# Investigation into the death of a man, in May 2011, whilst in the custody of HMP Frankland

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

**December 2011**

This is a report into the death of a man whilst in the custody of HMP Frankland. A post mortem showed that he died from “pressure on the neck due to hanging”.

I offer my sincere condolences to the man’s family and friends for their loss. One of my Family Liaison officers contacted the man's partner to inform her about the investigation and to provide her with an opportunity to raise any issues about the care the man received in custody.

The investigation was carried out by my one of my investigators. Both he and I would like to thank the Governor and his staff, particularly the Head of Business Unit, for their co-operation during the course of our enquiries.

Throughout his time in custody the man did not appear to have any mental health problems nor did he give any indication that he was intending to harm himself. There were no notes found in his cell at the time of his death. I have found no evidence to suggest that Frankland could have reasonably prevented the man’s death.

The clinical care that the man received whilst in custody was also reviewed. I would like to thank County Durham and Darlington Primary Care Trust for appointing the clinical reviewer to review the man’s clinical care. The review shows that the man received a high standard of care whilst in custody that was equitable to that which he could have expected in the community.

I make no recommendations but do recognise the best practice of the family liaison officers and the emergency response by staff.

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

**Thea Walton**
**Acting Deputy Ombudsman** **December 2011**

**CONTENTS**

## SUMMARY

1. The man was born in March, had a partner and prior to entering custody lived in the Greater Manchester area. The man had a history of pain from an old injury to his jaw for which he was prescribed pain relief and was prescribed cream for psoriasis on his hands. He was a smoker but had no other physical or known mental health problems.

2. The man was remanded into custody at HMP Forest Bank on 28 September 2006. He was convicted on 3 September 2007 and given indeterminate life sentence to serve a minimum of six and a half years before parole could be considered. The man transferred to HMP Frankland on 8 November 2007.

3. During his time at Frankland the man had contact with healthcare staff for pain relief for his jaw, cream to treat his psoriasis, dental work and smoking cessation. The discipline and workshop staff did not have any concerns about him whilst he was at the prison.

4. The man gave no indication that he intended to take his own life, and did not share any worries or concerns with healthcare or discipline staff.

5. At 5.45am on the day the man died he was found hanging in his cell and emergency medical assistance was called. Healthcare staff began cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over his care. The paramedics confirmed that the man had died at 6.09am.

6. Frankland followed the requirements of Prison Service Order 2710 'Follow up to death in custody' by maintaining contact with the man's partner, providing support and offering assistance towards the cost of the funeral.

7. It is the clinical reviewer's opinion that the healthcare and attention the man received at Frankland was equitable to that which he could have expected to receive in the community.

8. I make no recommendations but do recognise the speed and professionalism of the staff who responded to the emergency situation and the best practice shown by the prison family liaison staff in contacting the man's family.

## THE INVESTIGATION PROCESS

9. The investigation was opened on 16 May 2011 when one of my investigators, issued notices announcing the investigation to staff and prisoners and inviting anyone with any information relevant to the investigation to contact him. One prisoner came forward as a result.

10. The investigator visited HMP Frankland on 18 May 2011. During his visit he was given copies of all documentation relating to the man and visited the cell he occupied. The investigator also met a member from the, Independent Monitoring Board (IMB) member (IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained) who confirmed that this was not the man's first time in prison, that he had not sought any help from the IMB and that he had not undertaken any courses to address his offending behaviour.

11. The investigator returned to Frankland on the 21 and 22 June 2011 and interviewed six members of staff and one prisoner. The investigator provided written feedback on the initial findings to the Governor on 28 June 2011.

12. County Durham and Darlington Primary Care Trust appointed the clinical reviewer to review the man's clinical care. My investigator and the clinical reviewer discussed aspects of the man's treatment at Frankland. I am grateful to the clinical reviewer for his timely and considered report.

13. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

14. A member of my family liaison officers contacted the man's partner to inform her about the investigation and to invite her to ask any questions or raise any concerns about the care the man received in prison. The man's partner said she had no issues or concerns that she wished the investigator to consider.

