Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Fraser a prisoner at HMP Lindholme on 24 September 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 Anthony Fraser died in hospital of bone cancer on 24 September 2015, while a prisoner at HMP Lindholme. He was 62 years old. I offer my condolences to Mr Fraser's family and friends.

I am satisfied that, generally, Mr Fraser received an appropriate standard of care at Lindholme, which was equivalent to that he could have expected in the community. However, although he had suffered from a terminal illness for some time, there were no effective palliative or end of life care plans and liaison with his family was poor. I am not satisfied that decisions about the use of restraints fully took into account up to date information about his health and mobility.

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 **April 2016**

Contents

Summary

Events

1. In October 1992, Mr Anthony Fraser was sentenced to life imprisonment. He had been at HMP Lindholme since November 2008.

2. In May 2012, Mr Fraser reported recurring back pain. A nurse referred him for blood tests which identified significant abnormalities. After further tests, including a bone marrow biopsy in June 2012, a doctor diagnosed multiple myeloma, an incurable form of bone cancer affecting blood plasma cells.

3. Mr Fraser immediately began a course of chemotherapy. In October, he had further treatment in preparation for stem cell collection. In May 2013, he had a bone marrow transplant.

4. Prison healthcare staff continued to manage Mr Fraser's condition, in consultation with hospital specialists and he remained fairly stable for the next few months. In April 2014, Mr Fraser reported increased pain, shortness of breath and swollen ankles. Tests showed his myeloma had worsened. He had another course of treatment over the next few months and responded well.

5. On 19 August 2015, Mr Fraser was admitted to hospital after he reported no feeling or movement in his right leg. He died in hospital on 24 September, from relapsed multiple myeloma.

Findings

6. Mr Fraser was appropriately referred to specialists in 2012, and his condition was diagnosed. His initial treatment appeared successful. Mr Fraser's subsequent treatment and pain management at the prison was of a high standard, although healthcare staff did not begin a formal palliative care plan or end of life care when his condition worsened. There was generally good communication between prison and hospital staff, who kept Mr Fraser informed and involved in his care. We consider that Mr Fraser's care at Lindholme was equivalent to that he could have expected to receive in the community.

7. Partly because of the lack of effective palliative care planning, family liaison arrangements were poor. The prison did not nominate anyone to liaise with his family during his cancer treatment and it took too long to inform them of his final admission to hospital. Although it did not cause the delay, Mr Fraser's next of kin records had not been updated for several years. Officers accompanying Mr Fraser in hospital did not allow him and his family appropriate private time together at the end of his life. Decisions about the use of restraints were not always based on up to date assessments of his health and mobility.

Recommendations

- The Head of Healthcare should ensure that end of life and palliative care plans are initiated at an appropriate stage, for prisoners who are diagnosed with a terminal illness. They should include all aspects of a patient's care, including effective pain relief and psychological and emotional support. Plans should be discussed with the patient and their family and regularly reviewed.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. Families of dying prisoners should be allowed private time with them towards the end of their lives.
- The Governor should ensure that a member of staff is appointed to liaise with families when a prisoner is diagnosed with a terminal or serious illness, that next of kin details are kept up to date and that families are informed promptly when a seriously ill prisoner is admitted to hospital.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

11. We informed HM Coroner for South Yorkshire East District of the investigation, who confirmed the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers and the investigator met members of Mr Fraser's family, to explain the investigation. His family asked us to consider the following:

    - The overall standard of healthcare, including a delay in Mr Fraser's diagnosis and treatment; the management of his chronic diseases and medication; and the lack of palliative and end of life care.
    - They believed that the use of restraints contributed to a delay in his treatment, and should have been removed sooner.
    - His location did not meet his needs.
    - Whether the prison did everything they could for Mr Fraser to be considered for compassionate release.
    - Mr Fraser's next of kin details were out of date and there was a delay in contacting them after he was admitted to hospital.
    - They were not allowed private time with Mr Fraser until just before he died.

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

14. Mr Fraser's family received a copy of the initial report. They did not make any comments.

15. We shared the initial report with the Prison Service and there were no factual inaccuracies. The prison submitted an action plan in response to our recommendations and this has been appended to this report.

