Investigation into the circumstances surrounding the death of a man at HMP Frankland in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Frankland. He died in his cell in the prison's healthcare centre in July 2009. He was 44 years old. The cause of death was recorded as biventricular failure (heart failure) caused by hypertensive heart disease (heart disease related to high blood pressure) and chronic renal (kidney) failure. I offer my sincere sympathy and condolences to his family and all who have been affected by his loss.

The investigation was carried out by my colleague. An independent review of the man's medical care in prison was begun by the clinical reviewer on behalf of the local Primary Care Trust (PCT). Unfortunately, due to unforeseen circumstances, she was unable to complete the review. I am most grateful to the patient safety and integrated governance manager at the local PCT for concluding the review. Regrettably, this led to a significant delay to receipt of the clinical review and subsequent issuing of this report, for which I must apologise.

I would also like to thank the Governor and staff of Frankland for their full and ready co-operation during the course of the investigation. My particular thanks go to the head of the business unit and her colleague for their work in liaising with the investigator.

The man is described as a disruptive prisoner whose failure to cooperate with his treatment plan meant that staff found him difficult and challenging to manage. I am satisfied that staff did all they could to persuade him to co-operate with his recommended medical care, and commend them for their efforts to resuscitate him on two occasions. His reluctance to follow his treatment plan led to a continual deterioration in his health. The clinical reviewer concludes that his life might have been prolonged had he accepted all his treatment.

I make six recommendations, regarding diet and exercise, the use of care plans and the use of ACCT (Assessment, Care in Custody and Teamwork, the process used to monitor and support prisoners assessed as at risk of suicide or self-harm).

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.

Jane Webb
Acting Prisons and Probation Ombudsman November 2010

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SUMMARY

When he was first imprisoned in June 1999, the man had already suffered from high blood pressure for several years. He was said to refuse to take his prescribed medication before coming into prison, and so his blood pressure did not improve during his time in custody. By the time of his transfer to HMP Frankland in August 2007, he had developed advanced kidney disease.

The man's conduct in prison was reported to be poor prior to his arrival at Frankland. Records indicate that he was regularly abusive and threatening to staff and he was reported as someone who "easily loses his temper and cannot see any viewpoint other than his own". He was subject to numerous adjudications (prison disciplinary hearings) and spent a lot of time in the segregation unit and on the basic IEP level (Incentives and Earned Privileges, a system designed as an incentive to reward good behaviour in prison which has three tiers; basic, standard and enhanced).

On account of his worsening kidney disease, the man was required to start dialysis in July 2008. This meant that he had to visit hospital three times a week for dialysis treatment, each session lasting for several hours. He did not accept all his dialysis treatment. He regularly refused to go to hospital for his scheduled sessions, or would terminate the sessions early. His conduct in hospital was often described as poor, and it was reported on several occasions that he was abusive to hospital staff.

Although the man went through periods where he attended dialysis more regularly, the combination of his missed sessions and refusal of medication meant that his condition continued to deteriorate. He was warned on numerous occasions that if he did not co-operate the consequences were likely to be serious. He seemingly ignored this advice and eventually he developed severe heart disease. On a morning in July 2009, he was found collapsed in his cell. Healthcare staff attempted to resuscitate him and an ambulance was called, but he was pronounced dead at 12.02pm. The cause of death was established by a post mortem as biventricular failure (heart failure) caused by hypertensive heart disease (heart disease related to high blood pressure) and chronic renal (kidney) failure.

I am told that the man was a very difficult and challenging prisoner for staff at Frankland to manage. Nevertheless, I am satisfied that staff did all they could to encourage him to comply with his treatment plan. The clinical reviewer describes the care he received as being to a "very high standard". Indeed, on two occasions the prompt actions of staff in resuscitating him helped to prolong his life further. The report makes a total of six recommendations, in areas including diet and exercise, the use of care plans and the use of ACCT.

THE INVESTIGATION PROCESS

1. The investigation was opened on 9 July 2009 when the investigator issued notices announcing it to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. Two prisoners submitted statements as a result.

