Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Fraser a prisoner at HMP Littlehey on 10 March 2016

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 John Fraser died on 10 March 2016 of pancreatic cancer, while a prisoner at HMP Littlehey. He was 67 years old. I offer my condolences to Mr Fraser's family and friends.

In September 2015, Mr Fraser began to report ongoing constipation and abdominal pain. Blood tests taken at HMP Chelmsford in October 2015 showed abnormalities but these were not followed up then, or when he transferred to HMP Norwich briefly in November, or when he was sent to Littlehey later that month. I am concerned that this oversight led to a delay in Mr Fraser's diagnosis. In January 2016, when a GP at Littlehey referred him urgently to a specialist, the referral was delayed at the prison for several days. While an earlier diagnosis might not have altered the outcome for Mr Fraser, it would have allowed an opportunity to plan for end of life care.

Although a humane decision was subsequently made to remove restraints, I do not consider that the decision to restrain Mr Fraser when he was first admitted to hospital at the end of February, properly took into account how his poor health and mobility affected his risk of escape.

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 **September 2016**

Contents

Summary

Events

1. On 28 August 2015, Mr John Fraser was recalled to prison after breaching the conditions of his licence. He was sent to HMP Chelmsford. Shortly afterwards, he began to report ongoing abdominal pain and constipation, which doctors treated with laxatives and medication to relieve irritable bowel symptoms. Two blood tests in October, showed abnormal liver function but no one at Chelmsford followed these up.

2. On 6 November, Mr Fraser transferred to HMP Norwich and, on 25 November, to HMP Littlehey. Mr Fraser continued to complain of ongoing abdominal pain and constipation, but neither prison noted or investigated the abnormal blood results. It was not until 5 January 2016, that a doctor at Littlehey made an urgent referral for suspected cancer, when he noted Mr Fraser had lost a lot of weight. However, the referral was not sent from the prison until 11 January. On 21 January, a consultant examined Mr Fraser and hospital investigations showed suspected pancreatic cancer, which would need further tests to confirm.

3. On 23 February, Mr Fraser had increased abdominal pain and a prison GP told him that the hospital suspected he had pancreatic cancer. He was admitted to hospital with jaundice and a high temperature. Managers decided he should be restrained but removed the restraints after two days. Mr Fraser's health deteriorated quickly in hospital. On 9 March, hospital doctors confirmed Mr Fraser had terminal pancreatic cancer. He died the next day.

Findings

4. The investigation found that there was a delay in diagnosing that Mr Fraser had pancreatic cancer. The clinical reviewer considered that Mr Fraser's persistent abdominal symptoms and the repeated abnormal blood tests should have led to an urgent referral to a specialist earlier. Pancreatic cancer is an aggressive disease and the chances of survival are poor but earlier referral to a specialist might have led to an earlier diagnosis, treatment and symptomatic relief. We are concerned that abnormal blood results and other symptoms were overlooked and not followed up. When, eventually, a doctor at Littlehey made an urgent referral for suspected cancer, the referral was further delayed at the prison for several days.

5. We do not consider that the use of restraints when Mr Fraser was first admitted to hospital on 23 February, was justified by a properly considered risk assessment which took into account his health and poor mobility at the time.

Recommendations

- The Heads of Healthcare at HMP Chelmsford, HMP Norwich and HMP Littlehey should ensure that all abnormal blood test results are highlighted, followed up, and actioned, by appropriate use of SystmOne to allow effective continuity of care.

- The Head of Healthcare at HMP Littlehey should ensure that all urgent referrals are sent within 24 hours.
- The Governor of HMP Littlehey 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.

The Investigation Process

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

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

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

9. We informed HM Coroner for Cambridgeshire and Peterborough District 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 Fraser's daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Fraser's daughter asked why the prison did not refer Mr Fraser to hospital sooner, especially when he first complained of stomach pains.

11. 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.

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

13. 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 Littlehey

14. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men. A large proportion of the population are men convicted of sexual offences.

15. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

16. The most recent inspection of Littlehey was in March 2015. Inspectors reported that there was effective clinical leadership and there had been a significant improvement in patient care since the previous inspection. Nurses with additional specialist training and skills ran relevant clinics for prisoners with lifelong health conditions. Each GP had an identified specialism, including chronic pain management.

