Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Francis a prisoner at HMP Stocken on 14 October 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Francis died of lung cancer that had spread to his brain on 14 October 2016, while a prisoner at HMP Stocken. He was 49 years old. I offer my condolences to Mr Francis' family and friends.

I am satisfied that the prison healthcare team monitored Mr Francis appropriately through multidisciplinary meetings. However, no care plans were put in place and his end of life care wishes could have been better managed. Despite these concerns, I am satisfied that Mr Francis' standard of care at the prison was equivalent to that he could have expected to receive in the community.

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 **February 2017**

Contents

Summary

Events

1. On 16 October 2015, Mr Edward Francis was sentenced to five years imprisonment for firearms offences. He was sent to HMP Woodhill and transferred to HMP Stocken on 3 November.

2. Mr Francis remained in good health until 19 May 2016, when he complained of knee and ankle pain with some swelling. A prison doctor referred Mr Francis to the rheumatology department at hospital on 15 June, after he complained of further pain in his shoulders, elbows and wrists.

3. On 24 June, a prison doctor made an urgent referral for a chest x-ray to hospital (under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks) when Mr Francis complained of a cough and other symptoms.

4. Mr Francis was taken to hospital on 1 July. On 11 July, after a bronchoscopy and CT scan a hospital doctor confirmed a diagnosis of lung cancer which had spread to Mr Francis' brain. Doctors gave him a prognosis of up to one year to live. A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was put in place to reflect Mr Francis' resuscitation wishes.

5. Mr Francis started radiotherapy treatment on 5 August. This was stopped on 10 August when his condition deteriorated. Mr Francis spent about six weeks being cared for at a nursing home in Leicestershire, before being transferred back to hospital on 5 October for more radiotherapy. Mr Francis died nine days later.

Findings

6. We are satisfied that the prison healthcare team monitored Mr Francis appropriately through multidisciplinary meetings but no care plans were put in place. Anyone with complex needs or a diagnosis of cancer should have a care plan in place that is reviewed on a regular basis.

7. The investigation also found that the prison did not discuss Mr Francis' resuscitation wishes with him. This was first done when he was admitted to hospital in August. A hospital doctor spoke to Mr Francis about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to which he agreed. An issue as sensitive as this should ideally have been discussed with Mr Francis by a prison doctor or someone he was familiar with.

8. Despite these omissions, the clinical reviewer was satisfied that Mr Francis' standard of care at the prison was equivalent to that he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that all prisoners with cancer and/or a terminal diagnosis have care plans in place that reflect their individual needs.
- The Head of Healthcare should remind healthcare staff of the importance of discussing DNACPR orders with prisoners with a terminal illness.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Francis' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Francis' clinical care at the prison.

12. We informed HM Coroner for Rutland and North Leicestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Francis' wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

14. The investigation has assessed the main issues involved in Mr Francis' 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.

15. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stocken

16. HMP Stocken is a medium security prison in Rutland which holds up to 842 men. Healthcare is provided by Care UK, and the mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. GP provision is via 2 permanently employed GP's who provide 10 sessions per week.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stocken was in July 2015. Inspectors reported that health services were good, particularly in identifying and supporting prisoners with complex health needs. Waiting times for GP, nurse and dental service appointments were acceptable but prisoners waited too long for most other health services.

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 April 2016, the IMB noted that the healthcare department were in the process of employing two full time doctors, no longer being reliant on agency doctors. There was also still a national shortage of trained nurses. However, this did not currently affect service delivery. The Board found that healthcare provision matched, and in many cases exceeded, care available to patients outside.

Previous deaths at HMP Stocken

19. Mr Francis was the third prisoner to die from natural causes (the second from cancer) at Stocken since January 2015. There were no similarities with the previous deaths.

Findings

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

20. On 16 October 2015, Mr Edward Francis was sentenced to five years imprisonment for firearms offences. He was sent to HMP Woodhill.

21. Mr Francis was transferred to HMP Stocken on 3 November. At his reception health screen, a nurse noted that Mr Francis smoked cigarettes, but declined a referral to the smoking cessation nurse to help him stop smoking. No healthcare concerns were raised at this time.

22. Mr Francis remained in good health until 19 May 2016, when he complained of knee and ankle pain with some swelling. A prison GP prescribed naproxen (an anti-inflammatory) and requested a blood test. Mr Francis saw another GP eight days later on 27 May, when his blood test result returned as abnormal. Mr Francis reported continued pain but reduced swelling. He told the GP that despite the pain in his knees and ankles he felt well in himself. The GP requested more blood tests.

