

**Investigation into the circumstances surrounding
the death of a man in custody at HMP Frankland
who died at University Hospital, County Durham**

**Report by the
Prisons and Probation Ombudsman
for England and Wales**

May 2005

This is a report and findings into the death of a man in August 2004 at University Hospital, County Durham. In compiling the report, I commissioned a Clinical Review of the care and treatment received by him at both HMP Frankland and the University Hospital. The review has been undertaken on behalf of the Durham Primary Care Trust (PCT).

Every death is tragic, but especially so whilst in custody, and I offer my sincere condolences to the man's family and friends.

The investigation was carried out by a member of my office. I would like to thank the Governor of Frankland for providing my investigator with suitable accommodation and facilities from which to work. I also wish to thank the Liaison Officer for her support and assistance throughout the investigation.

I note with concern that the Thoracic and General Medicine Consultant treating the man complained to the Governor about cancelled CT scan appointments and said, *this man never got the assessment of his lung cancer that he should have had with a view to proper treatment*. This report shows that one appointment was cancelled by the prison. The Consultant treating him believes that at least one other appointment had been made with the prison, but was not facilitated. My investigation has shown that the hospital's own computer records do not identify any other appointments. It seems there was a breakdown in communication, but it is not clear where this occurred.

Other issues of concern include internal communication within the prison, prisoners smoking in Healthcare, the use of restraints and the use of release on temporary licence (ROTL) for terminally ill prisoners. I commend the Governor for having issued new instructions in respect of the latter two matters during the course of this investigation.

The Clinical Review makes no recommendations. The investigation report makes five recommendations for local action.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 28 August 2004, the man was admitted to the University Hospital, County Durham. He died on 31 August, following deterioration of his medical condition. On 15 April 2004, he had been seen by his GP and diagnosed with *right basal pneumonia with pleurisy* and treated with Erythromycin. The Clinical Review describes the ongoing treatment as a *history of terminal illness*. He had been due to have a CT scan on 26 July, but this was cancelled by the prison. He had not had a scan by the time he died.
2. A Consultant in Thoracic and General Medicine at the University Hospital raised concerns regarding two missed appointments with the Governor. The Governor passed the letter to the investigation team. The investigation team was able to establish that one appointment had been cancelled by the prison but that the University Hospital computer records did not identify any other appointment. The Consultant's evidence strongly suggests that there was a breakdown in communication, but it is not at all apparent where this occurred.
3. The investigation has revealed communication difficulties between Frankland's Healthcare Department and the Detail Office. Concern is also raised about prisoners smoking in Healthcare.
4. The investigation has also focused on the use of restraints and ROTL both in the case of the man and more generally. These matters have been the subject of new guidelines issued by the Governor, an action that is welcomed.

HMP FRANKLAND

5. HMP Frankland is a maximum security establishment holding category A and category B adult male prisoners. It is part of the high security directorate of the Prison Service.
6. Frankland opened in October 1980 as a temporary prison staffed by the army. After three months the establishment was closed for further modification. It reopened as a fully operational high security prison in April 1983. Two further wings were opened in 1998, bringing the establishment's certified normal accommodation to 653. Prisoners are held in single cell accommodation in six wings, four of which house vulnerable prisoners. The establishment's performance rating is "High Performance", which is the highest level achievable.
7. An inspection report by HM Chief Inspector of Prisons (March 2003) described Frankland as offering a safe environment, based upon good relationships between staff and prisoners, with appropriate levels of interaction and good staff understanding of individual prisoners and their needs.
8. The final Standards and Security Audit carried out during February and March 2003 gave an overall "good" rating for both categories. (Good is defined as follows: The establishment or group performs to a high standard. The evidence gives assurance that risks are being effectively managed.)

