Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Howard a prisoner at HMP Frankland on 2 October 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Robert Howard died of lung cancer that has spread to other areas in the body in hospital on 2 October 2015, while a prisoner at HMP Frankland. He was 71 years old. I offer my condolences to Mr Howard's family and friends.

I am satisfied that the care Mr Howard received in prison was equivalent to that he could have expected to receive in the community. Although Mr Howard had been unwell for some months, his cancer was not formally diagnosed until the day he died. Nevertheless, I consider that prison healthcare staff were persistent in trying to establish the cause of Mr Howard's symptoms and referred him appropriately for specialist investigation.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. On 22 October 2003, Mr Robert Howard was sentenced to life imprisonment for murder and sexual offences. He had been at HMP Frankland since October 2005. Mr Howard suffered a stroke in 2011 that impaired his health and mobility. He smoked cigarettes but declined help to give up smoking. Healthcare staff saw and treated Mr Howard frequently for various conditions.

2. In August 2015, Mr Howard reported tenderness in the upper stomach area and weight loss. A doctor referred Mr Howard for an urgent appointment under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Hospital doctors investigated but, after tests, including X-rays in late August and September, found no evidence of cancer.

3. Mr Howard's health continued to decline but he refused to move to the prison's inpatient unit until 17 September. On 23 September, after abnormal blood test results, a prison doctor made referred Mr Howard to see a blood specialist urgently.

4. On 25 September, Mr Howard was admitted to hospital, as his condition could not be managed effectively in prison. On 1 October, after further clinical investigations, doctors suspected a cancerous tumour in Mr Howard's lung. On 2 October, doctors confirmed lung cancer and Mr Howard died at the hospital later that day.

Findings

5. We consider that the prison's healthcare team responded appropriately and competently to the range of symptoms that Mr Howard presented. Although Mr Howard's cancer was not formally diagnosed until the day he died, prison healthcare staff had suspected cancer and referred him appropriately for investigation. We are satisfied that the care Mr Howard received was equivalent to that he could have expected to receive in the community. We make no recommendations.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and she spoke to him by telephone.

7. The investigator obtained copies of relevant extracts from Mr Howard's prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr Howard's clinical care at the prison.

9. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Howard's sister, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why doctors had not been able to diagnose Mr Howard with lung cancer until the day he died and for the circumstances of the diagnosis.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

12. Mr Howard's sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Frankland

13. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 men. There is 24-hour inpatient care. Until April 2015, Care UK was the healthcare provider. G4S is the current provider.

HM Inspectorate of Prisons

14. The most recent inspection of Frankland was in December 2012. Inspectors noted that security was usually applied proportionately. Health services provided a high quality of care for patients with chronic diseases and life-long conditions, but waiting times for the GP and some specialist services were too long. Staff shortages inhibited the development of services. The Care Quality Commission took part in the inspection, and found that the services operated by Care UK were of a good standard and working relationships with other partners helped them to deliver effective care.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to November 2013, the IMB said the quality of healthcare services was good. The number of healthcare staff vacancies, which had previously affected the delivery of services, had reduced.

Previous deaths at HMP Frankland

16. Mr Howard was the sixth prisoner to die from natural causes at Frankland since January 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

17. On 22 October 2003, Mr Robert Howard was sentenced to life imprisonment for murder and sexual offences. He had been at HMP Frankland since 21 October 2005. In 2011, he suffered a stroke, after which his health and mobility were poor. Mr Howard smoked cigarettes but refused help and advice to give up. Healthcare staff assessed him frequently and, on 6 May 2015, recorded his weight as 67.7kgs.

18. On 1 June 2015, a prison GP saw Mr Howard who complained of a burning pain in the right side of his chest. Mr Howard refused blood tests. The doctor diagnosed heartburn and prescribed medication to reduce stomach acid. On 15 July, a nurse diagnosed a cold when Mr Howard said he was breathless.

19. On 27 July, a doctor admitted Mr Howard to the inpatient unit with stomach pain and prescribed pain relief and medication for stomach cramps. Mr Howard asked to go back to his wing the same day.

20. On 4 August, Mr Howard told a prison GP that he had night sweats and stomach pain. A urine test indicated a kidney infection. The GP prescribed antibiotics and ordered blood tests. Mr Howard declined to be admitted to the inpatient unit. A nurse checked him in his cell on 7 August and Mr Howard said he was feeling better.

