative services in the community, in considering treatment options. The man was given information about the likely progress of his disease and was actively involved in considering options for his care and treatment. Although his disease was terminal, he commenced a course of palliative chemotherapy aimed at reducing his symptoms and prolonging life. Unfortunately, he suffered unpleasant side effects from the chemotherapy and chose to discontinue the treatment. As his disease progressed, appropriate adjustments were made to his pain relief medication and he was also prescribed dietary supplements.

4. During discussions about his treatment, the man expressed a wish to end his life in a hospice. His potential suitability for early release from prison on compassionate grounds was considered at a multi-disciplinary review in January 2010. The review panel concluded that he continued to present too high a risk to the public so that early release would not be appropriate. At that point, his life expectancy was considered to be something between one week and six months.

5. At the end of January, the man was transferred to outside hospital after reporting to staff that he was experiencing severe chest pain. There was a considerable delay in transferring him to hospital but this was eventually done by emergency ambulance. At hospital he was diagnosed with pneumonia and a blood clot on the lung. Around a week later he was transferred back to Frankland but he died later that same day.

6. The clinical review into the man’s care found that his referral to a gastroenterologist was appropriate and his pain and symptom management seemed in general to have been effective. The clinical reviewer found some instances when the man’s care and treatment could have been better. With regard to his terminal illness this included two instances when night-time pain relief medication was not issued and the excessive delay in transferring him to outside hospital referred to above. In addition, communication problems between the prison and outside hospital meant that an umbilical hernia first diagnosed in November 2007 was never repaired. We make seven recommendations relating to the above and a further one in relation to liaison with his next of kin. It is disappointing to find that two of the recommendations are very similar to those which have been made in previous investigations.

THE INVESTIGATION PROCESS

7. This investigation was opened on 24 February 2010 when the investigator visited HMP Frankland. He was provided with prison documentation about the man. Notices were issued informing both staff and prisoners of the investigation asking anyone with information pertinent to the investigation to contact the investigator. No responses were received.

8. The local PCT were asked to conduct a review of the man's clinical care while in custody. The PCT commissioned a private company, Custodial Care Innovative Solutions (CCIS), to conduct the review on its behalf. CCIS appointed a clinical reviewer to conduct the review. We thank CCIS and the clinical reviewer for their assistance.

9. The investigator wrote to HM Coroner for Durham and South Darlington to inform him of the investigation and requested a copy of the post mortem report. A copy of this report will be provided to the Coroner to assist him with his investigations.

10. The man had lost contact with his own family many years ago but for around twenty years he had been in contact with a prison visitor[1], who became a friend. Although she had not visited him for a number of years they kept in touch by letter.

11. My Senior Family Liaison Officer contacted the man's friend to inform her of the investigation and to give her the opportunity to raise concerns or questions about the death. She said that he had written to her with the news of his terminal illness shortly after his diagnosis in 2009, but told her that he did not want her to visit him at that time. She later asked a prison chaplain to speak with him to check if he had changed his mind. The chaplain subsequently confirmed that the man did then want her to visit. She said though that the prison's security unit failed to grant clearance for her to visit him before he died. Her distress at this missed opportunity was compounded when she discovered that in the days leading up to his death he was being treated in the same hospital and at the same time as another prisoner who she had visited at the same time and place. We address these issues later in the report.

12. The publication of this report has been severely delayed through workload pressures, for which we apologise.

[1] Prison visitors are volunteers who support prisoners, particularly those who have little or no family support.

HMP FRANKLAND

13. 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 holds high risk remand prisoners. (Category A prisoners are those whose escape would be highly dangerous to the public or state. Category B prisoners are those for whom the highest security conditions are not needed but for whom escape must be made very difficult.) Frankland's operational capacity in May 2010 was 859.

14. Healthcare services at Frankland are provided by the local Primary Care Trust (PCT). The healthcare in-patient facility at the prison comprises both dormitory and single bedded accommodation. A number of clinics are conducted by visiting professionals.

15. The prison has a specialist unit known as the Westgate Unit, one of four Dangerous and Severe Personality Disorder Units (DSPDs) in England and Wales. This is a self-contained unit within the prison that was opened in 2004. It has room for 80 prisoners and was where the man was held during his time at Frankland. The Westgate Unit does not have overnight nursing cover.

16. The last inspection of Frankland by Her Majesty's Chief Inspector of Prisons (HMCIP) prior to the man's death was a full unannounced inspection in the spring of 2008. HMCIP made the following observations:

> "Health services were in general good … Accommodation was well maintained and exceptionally good on the DSPD unit. On that unit too, there were excellent multidisciplinary relationships, which maintained stability, and innovative work was carried out among some extremely challenging and vulnerable prisoners."

17. Other comments were less positive. The report criticised the poor support for life and indeterminate sentenced prisoners in the prison and the lack of encouragement for prisoners to maintain family contacts.

18. Every prison is overseen by an Independent Monitoring Board (IMB). The IMB is made up of local people who visit regularly and monitor conditions within the prison. Each IMB reports annually in writing to the Secretary of State about the prison. The last published IMB report prior to the man's death was for the period December 2008 to November 2009. Comments about the Westgate Unit were particularly favourable:

> "The Board considers this an outstanding unit in the supportive involvement by all of the staff and this is reflected in the very low numbers of applications (complaints) received by the IMB from this unit."

