PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in January 2012 at HMP Frankland

Report by the Prisons and Probation Ombudsman for England and Wales

June 2012

This is the report of an investigation into the death of a man who died in the healthcare centre at HMP Frankland in January 2012. He was 61 years old. He died of pneumonia and lung cancer. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local Primary Care Trust. Staff at Frankland fully co-operated with the investigation.

The man had generally been a healthy man, although he had had some contacts with healthcare during his time at Frankland because of chest problems. He was appropriately assessed and treated by prison healthcare. In 2011, following a chest X-ray and scan, he was diagnosed with lung cancer.

He lived less than two weeks after he was diagnosed with cancer and only four days after he was informed of his illness. Frankland made considerable efforts to care for him effectively and according to his wishes but, although the prison has well developed palliative care arrangements, a final end of life plan was not fully implemented in time. He decided only the day before he died that he would like the prison to contact his family, by which time it was too late.

The investigation has identified a need for better attention to individual risk assessments for hospital visits and a need to keep family contact details up to date. Nevertheless, I am satisfied that, overall, the prison provided appropriate and sensitive care for the man's last days.

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 **June 2012**

CONTENTS

Summary

The investigation process

HMP Frankland

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to 15 years imprisonment on 14 October 2005 for offences relating to drug importation. He was sent to HMP Manchester and transferred to HMP Frankland on 14 March 2006. The only declared problem on health screening was that of a painful left shoulder for which he was referred for physiotherapy.

2. On 18 June 2007, the man was seen by a member of healthcare staff as he reported feeling unwell; he stated that he was having hot and cold sweats and that he had pain on the left side of his chest. He was referred to be seen by a doctor on the following day.

3. On 19 June 2007, he was examined and a provisional diagnosis of a chest infection was made. He was prescribed antibiotics and a chest X-ray was arranged. The results of the X-ray showed a shadow on the lung. As he had said that he had previously been exposed to asbestos, a doctor from the hospital arranged for a bronchoscopy and a CT scan. The CT scan was scheduled for 11 January 2008 and the bronchoscopy for 23 January.

4. An escort for the bronchoscopy could not be arranged by the prison, and it was never carried out. Following the scan the man was discharged from the clinic as the scan showed no signs of cancer and he had also put on weight.

5. The records show that he continued to see healthcare staff regularly, mainly for minor ailments and smoking cessation advice, with one incidence of a suspected chest infection, which was negative.

6. On 28 November 2011, the man had chest pain. An X-ray was carried out, which showed a shadow on his lung. He was referred to hospital, where a bronchoscopy was undertaken.

7. On 6 January 2012, HMP Frankland were informed that the man's bronchoscopy confirmed that he had lung cancer, which was fast growing. An appointment was booked for him to see a consultant at hospital on 20 January 2012, to inform him of his diagnosis. Because of the long wait, the doctor at Frankland decided to inform him of the diagnosis before the appointment.

8. Palliative care plans were begun and, at his request, the man remained on his residential wing. His health deteriorated very rapidly and he died in January 2012.

9. In the days that followed, the prison family liaison officer maintained contact with the man's family and offered support and financial assistance towards the funeral expenses.

10. The timeframe between the man's diagnosis and his death was very short; however his wish to remain on the wing was respected and accommodated. The clinical reviewer said "it is difficult to see how his care could have been managed any better within the community".

11. We make two recommendations, about maintaining up to date next of kin contact details and the levels of restraints used when the man attended an outside hospital appointment.

THE INVESTIGATION PROCESS

12. This office was informed of the man's death on 14 January 2012. The investigator issued notices announcing the investigation to staff and prisoners and asking anyone with relevant information to contact her. One prisoner came forward. She spoke to him as part of the investigation. This conversation was recorded in a letter to him.

13. The investigator visited Frankland on 23 January; she met the Governor, the Prison Liaison Officer, a representative from the Independent Monitoring Board (IMB), the prison Family Liaison Officer and the Operational Manager in charge of healthcare. She also visited the healthcare centre. She obtained copies of the man's records.