INVESTIGATION PROCESS

9. The investigation commenced with a meeting between my investigator and the Governor at the prison, followed by meetings with members of the Prison Officers' Association (POA) and Independent Monitoring Board (IMB).
10. The Governor appointed a member of his staff to act as Liaison Officer to the investigator. He also made available a number of documents relating to the period of the man's custody. The documents were examined and the investigator identified whom he would seek to speak to.
11. The investigator commissioned a Clinical Review of the care and treatment of the man whilst in custody. This was carried out on behalf of the Durham PCT.
12. Following a number of informal interviews and examination of the documents, the investigator briefed the Governor with his overall findings.
13. The draft report was completed and issued to the Prison Service. One of my office's Family Liaison Officers, who was in correspondence with a member of the man's family, issued the draft report for their comments.
14. His family asked a specific question regarding the extent of his illness and level of the cancer. The Governor raised a number of questions regarding the report, which the investigator agreed to review.
15. The report was amended and reissued to the Prison Service and the man's family, for any further comment.

FINDINGS

16. The man was admitted into the University Hospital, County Durham on 28 August and died on 31 August. A post-mortem was carried out on 1 September at University Hospital and gave the cause of death as *disseminated small-cell anaplastic carcinoma of the lung*. The toxicology report identifies *morphine levels consistent with the therapeutic use appropriate for someone suffering from the terminal stages of malignant disease*. His family asked the investigation team what the level of the cancer was, but we have been unable to obtain an answer to this question.
17. He had presented on a number of occasions at Frankland's Healthcare Centre, which resulted in the medical staff referring him to outside hospital for further tests. The Clinical Review notes that the *history of terminal illness* began on 15 April 2004. The Governor made available to my investigator a copy of a letter from the Consultant in Thoracic and General Medicine at the University Hospital of North Durham, which raised a specific complaint regarding the care and treatment of the man whilst at HMP Frankland. The complaint concerned the cancellation on two occasions of hospital appointments for a CT scan. My investigator was able to establish that one appointment was cancelled on 20 July 2004 for an appointment scheduled for 26 July at 10am. The appointment letter clearly has the entry "*cancelled, no staff*" written on it. The investigation team was unable to understand why, some six days prior to the appointment, sufficient staff could not have been found to undertake the escort. On examination of the establishment detail records, the Detail Manager on duty at the time of the investigation was unable to explain why the escort was cancelled, as sufficient staff were available to take the man to the appointment. The doctor concluded, *he was eventually admitted as an emergency but died just before the third appointment for a CT scan. This man never got the assessment of his lung cancer that he should have had with a view to proper treatment*. The Clinical Review comments on this.
18. The investigator wrote to the Consultant seeking clarification of the missed appointments. She replied on 21 March enclosing a copy of a hand written diary entry, and a copy of her request for CT scan. The Consultant explained that the hospital staff said that they would have sent the appointment to the medical officer at the prison. My investigator contacted the University Hospital Health Records Department. Their computer records did not show any appointment for the man on 29 June. My investigator was also unable to trace any record that the hospital made an appointment with the prison for 29 June. My investigator spoke to the prison Healthcare Administration Manager. She said that the prison receives a large number of telephone calls from the University Hospital asking why a particular prisoner has not attended an appointment. Very little appears to have been done to eliminate this problem.

The Governor and PCT should review communication between external hospitals and the prison.

19. In his Clinical Review, the doctor writes: had the man been resident in the community; he would have had a CT scan on 29 June 2004. Both this appointment and his subsequent one on 26 July 2004 were cancelled and he had still not had the scan

when he died on 31 August 2004. It would appear that both appointments were cancelled because of a lack of staff to escort him to appointments, but I can find no evidence that clinical advice was requested before the appointments were cancelled. Clinical advice would almost certainly have highlighted the seriousness of his underlying condition. The University Hospital computer records do not support this finding. However, the investigation team strongly agree that clinical advice should always be sought before cancelling a medical appointment.

The Governor should remind staff that clinical advice is sought from the PCT before any medical appointment is cancelled.

