Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Franks, a prisoner at HMP Wakefield, on 5 December 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Wayne Franks died on 5 December 2022, at HMP Wakefield. He was 47 years old. The cause of his death was heart disease and an enlarged heart, as well as a high level of dihydrocodeine that had not been prescribed to him. I offer my condolences to Mr Franks' family and friends.

The clinical reviewer concluded that Mr Franks' clinical care was reasonable and equivalent to that which he could have expected to receive in the community. However, there was no care plan in place to guide the management of his long-term hypertension and ensure the appropriate level of care.

The investigation could not establish how Mr Franks obtained illicit medication. However, I am satisfied that Wakefield is actively addressing the unsafe medication practices identified by HM Chief Inspector of Prisons and the Independent Monitoring Board, as well as the issues highlighted in this report.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. Mr Wayne Franks had been in prison since March 2003. On 5 May 2004, he was sentenced to life imprisonment for murder and served most of his sentence at HMP Wakefield.

2. Mr Franks was diagnosed with high blood pressure in 2014. His blood pressure and cholesterol levels were regularly monitored, and his medication adjusted.

3. Between 2004 and 2016, Mr Franks was thought to be involved in dealing and using illicit prescription medication, but there was no recent evidence of this.

4. On 21 January 2021, Mr Franks reported recurrent chest pains. Heart tracing tests were conducted that day as well as several times over the following months and the results were all normal.

5. In December 2021, Mr Franks' prescription for dihydrocodeine (an opioid painkiller) was changed from in-possession to supervised. From March 2022, it was gradually reduced and stopped, with ibuprofen and paracetamol prescribed as alternatives.

6. Just after 4.35pm on 5 December, a prisoner told a prison officer he was concerned about Mr Franks. The officer went into Mr Franks' cell and found him unresponsive. Staff were unable to revive him, and paramedics confirmed his death at 4.57pm.

7. The pathologist found a high level of dihydrocodeine in Mr Franks' blood, which contributed to his death. There were also traces of carbamazepine and galantamine, which had not been prescribed to him.

Findings

8. The clinical reviewer concluded that Mr Franks' clinical care was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, although his blood pressure was monitored regularly, there was no care plan in place to underpin the management of his long-term condition.

9. We do not know how Mr Franks obtained illicit medication, but we note that the prison has taken active steps to address weaknesses in safe prescribing systems, identified by HM Chief Inspector of Prisons and the Independent Monitoring Board.

Recommendations

- The Head of Healthcare should ensure that personalised care plans with aims, planned interventions and monitoring, are in place for all patients with long-term health conditions.

The Investigation Process

10. HMPPS notified us of Mr Franks' death on 5 December 2022.

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

12. The investigator obtained copies of relevant extracts from Mr Franks' prison and medical records. After notification of the cause of death, she spoke to the Head of Drug Strategy and Healthcare Provision.

13. NHS England commissioned a clinical reviewer to review Mr Franks' clinical care at the prison. The investigator and clinical reviewer jointly interviewed three healthcare staff on 2 February 2023.

14. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Franks' daughter to explain the investigation. She had no specific matters that she wanted us to consider.

16. We suspended our investigation in March 2023, pending the outcome of toxicology tests and receipt of the post-mortem report. We resumed the investigation in December 2023.

17. We sent a copy of our report to Mr Franks' daughter. She did not report any factual inaccuracies.

18. The initial report was shared with HMPPS. They found no factual inaccuracies.

Background Information

HMP Wakefield

19. HMP Wakefield is a high security prison, with an operational capacity of 750. Most of the men are serving either life or indeterminate sentences, or determinate sentences of over ten years. Practice Plus Group provides healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was in November 2022. Inspectors reported that there was an appropriate range of primary care services, but there were not enough clinical leads, so there were gaps in cardiology and respiratory diseases. Patients with long-term conditions received adequate care and were regularly invited for review, but inadequate staffing levels had affected outcomes in most areas of health provision and the majority of care plans were poor.

21. Inspectors noted that the pharmacy team monitored the prescription of medicines liable to be misused. However, medicines management was poor, oversight inadequate, and the transport and storage of some medication was not in line with safe standards.

Independent Monitoring Board

22. 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 2022, the IMB reported that primary care services had been accessible, with increased capacity to treat complex patients, but there had been periods of understaffing.

23. The Board found that the prison monitored and reviewed substance misuse and had implemented processes such as routine random prisoner testing. However, illicit drug use had remained constant, including the inappropriate use of prescribed medication. The healthcare provider was trying to implement safer prescribing.

Previous deaths at HMP Wakefield

24. Mr Franks was the 27th prisoner to die at Wakefield since December 2019. Twenty-three of the previous deaths were due to natural causes and three were self-inflicted. There have since been seven deaths, six due to natural causes and one self-inflicted. We have raised the issue of care plans for prisoners at Wakefield several times.

Key Events

25. Mr Wayne Franks was remanded to HMP Hull in March 2003. He was later convicted of murder and, on 5 May 2004, sentenced to life imprisonment, with a minimum period to serve of 20 years. Mr Franks served most of his sentence at HMP Wakefield, with a short transfer to Rampton Hospital in 2003/2004, and periods at other prisons between 24 April 2013 to 28 March 2014.

26. While at HMP Frankland in 2013/14, Mr Franks was diagnosed with high blood pressure. He also had longstanding mental health problems but did not fully engage with the mental health team.

27. Between 2004 and 2016, several security intelligence reports suggested that Mr Franks was involved in trading diverted prescribed medication, mostly supplying but occasionally as a user. He admitted to healthcare staff that he had often bought illicit medication.