19. In the two years prior to the man's death, there were ten deaths at Frankland through natural causes. Two of the recommendations made in those cases were not dissimilar to two of the recommendations made in this case. One of these was about the way in which a staff handled a potential medical

emergency. The other was about arrangements for prisoners being taken to outside hospital.

KEY EVENTS

20. The man was born in November 1953. His available prison records contain very little information about his childhood and early adolescence, but court records show that he began offending at an early age. He had served three prison sentences by the end of 1989, spending most of his previous 13 years in custody. In January 1991 he was arrested and charged with further serious offences. He was subsequently convicted and sentenced to life imprisonment.

21. The man spent time in a number of different prisons over the following years before being transferred to HMP Frankland in August 2007. On arrival there he was seen by a nurse for a reception health screen assessment (part of the standard reception process when prisoners arrive at a new prison). She noted that the man had a medical history of hypertension (high blood pressure), ischaemic heart disease (heart muscle damage though reduced blood supply most often due to narrowing of the coronary arteries), and exercise induced asthma. From reception, he was moved to the Westgate Unit, a Dangerous and Severe Personality Disorder Unit (DSPD).

22. On 3 September, the man consulted one of Frankland's doctors, reporting constant discomfort in his stomach. The doctor diagnosed an umbilical hernia[2] and wrote a letter referring him to a consultant colorectal surgeon based at hospital.

23. Following the referral, the man was reviewed by the consultant on 5 November at one of his periodic colorectal clinics held in the Westgate Unit. The consultant confirmed the diagnosis of an umbilical hernia and placed his name on a waiting list for a repair.

24. In the middle of February 2008, a member from the Westgate Unit Healthcare team telephoned the consultant's office to query if a date had been set for the man's hernia repair. She noted that the consultant would be asked if an appointment could be offered in the near future.

25. On 8 May, the man consulted another of Frankland's doctors complaining of increased pain at the site of his hernia. The doctor prescribed codeine phosphate (an opioid based analgesic used for mild to moderate pain).

26. In early September, the man asked healthcare staff about progress for his proposed hernia operation. He pointed out that he had been waiting for surgery for almost a year and the condition was causing pain and discomfort. Healthcare staff telephoned the consultant's waiting list officer and was told that he had removed all prisoners from his lists because of problems earlier in the year with prisoners missing appointments due to problems with escorts. (When prisoners are taken to outside hospital appointments they are accompanied by prison officers acting as escorts. Sometimes hospital appointments have to be cancelled due to the unavailability of escorting officer.) Healthcare was told that

[2] An umbilical hernia occurs when fatty tissue or a part of the bowel pushes through a weak spot in the abdominal muscle wall near the navel.

letters to all prisoners affected should have been issued, but it seems Frankland had received no such letters. The waiting list officer said that he would ask the consultant to see the man at his next clinic at the prison.

27. On 9 October, the man saw a nurse complaining of chest pain. He said that the pain was sometimes worse after eating and worse when lying down at night. He said the pain was not the same as angina pain, with which he was familiar. An appointment was made for him to see one of Frankland's doctors at a clinic the next day. An electro-cardiogram (ECG) and other tests were conducted which revealed that the pain was most likely due to gastric problems. The man was prescribed Omeprazole (a medicine used to treat a variety of different gastric conditions).

28. Towards the end of October, the man made a further enquiry about his hernia operation. Frankland contacted the consultant's secretary who said that the consultant had not been told about seeing the man but would see him at his next clinic. (No note was made of the date of this next clinic.)

29. At the end of January 2009, the man reported to a nurse that he was having difficulty swallowing solid foods. He explained that he was experiencing a lot of discomfort. He said it felt as though the food was getting trapped before entering his stomach and he would then regurgitate it. A blood test was arranged for investigations, which included investigation that the man might have Helicobacter pylori (a bacterium found in the stomach and duodenum causing chronic inflammation of the stomach lining and associated in a low percentage of cases with stomach ulcers and stomach cancer). He reported similar stomach problems to a different nurse a few days later and an appointment was made for him to see a prison doctor. The nurse also noted that the Helicobacter pylori test was negative.

30. The man saw a prison doctor on 5 February and reported the same symptoms as before. However, he denied any weight loss, said there was no blood in his vomit and denied any problems with his bowels or any other symptoms. The doctor prescribed metoclopramide, a medicine used for gastro-intestinal problems and noted that if the symptoms persisted, a specialist referral should be considered.

31. On 17 February, the man was seen by a clinical nurse manager for routine blood tests. He reported that the medication he had been prescribed was not helping so she made arrangements for him to be reviewed by a doctor.

32. The man was reviewed by a prison doctor two days later when he confirmed that his gastric symptoms were persisting. The doctor requested a "stool" helicobacter pylori test and wrote to the gastroenterology department at the hospital the following day asking for him to be reviewed.

33. The man was seen at the hospital's gastroenterology clinic on 3 April. On the same day, a member of healthcare again chased up the hernia referral by telephoning the consultant's secretary. She was advised that the best way

forward was to make a new referral. A new referral letter to the consultant was sent that day.

34. The man returned to the hospital on 27 April for an endoscopy. An area in his oesophagus[3] was identified as appearing abnormal so biopsies were taken for examination. He was told that he might have cancer but this could only be confirmed once the biopsies were examined. On his return to Frankland, a nurse recorded spending time talking with the man. She told him that another of the nurses would see him the next day and if he needed support during the night he would be able to telephone the Samaritans.

