

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Clayton, a prisoner at HMP Frankland, on 22 December 2024

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



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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 December 2017, Mr Douglas Clayton was sentenced to 18 years in prison for sexual offences. He died of bronchopneumonia on 22 December 2024, at HMP Frankland. He was 80 years old. We offer our condolences to Mr Clayton's family and friends.
4. The Ombudsman's office wrote to Mr Clayton's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Clayton's next of kin enquired about his leg ulcers and asked for a copy of our report. The next of kin's question has been addressed in the clinical review.
5. NHS England commissioned an independent clinical reviewer, to review Mr Clayton's clinical care at Frankland. The clinical reviewer's report is attached as Annex 1.
6. The PPO investigator and the clinical reviewer jointly interviewed three healthcare staff on 24 April 2025. The transcripts of the interviews are attached as Annex 2.
7. The clinical reviewer concluded that the clinical care Mr Clayton received at Frankland was not of the required standard and was partially equivalent to what he could have expected to receive in the community.
8. She found that although there were elements of good care, there was no evidence in Mr Clayton's medical records of a care coordinator to facilitate all his care needs, and although Mr Clayton was recorded as a complex case, there were no complex care notes in his medical records. The clinical reviewer also found that Mr Clayton's complex care plan had not been updated since March 2024, and his ReSPECT form that was activated in 2020, was not reviewed or updated during his time at Frankland. The clinical reviewer made recommendations not related to Mr Clayton's death that the Head of Healthcare will wish to address.
9. Ms Wallis investigated the non-clinical issues relating to Mr Clayton's care. We did not find any non-clinical issues of sufficient concern to warrant a recommendation.

Governor to note

10. The Managing Conveyance Policy Framework says that ambulance staff may bring patient devices (which include a laptop/pad containing medical applications) into a prison for the purpose of delivering clinical care. Ambulance staff are also permitted to enter the prison with mobile phones (both work and personal) to ensure their entry into the prison is not unduly delayed.

11. When the first set of paramedics arrived at the prison, it took 10 minutes for them to get from the prison gate to Mr Clayton because they were searched for technical devices. Although this did not affect the emergency care given to Mr Clayton, the ambulance crew could have arrived more promptly if prison staff had adhered to the policy.
12. The Safer Custody team told us that a mandatory search would have been conducted to ensure no unauthorised persons were on the vehicle and to ensure the ambulance staff had no personal mobile phones in possession as per their policy. However, according to Frankland's Escorting Vehicles Policy, ambulance paramedics should not be searched when entering the prison, and the policy is not clear about whether technical devices should be seized at the gate before entering the prison. We bring this matter to the Governor's attention.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
14. Mr Clayton's family received a copy of the initial report. They did not make any comments.

Adrian Usher
Prison and Probation Ombudsman

September 2025

Inquest

At the inquest held on 15 December 2025 the coroner concluded Mr Clayton died of natural causes.

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