## HMP FRANKLAND

15. HMP Frankland is one of eight high security establishments in England and Wales. Frankland holds convicted category A (maximum security) and B (high risk) adult male prisoners, and also holds high risk remand prisoners. The operational capacity of the prison is 859.

16. 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. Two of these single rooms are equipped to infection control standard (UPVC clad walls, anti-slip flooring, hospital bed with specialised mattress and pillows).

17. The most recent inspection of Frankland by HM Chief Inspector of Prisons was conducted in November 2010, and the report says:

> "On our last inspection, we identified a number of concerns, principally with regard to safety arrangements. Commendably, on our return for this unannounced follow-up inspection, we found that there had been significant improvement and outcomes were now reasonable against all four of the Inspectorate's tests of a healthy prison: safety, respect, purposeful activity and resettlement.
>
> "Sentence planning was much improved, with good offender management, up to date assessments and an impressive range of interventions. The support to maintain family ties and to address substance abuse was satisfactory. However, the reducing reoffending strategy needed to be informed by an up to date needs analysis and the demand for offending behaviour programmes still outstripped supply.
>
> "Frankland has both expanded and improved since our last visit. It now houses more serious offenders than any other prison in the country, but does so in an environment which is essentially safe, decent and purposeful. It also places an appropriate focus on reducing the multiple risks and needs that these prisoners pose. There are, inevitably, a number of areas where we consider further progress is required, but staff and managers are to be commended on what has so far been achieved."

18. All prisons in England and Wales have an Independent Monitoring Board. Members are unpaid volunteers from the community appointed by the Secretary of State for Justice. They 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 2009 to 2010 does not raise any issues that are relevant to the circumstances of the man's death.

### Assessment, Care in Custody and Teamwork

19. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – 'Suicide

prevention and self-harm management' details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. Any member of staff who is concerned about a prisoner can start the ACCT process by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.

20. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

**Indeterminate sentences**

21. An indeterminate sentence is a sentence, where a minimum tariff is given, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner's risk factors are identified by psychological assessments and they are required to complete prison courses that might help to reduce their risk and improve their chances of being considered for parole.

**Previous deaths at Frankland**

22. Since my office took over responsibility for investigating all deaths in prison custody in 2004, there have been four apparently self inflicted deaths at Frankland up to and including the man's death. None of the issues arising in any of those other cases are directly relevant to the circumstances surrounding the man's death.

## KEY EVENTS

23. The man was born in March, lived with his partner in the Greater Manchester area, and had a criminal record which had resulted in previous custodial sentences.

24. On 28 September 2006 the man was remanded into custody at HMP Forest Bank for robbery with a weapon. He remained at Forest Bank until he was convicted on 3 September 2007 and given an indeterminate life sentence to serve a minimum of six and a half years before parole could be considered. The man remained at Forest Bank until he was transferred to HMP Frankland on 8 November 2007.

25. When the man arrived at Frankland, a nurse conducted a routine healthscreen check. The nurse recorded the man's height and weight, he was a smoker and his blood pressure was 127/83 (which was within the normal range for blood pressure). (A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.)

26. The man told the nurse that he had no history of drug or alcohol abuse, did not have any mental health history and had never been prescribed antidepressants. He also said that he had no other illnesses and never had any thoughts of self harm. The nurse assessed that the man was fit for normal location, employment and the gym.

27. In the four years from that initial assessment up to the day of his death, the man had a total of 63 interventions with healthcare staff which included appointments with prison doctors, nurses, the dentist and smoking cessation advisers. The man never raised any concerns outside of his physical health needs and his mental health was never recorded as an issue.

28. From June 2008 prison doctors prescribed the man Donovex cream on a repeat prescription for psoriasis (a skin condition which results from abnormal activity of the body's immune system) on his hands and pain relief as he experienced discomfort from an injury to his jaw for which he had surgery in 2006.

29. Prison Dr A, referred the man to the maxillofacial surgeon (specialist in facial injuries) at the Sunderland Royal Hospital for a specialist assessment of his jaw on 18 March 2009. However the man refused to attend the appointment arranged for 17 June 2009 and signed a disclaimer which stated:

> "I understand that my refusal to attend this appointment may result my name being taken off the waiting list."

