

**Investigation into the circumstances surrounding the
death of a man
at HMP Frankland in May 2010**

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

February 2011

This is the report of an investigation into the death from natural causes of a man at HMP Frankland on 4 May 2010.

The man had not been in contact with his family for several years and, when asked about them by prison staff, he would say that he had no next of kin. Nevertheless, I offer my sympathy to all those touched by his death. I am sorry that my report has been delayed and hope that this had not caused any additional distress.

A clinical review of the man's care and treatment was undertaken by a registered mental health nurse, supported by a doctor, from the NHS County Durham Primary Care Trust. I am grateful to the clinical reviewer and the doctor for their assistance.

A post mortem examination confirmed the cause of death to be acute bronchopneumonia (a chest infection). The man had a complex history of mental and physical health problems and at times refused to go to prison healthcare and to outside hospital for necessary medical treatment.

The clinical reviewer concludes that the man received intensive nursing care of a high standard in Frankland, and comments that the nursing staff should be commended for the care and attention they gave the man.

I, too, note the care taken by the prison and healthcare staff when looking after the man. I would be grateful if the Governor and healthcare manager would share my report with all the staff and pass on my thanks for their patience and dedication towards the man.

I make one recommendation about checking the weight of prisoners who, like the man, are in poor health.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

The man had a difficult childhood and committed his first offence when he was 12 years old. In 1978, he was convicted of the murder of a fellow prisoner in the young offender institute where he was awaiting sentence for an earlier conviction. At the time of his death, the man had been either in prison or NHS secure hospitals continuously for 33 years.

The man had a history of mental illness (paranoid schizophrenia), from which he suffered intermittently throughout most of his life. He also had several physical health problems, including type 2 diabetes (non insulin dependent diabetes), deep vein thrombosis (blood clots in veins) and peripheral vascular disease (the blood did not reach the extremities of his body, resulting in the death of the body tissue). He also had a history of non compliance with medical treatment.

It was in 1996 that the man was diagnosed with type 2 diabetes. He was prescribed medication, but did not take it regularly. In early 2008, the man's toes became gangrenous and he required what was to be the first of a number of operations on his toes, feet and legs. Each time that treatment was proposed, the man accepted in principle the need, but would delay going into hospital, or discharge himself from hospital against medical advice.

Towards the end of 2009, the man was told that he needed an operation to remove his leg above the knee. Although he seemed to understand the consequences of not having surgical intervention, he refused to have the operation. The man told staff that he wanted to remain in prison, rather than hospital. In his final months he received intensive nursing care in Frankland's healthcare unit.

The man seems to have been a difficult and challenging patient for staff at Frankland. Nevertheless, as my report shows, I believe that they did all they could to make this time more comfortable for him and I consider that he received a high standard of care. I am satisfied that the care the man received was at least to a level expected in the community.

This report includes one recommendation with regard to prisoners on the chronic disease register receiving regular weight checks.

THE INVESTIGATION PROCESS

1. The Ombudsman's appointed investigator first visited HMP Frankland on 14 May 2010 when he met one of Frankland's managers, one of the nurses involved in the man's care and the principal officer in healthcare. The investigator also met a representative from Frankland's Independent Monitoring Board.
2. County Durham Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Frankland and I am grateful to the clinical reviewer and the GP advisor for their report.
3. The clinical reviewer spoke to the investigator at the start of the review and kept in regular contact throughout. The clinical reviewer examined the medical records, including those recorded on the computerised system, and made two visits to Frankland to familiarise himself with the practices and to interview staff. He also spoke with the consultant vascular surgeon at the local hospital who was responsible for the man's treatment in hospital.
4. Given the number of years that the man spent in custody, I have taken the decision not to investigate events over the whole of his sentence. I have focussed on the time that the man spent at Frankland, from when it was identified that he needed treatment, including an operation, for peripheral ischaemic vascular disease.