23. A prison GP referred Mr Francis to the rheumatology department at hospital on 15 June, after he complained of further pain in his shoulders, elbows and wrists. The GP noted that Mr Francis had lost some weight but did not ask for this to be monitored. Omeprazole was prescribed to help ease indigestion, believed to be caused by his pain relief medication.

24. The GP reviewed Mr Francis on 20 June, after he complained of pins and needles and weakness in his left hand over the weekend. Mr Francis was taken to the Accident and Emergency Department in hospital for review the same day. He returned to the prison later that day with a recommendation that he have a CT scan. The prison sent the referral that day.

25. On 24 June, the GP made an urgent referral for a chest x-ray to the hospital (under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks) when Mr Francis complained of suffering with a cough for one month and showed symptoms of possible clubbing (swelling of the ends) of his fingers. This is the first reporting of a cough in Mr Francis' medical records.

26. Mr Francis was taken to hospital on 1 July, after he complained again of arm weakness and spasms. The hospital admitted him as an inpatient.

27. On 8 July, a doctor from the hospital contacted the prison's healthcare department to inform them that a bronchoscopy had showed lesions on Mr Francis' lungs. Mr Francis returned to the prison the following day, 9 July. A CT scan two days later at another hospital confirmed a diagnosis of lung cancer with brain metastases. (Metastases are the spread of cancer from one organ to another.) A hospital doctor spoke to Mr Francis to explain their findings and told him he had roughly one year to live, dependant on the success of any treatment given. The hospital prescribed dexamethasone, an anti-inflammatory steroid medication to prevent swelling in his brain.

28. Mr Francis' first significant symptoms occurred on 18 June 2016, when his left hand started to shake. He was appropriately taken to hospital for review. Six days later on 24 June, a prison GP made a "two week wait" referral after Mr Francis complained of a cough for one month. The clinical reviewer commented that Mr Francis was "comprehensively reviewed and he was promptly referred for an x-ray under the rule". We consider that obtaining a diagnosis and informing Mr Francis of his condition was prompt.

Mr Francis' clinical care

29. On 12 July, the day after receiving his diagnosis Mr Francis went to see a prison GP. He reported being pain free but tired. The GP noticed that despite eating, Mr Francis had lost weight. He prescribed high calorie food supplement drinks to help maintain his weight. Mr Francis told him that he was still coming to terms with his news.

30. A prison multi-disciplinary meeting was held on 28 July, to discuss Mr Francis' diagnosis, his treatment plan of radiotherapy, and his social care needs. It was agreed that (because 24 hour healthcare was not available at the prison) if Mr Francis became unwell during the night he should be admitted to hospital rather than waiting for healthcare to attend the next morning.

31. Mr Francis was admitted to hospital on 1 August, when he became unwell. He moved to the oncology ward four days later, on 5 August, where he received radiotherapy treatment. During a multidisciplinary case conference at the hospital on 9 August, hospital staff described Mr Francis' prognosis as poor. A hospital doctor spoke to Mr Francis about a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to which he agreed. (A DNACPR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

32. Mr Francis' radiotherapy treatment had to be stopped on 10 August, when his condition deteriorated. Stocken do not have 24 hour nursing care available so Mr Francis was transferred to a nursing home on 19 August.

33. Mr Francis was transferred back to the hospital on 5 October to receive more radiotherapy treatment. On 13 October, a hospital oncologist explained that Mr Francis had deteriorated rapidly and his prognosis was very poor, and was now likely to be measured in days rather than weeks. Mr Francis died at 4.15pm the following day. Mr Francis' wife and brother were at his bedside when he died. The post mortem report indicated that Mr Francis died from lung cancer that had spread to his brain.

34. We are satisfied that the prison healthcare team monitored Mr Francis appropriately while at Stocken through GP review and frequent multidisciplinary meetings. Although there were multidisciplinary meetings there were no care plans in place for Mr Francis to ensure his daily needs were met. Anyone with complex needs or a diagnosis of cancer should have a care plan in place that is reviewed on a regular basis. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners with cancer and/ or a terminal diagnosis have care plans in place that reflect the needs of the individual.