21. The blood tests indicated an iron deficiency (which can be caused by a gastric bleed) and a prison GP examined him again on 10 August. The doctor noted some tenderness in the upper stomach area, raised inflammatory markers and some weight loss (although there was no weight recorded). The GP was concerned the symptoms indicated cancer and referred Mr Howard urgently to a gastroenterologist (a specialist who investigates stomach, intestines and liver issues) under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

22. On 24 August, a specialist at the hospital saw Mr Howard, noted that a scan indicated Mr Howard had numerous gallstones and planned further investigations. Later that day, Mr Howard told a prison GP he had coughed up blood. The GP referred Mr Howard for an urgent chest X-ray, which showed no abnormality. The doctor prescribed antibiotics and liquid meal supplements. He advised Mr Howard to drink plenty of fluids.

23. On 7 September, Mr Howard had a chesty cough, but continued to smoke. A prison GP prescribed further antibiotics and referred Mr Howard for another chest X-ray. Mr Howard again declined to be admitted to the inpatient unit.

24. On 9 September, Mr Howard had a chest X-ray and an endoscopy (where a camera is inserted through the throat into the stomach). The X-ray was normal and the endoscopy showed a minor stomach irritation. There were no indications of cancer.

25. On 15 September, a nurse noted Mr Howard was weak and could hardly eat or drink. His weight was 49kgs. He would not move to the inpatient unit for

observation. The next day, the nurse assessed Mr Howard and was satisfied that he had the mental capacity to make decisions about his medical care.

26. On 17 September, Mr Howard agreed to move to the inpatient unit. Nurses monitored him and noted he found swallowing difficult. Doctors offered to prescribe his medication in liquid form but he declined this. Although he had no clear diagnosis, he was referred to a palliative care nurse, as his condition was very poor.

27. On 23 September, a prison GP reviewed a blood test and noted Mr Howard had raised CRP (C - reactive protein), which can indicate inflammation in the body. She prescribed antibiotics and anti-sickness medication, arranged further blood tests and made a two week urgent referral to a haematologist (a specialist in diseases of the blood) for suspected cancer.

28. On 24 September, a prison GP reviewed Mr Howard, who was very dehydrated. He prescribed a saline infusion to be given under the skin, a way of administering fluids when a patient's veins cannot be accessed because of poor circulation. Healthcare staff at Frankland did not have the training or equipment to do this and a multidisciplinary meeting the same day agreed that Mr Howard needed to be managed in hospital.

29. On 25 September, Mr Howard moved to hospital. No restraints were used. In hospital, tests for suspected tuberculosis were negative. Mr Howard health declined and hospital staff continued clinical investigations.

30. On 1 October, hospital doctors suspected that Mr Howard had a tumour in his lung. On 2 October, doctors confirmed a diagnosis of lung cancer, including small cell or squamous lung malignancy. Mr Howard died later that day, at 1.45pm.

Contact with Mr Howard's family

31. On 17 September, the prison appointed an officer as the prison's family liaison officer. She went to see Mr Howard that day to introduce herself and offer support. The next day, Mr Howard told the officer and a prison chaplain that he did not want anyone to contact his sister, his next of kin, unless he became seriously ill or after his death. His sister lived in Ireland and he had not been in contact with her for many years.

32. On 21 September, at Mr Howard's request, the officer tried to contact his sister, without success. The chaplain liaised with a colleague in Ireland and by 27 September had obtained a telephone number for Mr Howard's sister. The officer telephoned and told her that Mr Howard's health was failing. Mr Howard's sister asked the officer to keep her updated.

33. On 2 October, the officer and a chaplain visited Mr Howard in hospital. The officer tried to telephone Mr Howard's sister twice, but was only able to leave a message. After Mr Howard died, the officer was still unable to speak to Mr Howard's sister. She then arranged for a local priest to visit Mr Howard's sister and inform her of his death.

34. On 3 October, another family liaison officer spoke to Mr Howard's sister and offered condolences and support. Mr Howard's sister asked the prison to arrange the funeral service, which was held on 28 October. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

35. After Mr Howard's death, a prison manager debriefed the escort staff to offer his support and that of the staff care team.

36. The prison posted notices informing staff and prisoners of Mr Howard's death, and offering support. The chaplain held a memorial service in the prison chapel.

Cause of death

37. The coroner gave the cause of death as metastatic squamous cell carcinoma (cancer that had spread throughout the body).

Findings

Clinical care

38. The clinical reviewer was satisfied that the prison's healthcare team acted appropriately and competently in responding to Mr Howard's range of symptoms. They referred Mr Howard under the NHS cancer pathway for suspected cancer twice, once for possible stomach cancer and then for blood cancer. They referred him for two chest X-rays, which were normal. The clinical reviewer noted that lung cancers sometimes do not show up until a late stage in their development. This appears to have been the case with Mr Howard.

39. There was also evidence of good record keeping, teamwork and proactive planning of Mr Howard's medical and nursing care as his health deteriorated. The healthcare team kept in frequent contact with hospital staff for information and advice. We consider that Mr Howard's care at the prison was equivalent to that he could have expected to receive in the community.

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