Background Information

HMP Lindholme

16. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic and some specialist services. There is no inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lindholme was in February 2013. Inspectors reported some significant problems at the prison. However, they found that healthcare provision was reasonably good, with a range of services that met prisoners' needs.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2015, the IMB considered that healthcare provision was adequate. However, the IMB was not satisfied with the arrangements for escorting prisoners to hospital for consultations or treatments and considered that prison operational requirements took precedence over medical needs.

Previous deaths at HMP Lindholme

19. Mr Fraser was the second prisoner to die from natural causes at Lindholme since 2011. In the investigation into a death at the prison in 2015, we found a delay in dealing with a referral for suspected cancer, which was principally the responsibility of the hospital.

Findings

The diagnosis of Mr Fraser's terminal illness and informing him of his condition

20. In October 1992, Mr Anthony Fraser was convicted of murder and sentenced to life imprisonment. He had been at HMP Lindholme since November 2008.

21. On 13 March 2012, Mr Fraser told a nurse he had lower back pain, which he believed had been caused by an injury at his work in the prison bakery. The nurse gave him ibuprofen gel (an anti-inflammatory painkiller). A prison GP examined him three days later and diagnosed back strain.

22. Mr Fraser saw the GP again on 16 April, with shortness of breath, fatigue and recurrent boils on his chest and leg. The GP prescribed an antibiotic and planned to arrange blood tests if he did not improve.

23. On 25 April, a GP reviewed Mr Fraser and suggested a referral to a specialist, as his condition had not improved. Initially, Mr Fraser said he did not want this but on 2 May, he changed his mind. The GP referred him to the general surgery department at the hospital.

24. Mr Fraser's back pain persisted before he had got an appointment and a nurse requested blood tests, which were taken on 15 May. On 22 May, a consultant haematologist at the hospital faxed a letter to the GP with the test results, which showed abnormal levels of immunoglobulin (antibodies in the blood) and creatinine (a chemical waste product in the blood that passes through the kidneys to be filtered and eliminated in urine). The consultant advised that Mr Fraser almost certainly had myeloma and asked the GP to refer Mr Fraser urgently to the hospital's haematology clinic. A healthcare administrator faxed and posted the referral the same day. On 11 June, an appointment was received for 18 June.

25. The day after Mr Fraser's appointment, the hospital telephoned to advise that he needed an urgent bone marrow biopsy on 21 June. Mr Fraser attended as a day patient. Shortly after he got back to Lindholme, a consultant asked for him to return to hospital for immediate admission. After further tests, doctors diagnosed multiple myeloma (a type of bone marrow cancer). Hospital doctors fully informed Mr Fraser of his diagnosis and healthcare staff at the prison supported him appropriately.

26. We are satisfied that Lindholme referred Mr Fraser urgently to hospital for treatment the day that consultant haematologist identified that his tests results indicated myeloma. His hospital appointment was then four weeks after that. While it might have been appropriate for healthcare staff to have queried this, the actions of the hospital are outside the remit of this investigation. Mr Fraser received successful treatment after that and the clinical reviewer was satisfied that the length of time until his first appointment did not affect the ultimate outcome.

Mr Fraser's medical treatment

2012

27. Mr Fraser began a course of oral chemotherapy and returned to Lindholme on 27 June. Prison healthcare staff created appropriate care plans and involved Mr Fraser in the management of his continuing treatment. He attended outpatient hospital appointments. He kept his medication in his cell and had a thermometer to monitor his temperature. Mr Fraser's illness led to decreasing mobility and he had a walking stick to help him get about.

28. In October 2012, the hospital transferred Mr Fraser's treatment to a hospital in Sheffield. His planned treatment included preparation for stem cell collection and a bone marrow stem cell transplant. In November, Mr Fraser told healthcare staff that he had concerns about the treatment and was particularly worried about infection control. He said that he would not have treatment unless the prison allowed him to attend hospital without restraints. Mr Fraser then sought legal advice about the use of handcuffs.

29. On 15 November, a prison matron discussed Mr Fraser's concerns and the possible impact of delaying the treatment. Mr Fraser said he understood the risks, but wanted to complete the legal process. The nurse contacted the transplant coordinator at the hospital who advised that a short delay would not pose a significant increased risk. However, there is no record of any plans to review this.

30. Mr Fraser finished his chemotherapy in November. On 21 November, he told the nurse he wanted to complete the course of injections to mature and harvest his cells for his stem cell transplant, planned for the New Year.