Independent Monitoring Board

17. 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 January 2016, the IMB reported that the prison ran several specialist clinics and there had been a higher level of expenditure on health provision than expected due to the significant demands for healthcare services.

Previous deaths at HMP Littlehey

18. There have been 14 deaths from natural causes, at Littlehey, since January 2014. We have raised the issue of a delays in an urgent referral and the unjustified use of restraints in another recent investigation.

Findings

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

19. On 20 August 2015, Mr John Fraser had been released from HMP Bure but on 27 August was recalled to prison and remanded to HMP Chelmsford charged with a further offence. (On 25 September, he received a two-year prison sentence.) He had a history of high blood pressure, smoked tobacco and suffered from psoriasis (a skin condition). Shortly before his release from Bure, he had reported being tired and suffering from constipation. Blood tests at Bure had indicated abnormal liver function but there is no record that they were followed up before his release.

20. On 7 September, a prison GP examined Mr Fraser who said he had had constipation for the past three weeks and some abdominal pain. The GP noted that Mr Fraser had no rectal bleeding or other suspicious symptoms. He prescribed laxatives, requested blood tests and planned to review Mr Fraser in one month. The blood results were mostly normal, but there was a request for a repeat full blood count. There is no record that the repeat test was done.

21. On 8 October, Mr Fraser told a prison GP that he was still constipated and now had persistent abdominal pain. The GP prescribed a laxative, medication to relieve irritable bowel syndrome and pain relief. He also prescribed an iron supplement. The GP ordered routine blood tests, which were taken on 9 October and again 22 October. Both showed abnormal liver function. The GP saw Mr Fraser again on 26 October, and prescribed an antibiotic but took no action about the blood results.

22. On 6 November, Mr Fraser was transferred to HMP Norwich. Although he complained of abdominal pain to doctors throughout his time at Norwich, no one noted the abnormal blood results from October or followed these up. The Head of Healthcare in Norwich commented to say they could see no evidence that healthcare staff had access to Mr Fraser's previous medical notes when he arrived, which meant they could not see the abnormal blood test results. The evidence provided to the PPO appeared to show that Norwich did have access.

23. On 25 November, Mr Fraser transferred to HMP Littlehey. At an initial health screen, a nurse noted Mr Fraser's medications and that he had no outstanding hospital appointments. The nurse did not note the blood test results from October.

24. On 28 November, a nurse gave Mr Fraser suppositories when he complained of chronic constipation and abdominal pain. On 2 December, a prison GP reviewed Mr Fraser and noted that he had suffered constipation since August, but had not lost weight and had no rectal bleeding or other suspicious symptoms. The doctor did not note the abnormal blood tests. He diagnosed constipation and prescribed a laxative.

25. On 5 January 2016, a prison GP examined Mr Fraser after he had reported ongoing abdominal pain. The GP noted that Mr Fraser had lost 11kg in the last two months, but had no other suspicious symptoms. The GP made an urgent referral to the colorectal department at hospital under the NHS pathway, which

requires patients with suspected cancer to be seen by a specialist within two weeks. However, the prison did not fax the referral letter to the hospital until 11 January. On 13 January, blood tests showed abnormal liver function. The records noted that Mr Fraser was due to see a specialist.

26. On 21 January, a colorectal consultant reviewed Mr Fraser and referred him for a CT scan. On 22 February, the hospital sent the results to the prison, which showed significant ascites (a build up of fluid in the abdomen) and a mass in Mr Fraser's pancreas. Hospital doctors suspected pancreatic cancer and planned further investigations to confirm this.

27. On 23 February, Mr Fraser, had increased abdominal pain and distension and a nurse noted that he looked jaundiced and had a high temperature. Later that day, a prison GP told Mr Fraser that hospital doctors suspected he had pancreatic cancer. Because of his jaundice and high temperature, the doctor sent him to hospital.

28. In hospital, doctors drained the fluid from Mr Fraser's abdomen and gave him pain relief. Mr Fraser remained in hospital. On 9 March, after further investigations, hospital doctors told him that tests had confirmed he had inoperable pancreatic cancer and that he had no more than a week to live.