35. The consultant finally saw the man again about his hernia on 29 April. After the consultation the doctor wrote to Frankland to explain that treatment for the oesophageal lesion was now the medical priority. He wrote that if the man were to be operated on for that problem, the hernia could probably be repaired at the same time. Otherwise, if the oesophageal lesion were to prove inoperable he could repair the hernia at a later date.

36. A diagnosis of oesophageal cancer was confirmed in early May. An entry in the man's clinical records on 8 May by a nurse spoke about her seeing him that day to discuss a number of issues. They spoke about his prescribed pain control and he mentioned that some of his prescribed medication was causing him constipation. She told him that she would follow up alternative pain relief options and treatment for his constipation. They also spoke about dietary needs. He said he was enjoying the food supplement drinks that were being provided for him but also said that he would like to try "build up soup".

37. The man complained to the nurse on 13 May about increasing pain. He said that he had reduced his intake of codeine due to constipation. The nurse advised an increase in the codeine prescription, supplemented with Senna to deal with constipation. The following day a prison doctor prescribed Tramadol for pain relief in place of codeine. He was to be given 50mg to 100mg of Tramadol four times per day.

38. The Tramadol prescription was altered to 100mg three times a day on 22 May to provide better control of the breakthrough pain that the man was experiencing (breakthrough pain is defined as abrupt, short lived and intense pain that breaks through the around-the-clock analgesia used to control persistent pain). He was also prescribed 500mg soluble paracetamol tablets to be taken in between the doses of Tramadol.

39. The man was seen by a nurse on 27 May for discussion about support during his illness. She noted that he appeared realistic about the likely outcome. She asked him if he would like twice weekly consultations to allow him to talk through his feelings and he accepted that offer. He was weighed the following day and noted to be 88 kilograms.

[3] The oesophagus is the muscular tube that carries food from the mouth to the stomach.

40. On 29 May, the man had a consultation at the department of medical oncology at the Centre for Cancer Care (based in a hospital). He was told that he had "an incurable and advanced cancer" but that he would be offered up to eight cycles of palliative chemotherapy aimed at shrinking the cancer to lessen the symptoms of his disease and to prolong his life.

41. The following day, the man was seen by a nurse for support. She noted that he appeared positive and motivated about receiving chemotherapy. She also noted that his pain was becoming more difficult to control. He mentioned that he might submit an application for early release from custody on compassionate grounds. (A prisoner suffering from a terminal illness where death is likely to occur soon can be considered for early release on compassionate grounds. Before early release can be granted a clear medical opinion on likely life expectancy must be obtained. The Secretary of State must also be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison.) I discuss this issue in more detail later in my report.

42. At a consultation on 2 June with a nurse, the man reported that he was having difficulty swallowing meals and said that he would rather take a pureed diet in preference to food supplements. He again mentioned pain relief. He was receiving his last dose of Tramadol at about 6.30pm and by the early morning of the following day was experiencing a great deal of breakthrough pain. She arranged for him to be issued with an additional dose of Tramadol later in the night. He also asked to speak with a Rabbi (he had recorded his religion as Judaism). He was asked whether he wished to resume contact with his family, with whom he had lost contact many years previously, but said that that he did not.

43. The man's medication was reviewed several times in the following days leading to the Tramadol being discontinued and being replaced by a stronger pain killer, morphine sulphate.

44. The man received his first course of chemotherapy on 19 June at the Centre for Cancer Care. There is evidence afterwards of some confusion at the prison about how best to support the chemotherapy programme as the hospital had not sent the prison a treatment plan. The problem was resolved on 22 June when a nurse spoke to a community Macmillan nurse to arrange for the plan to be faxed to the prison.

45. During a support meeting with a nurse on 27 June the man reported that he felt well supported and expressed a hope of being transferred in due course to a hospice for end of life care. She noted that he had lost a substantial amount of weight. His weight that day was 78 kilograms. It seems that the plan to provide him with pureed food had not been followed through and he was not taking many of the prescribed food supplement drinks because he did not like the flavours. The nursing staff advised that a pureed diet supplemented with specialist drinks would be enough for him to maintain weight. A few days later she recorded that the drink flavours he preferred were then being provided.

She also recorded that the man was suffering symptoms of nausea, vomiting and constipation.

46. On 1 July, the nurse saw the man for “symptom management review”. He reported symptoms of nausea and vomiting, usually occurring a period of time after eating. She advised him to take anti-nausea medication 20 to 30 minutes before eating and she advised him about fluids and diet. They also spoke about pain control. He said that his pain was manageable most of the time, but would increase at times but with no particular pattern for this. She told him that she would speak with one of the doctors. The following day, a prison doctor increased the strength of the morphine sulphate tablets.

47. The man was supplied with a food blender on 5 July allowing him to puree his own food.

48. The man received his second course of chemotherapy treatment on 10 July when he unfortunately suffered one of the recognised side effects of chemotherapy, a laryngeal spasm. (Laryngeal spasm is the narrowing or closing of the vocal cords. It can cause difficulties with speaking or breathing, and can make the person feel that they are choking.) He was treated with antihistamines and he remained in hospital over the weekend.