2013

31. On 6 February 2013, Mr Fraser refused to attend an outpatient appointment. He said that he had not been warned of the appointment and did not want to go until he resolved the issue of handcuffs. He said he understood the consequences of delaying treatment. On 11 February, the nurse had a long discussion with Mr Fraser about his intentions. He said that he could not cope with going to hospital in handcuffs. On 11 March, Lindholme agreed that escort officers should not use restraints while he was in the hospital ward.

32. On 7 May, Mr Fraser was admitted to hospital for a stem cell transplant. Healthcare staff liaised with the hospital to plan his medical care when he returned to prison. This included taking anti-viral and anti-fungal medication and regular temperature checks. The hospital stipulated he should drink extra milk and maintain a good calcium and fluid intake. He was discharged from hospital on 24 May.

33. Over the following months, healthcare staff monitored Mr Fraser and checked his blood pressure, weight and general wellbeing. He also attended hospital appointments.

2014

34. On 16 January 2014, a prison GP prescribed tramadol (an opiate-based painkiller) when Mr Fraser reported hip and leg pain. He also received support from the prison physiotherapist for his mobility problems.

35. On 17 April, the nurse requested urgent blood tests as Mr Fraser had increased pain, shortness of breath and swollen ankles. On 22 April, the results showed abnormalities and the nurse arranged an urgent appointment with Mr Fraser's consultant. On 2 May, the consultant diagnosed deterioration of his myeloma. Mr Fraser started further treatment to kill the myeloma cells, consisting of a combination of dexamethasone tablets and twice weekly bortezomib injections, at hospital. Staff reviewed him weekly and liaised with the hospital team.

36. On 28 July, the oncology team at the hospital had written to say that while Mr Fraser had initially responded well to treatment, further active treatment carried an increased risk of significant side effects, including the possibility of death. Mr Fraser agreed that once he finished the current course he would not pursue further active treatment for myeloma. The GP said that Mr Fraser was not on a care pathway, or considered to be in the end stages of life at this point. The hospital consultant told the investigator that although Mr Fraser's cancer was incurable, he was still undergoing treatment to extend his life and the consultant did not consider he needed formal palliative care at that stage.

37. On 27 August, Mr Fraser told a nurse that he found it difficult to get to the healthcare centre to collect his tramadol (a controlled, opiate-based drug which prisoners cannot keep in their possession) and did not want to become addicted. Two days later, the GP replaced the tramadol with a fentanyl patch (to control chronic pain).

38. On 3 September, Lindholme received a fax from the hospital listing several appointments for chemotherapy. The fax indicated that the first treatment was due to start the previous day, 2 September. Owing to this error, the hospital deferred the start of the treatment to 9 September. By 4 November, Mr Fraser had completed eight cycles of chemotherapy. The consultant noted a satisfactory response and that his myeloma was stable. He stopped Mr Fraser's bortezomib injections and planned to review him in two months.

39. On 29 December, a GP examined Mr Fraser, who felt repetitive muscle spasms in his left arm. He considered this was a side effect of the medication, fluconazole (an anti-fungal medication prescribed to prevent yeast infections in patients treated with chemotherapy). The GP requested blood tests and planned a brain scan if the symptoms did not improve. He also asked prison staff to appoint a prisoner carer to assist Mr Fraser with his daily activities.

40. Mr Fraser's spasms continued and he developed slurred speech. On 31 December, he was admitted to hospital. During his admission, he was diagnosed with diabetes.

2015

41. On 8 January 2015, the hospital discharged Mr Fraser. On 14 January, the GP noted that an MRI scan had showed multilevel degenerative disc disease of the spine, but no spinal cord compression (where cancer grows in or near the spine and presses on the nerves or spinal cord). Healthcare staff continued monitoring him for the next few months and the physiotherapist helped with his mobility issues and joint pain.

42. On 14 August, Mr Fraser fell on the wing. He reported that his legs were weak, he had pain down his left side and back, he was constipated and could not sleep. The GP prescribed a laxative and a painkiller. Mr Fraser's symptoms continued. Nurses reviewed him the next day and noted his condition had deteriorated. They sent him to the hospital by ambulance and he returned to Lindholme later that day, with pain relief (co-codamol) and a laxative.