35. Mr Francis' DNACPR order was initiated by a hospital consultant on 9 August. The consultant discussed this with the prison during the multidisciplinary meeting held that morning before speaking to Mr Francis. An issue as sensitive as this should ideally have been discussed with Mr Francis in person by a prison doctor or someone he was familiar with at the prison. We make the following recommendation:

The Head of Healthcare should remind healthcare staff of the importance of discussing DNACPR with prisoners with a terminal illness.

36. Mr Francis was able to access outpatient appointments and receive treatment as prescribed by his consultants. Healthcare staff monitored him frequently and referred him promptly when he reported suspicious symptoms. Because of this, and despite the concerns set out above, we conclude that Mr Francis' care was equivalent to that he could have expected to receive in the community.

Mr Francis' location

37. A personal emergency evacuation plan (PEEP) was completed with Mr Francis on 20 July 2016. A PEEP is a written document detailing what extra assistance a person will need if they are required to evacuate a building in an emergency.

38. When Mr Francis' health deteriorated on 1 August, he was admitted to hospital. On 10 August, a course of palliative radiotherapy was abandoned due to further deterioration in Mr Francis' health. Because the prison could not provide the level of care Mr Francis needed, they moved him to a nursing home on 19 August under the escort of one prison officer.

39. Mr Francis remained at the nursing home until 5 October before being readmitted to hospital. Mr Francis died nine days later on 14 October.

40. We are satisfied that Mr Francis was appropriately located throughout his illness.

Restraints, security and escorts

41. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

42. Mr Francis was admitted to hospital on 1 August when he became unwell. The prison assessed Mr Francis as being a medium risk to the public and restrained him by a single handcuff, escorted by two prison officers.

43. In discussion with a prison GP, the duty governor reviewed Mr Francis' risk the following day, 2 August. The GP explained that due to ill health, Mr Francis' ability to escape was low. Mr Francis' health had deteriorated overnight and now

required help with personal care and feeding. The duty governor authorised the removal of Mr Francis' restraints. Mr Francis remained unrestrained.

44. Mr Francis was released on temporary licence on 5 August. An officer remained with Mr Francis to support him while at the hospital. Mr Francis was unrestrained when he died on 14 October.

45. We are satisfied that these decisions were appropriate and proportionate.

Liaison with Mr Francis' family

46. The Head of Safer Custody and a prison officer shared the role of family liaison officer. The officer spoke to Mr Francis on 23 July. He introduced himself and explained his role and what he would be doing to support Mr Francis and his family. During this meeting they also discussed the possibility of compassionate release and where Mr Francis would like to be cared for at the end of his life. The officer met Mr Francis' wife that afternoon before a prison visit.

47. The Head of Safer Custody and the officer kept in regular contact with Mr Francis' family and invited his wife and brother to attend a multidisciplinary case conference at the hospital on 9 August, to ensure they were kept up to date with Mr Francis' condition.

48. Mr Francis died on 14 October. The officer attended the hospital to offer support to Mr Francis' family who were with him when he died.

49. Mr Francis' funeral was on 4 November. Mr Francis' family arranged the funeral and did not ask for any assistance from the prison. The prison offered a contribution towards the cost of the funeral in line with national policy. At the time of writing this report, they were waiting to see if this would be accepted.

50. I am satisfied that the prison offered a good level of support to Mr Francis and his family.

Compassionate release

51. Release on temporary licence (ROTL) can be granted for precisely defined and specific activities which cannot be provided in the prison. A risk assessment is completed to ensure that the prisoner's temporary release does not present unacceptable risks. The governor of the prison is able to grant the temporary licence and will decide on whether the prisoner is to be accompanied by staff.

52. Mr Francis was granted release on temporary licence on 5 August 2016. A prison officer remained with Mr Francis to support him while at the hospital and nursing home. Mr Francis was not restrained and the officer on duty left the room to provide Mr Francis and his family with the privacy required.

53. An early release on compassionate grounds application was started on 18 August. However, Mr Francis' consultant was unable to comment on Mr Francis' life expectancy at this time. Among the criteria for early release (as set out in Prison Service Order (PSO) 6000) it states that a person can be permanently released from custody before their sentence has expired if they (usually) have a life expectancy of less than three months. However, as a clear medical opinion

of life expectancy could not be provided, Mr Francis' application could not be considered at that time. On 13 October Mr Francis' consultant provided a letter confirming that "his prognosis is very poor and likely to be measured in days or weeks". Mr Francis died the next day before any application for early release could be considered.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141