Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Timothy Frank, a prisoner at HMP Ranby, on 10 February 2025

A report by the Prisons and Probation Ombudsman

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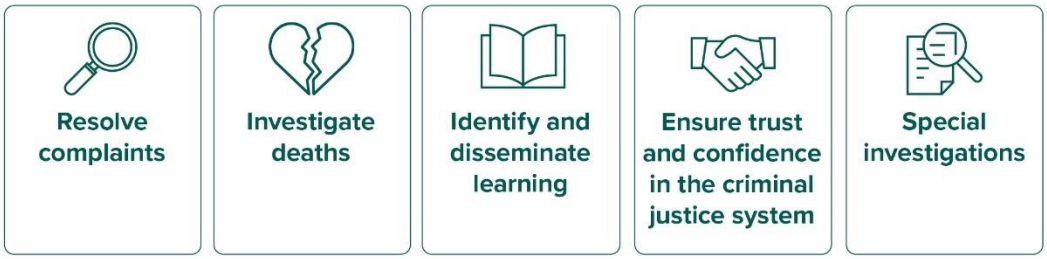
OUR VISION

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

1. 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.

2. 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.

3. In March 2008, Mr Timothy Frank was sentenced to life imprisonment, with a minimum tariff of 10 years, for wounding and other acts endangering life. He was sent to HMP Leicester.

4. In December 2019, Mr Frank was released from prison but in May 2022, he was recalled to prison after he was arrested and charged with assaulting another person. In August 2023, he was sentenced to 34 months in prison for wounding or inflicting grievous bodily harm.

5. Mr Frank died in hospital of Ischaemic heart disease on 10 February 2025 while a prisoner at HMP Ranby. He was 54 years old. We offer our condolences to Mr Frank's family and friends.

6. The Ombudsman's office wrote to Mr Frank's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They wanted to know if Mr Frank was prescribed any medication and whether he had a heart condition. These questions have been addressed in the clinical review.

7. NHS England commissioned an independent clinical reviewer, to review Mr Frank's clinical care at HMP Ranby. The clinical reviewer's report is attached as Annex 1.

8. The PPO investigator and the clinical reviewer completed two joint interviews on 14 April 2025. These are attached as Annex 2.

9. The clinical reviewer concluded that the clinical care Mr Frank received at Ranby was of not of the required standard and not equivalent to what he could have expected to receive in the community. She found that Mr Frank waited nearly three months for an appointment with the GP following abnormal blood results and healthcare staff were not able to take his blood pressure due to faulty equipment.

10. Mr Frank had hypertension, but he was not monitored regularly which led to inconsistency in his care and treatment. Mr Frank had his prescribed medication for hypertension in possession, despite concerns being raised about his adherence. The clinical reviewer found healthcare staff did not follow up with these concerns or check with Mr Frank. The clinical reviewer made two recommendations not related to Mr Frank's death that the Head of Healthcare will wish to address.

11. We make two recommendations relating to his death:

    - **The Head of Healthcare should ensure that if a prisoner has a medical condition, a care plan is put in place as soon as healthcare staff are made aware of this condition and it is updated on a regular basis.**

- **The Head of Healthcare should review the GP triage process to ensure prisoners are placed on the correct waitlist depending on their need.**

12. The investigator investigated the non-clinical issues relating to Mr Frank's care.

13. We did not find any non-clinical issues of concern.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

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

Adrian Usher
Prison and Probation Ombudsman **October 2025**

Inquest

16. At the inquest held on 6 January 2026 the coroner concluded Mr Timothy Franks died of natural causes.

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