30. Prison Dr B made a second referral to the maxillofacial consultant on 15 October 2009, but again on the day of the appointment, 2 December 2009, the man refused to attend as he wished to see his case worker and signed another disclaimer. The man gave no indication to healthcare staff that there was any other reason in refusing to attend the appointment and it was not considered a

mental health issue. Following this failure to attend the scheduled appointment the hospital removed the man from the waiting list.

31. The man was encouraged by healthcare staff to start smoking cessation sessions in June 2008 and January 2010. On both occasions he tried nicotine replacement therapy for a period of four weeks but returned to smoking cigarettes.

32. On 11 June 2010, the man saw prison Dr A as he complained that the psoriasis on his hands had become worse. The doctor prescribed aqueous cream and liquid paraffin shower gel (to help reduce skin dryness associated with skin conditions) in addition to the Donovex.

33. Six days later staff on the wing referred the man to healthcare as he complained of chest pain. Nurse A saw the man at 1.41pm and recorded his blood pressure as 126/88 (within normal limits). He told the nurse that he had pain in the centre of his chest that went around to his back but had no pain in his arms. The nurse then conducted an electrocardiography (ECG) (interpretation of the electrical activity of the heart) and the results showed no abnormal activity. Forty minutes later Nurse B took the man's blood pressure again and it was 120/75 (still within normal limits).

34. In the months that followed the man continued to have prescribed pain relief for his jaw and cream for his psoriasis which was reviewed on a regular basis by prison doctors. There were no concerns recorded regarding his mental health.

35. On the 19 October a Sentence Planning and Review Meeting was held at Frankland to consider the man's sentence progression. At this meeting it was explained to the man that he needed to take part in specified offending behaviour programmes (rehabilitation programmes designed to identify the reasons for offending and reduce and monitor these) before he could be considered for any transfer to a lower category prison. The man agreed to have his name added to the waiting list participate in the Thinking Skills Programme, which it was hoped he would have completed within 12 months.

36. The man was employed in the prison workshops, latterly in the upholstery workshop. The workshop instructor told my investigator that the man worked directly under his supervision and that he found him to be hardworking, personable with a good sense of humour. He went on to say that the man was never a problem for staff and got on well with other prisoners during his time in the workshop. He added that at no time did the man appear depressed in anyway or gave indication whatsoever that he had any intention of harming himself.

37. The man's personal officer (personal officers are the first point of contact for a prisoner) said at interview that he had first known the man in 1994 when he had been at Frankland serving a previous custodial sentence. The officer described the man as a likeable prisoner who did not present staff with any problems who got on well with his fellow prisoners. The officer appears to have been an attentive personal officer, updating the man's prison computer records on a

regular basis noting his attendance in the workshops, his interaction with other prisoners and visits from his partner. There were no concerns raised about the man, and the last recorded visit made by his partner was on 5 April 2011.

38. The man's personal officer said that at no point since the man's arrival at Frankland in 2007 had he been assessed as being at risk and placed on ACCT support.

39. The man's personal officer did say that the man previously had a history of being in debt to other prisoners. This was because he borrowed items from other prisoners, such as tins of food, toiletries or tobacco, and, as was usual practice amongst prisoners, was then required to pay back two items (a form of interest). The officer said that from the time of his transfer to D Wing on 4 November 2010, and in the months leading up to his death, the man was not known to be in debt to other prisoners on the wing.

40. Senior Officer (SO) A confirmed at interview that the man had not caused staff any problems and had never been placed on ACCT support throughout his time in custody.

41. When asked by the investigator how the man appeared in the days leading up to his death both the man's personal officer and SO A said that he appeared his usual self, in good spirits, enjoying banter with staff and prisoner's alike. On the evening immediately prior to his death the man had been out on evening association talking to his peers and staff about Manchester United and was looking forward to the Champions League Final. He had given absolutely no indication of being troubled or of having any thoughts of self harm.