2. The investigator first visited Frankland on 15 July 2009. He toured the establishment, including the healthcare centre, segregation unit and G wing, all of which the man had lived on during his time at the prison. The investigator was also given copies of the man's prison files. The investigator and a colleague returned to Frankland on 24-26 November and interviewed 11 members of staff. A third visit planned for January 2010 was cancelled due to adverse weather conditions. The investigator eventually returned on 2-3 March when he interviewed a further three members of staff.

3. An independent clinical review of the man's health needs whilst he was in custody was initially undertaken by a clinical reviewer on behalf of the local Primary Care Trust (PCT). She is employed by Primecare, a provider of primary care services, who were contracted to undertake several clinical reviews for the local PCT. She visited Frankland with the investigator in both November 2009 and March 2010 and participated in a number of interviews. Unfortunately, due to unforeseen personal circumstances, she was unable to complete the review. The patient safety and integrated governance manager for the local PCT was subsequently appointed in June 2010. I am grateful to her for taking on and completing this work at short notice. Unfortunately, this disruption meant that the clinical review was not completed until July 2010, a year after the man's death.

4. One of my family liaison officers spoke to the man's brother over the telephone on 27 July 2009, during which he set out some initial concerns that the family had regarding his treatment at Frankland. The man's mother subsequently wrote a full statement which she sent to the investigator, via her solicitor, in November 2009. She raised the following issues that she wished the investigation to address:

    - She asked why her son did not receive dialysis three times. She gave examples of him being treated unfairly by prison officers whilst in hospital. She also said that on two occasions her son was denied dialysis due to the conduct of prison officers. On the first occasion, he asked hospital staff if he could have dialysis in a different arm to usual, as his arm was hurting. The prison staff escorting him refused this request and he therefore returned to prison without dialysis. On the second occasion, he was taken straight back to prison after arriving at hospital after being told he had "assaulted a nurse".

- She said that on one occasion her son was assaulted by an officer when a cell door was shut on his finger.

- Her son spent a large proportion of his time on a basic regime and in the segregation unit. She asked whether this could have exacerbated his health problems.

- The post mortem report revealed a number of scars and marks on his body. She asked how he received these marks.

- His property was not returned to the family, despite several requests. She was particularly keen to obtain any correspondence that her son had in his cell.

5. The man's sister telephoned the family liaison officer in February 2010 and subsequently spoke to another of my family liaison officers in March 2010. She raised the following issues for the investigation to address:

    - She did not hear of her brother's death until seven months after he died. She said she was not named as next of kin as she was estranged from her mother and other brother, and asked how the prison normally deals with such issues.

    - He did not speak to any family members for a week or two before he died. His sister queried whether he was asked if he wanted one of his relatives to be contacted when his health deteriorated.

    - If he had refused contact with his family, this could be evidence that he was suffering from dementia as a result of end stage renal failure.

    - Whether he was on an organ transplant list, as she had offered one of her kidneys to her brother?

    - Why he was not moved to a prison closer to his family when he became ill and why his security category was not reviewed as he had not always been in a high security prison?

    - She was concerned that all of her brother's correspondence had been returned to her estranged family, and that this included personal letters she wrote to him.

6. The report was sent in draft to the man's mother, via her solicitor, in September 2010. Her solicitor subsequently replied in November that she did not wish to make any comments on the draft report. The man's sister contacted another of my family liaison officers shortly before the draft report was issued to say that she did not wish to receive a copy.

HMP FRANKLAND

7. HMP Frankland is one of eight high security prisons in England and Wales. Frankland holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. G wing, where the man lived for some time, is for prisoners who are suitable for a normal prison wing. The operational capacity of the prison is 750.

8. Frankland has a large segregation unit, where the man also lived for some time. The purpose of a segregation unit is to hold prisoners separately from the rest of the population. This is usually as a disciplinary measure or punishment for a breach of prison rules. Frankland's segregation unit has 27 single cells.

9. Healthcare services at Frankland are provided by the local Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two wards, holding a total of seven patients, and ten single cells. The man lived in one of these cells for the last two and a half weeks of his life.

10. HM Chief Inspector of Prisons conducted a full announced inspection of Frankland in February 2008. Her report was broadly positive about health services provided at Frankland, and found the provision was equivalent to that which prisoners could expect to receive in the community.