14. The investigator informed HM Coroner of the investigation and obtained a copy of the post mortem report. A copy of this investigation report will be sent to the Coroner to assist with his enquiries.

15. The investigator returned to the prison in April to interview staff. Following the interviews, written feedback was given to the Governor. The interviews were recorded.

16. A review of the man's medical care was carried out by a clinical reviewer on behalf the local Primary Care Trust. The investigator and the clinical reviewer discussed the man's care.

17. One of our family liaison officers wrote to the man's wife on 17 February 2012. She explained the purpose of the investigation and offered her the opportunity to be involved in the investigation process. No reply was received.

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

HMP FRANKLAND

19. Frankland is a purpose built high security prison in Durham. It holds a maximum of 859 category A and category B male prisoners in single cells. Prisoners at Frankland have either received a life sentence, an indeterminate sentence for public protection or a determinate custodial sentence of more than four years. The prison also holds some high risk remand prisoners.

20. Until April 2011, healthcare services at Frankland were provided by the local Primary Care Trust. A different provider now provides healthcare services at Frankland and a number of prisons in the area. There is 24 hour inpatient care.

HM Inspectorate of Prisons (HMCIP)

21. HM Inspectorate of Prisons conducted an unannounced full follow up inspection in November 2010. The inspectorate found that, after recent staff shortages, health services had improved. However, waiting times to see a prison doctor were described as "unacceptably long". Palliative care arrangements were described as excellent with good links to local services. Macmillan nurses ran drop in sessions for prisoners and structured sessions for prison officers, to give them a better understanding of the needs of prisoners with palliative care needs.

Independent Monitoring Board (IMB)

22. Each prison has an IMB who are unpaid members of the local community, who monitor all aspects of prison life to ensure proper standards of decency and care are maintained. The most recent annual report published by the Board at Frankland covers the year ending 30 November 2011. Like the Inspectorate the IMB were very positive about palliative care provision. The Board noted that the recent introduction of nurse triage has significantly reduced GP waiting time.

ISSUES

The diagnosis of the man's terminal illness

23. The man had been in prison since October 2005, and was transferred from Manchester to Frankland on 14 March 2006. The only declared problem during his initial health screening was that of a painful left shoulder, for which he was referred for physiotherapy.

24. On 18 June 2007, the man was seen by a member of healthcare staff as he reported feeling unwell; he stated that he was having hot and cold sweats and that he had pain on the left side of his chest. He was listed to be seen by a doctor the following day.

25. On the 19 June 2007, the man was examined and a provisional diagnosis of a chest infection was made. He was prescribed antibiotics and a chest X-ray was ordered.

26. The X-ray was carried out on 29 June and showed a shadow on the man's lung. Because of the shadow and the fact that he had said that he had previously been exposed to asbestos, a doctor arranged for a bronchoscopy (this is a procedure that looks into the main tubes that carry air into the lungs) and a Computed Tomography (CT scan - uses X-rays and a computer to create detailed images of the inside of the body). The prison received the letter for the appointments on 10 December 2007. The bronchoscopy was scheduled for 23 January 2008 and the CT scan was set for 11 January.

27. The record shows that the prison was unable to provide an escort for the bronchoscopy (but no reason is given). The CT scan was carried out on 11 January. There is nothing in the notes as to whether a further appointment for a bronchoscopy was sought by the prison.

28. The CT scan showed normal lung function and the man had gained some weight. Because of this, he was discharged from the doctor's clinic. This is clear from the doctor's letters but it does not appear to have been communicated to him. He believed he still needed a bronchoscopy and, in July 2011, made a healthcare complaint, querying why his appointment was never re-booked.

29. It is not possible to say whether a bronchoscopy carried out in 2008 would have shown any earlier signs of cancer.

30. In the eight months between May and December 2008 the man attended healthcare for various ailments and smoking cessation advice. No further chest related problems were mentioned.

31. On the 4 December 2008, the man reported that he had coughed up some blood stained mucous. This is recorded by two members of healthcare staff. Physical examinations were undertaken and no infection was found.