HMP FRANKLAND

5. HMP Frankland is one of eight high security establishments in England and Wales. Frankland holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. The operational capacity of the prison is 859.
6. Healthcare services at Frankland are provided by the County Durham Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two wards with capacity for three and four prisoners respectively and ten single rooms. The man lived in one of the single rooms for the last months of his life.
7. The most recent full inspection of Frankland by the Chief Inspector of Prisons, is dated February 2008, describes Frankland as “drifting” in some key areas, notably in relation to safety with a lack of evidence of a robust violence reduction strategy and effective staff-prisoner relationships.
8. In regard to the healthcare unit and caring for the health of prisoners, the report found that healthcare services were generally good although staffing levels were low. The in-patient unit was a positive environment and patients were well cared for, although a new day care centre to support mentally ill patients was much needed. There was excellent collaborative work between County Durham Primary Care Trust and the prison with prisoners able to access equitable NHS services while in prison.
9. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The Board’s report for the year from 2008 to 2009 does not raise any issues that are relevant to the circumstances of the man’s death.
10. The clinical reviewer found that Frankland is in the process of moving to a new system of recording healthcare information. The existing system in use at Frankland is known as EMIS. This is being replaced by a product known as “System One” which, I understand, the Prison Service is introducing in all prisons. This will provide for easier exchange of information when a prisoner moves between prisons. The clinical reviewer’s report highlights the need to ensure that all staff are fully trained to use System One.
11. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been 39 deaths attributed to natural causes at Frankland up to and including the man’s death. None of the issues arising in any of those cases are directly relevant to the circumstances surrounding the man’s death.

KEY EVENTS

12. The man was the youngest of five boys and also had nine older half-siblings from both of his parents' previous marriages. He described his childhood as difficult. He spent time in local authority residential care and, by the age of 14, was placed in a residential school. Following a conviction for assault occasioning actual bodily harm, the man was sentenced to three months in a young offenders institute (YOI).
13. While at the YOI, the man was involved jointly in a fatal attack on another young person. He was subsequently convicted of murder and sentenced to be detained at Her Majesty's pleasure¹. The trial judge described him as "not unintelligent". (The man has since been described by clinicians as having an IQ at the lower end of ordinary intellectual functioning.) He was 17 when he committed the offence. At the time he was awaiting sentencing for sexual offences and theft.
14. During the early years of the man's time in custody he spent time at several YOI's as well as time in NHS secure hospitals. In May 1988, the man was transferred to the acute psychiatric unit at HMP Grendon. He left Grendon in December 1991 and was unable to settle at a number of prisons before being moved to Frankland in January 1994. The prison records indicate that, throughout his time in prison, staff expressed concern regarding the man's mental health and his ability to comply with the regime. Towards the end of 1994, the man was diagnosed as suffering from mental illness (paranoid schizophrenia) and, in May 1995, transferred from prison to an NHS secure hospital.
15. In 1996, the man was diagnosed with type 2 diabetes (also known as non-insulin dependent diabetes mellitus). The diabetes was controlled by close dietary management and Metformin medication. He also had a history of deep vein thrombosis (formation of a blood clot in a deep vein) for which he was prescribed anti-coagulants (which stop the blood from clotting).
16. The man remained in a secure hospital until January 2001 when he transferred back to Frankland, following a change in his psychiatric diagnosis. He returned to a secure hospital between January 2003 and February 2004, returning to Frankland in March 2004. At the end of 2005 and in early 2006, the man was considered again for transfer to secure hospital but the clinical assessment was that he did not require further treatment in a secure hospital setting. Although the man's mental illness was assessed in 2007 as in remission, he was treated for paranoid schizophrenia (risperidone) right up until his death. The man had a life long history of obesity, and is reported to have been a heavy smoker from a young age.
17. In January 2008, in Frankland, the man complained of numbness in his toes. On 14 January, he was seen by one of Frankland's doctors who determined

¹ Being detained at Her Majesty's Pleasure is the sentence given to a person under 18 years of age who is convicted of an offence for which an adult would receive a mandatory life sentence (such as murder).

that he should be referred to a vascular clinic for assessment for suspected peripheral ischaemic vascular disease. He was seen by healthcare staff on a number of occasions during the following two weeks, although on one occasion, 24 January, he refused to go to healthcare for his feet to be assessed.