11. She also found that black and minority ethnic and Muslim prisoners were over-represented in the segregation unit. She recommended that a full review be carried out to improve the operation of the unit and treatment of prisoners. A second recommendation was for the consistent over-representation of black and minority ethnic prisoners in areas such as segregation to be investigated and addressed.

12. The Independent Monitoring Board (a body of local people who independently monitor and report on the prison) report for 2007-08 noted that there had been several beneficial changes in the healthcare department recently. However, they highlighted staff shortages and a higher proportion of missed outside hospital appointments than expected.

13. This was the fourth death that the Ombudsman has investigated at Frankland in 2009. There have subsequently been a further seven deaths at the establishment. All but one of the other deaths were due to natural causes. One of the earlier deaths also involved a prisoner with a long term medical condition. The Ombudsman's report recommended that such prisoners should be regularly reviewed in accordance with national guidelines.

KEY FINDINGS

14. The man was first imprisoned in 1991, when he received a 30 month sentence for wounding. He served shorter sentences of less than six months on two further occasions in the 1990s. After being remanded into custody at HMP Nottingham on 22 June 1999, the man was convicted of wounding with intent on 17 September. Two weeks later he was sentenced to life imprisonment with a tariff (the minimum time that must be served before a prisoner is eligible for release) of three and a half years.

15. The man arrived at Nottingham on 22 June 1999. He had suffered from high blood pressure and high cholesterol for a number of years and was prescribed a variety of medications for these conditions. From his first months in prison, his compliance with his medication was poor. There were also numerous examples of him being reported as abusive and threatening to staff and failing to obey prison rules.

16. The first sign that the man might be suffering from kidney disease came in May 2000, when a urine test at HMP Gartree (where he had recently moved to undertake some of the courses necessary to progress through his sentence) showed an absence of proteins in his urine. An appointment was made for a scan of his kidneys at a local hospital. However, he refused to attend this appointment.

17. In October 2001, the man moved to HMP Parkhurst ,which was arranged to “allow a fresh start”. He was referred to a local hospital in early 2002 after his blood pressure began to rise. This was seemingly as a result of him refusing to take his medication. He continued to refuse to take his blood pressure medication for several months.

18. The man was persuaded to visit a local hospital in December 2002 for a scan of his abdomen. This showed that he had small kidneys and, therefore, likely kidney impairment. A scan of his chest several months later showed the left side of his heart was enlarged (a condition usually associated with high blood pressure).

19. After two years at Parkhurst, the man transferred to HMP Dovegate in November 2003. Dovegate is closer to his family, and the aim was to make it easier for him to maintain his ties. However, he did not settle at Dovegate and moved to HMP Garth after four months, again, for a “fresh start”. In August 2004, he moved again, after threatening to kill the deputy governor. On this occasion he moved to HMP Swaleside.

20. After attending an outpatient appointment with a kidney specialist at a local hospital in early 2005, the man was provisionally diagnosed with hypertensive nephropathy (kidney disease resulting from high blood pressure). However, he refused to provide the blood and urine samples necessary to confirm this diagnosis. Throughout his time at Swaleside, he regularly failed to take his prescribed medication and declined scans that

would diagnose his kidney condition. His blood pressure continued to be poorly controlled, partially because he did not take his medication regularly.

21. By late 2006, the man's kidney disease had worsened and was now described as "advanced renal [kidney] disease". He continued to refuse the weekly blood tests that would monitor his condition. In January 2007, he transferred to HMP Whitemoor, a high security prison. It is not clear why he moved to the high security estate, although it appears from the records that he continued to be abusive to staff before moving.

22. The man's conduct was reported to be poor during his seven months at Whitemoor. In late March he assaulted an officer and, in July, set fire to his cell and was subsequently moved to the segregation unit. Shortly afterwards, he refused food and drink for several days. A mental health assessment described him as someone who "easily loses his temper and cannot see any viewpoint other than his own".