32. He continued to attend appointments with healthcare, until November 2011, but none of them related to chest related symptoms.

33. On 28 November 2011, a prison doctor recorded that he had chest pain, and the following day an X-ray was carried out at Frankland. The results of the X-ray were received on 13 December 2011 and she records that the results were suspicious. The same day, a referral to see the chest physician at hospital was made under the two week referral rule (this is a standard set by the Department of Health to ensure that all patients suspected of having cancer are referred urgently).

34. A bronchoscopy was carried out on 4 January 2012 at hospital and the man was diagnosed with small cell lung cancer. (There is nothing in the record that explains the time lapse between his referral and bronchoscopy). On 6 January 2012, a conversation between the lung care specialist at the hospital and healthcare staff at Frankland concluded that his cancer was very fast growing.

35. The Clinical reviewer says in his report that:

> "when a life threatening illness was suspected, an urgent referral using NHS 14 day rule mechanism was used, and a diagnosis was made"

36. In light of the clinical reviewers comment, and evidence in the man's clinical records, we conclude that the diagnosis of his terminal illness was appropriately made.

Informing the man about his condition and treatment

37. On 16 December, the prison doctor wrote to the man informing him of the results of the X-ray. She told him that the X-ray showed some congestion on the left side of his lung and that this required further evaluation. She explained that she wanted to let him know about the referral so that he was not alarmed when notified of the appointment.

38. On 6 January, a lung care specialist confirmed to Frankland that a doctor at hospital would inform the man of his diagnosis and discuss future treatment plans at an outpatient's appointment booked for 20 January 2012.

39. The clinical team manager made an entry in the man's medical records on 9 January stating that he was not aware of his diagnosis and discussed this with the prison doctor. The doctor decided to see him as she was concerned about the wait and, on 10 January, informed him of the diagnosis.

40. On 13 January, the man asked for a friend on the wing to be present at all consultations so that he could have a clearer understanding of any information given to him. This was agreed and a consent form was signed.

41. The Clinical reviewer comments that:

> "He was given full information about his condition and had time with primary care doctors to fully discuss the diagnosis and outline his wishes for future care".

42. Healthcare staff at Frankland were appropriately concerned about the delay in telling the man his diagnosis, and took steps to inform him of this before he was due to see a doctor at hospital. This sensitive approach ensured that he was kept informed about his condition and was treated with respect and dignity.

The man's medical appointments and treatment

43. Following the diagnosis of lung cancer, the man attended regular appointments with healthcare staff at Frankland, to manage his medication and general health needs associated with his condition. He was due to see a hospital doctor on 20 January 2012 to discuss treatment options. However his health declined rapidly and he died before this appointment occurred. Because of the very short period between the diagnosis and his death, his involvement with Macmillan nurses was limited. As he had not been seen by the hospital doctor the treatment options had not been discussed.

44. Healthcare staff attended and nursed the man regularly on his wing. One evening in January staff on the wing radioed a code black. (Prisons use coding systems for emergency situations. At Frankland code black relates to the loss of consciousness.) A nurse attended. She found that he was clearly very unwell and his breathing was very laboured. He refused to be taken to an outside hospital but agreed to attend healthcare. He then agreed to go to hospital, so an emergency ambulance was called at 10.30pm. She told us that she remained with him, comforting him while waiting for the ambulance, but approximately ten minutes later he died.

45. The prison made every effort to accommodate the man's wishes. We and the clinical reviewer are satisfied that his treatment was appropriate.

The man's pain relief and medication

46. In the two weeks before the man's death he was prescribed the following medication:

    Codeine (pain relief)
    Chlorpromazine (Sickness in advanced diseases/ palliative care)
    Tramadol (pain relief)
    Zopiclone (to assist sleep)
    Docusate (stimulant for constipation)
    Aspirin (pain relief)

47. On 13 January, the clinical team manager and the Macmillan practice development nurse met with the man. They recorded that he had not had a bowel movement for four days; he was taking codeine at 15mg four times a day and his medication was to be reviewed that same morning by a doctor.