49. On 14 July, the man received an “advanced care planning” assessment by a community consultant in palliative care and the Macmillan nurse. Following the assessment the consultant wrote to Frankland summarising the meeting. She explained that she had increased and altered doses of medications to help control breakthrough pain, to reduce nausea and vomiting, and to help with constipation. She noted that while the man understood that chemotherapy was aimed at extending his life, he was suffering extreme fatigue, felt his symptoms had got worse and was considering stopping this treatment.

50. After discussing with a number of medical professionals the effects he had experienced from his chemotherapy treatment, the man decided that he would not have any further chemotherapy. (He had the mental capacity to make such a decision about his care.)

51. Entries in the man’s records made by a nurse on 18 and 19 July show that there had been problems the two previous evenings with provision of some of the night time analgesia. The nurse telephoned the Macmillan nurse who discussed the problem with the community consultant in palliative care. The consultant advised prescribing 50mcg (microgram) fentanyl patches. (Fentanyl is an opioid analgesic. Patches are available in varying doses and are applied to the torso or upper arm and worn continuously for 72 hours before being replaced. The fentanyl is steadily absorbed from the patch through the skin into the bloodstream, to provide continuous relief from severe pain.) Oramorph (morphine sulphate analgesia) was prescribed to deal with any breakthrough pain.

52. An entry in the man’s clinical records made by a nurse on 8 August noted that his pain was being controlled well on his present medication. He reported that

his appetite was good and that he had only had one episode of vomiting in the past week. He reported some difficulty sleeping however and the nurse noted that she would discuss the problem with the Macmillan nurse. After discussion with the palliative care team, the strength of the night sedation was increased.

53. The man's fentanyl patch was due to be changed on the morning of 13 August, but patches for the appropriate dosage were not in stock. He was given Oramorph to deal with breakthrough pain while a further supply of fentanyl patches was being obtained. A new patch was obtained and applied that afternoon.

54. A nurse made an entry in the man's clinical records on 4 September about a conversation with him about pain control. He mentioned that he was experiencing pain at around lunchtime, but it seems he was not asking for additional Oramorph to deal with this. The nurse told him to make sure he ask staff to contact healthcare whenever he was in need of additional pain relief. During the same consultation the man said that he wanted to revoke a previous decision that he did not want to be resuscitated in the case his heart stopped beating. He said he now wanted resuscitation to be to be attempted.

55. An entry in the man's clinical records on 6 September refers to an error with his prescription chart that seems to have resulted in the cancellation of his fentanyl patch prescription. A nurse authorised a patch to be supplied without prescription. The fentanyl was re-prescribed on 10 September when the 50mcg patches were exchanged for 75mcg patches. A fortnight later, the fentanyl was further increased to 100mcg patches.

56. A prison doctor reviewed the man on 8 October and noted that he had no new problems, was pain free and reported being satisfied with his overall care.

57. The man should have attended the consultant colorectal surgeon's outpatient clinic at the main healthcare unit on 21 October for review of his umbilical hernia. Unfortunately, he was not able to attend as he apparently needed a wheelchair to get there from the Westgate unit and no wheelchair was available.

58. At another review with a prison doctor on 12 November, the man again reported satisfaction with his pain control and that he was eating and drinking. The doctor noted as his own observation that he seemed alert and comfortable, although there was a slight slurring in his speech.

59. In a note of a review on 24 November, a nurse recorded that the man's speech was more slurred than usual. He said that he had noticed the symptom too, but he denied any facial pain. She also noted that his right hand grip was weakened compared to that from his left hand. She arranged for him to be reviewed by one of Frankland's doctors, and also by the Macmillan nurse.

60. Two days later, one of Frankland's doctors noted that he suspected the man's slurred speech might be due to cerebral metastases (brain tumours arising as secondary growths from the original cancer site). The doctor telephoned the

community consultant in palliative care and they agreed that he should be prescribed steroids. The medication seems to have had a fairly rapid effect as the man told the Macmillan nurse just a few days later that his symptoms had already alleviated.

61. An entry in the man's clinical records at the end of November mentioned him reporting to a prison doctor that the pain relief he was getting from his fentanyl patches was wearing off sooner than previously. The doctor noted that he should use Oramorph for breakthrough pain and that the fentanyl dose should be adjusted.

62. The man had problems with swollen ankles and legs at the end of December, resulting in him falling in his cell on 7 January 2010. He appeared to have suffered only minor bruising, but the following day he was found collapsed in his cell. He was sent to outside hospital where investigations confirmed presence of cerebral metastases.

63. On 10 January, the man asked to be discharged from hospital and to return to Frankland. He was initially taken into the main healthcare unit where he told a nurse that he was feeling weak, but pleased to be back in the prison. He said that he was hoping to return to the Westgate Unit and believed that he would be able to cope there despite the state of his health. After discussions between the Westgate Unit's nursing staff and the Governor about their ability to manage his needs, he returned to the unit on 11 January.

64. On 15 January, a multi-disciplinary team met to consider the man's possible early release from custody on compassionate grounds. Internal representatives included managerial, public protection, discipline and clinical staff from Frankland, as well as two prison chaplains. External representatives included his offender supervisor and a community consultant in palliative medicine. Having taken account of the evidence presented by the various participants, the conclusion reached was that he continued to present a high potential risk to the public. The consultant confirmed that the man's cancer had spread to his brain and explained that life expectancy at that time was anything between one week and six months. The panel concluded that early release on compassionate grounds would not be sought, although the potential for end of life care within a hospice would need to be reviewed in due course bearing in mind the outlined risks to the public.