18. Following a visit to the vascular clinic at the local hospital on 29 January, a consultant general vascular surgeon telephoned the prison to say that he would admit the man for an amputation of a toe on the left foot and possibly further surgery. However, the man refused to consent to treatment, and, on 31 January, signed his own discharge from hospital, despite being told that lack of treatment might cause him to lose his leg.
19. On return to prison, the man refused to stay in healthcare and said this was because he could not smoke there. The policy on smoking in the healthcare centre of Frankland is the responsibility of County Durham Primary Care Trust. On 1 June 2007, a total ban of smoking was introduced anywhere in healthcare, including the inpatient area and garden. From 1 July 2007, Frankland became a no smoking prison, with the exception of prisoners being able to smoke in their own cells. Smoking cessation clinics are available at Frankland and prisoners are offered nicotine replacement therapy.
20. The man was offered nicotine products to help give up smoking, but he declined. The doctor from the prison that recommended he should be referred to a vascular clinic liaised with the surgeon on the treatment he advised, which was flucloxacillin and sodium fusidate medication (used to treat infections). A mental health capacity test was undertaken on 1 February². The man was shown to understand the consequences of his decision to refuse treatment. He told a nurse, that he found the local hospital environment stressful due to being handcuffed to prison staff³ when nurses were giving personal care, and this led to him discharging himself.
21. The man had regular consultations with the doctors in Frankland over the following few months. The doctor who recommended referral to the vascular clinic examined the man on 4 February and confirmed that he was accepting his medication. When Frankland's medical officer (the doctor in charge) reviewed the man on 3 March, he warned him of the risk of refusing surgical intervention. The man continued to receive his medication for paranoid schizophrenia by the depot method and his mental state remained stable. (Depot is the method of administering the medication by injection to guarantee compliance.)

² The Mental Capacity Act 2005 requires that a person must be given appropriate help and support to enable them to make their own decisions or to maximise their participation in any decision making process.

³ If a prisoner is admitted to outside hospital, depending on the risk assessment carried out by the prison, they are generally escorted by two officers who stay beside their bed at all times. Two or three daily shifts of officers will stay with the prisoner until treatment is completed. In addition restraints, such as handcuffs, may be used.

22. When the man consulted another of Frankland's doctors in early June he said that his toes, which were gangrenous, were causing him pain. He agreed to be admitted to hospital and was referred to the consultant general vascular surgeon at the local hospital. On 12 June, the great (big) and the small toe of his left foot were amputated. On return from hospital the man spent a week in Frankland's healthcare centre before asking to return to the wing so that he could smoke. The medical officer from Frankland agreed to him returning to the wing for 24 hours for that purpose.
23. The clinical record shows that in the following months the man was regularly reviewed by healthcare staff to have the dressing on his foot changed, for injecting his medication, and monitoring his diabetes. When assessed on 23 October, the small toe was noted to be 98 percent healed and the great toe was 20 percent slough (dead body tissue). The record notes the occasions when the man failed to go to medical appointments. On 8 January 2009, he refused to attend the consultant general vascular surgeon's clinic in Frankland for blood tests (periodically the surgeon held a clinic in the prison), and on 12 January he refused to go to a medical review. When asked why he failed to attend, on each occasion the man said he "couldn't be bothered". When he was reviewed on 17 January by a nurse, it was noted he had replaced the dressing on his foot with a milk and bread poultice (a homemade dressing).
24. In February 2009, the man told a nurse that he was very worried about the big toe area on his left foot which he found very painful. He was examined by another of Frankland's doctors, who prescribed oral antibiotics and referred him to the consultant general vascular surgeon.
25. The consultant general vascular surgeon reviewed the man on 11 March and decided that he should be admitted to hospital for surgery. The man went into the local hospital on 13 March where preparation for further surgery was started by first taking action to stabilise his diabetes. Two days after admission to hospital, the man discharged himself against medical advice.
26. On 6 May, at the consultant general vascular surgeon's clinic at Frankland, the man agreed to be readmitted to hospital. He was admitted to the local hospital on 8 May and two days later his right forefoot was amputated. On 15 May, he once again discharged himself from hospital against medical advice and returned to Frankland's healthcare centre. Nine days later, on 24 May, he discharged himself from healthcare despite being advised that it would be beneficial to his recovery to remain there.
27. On 4 June, he was readmitted to healthcare suffering from pain where the great toe of his left foot had been amputated. The man was given appropriate treatment but, on 8 June, he refused further help and to remain in healthcare.
28. A multidisciplinary case conference was held on 12 August at which the medication prescribed to the man was reviewed. He continued to be prescribed Metformin (for diabetes) and risperidone (for schizophrenia), as well as aspirin and antibiotics on an intermittent basis. The record of the meeting notes that there were no concerns about the man's mental state

which was assessed as stable. (The record does not include any further detail of the meeting.)