20. The Clinical Review doctor also says: in hindsight, it is apparent that the man's cancer had spread and that the outcome was not greatly affected by the delay in diagnosis. At the time the scan was due, it was not apparent that spread had occurred and at that stage it was reasonable to assume that an early diagnosis would have led to treatment which could have improved his quality and quantity of life. I think the Consultant's complaint about the cancellation of the scans is fully justified. As noted, a handwritten diary entry and note from her requesting a CT scan on the dates in question are available, but the University Hospital computer records do not offer further support. The investigation team found no evidence of the University Hospital having made an appointment for 29 June with the prison. I have concluded that there was a serious breakdown in communication between the hospital and the prison, but I am unable to say where this occurred.
21. To understand the reasons why the man's appointment(s) was cancelled, my investigator interviewed the Detail Manager (responsible for the day-to-day staffing arrangements) and Healthcare Manager. It became clear that a communication problem exists between the two departments that requires addressing. The Healthcare Centre Administration Clerk is responsible for making the appointments and she then informs the Detail Office. The Detail Office is responsible for providing the necessary staff. Complications arise when the number of staff profiled to undertake escorts is exceeded. This results in the Detail staff asking the Healthcare Centre either to cancel or rearrange an appointment. The clerk will then raise the lack of staff with the Healthcare Manager, who, if the appointment is urgent, will contact the Detail Office to say that the escort must go ahead. This in turn leads the Detail staff to say that, unless they receive an order from a governor grade that the escort must go out, then the appointment cannot go ahead. The investigator asked the Administration Manager about the relationship between the Healthcare Department and the Detail Office. She said, "it's a waste of time speaking to them". Detail staff said that the relationship was good.
22. The Governor has as part of his management team a link governor. The link governor has responsibility for both the detailing of staff and Healthcare. The Healthcare Manager informed the investigation team during a recent visit that, whilst some improvements had occurred recently in communication between departments, she still experienced difficulties in facilitating prisoner appointments to outside hospitals. She said that Detail staff still insist that she should contact the Duty Governor when requesting additional escorts. My investigator spoke to Detail staff and they confirmed that the Healthcare Manager would be asked to speak to the Duty

Governor and seek his/her permission to facilitate additional escorts to hospital. They also said that, once the Healthcare Manager has been directed to the Duty Governor, they will expect to receive a phone call within five to ten minutes from the Duty Governor instructing them to facilitate the escort. In anticipation of the phone call, they begin the process of arranging the escort. The Healthcare Manager is not aware that, having been instructed to seek the Duty Governor's permission to go ahead with the escort, the Detail staff are already in fact making the necessary arrangements to facilitate the escort. This is a waste of the Healthcare Manager's time, and an unnecessary bureaucratic obstacle which should cease.

23. Additionally, the Healthcare Manager explained that Detail staff will ask her to prioritise her appointments and to cancel any non urgent case if an additional prisoner is required to attend hospital. She said, "*I am a nurse, they could all be critical.*"
24. My investigator asked the Healthcare Manager if she felt she had any authority to insist that a prisoner be taken to the hospital for an appointment, even if the case was urgent. It was clear from her answer that she did not have this level of authority or confidence to insist. Detail staff were asked how they viewed the authority of the Healthcare Manager. They said that they did not regard her as having any operational managerial responsibility, and would refer to the Duty Governor for decisions. It is clear that the Healthcare Manager and Administration Manager feel isolated and that difficulty with communication exists between Healthcare and the Detail Office. The Healthcare Manager and Administration Manager said that *they felt disempowered and frustrated*. It was evident to the investigator that communication between the two departments was not on a sound footing, and that this is affecting the work of the establishment. The investigator discussed this with the Governor. He was aware of the issues and had held previous meetings to resolve the problems.

The Governor and PCT should seek to resolve the communication difficulties between the Healthcare Department and Detail Office.