65. For many years past the man's only outside personal contact was a prison visitor who became a friend. She told the investigator that she had known him for around 20 years. Although she had not visited him very often and had not done so for quite a number of years they had kept in contact by letter. When he was diagnosed with a terminal illness he wrote to inform her of this but also wrote that he did not want her to visit at that time. In January 2010 his friend asked one of Frankland's chaplains to check if the man would like her to visit. When the chaplain checked, the man said that he would like to see his friend and when this news was passed back to her she submitted an application to visit.

66. The Westgate Unit continued to manage the man's nursing needs without any particular problems through the rest of January, until he complained of chest pain on the morning of Sunday 31 January. A nurse was called to the unit at 8.30am when he described pain and tightness in the front of his chest and a feeling of numbness running down his left arm. He said these symptoms had started at around 5.30am and he scored the pain as being nine out of ten on a scale where ten describes the most intense pain.

67. The nurse telephoned healthcare to find out if there was a nurse available to carry out an ECG but was told all the nurses were out on the wings delivering morning treatments. She telephoned the out-of-hours healthcare advice service and was advised that the man should be sent to hospital. She told the out-of-hours operator that she needed a doctor to sanction a transfer and the operator said she would arrange for a doctor to call back.(there are no doctors on duty in the prison on a Sunday). She noted in his records that when the return call was made, the caller was not a doctor. She repeated that she needed a doctor to sanction transfer to hospital and she was advised that the next best option after hospital was for the man to be taken to the healthcare unit. Following this advice, the man was taken to healthcare where an ECG was performed.

68. At 11.05am an entry was made in the man's records noting that he was experiencing pain when breathing and that his lips were cyanosed (cyanosis is where the bodily extremities turn blue due to lack of oxygen). The entry went on to say that a doctor had advised that he should be sent to hospital by emergency ambulance. (It appears that this advice was given by telephone.)

69. The next entry in the man's records was made just over an hour later, at 12.14pm. He was still in Frankland, but ambulance paramedics were with him. The paramedics then took him to hospital.

70. On 4 February, a hospital Macmillan nurse visited Frankland to discuss with two of Frankland's nurses the man's needs on discharge from hospital. His needs included continuous oxygen via a compressor. An entry in his records refer to the fact that the compressor would be provided by a private contractor that afternoon and that as the equipment could not be accommodated on the Westgate Unit, he would be taken into the main prison healthcare unit.

71. A discharge letter from the hospital to Frankland summarised the man's clinical conditions as metastatic oesophageal cancer[4], pulmonary embolism[5] and pneumonia[6]. The letter advised on his ongoing treatment, which included oxygen to deal with his pneumonia and pulmonary embolism. The letter concluded that in view of the advanced stage of his illness, together with his expressed wishes, he should not be resuscitated in case of cardio respiratory arrest.

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[4] Widespread cancer of the gullet.
[5] A blood clot on the lung.
[6] A serious lung infection.

72. The man returned to Frankland at around midday on 5 February. A prison doctor noted in his medical record soon afterwards that he was “gasping-on-oxygen”. She also noted that his skin was mottled and he was only able to speak with difficulty.

73. When a Health Care Support Worker checked the man at just before 2.00pm she found that he was no longer breathing. A nurse and a prison doctor both came to check him and confirmed that he had died.

74. The man had lost contact with his family many years before. However, he had had contact over an extended period with a prison visitor who became a friend. He told the prison that he wanted her to be treated as his next-of-kin. Staff from Frankland telephoned his friend to inform her of his death.

75. Frankland made arrangements for the man to be cremated. A prison chaplain conducted the funeral service. The man’s friend attended the service as did other representatives from Frankland.

76. Following post mortem examination, the consultant pathologist explained in his report that:

> “The immediate cause of [the man’s] death is best regarded as a combination of acute bronchopneumonia and pulmonary thromboembolism, in other words a chest infection and blood clots partly blocking the vessels to the lungs. Post mortem examination confirmed the presence of both these conditions as diagnosed and indeed treated in hospital.
>
> “[The man’s] underlying problem and the ultimate cause of his fatal bronchopneumonia and pulmonary thromboembolism had been an oesophageal adeno carcinoma with widespread metastases. At post mortem metastatic spread was seen in lymph nodes in the abdomen, in the brain, the right adrenal gland and extensively in both lungs.
>
> “Elsewhere examination did show severe pulmonary emphysema which is usually a result of cigarette smoking and could be regarded as having contributed to death …”

ISSUES

Diagnosis and treatment of terminal cancer

77. In October 2008, the man reported to a nurse that he was experiencing chest pain that was sometimes worse after eating and worse when lying down at night. Investigations suggested that the likely cause was a gastric problem and he was prescribed medication for that. Three months later the man began to report difficulties in swallowing food as well as symptoms of nausea and vomiting. Blood tests ruled out the first potential diagnosis considered by the doctors at Frankland (Helicobacter pylori) and he was referred to the gastroenterology department at the hospital for further exploration. Tests and examinations led to the diagnosis of cancer of the oesophagus, which by then, was advanced and incurable. The man began to receive a course of palliative chemotherapy, but he discontinued treatment due to the unpleasant side effects. As the cancer progressed, he went on to develop cerebral metastases.