The doctor records that palliative care was the only option as he was terminally ill. He was prescribed laxatives and other medications to assist with constipation. Codeine was replaced with tramadol and he was given zopiclone to help him sleep. The doctor recorded that his medication should be reviewed on 16 January.

48. We are satisfied that the man's pain relief and medication was appropriately managed. When considering his pain relief and medication the clinical reviewer said:

> "The prisoner was reviewed regularly and provided with appropriate symptomatic and pain relief medication".

Liaison with the man's family

49. On 11 January 2012, the clinical team manager spoke to the man about informing his wife of his diagnosis and the prison family liaison service. He decided he wanted to wait until he was aware of all treatment options. However, a few days later, he told her that he would like contact with his family, and she was due to arrange this through the prison family liaison officer. Unfortunately, he died the next day, so contact with his family was not made before his death.

50. When the prison tried to inform the man's wife of his death, they were unable to establish her current address. The records showed that she lived in the abroad, but when his postal records were checked it appeared she had an address in Scotland. The Scottish Police were asked to attend the address to establish if it was correct and to inform the family of his death. There was no reply at the house when the police went so the address was not verified. The prison liaison officer called the telephone number that was on record but there was no reply. Eventually his wife was contacted on her mobile telephone, (obtained from her husband's contact numbers) and was informed of her husband's death. She declined a visit from prison staff.

51. The prison followed the man's initial decision not to communicate with his family until he had more news about his condition. Unfortunately, he only decided that he wanted the prison to contact them the day before he died, too late for this be done. In line with national policy, the prison remained in contact with his wife, assisted with funeral arrangements and offered a contribution to the costs.

52. It is unfortunate that the man's wife had to be informed of her husband's death on the telephone. However, we accept that the prison made strenuous efforts to try to arrange for her to be told in person. The problem in contacting his family highlights the importance of prison's keeping up to date contact details for nominated next of kin. These could be checked annually, such as at sentence plan boards.

The Governor should ensure that there are processes in place to maintain up to date records of prisoners' next of kin contact details.

The man's location

53. The man wanted to remain on his wing with his friends for as long as possible. His medical record shows that on three separate occasions between 8 and 13 January, the option of moving to healthcare was discussed.

54. The investigator spoke to a friend of the man's. He said that it was important for the man that he remained on the wing, as this was where he was most comfortable.

55. The clinical team manager said that the man made it clear that he did not want to move to the inpatient unit in healthcare and that it was important that patients should be allowed to choose where they want to spend their last days. As part of Frankland's palliative care project, wing governors and the healthcare governor were all involved in discussing how best to manage him on the wing. Because he died so quickly after his diagnosis there was insufficient time to put well developed plans in place, but his wishes to remain on the wing in familiar surrounds were facilitated well.

56. While on the wing, healthcare staff maintained regular contact with the man to monitor his condition and health needs. He was given a mattress topper and extra pillows to make his living conditions more comfortable.

57. The Clinical reviewer comments that:

    "Both prison and healthcare staff respected the autonomy of the patient with regard to appropriate location".

58. We consider that staff at Frankland responded appropriately and sympathetically to the man in arranging for him to remain on the wing, where he preferred to be for his last weeks.

Compassionate release

59. On 10 January, during an appointment with the prison doctor, the man asked about the possibility of Early Compassionate Release (ECR). She advised him that he should speak to the Governor but suggested that he waited until the full facts of his illness and treatment were available.

60. A few days later the prison started completing the ECR forms. The man died the next day, before further progress could be made.

Palliative care plans

61. The clinical team manager explained to the investigator that Frankland was piloting a palliative care project team, which is headed by Macmillan Cancer Support, as a joint venture with the NHS. The Macmillan Adopted Prison Standards (MAPS) service improvement tool is used. This provides prison staff with a framework of good practice standards to measure and guide

service improvement and staff development, while recognising the unique challenges of the prison environment. These standards aim to promote development of timely effective systems, communication and quality personalised care. The clinical team manager said the project aims to give prisoners the same care, or equivalent care, to that which they would receive if they were in the community and had they been diagnosed with an end of life or life threatening illness.