2021/2022

28. On 11 January 2021, Mr Franks reported chest pains. Healthcare staff took an electrocardiogram (ECG – a test to record the electrical activity of the heart). The results of this, (and repeated ECGs in January, November and December) were normal.

29. On 21 January, a prison GP reviewed Mr Franks' medical records and noted a raised cholesterol level. She calculated a QRISK score which indicated that Mr Franks had a 10.76% risk of a heart attack, or stroke within ten years. (QRISK assesses the risk of developing cardiovascular disease. A score of less than 10% signifies low risk.) She requested an urgent review of Mr Franks' chest pain and blood tests, but there is no evidence that the latter was followed up.

30. Healthcare staff monitored Mr Franks' blood pressure regularly. He did not always comply with medical advice, such as requests for monitoring, attending appointments and taking medication.

31. On 10 December, an Advanced Nurse Practitioner (ANP) changed Mr Franks' dihydrocodeine prescription from 'in-possession' in his cell, to supervised dispensing, as it was a high-risk drug and often illicitly traded. He also noted that it should not be used long term and there was no reason for prolonged use in Mr Franks' case.

32. On 22 March 2022, the ANP started a gradual reduction of Mr Franks' dihydrocodeine, substituting ibuprofen and paracetamol.

33. On 7 November, the ANP held a general review with Mr Franks and prescribed alternative medications for high blood pressure and high cholesterol. Checks in late November and early December indicated that his blood pressure was within the acceptable range and his cholesterol level had reduced.

Events of 5 December

34. At midday on 5 December, an officer conducted the lunchtime roll checks on Mr Franks' landing, before prisoners' cells were locked. Mr Franks appeared to be asleep. The officer, who knew him well, said this was not unusual as Mr Franks slept for long periods during the day, especially around lunchtime.

35. Just after 4.35pm, a prisoner told an officer that he was concerned as he could not get a response from Mr Franks through his cell door. The officer went into the cell. There was no response when he called out to Mr Franks, so he touched his shoulder. It was cold and his lips were blue. The officer asked a colleague to radio a code blue (a medical emergency code which indicates a prisoner has difficulty breathing or is unresponsive) and an ambulance was requested at 4.39pm. Several other operational staff responded and began cardiopulmonary resuscitation.

36. Two nurses arrived and took over the resuscitation attempts, including use of a defibrillator, while waiting for the ambulance crew. An attempt to insert an airway failed, as Mr Franks' jaw was clenched.

37. Paramedics arrived at the cell at 4.57pm and confirmed Mr Franks' death.

Contact with Mr Franks' family

38. The prison's family liaison officer and a colleague went to the home of Mr Franks' daughter. They informed her of Mr Franks' death and offered support. The family liaison officer kept in touch over the following weeks.

39. The prison arranged and paid for Mr Franks' funeral.

Support for prisoners and staff

40. A prison manager and a custodial manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

41. The prison posted notices informing other staff and prisoners of Mr Franks' death and offering support.

Post-mortem report

42. The report of the post-mortem examination concluded that the cause of Mr Franks' death was ischaemic heart disease (blockage of the blood vessels supplying the heart), arising from coronary artery atheroma (fatty deposits) and cardiomegaly (enlarged heart) in the context of a high blood dihydrocodeine level.

43. Toxicology tests revealed the presence of dihydrocodeine, carbamazepine and galantamine. None of these drugs had not been prescribed to Mr Franks.

Findings

Clinical findings

44. The clinical reviewer concluded that Mr Franks' clinical care was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

Management of Mr Franks' hypertension

45. Although Mr Franks' blood pressure was monitored (with increased frequency in 2021/22), there was no hypertension care plan. The clinical reviewer noted that a care plan is the primary source of information to ensure that individual needs and goals are met. We agree that they are essential for effective management of long-term conditions. We recommend:

    The Head of Healthcare should ensure that personalised care plans with aims, planned interventions and monitoring, are in place for all patients with long-term health conditions.

Substance misuse and diversion of medication

46. Dihydrocodeine, found in Mr Franks' blood during toxicology tests, contributed to his death. Healthcare staff had stopped prescribing this to him in March 2022. We were unable to establish how Mr Franks obtained the drugs. He had previously traded and used illicit medication over a long period, but in recent years there was no evidence that he had been involved in such activity.

47. The Inspectorate and the IMB were critical of the safe management and inappropriate use of prescribed medication, respectively. There has since been a review of transporting medicines and issuing in-possession medications and more secure processes have been implemented.

48. The Head of Drug Strategy and Healthcare Provision told the investigator that in January 2023, the prison had formed a dedicated healthcare staffing group, to ensure consistency in healthcare-related operational tasks such as supervision of the inpatient unit, medication queues, clinics and hospital escorts. Medication dispensing is strictly supervised by the same group of experienced prison officers. Prisoners are not allowed to leave until the nurse is satisfied that the medication has been swallowed and, in the event of concerns, the officer is alerted and escorts the prisoner away to be searched. As a result, there had been a significant reduction in the trading of medication, which was no longer a widespread problem. Currently, the drugs of concern are mainly psychoactive substances. The drug strategy document is currently being updated.

49. Additionally, a dedicated nurse has reviewed all high-risk and tradeable medication prescribed to individual prisoners and made adjustments, where necessary. An example of this is that no prisoners at Wakefield are currently prescribed tramadol.

50. In view of the considerable steps taken to address concerns about the misuse of medication, we make no further comment.

Inquest

51. At an inquest held on 20 May 2024, the Coroner concluded that the Mr Franks' death was misadventure – a chronic heart condition in the context of high levels of dihydrocodeine which was illicitly obtained in the prison.

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