29. On 11 September, the man refused an appointment to attend healthcare to see the consultant general vascular surgeon even though an officer offered to take him there in a wheelchair. He also refused to see the surgeon when the consultant went to the wing where the man lived. The surgeon told the staff that, if they had any further concerns, the man should be admitted to the local hospital as an emergency.
30. Ten days later, on 21 September, the man told the healthcare senior officer, that he was willing to see the consultant general vascular surgeon. She noted in the medical record that she believed he was frightened due to the pain, discomfort and general deterioration he was experiencing. The man had begun to suffer loss of bladder control the previous week, and now spent the daytime sitting in a chair. He declined the offer to be admitted to healthcare. He was admitted to the local hospital on 24 September, but discharged himself on the same day.
31. On 30 September, the County Durham Wheelchair Service agreed to supply a wheelchair for the man, which was delivered to Frankland on 3 October. On the same day (3 October) staff on the wing raised concerns with healthcare staff about the man's personal hygiene. Staff were taking his meals to him as his hygiene problems were affecting other prisoners.
32. An appointment was made for the man to see a doctor on 5 October, but he refused to attend. The staff on the wing considered it necessary for him to be admitted to the healthcare wing as his wounds were weeping freely and he was incontinent of urine. He also now required nursing intervention on a daily basis. In addition, he had not been complying with any of the suggestions to help him, such as spending time out of his wheelchair where he now remained day and night. The man told a registered mental health nurse, that he felt his mental state had deteriorated because of what the other prisoners said about him. The clinical record noted that the man "is already under the care of the mental health team and a member of staff is to have him reassessed further". There is no record of whether the assessment took place.
33. The man was admitted to healthcare on 5 October, though he went reluctantly. He initially declined the offer to wear a nicotine patch to help him stop smoking.
34. Another of Frankland's doctors reviewed the man on 6 October. The clinical record noted that the doctor had a 'frank' discussion with him about the consequences of refusing medical intervention. The man told her he believed he would be worse off having further treatment in hospital, but agreed to be admitted to hospital for surgery.

35. The local hospital confirmed on 8 October that a bed was available on the surgical admissions ward. However, the man was not taken to hospital as no staff were available to escort him.
36. Following further deterioration in the man's condition, the doctor that examined him in February and gave him oral antibiotics decided on 14 October that he should be taken to accident and emergency at the local hospital as an urgent GP admission. In his letter to the hospital the doctor reported that the man "admitted to being frightened about the future consequences of further treatment". He also noted that the man was "now generally unwell with nausea and vomiting and increased pain in his leg". Two days after admission, on 16 October, the man discharged himself against medical advice. He had been told that he would need an above knee amputation which he did not want.
37. The medical record on 17 November, states that the man "continues to want to stop smoking however finding [nicotine] patches unsuitable therefore will try inhalator". (The medical record does not record the date on which a nicotine patch was provided.)
38. On 8 December, one of the health support staff observed that the man looked unwell. He appeared confused and his lips were dry. She noted that he was taking little food or fluid. He declined to drink tea or to lie down to relieve the pressure on his buttocks. Separately another of Frankland's doctors saw the man and determined that he needed to go to hospital for treatment as an emergency admission. A staff nurse explained the consequences of not going to hospital and told him that there was a strong possibility that he could die if his gangrene was left untreated. The man continued to refuse to go to hospital. The clinical record noted that the staff satisfied themselves that the man had been given sufficient information and had the capacity to make an informed decision.
39. The following day, 9 December, Frankland's medical officer told the man that he could become dangerously ill because of his high potassium level. The doctor said that the prison healthcare did not have the facilities to treat his condition. The man said he would agree to go to hospital if he could be allowed to smoke three cigarettes. He was not allowed to smoke in the healthcare centre and staff were unsuccessful in finding a vacant cell on the wings where the man could smoke. Staff continued their efforts to persuade the man to go to hospital, and he agreed. He was admitted to accident and emergency of the local hospital on 9 December as an urgent GP admission.
40. During his stay in hospital, the man was diagnosed with tachycardia (accelerated heart rate) and given intravenous antibiotics. (Antibiotics administered intravenously results in a more rapid effect.) He was discharged back to Frankland on 22 December.
41. On 30 December, the man was assessed for a hoist to help him get in and out of bed and a pressure relieving cushion for a chair. Healthcare staff gave bed

baths (as he continued to be incontinent) and the wound dressing on his foot was changed regularly.