78. The clinical reviewer found that Frankland referred the man appropriately to the hospital's gastroenterology department following a relatively brief history of difficulty with swallowing. She found that support was given through referral to the Macmillan palliative care team and to a dietician for advice on diet and food supplements. She also found that the man was kept fully informed of the nature of the illness and of its implications and he was given the opportunity to discuss his fears and concerns. He was further supported through an end of life plan that was reviewed regularly as his illness progressed.

79. It is evident from the man's records that he wished to remain on the Westgate Unit if possible. It also seems clear that he recognised that the unit might not always be able to care for his needs as his illness progressed. Staff took account of his wishes as well as his needs and he was able to remain in the Westgate Unit to the last possible point. Staff deserve credit for their willingness to accommodate his wishes.

Provision of pain control

80. The clinical reviewer has commented that the man's pain and symptom management seemed, overall, to have been both appropriate and effective. He received ongoing support from the nurses and doctors at Frankland. Additional advice and support was provided through links with a Macmillan palliative nurse and a hospital based palliative care consultant. His records show that each time his existing levels of pain relief began to cease to be effective, adjustments were made to either increase the dose of medication provided or to switch to an alternative medication.

81. There were several instances, however, of problems with provision of medication. On two consecutive evenings in July 2009, the man was not given his night time medication (Oramorph). The clinical reviewer understands that the problem arose as a result of a medication prescribing policy at Frankland that indicated that two nurses were required to sign for the administration of the medicine. She points out that such a policy would be stricter, and inconsistent

with, national prescribing polices. Another problem related to provision of fentanyl patches. There were a number of occasions when Frankland found they were "out of stock" of patches with the correct dose of fentanyl and other analgesics had to be provided while stocks were replenished. The clinical reviewer has also indicated a separate occasion when a steroidal replacement medication (Dexamethasone) that had been prescribed was unavailable so a different medication was given instead. She has made the following recommendations, that we endorse:

The Head of Healthcare should review Frankland's policy on the administration of controlled drugs

The Head of Healthcare should conduct an audit of instances when medicines are found to be unavailable from the pharmacy and take action to remedy this

82. The clinical reviewer also found instances where provision of medication as shown on the man's electronic record did not match his prescription charts and has made the following recommendation.

The Head of Healthcare should conduct an audit of prescribed medicines documented on patients' electronic records to ensure alignment with their prescription charts

The man's nutritional needs

83. As the man's disease progressed he began to have difficulty in swallowing food. In a consultation with a nurse on 2 June 2009, he said that he would prefer pureed food, to food supplements. At a further consultation with the nurse towards the end of June, he said that he was not taking many food supplement drinks as he did not like the flavours and he repeated his request for a pureed diet. When he was weighed that day it was found that he had lost ten kilograms (22 pounds) in a month. It is not clear why no plan seems to have been implemented to provide a pureed diet when the need for this was first identified. Although we note, that a blender was later provided to him so he could then puree his own food.

Emergency admission to hospital on 31 January 2010

84. At 8.30am on the morning of Sunday 31 January 2010, officers from the Westgate Unit called a nurse to come to see the man. He told the nurse that for the past three hours he had been experiencing pain and tightness in his chest and numbness in his left arm. He described the pain as being "nine out of ten". She decided that an ECG examination was needed but there were no other nurses available to carry out the procedure. She then telephoned an out-of-hours healthcare service that advised that he should be sent to hospital. She seemed to believe that she needed authority from a doctor in order to sanction a transfer to hospital and neither of the two advisers from the out-of-hours service to whom she spoke was a doctor. In due course the man was taken to Frankland's healthcare unit and when contact was eventually made with a

doctor the advice, once more, was that he should be sent to hospital. Despite this advice, a further hour or so went by before ambulance paramedics were noted to be in attendance: this was almost four hours since first being assessed by the nurse.

85. The clinical reviewer has pointed out that the man was potentially experiencing a medical emergency and the indications were that he needed to go to hospital without delay. She considers the response to have been unacceptable, we concur entirely. She has made the following recommendation, which I fully endorse:

The Head of Healthcare should ensure that policies and protocols are in place for dealing with potential medical emergencies and that nursing staff understand their responsibilities when dealing with such situations

Treatment of umbilical hernia

86. The man was diagnosed with an umbilical hernia in September 2007 by one of Frankland's doctors. The diagnosis was confirmed at a colorectal clinic with a consultant surgeon in the following November and he was placed on a waiting list for surgical repair. In September 2008, he asked about progress with his outstanding operation. Staff at Frankland made enquiries of the hospital and were told that the consultant had removed all prisoners from his waiting list due to problems with prisoner escort arrangements. The hospital claimed to have sent letters to prisoners affected, but the man received no such letter. He was placed back onto a waiting list for surgery.

87. When the man was diagnosed with cancer this became the focus of his care and the consultant's plan for a hernia repair became dependent on any potential surgical treatment of the cancer site as well as on his potential fitness to undergo surgery. He had been due to attend a further review with the consultant in October 2009 but the appointment was cancelled as no wheelchair was available to take him from the Westgate unit to the main healthcare unit. We do not know what plans the consultant might have made had he examined the man that day. The appointment was planned and it is not acceptable that a wheelchair was not provided to facilitate the appointment.