42. At interview a fellow prisoner said that he thought that the man had received some bad news from a telephone call on the day before his death. The investigator has listened to the recording of the man's telephone call to his partner on the afternoon of 15 May. During the sixteen minute conversation they talk about football, cooking and general relationship matters. At no point did the man give any indication he was depressed or had plans to harm himself. At the end of the phone call he said he would call again the following evening.

43. The fellow prisoner also said that it was his understanding that the man was using drugs whilst at Frankland. The investigator has found no evidence of the man having any medication other than the prescribed pain relief and the post mortem report showed that he had not taken any other drugs.

44. Later that evening there were no concerns raised by staff for the man as the prisoners were locked in their cells for the night. When a prison enters 'night state', which is from 8.00pm to 7.30am there is a minimum number of staff on duty. For the man's wing there were two staff on duty Officer A and an Operational Support Grade (OSG). (An OSG is a member of prison staff at a grade below prison officer. They work in many areas of the prison and usually have limited contact with prisoners).

45. They performed the required checks at the start of their shift to confirm that all prisoners were present and there were no concerns. For security purposes OSG's on duty during the night do not have a set of keys and only Officer A had a set of keys. The staff do not undertake another roll check of prisoners until the early morning roll check some time between 5.30am and 6.00am.

46. During night state if prisoners require assistance or have an emergency then each cell has an alarm bell that can be pressed to call staff to that cell. At Frankland electronic records are kept that shows which cell and the time the bell had been used. The investigator has scrutinised the cell bell records for the man's wing for the night of 15 and early morning of 16 May which shows that the man did not use his cell bell at any time after lock up.

47. At approximately 5.45am on 16 May, the OSG was undertaking the early morning roll check and when he came to the man's cell he could see from the observation hatch that the man was lying face down on the floor, fully clothed, with a ligature around his neck which was attached to the heating pipes. The OSG immediately called to Officer A for assistance.

48. Officer A came from the landing below and immediately entered the man's cell. He cut the ligature from the pipes and then from around the man's neck. The officer turned the man onto his back and looked for signs of breathing and a pulse but was unable to find any. Using his radio Officer A called a Code Black (denotes that a person has been found not breathing) and asked for an emergency ambulance to be called. Officer A, who is first aid trained, then started CPR (cardio pulmonary resuscitation is a technique whereby oxygen is pumped around the body using a combination of chest compressions and rescue breaths.)

49. Officer B, a trained nurse with more than thirty years experience, was working as a nurse that night and was located in healthcare. He responded to the emergency call and took the emergency equipment bag with him. On arriving at the man's cell at 5.49am Officer B took over the man's care but was unable to find any signs of life. Due to his many years of experience it was apparent to Officer B that the man had died however he continued with CPR until the paramedics arrived. The Paramedics arrived at the man's side at 6.09am and confirmed that he had died.

50. A debrief was held for staff involved in the emergency incident and the services of the care team were made available to them. Prisoners were offered support by staff and the chaplaincy during the remainder of the day.

51. As the man's next of kin lived in the Stockport area, the head of Business Unit contacted HMP Manchester and asked if one of their family liaison officers could go and break the news of his death in person. Manchester readily agreed and their family liaison officer and the chaplain visited the man's partner later that morning.

52. The man's partner said that he had a stepmother that lived in a different area and she needed to be informed about the man's death. This information was

immediately passed to the head of Business Unit who visited the man's stepmother, accompanied by family liaison officer B, early that same afternoon to break the news of his death.

53. In the days that followed the family liaison officer from Frankland, the head of Business Unit, maintained contact with the man's partner and followed the guidance in Prison Service Order (PSO) 2710 'Follow up to deaths in custody' and offered support and assistance towards the costs of the funeral.

## ISSUES

### Suggestion of illicit drug taking

54. A prisoner interviewed as part of this investigation suggested that the man took illicit drugs on a regular basis and in particular on the day before his death. The investigation has found no evidence of this and furthermore the post mortem confirmed that any drugs present in the man's blood were as a result of prescribed medication. The post mortem report says there were no toxicological findings to account for the man's death.