29. The clinical reviewer considered that Mr Fraser's persistent abdominal symptoms and the repeated abnormal blood tests should have led to an urgent referral to a specialist earlier. In this respect, Mr Fraser's care was not equivalent to that he could have expected to receive in the community. We are concerned that the prison medical record system, SystmOne, was not used effectively to highlight these abnormal test results. Pancreatic cancer is an aggressive illness and, while an earlier referral and diagnosis might not have changed the outcome, it would have allowed appropriate palliative and end of life care.

30. We are also concerned about the delay in sending the prison GP's urgent referral to the hospital. Littlehey has a clear healthcare protocol that states urgent referrals (which are dictated by the GPs) should be written up and faxed with 24 hours. While this did not affect the outcome for Mr Fraser, in other cases such a delay could be critical. We make the following recommendations:

The Heads of Healthcare at HMP Chelmsford, HMP Norwich and HMP Littlehey should ensure that all abnormal blood test results are highlighted, followed up and actioned by appropriate use of SystmOne to allow effective continuity of care.

The Head of Healthcare at HMP Littlehey should ensure that all urgent referrals are sent within 24 hours.

Mr Fraser's clinical care

31. Mr Fraser's treatment after his terminal diagnosis was in hospital, which is outside the remit of this investigation. On 9 March, hospital staff began palliative treatment. Mr Fraser died at the hospital, the next day.

Mr Fraser's location

32. Mr Fraser initially lived in a cell on the third floor at Littlehey and prisoners and staff helped Mr Fraser collect his meals, as his mobility was poor. On 12 February 2016, officers moved him to a ground floor cell, when he was no longer able to use the stairs. After Mr Fraser was admitted to hospital on 23 February, he did not return to the prison.

33. When hospital doctors confirmed Mr Fraser's illness was terminal, prison nurses contacted a hospice. The next day, the hospice agreed to take Mr Fraser. Sadly, he died before he could move to the hospice.

34. We are satisfied that Mr Fraser was appropriately accommodated during his time in prison. Staff moved him to a ground floor cell when he was unable to manage the stairs and healthcare staff sent him to hospital when his condition deteriorated.

Restraints, security and escorts

35. 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 level of restraints used 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 assessment process and kept under review as circumstances change.

36. When Mr Fraser went to hospital on 23 February, prison staff assessed him as a low risk of escape and medium risk to the public. A nurse completed the healthcare section of the risk assessment and noted there was no medical objection to the use of restraints but did not say how his condition and mobility affected his risk of escape. The risk assessment noted that Mr Fraser was in a wheelchair at the time. A prison manager decided that officers should use an escort chain to restrain Mr Fraser for the journey and in hospital. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

37. On 25 February, another manager reviewed the risk assessment, noted that Mr Fraser was very ill, and decided that restraints should be removed.

38. We are pleased that managers reviewed the risk and removed Mr Fraser's restraints two days after he was admitted to hospital. However, when he first went to hospital, Mr Fraser was very ill with suspected pancreatic cancer. His mobility was very poor, to the extent that he needed a wheelchair. We are not satisfied that the risk assessment properly took into account how Mr Fraser's health affected his already low risk of escape. We make the following recommendation:

The Governor of HMP Littlehey 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.

Liaison with Mr Fraser's family

39. On 26 February, the prison appointed an officer as their family liaison officer, but she had some difficulty in obtaining details of a suitable family contact. On 3 March, Mr Fraser's ex-wife rang the prison because he had not been in contact with his daughter, and they were worried. The officer told her that Mr Fraser was ill in hospital. After this, she arranged for his daughter to visit him, and met her at the hospital to offer support.

40. Mr Fraser's daughter visited him in hospital on 10 March, and was with him when he died. The officer visited Mr Fraser's daughter at her home the next day to offer condolences and support.

41. Mr Fraser's funeral was on 14 April. The prison contributed to the costs in line with national policy.

Compassionate release

42. 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.

43. Hospital doctors confirmed Mr Fraser's terminal illness on 9 March, and he died the next day. We are satisfied there was no time for the prison to consider compassionate release.

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