43. Mr Fraser continued to experience difficulty standing. He had leg and back pain and shortness of breath. On the morning of 19 August, he told a pharmacy technician that his fentanyl patch no longer helped his pain, but co-codamol gave him some relief. In the afternoon, he said he had no feeling or movement in his right leg. At 3.10pm, a locum GP and a nurse assessed Mr Fraser and arranged for an ambulance to take him to hospital where he was admitted.

44. On 20 August, Mr Fraser moved to a hospital in Sheffield where he was diagnosed with spinal cord compression and treated with radiotherapy. He returned to hospital on 4 September. Prison staff contacted the hospital for updates and on 10 September,Modern Matron attended a meeting with Mr Fraser's consultant. The GP diagnosed a relapse of Mr Fraser's multiple myeloma, and said his prognosis was poor, with a life expectancy of weeks or months. He planned to prescribe oral chemotherapy and discharge him the next week. However, Mr Fraser's condition deteriorated and he died in hospital on 24 September. The hospital gave the cause of death as relapsed multiple myeloma.

45. The clinical reviewer considered that, overall, Mr Fraser received a good standard of care at Lindholme, equivalent to that he could have expected to receive in the community. We are satisfied that his care and treatment was appropriate and he was involved in decisions about his treatment, but note there was no formal palliative care plan. Palliative care is given to a person with a serious or life threatening illness. Its aim is not to cure the disease but to prevent or treat its symptoms. Although treatment can help to control multiple myeloma for several years, it is incurable. There was no evidence that Lindholme developed end of life or palliative care plans, or sought specialist support, such as advice from Macmillan nurses. We make the following recommendation:

    The Head of Healthcare should ensure that end of life and palliative care plans are initiated at an appropriate stage, for prisoners who are diagnosed with a terminal illness. They should include all aspects of a patient's care, including effective pain relief and psychological and emotional support. Plans should be discussed with the patient and their family and regularly reviewed.

Mr Fraser's location

46. Mr Fraser had a single room on the first floor of B Wing, a small unit shared with up to seven others. At 'lock up', the whole unit is locked, rather than prisoners' individual rooms. He had a disabled toilet, a seat to use when showering, and a walking frame. Disabled prisoners on B Wing have access to the healthcare centre, approximately 100 metres away, through a specific gate. Staff encouraged Mr Fraser to walk to the healthcare centre. He had the use of a wheelchair and other prisoners pushed him there, if he did not feel able to walk. Healthcare staff gave him medication on the wing.

47. In July and August 2014, as his condition and mobility deteriorated, staff spoke to Mr Fraser about the benefits of moving to a ground floor cell, as he sometimes had to be carried downstairs to use a wheelchair. Mr Fraser said he did not want to move, preferring to stay where he was with friends who helped and supported him.

48. Mr Fraser had completed the minimum term of his life sentence and was eligible to be considered for release on licence. The Parole Board had considered his suitability for release several times, but had never directed his release. A recurrent problem was finding suitable accommodation for his release. Local authorities could not agree on this, partly because of the significant cost of his care. In June 2015, the possibility of a move to alternative secure residential accommodation was discussed but funding had still to be resolved.

49. We are satisfied that staff at Lindholme took account of Mr Fraser's wishes about his location within the prison. We consider that it was appropriate for Mr Fraser to remain at Lindholme while the possibility of alternative accommodation was being investigated, should the Parole Board direct his release.

Restraints, security and escorts

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The use of restraints should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the risk assessment and kept under review as circumstances change. The judgment found that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

51. During the early stages of his treatment in 2012 two prison officers escorted Mr Fraser to his hospital appointments and he was restrained to one of them by handcuffs or an escort chain throughout. Mr Fraser challenged the need to use restraints, through his solicitors and this resulted in a lengthy legal process.

52. On 11 March 2013, after legal proceedings, the prison agreed, through a consent order, that only one officer would stay with Mr Fraser at the hospital. He would be handcuffed to the officer for the journey to and from the hospital, but on the ward handcuffs would be removed and the officer would remain outside, but keep Mr Fraser in sight. For movements around the hospital an escort chain was used. We have not seen the risk assessments on which the decisions were based.