42. A consultant psychiatrist saw the man on 7 January 2010 and changed the administration of the medication for his paranoid schizophrenia from the depot injection to an oral form. This was because the deterioration in his physical state meant that it was no longer possible to give an injection.
43. On 27 January, the man was seen by Frankland's medical officer who noted a general deterioration in his health. The man said he was unable to swallow solid food and so soft foods and food supplement drinks were provided. The medical officer referred him to the consultant general vascular surgeon who told him that, in view of the deteriorating condition, he needed to be admitted to hospital. On 29 January, he was admitted to the local hospital for possible surgery on his leg.
44. During the following week the man remained stable in hospital while a decision on surgery was being considered. On 8 February, he discharged himself from hospital despite being warned that such action might result in further deterioration of his health. On return to Frankland, the man told an officer that he knew the consequences of his action and said "I will die". That evening, he refused medication. The officer told my investigator that he had asked the man about his next of kin and was told he had no one who should be contacted. (His mother died in 1976. His father, who had visited him on a fortnightly basis until his own death, had died in 1989. Other members of the family did not visit and, in recent years, he received neither visits nor letters.)
45. Over the next few days the man refused food but took a little fluid of milk and water. On 15 February, he again refused his medication and also declined any help with his personal care. (The staff had continued to assist him with personal care as he had become doubly incontinent.)
46. On 22 February, Frankland's medical officer told the man that he might die if he did not accept medical intervention. The man said he would not attend an out patient appointment for an MRI scan (which visualises a detailed internal structure of the body) which had been arranged for him.
47. The consultant general vascular surgeon saw the man on 17 March and noted that he was continuing to refuse food, losing weight, and his leg ulcers had worsened. The consultant recorded "[he] is markedly deteriorating". The following day, a mental capacity test was undertaken by the doctor who had initially examined him in February and prescribed him oral antibiotics, along with a Registered General Nurse (RGN) who was the clinical team leader and another RGN. A palliative care Macmillan nurse was also present. (Macmillan nurses provide specialist advice and support for people who are near the end of their lives.) The man was offered information about his condition but did not want to discuss anything and declined any further management or treatment and transfer to hospital. The clinical record noted that he fully understood the seriousness of his medical condition, that he knew he would die if he refused treatment, and was able to retain the information

given to him and convey it back. The man said that the consultant general vascular surgeon had told him he would die without treatment and the man knew that he “would not make it without treatment”. The officer he spoke to on his return to Frankland and the RGN who was the clinical team leader reported that they had asked the prisoners on the man’s wing about visiting him in the healthcare centre but none of them wished to do so.

48. The doctor who had previously reviewed him on the 6 October saw the man on 26 March and noted that he was gaunt and sallow and continuing to lose weight. The following day, he was seen by Frankland’s medical officer who arranged an emergency admission to the local hospital. At the local hospital he was told that he should have an amputation of part of his leg and was taken on the surgical admissions ward.
49. On 29 March, the man discharged himself from the local hospital against the counselling and advice of hospital staff. On his return to healthcare at Frankland, he told the doctor he had most recently seen that he appreciated the risk that the deterioration in his condition could result in death unless treated, but he still did not want to return to hospital. The consultant general vascular surgeon also saw him and noted he was continuing to refuse food, losing weight and that his health was deteriorating. His psychiatric state was assessed as reasonable. Frankland’s medical officer and the consultant general vascular surgeon discussed whether to use a nasogastric feed (using a tube passed down the nose into the stomach to feed) but it was not felt to be a viable option in a prison setting. They agreed that the man should be placed on the end of life pathway. (The purpose of the pathway is to access high quality care for people approaching the end of life.)
50. The doctor he had seen last saw the man on 30 March and explained the risk that deterioration in his condition would result in death. The man repeated that he understood the risk but did not want to go to hospital.
51. Another doctor saw the man the next day, 31 March. The man said he was receiving adequate pain relief and did not need any further medical management. The clinical record states “[mental] capacity has been assessed by nursing staff and found to be present”. The clinical team leader contacted the Macmillan nurse the man had seen previously, who agreed to provide a palliative care plan.
52. A palliative care plan meeting took place on 1 April between the doctor who first saw him in February and prescribed oral antibiotics, the clinical team leader and the palliative care Macmillan nurse. The man was present, alert and responsive, though fatigued and unwell. He was told about the options for further treatment, and transfer to hospital but said that he did not want intervention, such as a blood transfusion. With regard to his recent self discharge from the local hospital, he said that his preferred place of care was in prison. He signed a “Not for Resuscitation” document and said that everything is “just being too much”. He asked for a cigarette and became agitated when he was not allowed to smoke. It was agreed the healthcare team would review him every day.