The Head of Healthcare should review provision of wheelchairs at Frankland to ensure that a sufficient number are available

88. It is unclear the extent to which hospital waiting lists were disrupted through the cancellation of appointments for prisoners from Frankland. Nor is it clear how and why the man appears not to have been informed that his name had been removed from the waiting list. The clinical reviewer has made the following recommendation, which we support:

The Governor and Head of Healthcare should conduct a review of the systems and processes for arranging for prisoners to attend outside hospital appointments

89. Although it is outside the remit of the Ombudsman's investigation, it is concerning that prisoners were apparently removed from a surgeon's waiting list with no apparent discussion or communication. The man was directly affected by this step and it is likely that others too must have been directly affected. We draw this matter to the attention of the Primary Care Trust as it appears to have implications for prisoners in terms of equality of care with patients in the community.

Other issues arising from the clinical review

90. The clinical reviewer has remarked on the absence of certain detail from the man's clinical records. Professional advice to nurses on clinical record keeping requires that when making a record, the entry should include the name, job title, date and time. Some of this information was often lacking. The clinical reviewer was informed by Frankland's clinical nurse manager that a new electronic record system (SystmOne) was about to be introduced and this was expected to deal with the problems highlighted. We understand that this system has now been introduced and we therefore do not make a recommendation in this regard.

91. The clinical reviewer found that the man received appropriate chronic disease management and treatment for his conditions of ischaemic heart disease, hypertension and asthma. She also commends the Westgate Unit for its support in assisting him in dying with dignity at a place of his choosing. She has recommended that Frankland and the PCT review the contract and specification for the provision of nursing support and provision of clinical services for the unit.

92. Another matter on which the clinical reviewer has remarked is the question of resuscitation. In September 2009, the man asked to revoke his previous decision that he should not be resuscitated in the case that his heart stopped beating. However, on 5 February 2010, a document was inserted into his file that resuscitation should not be attempted as doing so would not provide an acceptable length or quality of life. The document was marked to show that the decision not to resuscitate was not in accord with his previously recorded wishes. In the section dealing with communication with the patient, the form was noted to say that he was currently in hospital but the consultant had discussed the matter with him. No mention was made of the views expressed by him during his discussion with the consultant so we do not know if he was in agreement or otherwise of the decision not to resuscitate. The clinical reviewer has made a recommendation on this matter.

The Head of Healthcare should review the operation of the prison's resuscitation policy to ensure that it accords with NHS policy

Early release from prison on compassionate grounds

93. As it was becoming clear to the man that he was terminally ill, he expressed a wish to staff about moving to a hospice for his final end of life care. The possibility of pursuing this option was considered at a multi-disciplinary review on 15 January 2010. Panel members concluded that he continued to present a risk to the public so early release on compassionate grounds should not be sought at that stage. The panel concluded by advising that end of life care in a hospice would need to be reviewed in terms of the risks outlined. According to the community consultant in palliative care, his life expectancy at that point in time was somewhere between one week and six months.

94. The criteria for early compassionate release on medical grounds for life sentenced prisoners are set out in Prison Service Order (PSO) 4700:

> "… the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and
>
> "… the risk of re-offending (particularly of a violent or sexual nature) is minimal; and
>
> "… further imprisonment would reduce the prisoner's life expectancy; and
>
> "… there are adequate arrangements for the prisoner's care and treatment outside prison; and
>
> "… early release will bring some significant benefit to the prisoner or his/her family."

95. At the point that the multi-disciplinary panel met to consider the man's possible eligibility for compassionate release his potential life expectancy remained within a fairly broad range: running from as little as one week up to six months. The upper end of that range being well above the span indicated in PSO 4700. For that reason alone he did not meet the criteria for early release on compassionate grounds at that stage. Had there been time for the decision to be reviewed consideration would have to have been given to issues such as whether he would have gained significant benefit had he been released and whether he continued to present a high potential risk to the public. Consideration would also have needed to be given as to whether it was appropriate for him to be transferred to a hospice with two escorting officers for the final stages of his life. As it transpired however, there was no time for any such consideration due to the man's rapid deterioration and death.

Contact with the man's friend

96. Although the man's friend had not visited him for a number of years they had kept in contact by letter. Following his diagnosis his friend persuaded him to agree a visit by enlisting one of Frankland's chaplains to ask him directly on her behalf. This happened at some time in January 2010. She told my family liaison officer that she applied to visit him, but he died before her application was approved.

97. The information received from Frankland was that an appointment was made for a visit to take place on 3 February, but the visit was cancelled. The man's friend said that she had no knowledge of such an arrangement and subsequent cancellation. It is unclear why there appears to have been a breakdown in communication between Frankland and her about the arrangements for her to visit.

98. What is clear however is that the man's friend was not treated in the same way as would have been a blood relative or formal next-of-kin. Had she been deemed the man's formal next-of-kin, the notification to her of his death would have been made through a personal visit rather than by telephone (PSO 2710 that deals with actions following a death in custody is very clear that that is the preferred way the family or next-of-kin should be notified).