53. During 2014, it appears that restraints were applied again in hospital when it seemed that Mr Fraser might be deported at the end of his sentence. Their use continued for some time after the immigration authorities decided he would not be deported, apparently because the prison's offender management unit were slow to inform the security department. Restraints continued to be used for hospital appointments, even though by the latter part of 2014, Mr Fraser's mobility was poor and officers had to carry him downstairs in his wheelchair. Despite his poor mobility at the time, the healthcare input into risk assessments said there were no conditions that would affect his physical ability to escape. The risk assessments referred to information in 1993 (presumably from a previous prison sentence) that he was likely to escape. In February 2015, the deputy governor decided that two officers would accompany Mr Fraser to future hospital appointments, without using restraints.

54. After his final hospital admission in August 2015, two prison officers remained with Mr Fraser at all times, including during family visits. Despite requests for privacy, the officers did not leave Mr Fraser alone with his family until shortly before he died. In the days before he died, Mr Fraser was very ill and immobile. We consider that his family should have been allowed more private time with him, particularly as previously the consent order had agreed, when Mr Fraser was mobile, that there would be only one officer outside the ward. We do not consider that risk assessments throughout Mr Fraser's illness fully took into account the guidance of the High Court judgment and were not all informed by up to date healthcare input which properly commented on how his condition and mobility affected his risk of escape. We make the following recommendation:

    The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. Families of dying prisoners should be allowed private time with them towards the end of their lives.

Liaison with Mr Fraser's family

55. Mr Fraser's cancer was first diagnosed and treated in 2012, and it recurred in April 2014. His condition deteriorated significantly and he was admitted to hospital for the final time on 19 August 2015. No one informed Mr Fraser's family that he had been admitted to hospital.

56. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner dies or is seriously ill. Prison Service Instruction (PSI) 64/2011 says, "*Prisons must ensure that arrangements are in place for an appropriate member of staff to*

engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill."

57. On 2 September, the prison appointed a family liaison officer and a supervising officer as her deputy, but they did not go to see Mr Fraser in hospital until 10 September and did not contact his family before then. On 10 September, Mr Fraser told the Officer that in an emergency or if he died, he wanted her to contact his brother first.

58. While the officers were at the hospital on 10 September, Mr Fraser telephoned a family member, asking his family to visit him. The officer told Mr Fraser that she would contact his brother as soon as possible. The officer telephoned Mr Fraser's brother at 6.30pm, to introduce herself but there was no reply so she left a message with her contact details. She left another message the next day. Several family members visited Mr Fraser in hospital and the prison allowed him to make one phone call each day.

59. A senior prison manager took over family liaison, as the officer had other operational commitments. However, no one spoke to Mr Fraser's brother until after his death on 24 September. The senior manager went to the hospital and introduced himself to Mr Fraser's brother and they remained in contact about the funeral arrangements. Mr Fraser also had three daughters who asked to be dealt with independently of Mr Fraser's brother.

60. Mr Fraser's brother and sister visited Lindholme on 12 October for a memorial service and to meet other prisoners and staff, who had known Mr Fraser. Mr Fraser's funeral was held on 23 October and in line with national policy, the prison contributed to the costs. Mr Fraser's family said that contact with the prison after his death was generally good and the contribution of the prison chaplain to the memorial service and funeral was exceptional.

61. We consider that Lindholme should have appointed a family liaison officer at an earlier stage of Mr Fraser's illness, and informed his family about his hospital admission sooner. Until Mr Fraser indicated on 10 September, that he wanted his brother to be treated as his next of kin, his prison record identified his mother, who had died 17 years earlier, as his next of kin. These issues would have been resolved through appropriate palliative and end of life care planning. We make the following recommendation:

The Governor should ensure that a member of staff is appointed to liaise with families when a prisoner is diagnosed with a terminal or serious illness, that next of kin details are kept up to date and that families are informed promptly when a seriously ill prisoner is admitted to hospital.

Compassionate release

62. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

63. On 27 August 2015 a manager in the prison's offender management unit, began an application for compassionate release, requesting relevant reports. On 17 September, Mr Fraser's consultant noted that he was paraplegic, with septic arthritis and pneumonia. Although he could not accurately predict his life expectancy, the consultant indicated that, at most, Mr Fraser probably had only months to live. Mr Fraser's offender supervisor supported release on compassionate grounds and on 21 September the Governor of Lindholme endorsed the application, which was sent to the Public Protection Casework Section of the National Offender Management Unit. Sadly, Mr Fraser died before the application was considered. We are satisfied that Lindholme processed the application appropriately, once the prison received the information from the consultant.

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