53. The man was visited by the Roman Catholic chaplain on 2 April who gave him Holy Communion. The chaplain reported that the man both appeared, and stated, that he felt more relaxed and at peace afterwards.
54. Between 2 April and 4 May the man was seen each day by healthcare staff who administered his medication, gave him oral fluids and regularly changed his clothes and provided personal care. There were occasions when he declined any help from nursing staff, and refused to take liquids. He had been scheduled to go to hospital on 14 April for a gastroscopy (a procedure that visualises the upper part of the gastrointestinal tract) but refused to go. In addition, the doctor who initially saw him in February considered that he was not well enough to travel. An appointment to see the doctor on 22 April was cancelled with the doctor's agreement as the man was too poorly to go to the surgery. On 23 April, a "dynamic overlay mattress" was delivered to the prison and the following day a nimbus mattress was placed on the base of the bed to make sleeping more comfortable for the man.
55. At about 2.00am on 4 May the man was given his usual medication. He was checked by staff two hours later at 4.00am when he appeared to be comfortable. At 4.40am, a staff nurse made a routine check of prisoners and saw the man lying on the floor. The nurse went into the room with another staff nurse and on checking the man, found no apparent signs of life (no sign of breathing and no pulse). An emergency ambulance was called, which arrived at 5.15am. The staff nurse who found the man also called an out of hours doctor who examined him and confirmed death. The Macmillan nurse was also informed.
56. The police attended Frankland and found nothing suspicious about the death. A post mortem examination, made at the request of the coroner, revealed the cause of death to be acute bronchopneumonia (chest infection). The pathologist noted that Type 2 diabetes was known to hasten peripheral vascular disease (of which gangrene and ulcers are ultimately complications) and should be regarded as having contributed to the man's death.

ISSUES

The length of time the man served in custody

57. The man was sentenced in November 1978 to be detained at Her Majesty's Pleasure with a minimum term to be served of 12 years and one day. The term to be served was reached on 19 April 1990. After that date he was eligible to have his case for release considered by the Parole Board. (The Parole Board is responsible for the release of prisoners serving a life sentence, or sentence equivalent to a life sentence. A case cannot be referred to the Board until a prisoner has served the minimum term. The Board is empowered to direct release if satisfied that it is no longer necessary for the protection of the public that the individual should remain in prison.) The man also spent periods in NHS secure hospitals. Prisoners are not eligible to apply to the Parole Board whilst in a secure hospital.
58. The man's case was considered by the Parole Board in September 2004 and they decided not to direct his release from prison. The Board accepted the view given to them by a clinician that the man was not ready for release and should be rehabilitated through the health service system. From 1995 to February 2004, the man spent considerable periods in NHS secure hospitals being treated for his mental illness. He was again considered for transfer in late 2005 and early 2006 but was not transferred. The Parole Board last looked at the man's case in 2009 when it decided that it was not safe to direct his release from prison or to recommend that he should be moved to conditions of less security (Frankland is a high security prison). The grounds for their decision was that the man had not completed offending behaviour work and further work was required to address areas of risk. I am satisfied that proper consideration was given to whether he could be released and that the appropriate decision was made.

The man's refusal of medical intervention

59. The doctors at Frankland referred the man for medical treatment to the local hospital on six separate occasions between January 2008 and his death in May 2010. On five of those admissions, the man discharged himself from hospital. The clinical record shows that the man was warned three times by hospital staff about the consequences of refusing medical treatment. He signed a disclaimer to confirm that he understood what he was doing. The reasons which the man gave for discharging himself included that he felt stressed about receiving personal care whilst handcuffed to prison officers and that the hospital had made him sit around and were "mucking him around". He also said he was frightened about further treatment. When told that an above the knee operation was required, he told medical staff that he did not want the operation.
60. In the same period the man discharged himself four times from the healthcare centre at Frankland. The clinical record shows that he was warned each time of the consequences and signed a disclaimer to that effect. The reason why he discharged himself is recorded on one occasion, this was because he

could not smoke there. It also is apparent that, on some of the occasions when he refused to go to healthcare, it was also because he could not smoke there.