62. Unfortunately, in the man's case, because of the very short period of time between his diagnosis and his death, the end of life plan had not been fully implemented.

63. His medical records state that 'resuscitation was not attempted as he had a diagnosed terminal illness'. It does not appear that a 'Do not resuscitate' (DNR) form was completed. Had there been time to complete the end of life pathway, this would have been discussed with him, but he died only four days after being given his diagnosis.

64. The clinical reviewer comments that "even though end-of life care pathways were in a pilot phase within HMP Frankland, appropriate discussion regarding such planning did occur between the relevant health care professionals and the man to ensure that care took into account his wishes".

65. While the timeframe between the man's diagnosis and his death was very short, staff at Frankland worked together in a multidisciplinary approach, and responded appropriately and sympathetically to his individual needs.

Restraints and security

66. The man left the prison for a bronchoscopy appointment on 4 January 2012. He attended no further external appointments before his death. A Prison Escort Form (PER) was completed before he attended the bronchoscopy. The purpose of this form is to assess the level of risk posed by the prisoner, and determine the level of restraint with which they are escorted on.

67. He was double handcuffed, meaning that his wrists were handcuffed together, and then handcuffed to a member of prison staff.

68. The risk assessment noted that, in 2008, the prison had received an anonymous note that the man was planning an escape and that staff should remain vigilant at all times. However, there was no corroboration or evidence to support the information. It is apparent that the prison discounted this information as he was assessed as a low risk of escape and a low risk of outside assistance. He was further assessed as a low risk of hostage taking and a medium risk to public and hospital staff.

69. While we acknowledge that the man was a Category B prisoner (for whom escape must be made very difficult) and, at the time of this escort staff were not aware that he was terminally ill, his overall risk assessment is recorded as low to medium. There is some disjunction between the risk assessment and

the security measures involved. While double cuffing is routine for adult Category B prisoners on escort, one of the purposes of an individual risk assessment is to consider whether in a particular case, standard cuffing, or lesser restraints could be used. He was assessed as low risk of escape and low for other risks, so this should have been considered.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

CONCLUSION

70. In November 2011, the man was seen by healthcare staff after he reported chest pains. Appropriate referrals were made and investigations were carried out. On one occasion, when he was taken to hospital double handcuffs were used which does not appear justified by the risk assessment.

71. In January 2012, Frankland were informed that the man had cancer. Staff at Frankland informed him of his condition. His health deteriorated rapidly, and he died eight days later. During that time healthcare and prison staff worked together to make him comfortable on the wing. There was little time to develop final palliative care plans.

72. We agree with the clinical reviewer that the man's care was of a standard equal to what he might have expected in the community.

73. There was some difficulty in contacting the man's wife because information contained in his records was out of date. Appropriate family support was subsequently offered.

RECOMMENDATIONS

1. The Governor should ensure that there are processes in place to maintain up to date records of prisoners' next of kin contact details.

NOMS accepted this recommendation and make the following comment:

"It is now planned to check next of kin details on reception into Frankland An increase in the annual check to six monthly is also being introduced. A check will be initiated and completed in July 2012."

2. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

NOMS accepted this recommendation and make the following comment:

"Levels of restraint used on prisoners must at all times be proportionate to the perceived security risks and be balanced by considerations of care and decency for the prisoner.

Terminally or seriously ill prisoners may present a lower risk of escape and this is considered as part of the assessment process. The use of restraints on terminally or seriously ill prisoners is reviewed regularly taking into account clinical input, and the level of restraints will be adjusted in accordance with any deterioration in the prisoner's clinical condition or the intensity of the treatment that they are receiving.

In addition, a fresh risk assessment is carried out each time a prisoner is moved or their clinical condition is reviewed, in order to assess the appropriate level of restraint for transportation to or from hospital and during the prisoner's stay at hospital."