55. I am completely satisfied that the evidence gathered by this investigation, including the observations of staff, entries on wing history sheets, wing observation books, medical records and the post mortem result, proves that this suggestion is unfounded.

### Suggestion of debt problems

56. The same prisoner suggested that the man was indebted to other prisoners on the wing having used his canteen supplies to fund the purchase of drugs. The investigation has established that the man did have a history of being in debt to other prisoners but not during his time on D wing. The man's personal officer explained at interview how the debt system worked in the prison and that the man had previous problems on other wings but that this had not continued since he moved to D wing in November 2010.

57. Whilst I accept that it is common practice within prisons for prisoners do borrow and barter from one another there is no indication that the man was in debt to others at the time of his death.

### Suggestion of receiving bad news

58. The prisoner also told my investigator that he was aware that the man had received bad news during a phone call on the evening prior to his death. As part of the investigation process the investigator had listened to the man's call to his partner on the 15 May 2011. The man did not receive any bad news and throughout the entire duration of that call he gave no indication that he was depressed, felt in low mood or had any suicidal thoughts. The conversation was about normal daily matters and the man said that he would call the next day.

59. I therefore find that there is no basis upon which to substantiate the suggestion made by the prisoner.

### Clinical care

60. The clinical reviewer, has carefully considered the overall clinical care given to the man and concludes:

"Clinical assessment both during reception procedures and carried out during specific health events that the man experienced at Frankland were of an acceptable quality. More in-depth mental health assessment or any further or in-depth risk assessment of propensity for self harm or suicide were never indicated and therefore would not have been considered necessary by the healthcare or prison staff. In-depth assessment then would have been excessive and inappropriate especially taking into account of how the man presented himself to healthcare and custodial staff and from his medical / custodial history.

"He was custodially experienced and had consistently given the impression to both other prisoners and staff that he coped with prison life with no indication of any intent to take his own life. He had told healthcare staff during his reception on 9 November 2007 that he was 'not bothered about being at Frankland'.

"From a general standard of healthcare perspective, the Clinical Reviewer takes the view that the man received a good standard of healthcare whilst in prison and which was broadly commensurate to that which he could have expected to receive had he been in the community."

61. I am satisfied that the medical assessment and care that the man received whilst at Frankland was equitable to that which would have been available to him in the community and that at no time did he give any indication that he was vulnerable or in need of mental health assessment.

**Emergency response**

62. The staff response to the man's need for assistance was swift and professional. I recognise the actions and professionalism of all the staff who responded to the emergency situation. I also recognise the effective use of the coding system, which ensured clear that staff attending the man knew the situation and brought the correct equipment.

**Family liaison**

63. I am pleased to note that Frankland contacted HMP Manchester to ask their family liaison officer to visit the man's next of kin, and that Manchester readily agreed to do so. As Manchester was closer to the man's next of kin's home, it meant that the news of his death was given face to face in a timely manner, by an appropriately trained member of Prison Service staff. Staff at Frankland also acted immediately, when given the contact details by staff from Manchester, in breaking the news of the man's death to his stepmother who lived in a different area.

64. I judge that Frankland appropriately followed the guidance set out in PSO 2710 'Follow up to deaths in custody', and used best practice in contacting another establishment so the sad news of the man's death was given in person by prison service staff. I am pleased that Manchester readily agreed to assist.

## CONCLUSION

65. I am satisfied there was appropriate assessment made of the man's physical and mental health throughout his time in prison and that appropriate treatment and care was provided. I agree with opinion of the clinical reviewer that the standard of health care the man received at Frankland was equitable to that which he could have expected to receive in the community. The man exercised his right to refuse hospital treatment and there was no suggestion that he had any mental health needs.

66. Ultimately the man was an independent adult responsible for his own health and wellbeing. I am satisfied that the man gave no indication to staff, his fellow prisoners or his partner that he intended, or planned, to take his own life. Following the man's death I am satisfied that Frankland appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

67. My investigator followed up a number of suggestions that the man was affected by illicit drug taking, debt and bad news however there was no evidence to support any of these suggestions.

68. I make no recommendations, but I do recognise the professionalism of the staff who responded to the emergency incident and the best practice in family liaison.