99. It is well established that the prisoner population in England and Wales is an increasingly aging one. Moreover, Frankland's population is likely to include significant numbers who, like the man, have long been estranged from their blood relations. It is likely that a reasonable proportion will have as their nominated next-of-kin a person who is a friend. There would be strong merit in developing a local policy to incorporate advance planning for impending deaths. Such a policy might include such matters as early identification of the next-of-kin, establishing the relationship between that person and the prisoner, giving that person advance notice of a significant deterioration in the prisoner's health and deciding in advance the appropriate method to be used in notifying the next-of-kin about the death.

The Governor should ensure that adequate arrangements are in place to ensure that when prisoners are diagnosed with a terminal illness they are asked to confirm the identity of their next-of-kin

The Governor should review local policy to include the notification of a death in custody where a prisoner has no identifiable blood relation or other close relative

CONCLUSION

100. The man was a life-sentenced prisoner who was diagnosed with oesophageal cancer in April 2009 and who died 10 months later as a result of complications arising from that illness. This investigation has found that in general he received good quality care from Frankland's healthcare staff who treated him with kindness and compassion. In particular, his overall life chances were not compromised through being in prison custody. However, there were areas where it appears his medical care and treatment could have been improved. There were also areas in relation to liaison with his next-of-kin where best practice was not followed.

RECOMMENDATIONS

The following recommendations were made in the draft report and the responses from the Service are included in italics following each recommendation. Recommendations 1, 2, 3, 4, 6 and 7 were made by the clinical reviewer, all of which we endorse. The Governor and Head of Healthcare will wish to familiarise themselves with the contents of the clinical reviewer's report in full.

1. The Head of Healthcare should review Frankland's policy on the administration of controlled drugs.

   Response: recommendation accepted. At the time of the man's death, this policy was under the remit of the Prison Service. This policy was subsequently reviewed in terms of the secondary signature for the administration of a controlled drug especially in terms of night time administration along with the NMC Standards of Medicines Management and the policy was subsequently amended to reflect if in the event of no second qualified nurse to check and administer a controlled drug from a valid prescription. Target for completion: December 2011.
   Progress: Due to the changes to the Offender Health contract, Care UK's policies and procedures are now in place and therefore supersede existing contracts including the Controlled Drugs policy (June 2011).

2. The Head of Healthcare should conduct an audit of instances when medicines are found to be unavailable from the pharmacy and take action to remedy this.

   Response: recommendation not accepted. Due to the vast range of drugs which are available, it is inevitable that pharmacy are unable to hold every drug item within the British National Formulary (BNF), therefore because of this there will be times where drugs may not be available, however will be available within 24 hours.

   [The clinical reviewer's view on the Service response is that while she would not expect the prison pharmacy to store all drugs contained in the BNF, she would expect the pharmacy to maintain stocks of those drugs being prescribed routinely for particular prisoners.]

3. The Head of Healthcare should conduct an audit of prescribed medicines documented on patients' electronic records to ensure alignment with their prescription charts.

   Response: recommendation accepted. The administration of the controlled drug in this instance was not always recorded in the patient electronic medical records. However this is an isolated case and following review of a sample of patients who are administered a controlled drug, this is recorded in the patients' medical notes and corresponds with the individual prescription charts. Target date for completion: November 2011.
   Progress: A clinical review of a sample of medical notes against prescription charts for individuals prescribed a controlled drug matched the entry in the CD book, prescription charts and the medical notes (May 2011).

4. The Head of Healthcare should ensure that policies and protocols are in place for dealing with potential medical emergencies and that nursing staff understand their responsibilities when dealing with such situations.

Response: recommendation accepted. All policies and procedures are available to all clinical staff working on Westgate in regards to medical emergencies. Target date for completion: November 2011.
Progress: All policies and procedures have and are available to clinical staff to refer to for guidance and support (May 2011). All clinical policies and procedures are available via hard copy and electronically and there is a systematic approach in getting each member of staff to read each clinical policy and sign to say that they have read and understood this (November 2011).

5. The Head of Healthcare should review provision of wheelchairs at Frankland to ensure that a sufficient number are available.

   Response: recommendation partially accepted. There is one wheelchair available on all wings within HMP Frankland. Unfortunately due to a previous medical emergency, the wheelchair which is usually located on Westgate was in main healthcare and this was not returned back to Westgate. This was due to individual error. Target date for completion: November 2011.
   Progress: All staff briefed that any wheelchair used from a wing must be replaced that same day, unless being sent for repair, then mechanisms put in place to access another chair as an interim measure.

6. The Governor and Head of Healthcare should conduct a review of the systems and processes for arranging for prisoners to attend outside hospital appointments.

   Response: recommendation accepted. Work has been completed with Commissioners / Care UK / HMP Frankland and local Acute Trust for external consultants to carry out clinical assessments within the prison environment. Target date for completion: November 2011.

7. The Head of Healthcare should review the operation of the prison's resuscitation policy to ensure that it accords with NHS policy

   Response: recommendation accepted. Resuscitation policy reviewed and found to be in accordance with NHS policy.

8. The Governor ensure that adequate arrangements are in place to ensure that when prisoners are diagnosed with a terminal illness they are asked to confirm the identity of their next-of-kin

   Response: recommendation accepted. This will be included in the local Family Liaison Policy which is presently under review. Target date for completion: December 2011.

9. The Governor should review local policy to include the notification of a death in custody where a prisoner has no identifiable blood relation or other close relative

   Response: recommendation accepted. This will be included in the local Family Liaison Policy which is presently under review. Target date for completion: December 2011.