61. The clinical reviewer considers whether anything more could have been done by prison staff to make the man accept treatment. He finds that the man had received repeated counselling that he would die without further surgical intervention. He also comments that the man was mentally stable during the last two years of his life and continued to receive appropriate psychiatric treatment and oversight up until his death. The clinical reviewer concludes:

“It is clear from the records, and interviews with staff, that [the man] was very much aware of the consequences of not having treatment ... [and] there is no doubt that [he] had the capacity to make his own decision about his future”.

62. After so many years in prison and secure hospitals, I can understand that the man may well have been reluctant to leave what was a familiar environment. Smoking seems to have been an important consideration but I believe that Frankland’s staff attempted to meet his needs.

The man’s weight loss

63. It is evident from the medical records that the man had experienced severe weight loss prior to the start of the deterioration in his health in 2008. The clinical reviewer reports that when the man returned to Frankland from an NHS secure hospital in March 2004, he weighed 133kg. Ten months later, in January 2005 he weighed 146kg. But by March 2008, his weight had fallen to 79kg. The clinical reviewer concludes that the significant weight loss is consistent with, and probably due to, the man’s non compliance with the treatment for diabetes.
64. The clinical reviewer also highlights that he was unable to find a record of the man’s weight between January 2005 and March 2008. He is unable to say whether this is because the man was not weighed or because he refusal to attend diabetic reviews. The clinical reviewer adds that not all the records were available when he researched this issue as they were being archived in connection with the move to the new electronic recording system.
65. The clinical reviewer has recommended that the Head of Healthcare ensure that prisoners on the chronic disease register have a regular weight check. I endorse this recommendation.

The Head of Healthcare should ensure that prisoners on the chronic disease register have a regular weight check and that this is recorded in the prisoner’s medical record.

Use of restraints

66. The man told the staff at Frankland that he did not like being handcuffed to prison staff when he was in hospital and whilst nurses were attending to his personal care. A risk assessment is always made when prisoners attend hospital appointments. This determines the level of escort and the restraints (handcuffs) required for the safe custody of the prisoner. Restraints are applied if the risk assessment states that they are necessary, and prison staff are allocated to escort the prisoner. The risk assessment considers the prisoner's medical condition, their behaviour in prison, the nature of the offence, any risk to the public and hospital staff, the prisoner's motivation to escape, and the physical security of the hospital.
67. Following the risk assessment on the man, staff at Frankland decided that restraints should be used. It is unfortunate that he felt so concerned about being handcuffed that it affected his decision whether or not to accept treatment in hospital. However, given the man's history, I believe that the correct decision was made and the restraints were appropriate.

Clinical care

68. The man's clinical care was compromised by his frequent lack of co-operation with treatment. Nevertheless, he received extensive and detailed care. It included regular medical reviews including revisions of his medication, timely referrals to a consultant vascular surgeon, and engagement of the Macmillan palliative care team at the appropriate time.
69. There was one occasion when the man missed a hospital appointment because of a lack of staff available to escort him. Whilst there is no suggestion that this affected his care, the Governor will wish to satisfy himself about the adequacy of arrangements for provision of escorting staff.

CONCLUSION

70. The man had lived in prison and NHS secure hospitals continuously since the age of 16. He had complex physical and mental health needs. Whilst he accepted some surgical intervention, he had a history of refusing medical treatment. In 2009, when he was told that he would need an amputation of a leg above the knee, he refused any further surgery despite knowing that his decision would probably lead to his death.
71. I am satisfied that the man was fully aware of the consequences of his decision to refuse this treatment. I am also satisfied that he was cared for appropriately and with compassion by wing, healthcare and chaplaincy staff at Frankland.

RECOMMENDATION

1. The Head of Healthcare should ensure that prisoners on the chronic disease register have a regular weight check and that this is recorded in the prisoner's medical record.

Response from Service: Recommendation accepted. Healthcare have now moved IT systems to Systemone with clinical templates for all Long Term conditions. Within these templates are requirements for regular weight checks and dietary advice. These are now fully operational.