25. Correspondence was received from the Support Organisation for Falsely Accused People (SOFAP). The organisation forwarded a letter from a prisoner at Frankland, who wished to remain anonymous, that raised concerns about the care of the man and about smoking in the Healthcare Department. The concern from the prisoner regarding medical care referred to the cancellation of the appointment for the man to undergo a CT scan. The prisoner also referred to the man complaining to him that he was held in the waiting room whilst other prisoners were smoking, and that this affected his chest complaint.
26. My investigator visited Frankland's Healthcare Centre and spoke to nursing staff and the Healthcare Manager. He found the waiting rooms to be in poor decorative order, not well lit, with poor ventilation and no signs indicating that smoking was not allowed. The nursing staff accepted that smokers and non smokers were being held in the same waiting rooms and that smoking does take place. They felt that they had little control over the matter and would be vulnerable if they were to tell prisoners to stop smoking. The Manager accepted that at least one prisoner was smoking on the ward unchallenged. The Manager made immediate arrangements for no smoking signs to be fitted in the waiting room. On a later visit to the prison, the investigator found that

the signs had been installed. However, it was still evident that smoking was taking place in the room. The investigator discussed this with the Manager. She explained that not all officers will enter the room to check on the prisoners. She did not challenge the officers.

The Governor should remind all patrol staff of the need to enter the waiting rooms and supervise the area appropriately.

27. Observation into the waiting rooms is also poor and requires remedying, as they are ideal places for bullying to take place. This had been identified in an earlier report by HM Chief Inspector of Prisons. The Governor had submitted a bid for funding to improve the observation, which the investigator understands has been successful.
28. My investigator met one of the escort staff who was with the man at the time he died. He was not under restraint at the time of death. Staff observing him throughout the night had questioned the need for restraints with the day staff. The man had also been complaining to the staff about the use of the restraints. The officers demonstrated an appropriate level of care and concern for him when he was handcuffed in hospital by raising the matter with the establishment. At the same time, the Governor, who had returned to duty following the weekend, was briefed of the man's condition. Once his condition had become clear to him, he instructed that the handcuffs be removed with immediate effect. The Governor said that the weekend Duty Governor should have reviewed the use of restraints in consultation with medical advice. He has since issued new guidelines to his managers. This is welcomed.
29. My investigator discussed the concerns raised by the Consultant and the use of restraints with the Healthcare Manager. She described the man as being weak and dying and said that the use of the chain was in her opinion unnecessary. She did though acknowledge that it was the prison's responsibility to make the assessment. She gave an example of a man who attends hospital in a wheelchair and is so ill that he is not aware that the chain is on his wrist. My investigator raised this with the Governor and he will be seeking clarification of the circumstances. My investigator found on a recent visit to the prison that, since the investigation started, communication between the Security Department and Healthcare Department had improved, and that the views and concerns of the Healthcare staff are actively taken into consideration when making decisions regarding the need to handcuff a prisoner.
30. The prison records show that a risk assessment for the man's release on ROTL was being undertaken. However, he passed away before the licence was granted. The investigator discussed this with the Governor and he accepted that the process for ROTL should have been started earlier. He has since issued new instructions to his managers. This too is welcomed.
31. My investigator also examined the escort documentation and found that the Hospital Risk Assessment sheets entitled *In Charge* are not dated. This makes it difficult to audit the escort process.

The Governor and PCT should remind staff of the need to date entries on official documents.

32. My investigator met with the branch chairman of the POA, who raised no concerns regarding the care and treatment of prisoners. However, he did cite communication problems between the Healthcare Department and Detail Office. My investigator also met a member of the IMB who said that the smoking problems in the Healthcare Centre had been raised previously during meetings with the Governor. The board member supplied a written report to my investigator, dated 29 October 2004. The matter was raised with the Governor. The Governor responded in writing and said *There is no confirmatory evidence that the IMB did raise the matter with me at any meetings, and that the records of the issue being raised with and by the IMB are not frequent – one prisoner application in May 2003 and one rota visit report observation in August 2004.*

RECOMMENDATIONS

1. The Governor and PCT should review communication between external hospitals and prison.
2. The Governor should remind staff that clinical advice is sought from the PCT before any medical appointment is cancelled.
3. The Governor and PCT should seek to resolve the communication difficulties between the Healthcare Department and Detail Office.
4. The Governor should remind all patrol staff of the need to enter the waiting rooms and police the area appropriately.
5. The Governor and PCT should remind staff of the need to date entries on official documents.