23. As a result of the difficulties described at Whitemoor, the man moved to Frankland on 23 August 2007. At the time, his medication was listed as:

    - simvastatin (to reduce cholesterol and the risk of a heart attack)
    - aspirin (to thin the blood and prevent a heart attack)
    - nifedipine (usually known by the brand name Adalat, for treatment and prevention of high blood pressure and angina)
    - valsartan and doxazosin (both used to treat high blood pressure)
    - mirtezapine (an anti-depressant).

24. In early October, the man told a prison doctor he had been feeling unwell recently and experienced chest pains when smoking. The doctor sent a referral to the renal unit at the local Infirmary, in which he detailed the man's medical history. In his referral, the doctor said the man had small kidneys and had been suffering from chronic kidney disease for a number of years.

25. On 11 October, the man was moved to the segregation unit after he threatened to set fire to his cell. He remained on the unit for two weeks before returning to a cell on F wing. During his time on the segregation unit, he stopped taking his medication. He told staff this was because he was no longer given his medication 'in possession' (where a prisoner is given a supply of medication, in this case one week at a time, to keep in their cell and take as prescribed). The rules of the segregation unit are that all medication is given out by nursing staff at the time it is due to be taken.

26. The man returned to the segregation unit on 5 November, after being found guilty at an adjudication hearing (a prison disciplinary hearing) of using abusive language towards a member of staff. His punishment was to spend a week in cellular confinement. On his return to F wing, he was

initially reported to be quiet and compliant with the wing regime. However, after an adjudication hearing on 4 December, he was again sent to the segregation unit. On this occasion his punishment was 12 days cellular confinement after he was found guilty of a number of breaches of prison rules.

27. The requested appointment at the renal unit at hospital was made for 27 December. However, the man refused to attend the appointment and signed a disclaimer to this effect. There is no record of the reason why he did not wish to attend hospital.

28. Over the following weeks, the man continued to refuse his medication. He told healthcare staff he was worried about the side effects that the medication might cause. Prison Doctor A wrote a second referral to the Infirmary on 17 January 2008 after blood tests taken provided some abnormal results. He wrote that the man was "clearly in renal failure".

29. The prison doctor thought at the time it was "almost certain" that the man would require dialysis to treat his severe renal failure. (Dialysis is the artificial replacement of kidney function for people with renal failure. This is usually done by a process known as hemodialysis, whereby a patient is connected to a machine in hospital for around four or five hours at a time. Blood is drawn from the body, usually from the forearm, and 'cleaned' by the dialysis machine, before being returned to the body through a second access point in the forearm. An access point can also be made in the chest instead of the forearm.)

30. The prison doctor saw the man in his cell on 20 January to explain that he might require dialysis in the future. However, the man was described as "very reluctant" to discuss the matter and walked out of the meeting. The doctor therefore wrote to him a week later to explain that his kidneys were seriously damaged and he was likely to require dialysis. He also recommended to him that he should begin taking his medication again, although it does not appear that he did so.

31. The results of a blood test taken on 29 January were again abnormal. It was feared that the man might be at risk of a heart attack or stroke, and he was admitted to the Infirmary. When a prisoner is taken to hospital, either as an inpatient or outpatient, a risk assessment is completed to determine the level of security needed on the escort. The risk assessment determines the number of staff who must accompany a prisoner and the level of restraints to be used. In his case, the outcome of the risk assessment was that he should be accompanied by three prison officers and double cuffed (meaning that his hands were handcuffed together and one hand was also cuffed to one of the escorting officers).

32. The man returned to Frankland on 1 February, having been prescribed a course of epoetin injections (to increase red blood cells). It was planned that he would be admitted to hospital again on 6 February for surgery to insert a catheter in preparation for peritoneal dialysis. (This is a form of

dialysis whereby fluid is inserted into the abdomen. The abdomen is drained and any waste products are removed with the fluid.)

33. On account of the man's reluctance to take his medication or discuss his treatment, the prison doctors requested that he should be assessed by a member of the mental health in-reach team. He subsequently saw Community Psychiatric Nurse A on 5 February. He told the nurse that he had stopped taking his blood pressure medication because he thought the effects of smoking counteracted the benefits of the medication. He explained that he did not wish to stop smoking and therefore did not take his medication. The nurse concluded that there was "no obvious mental health concern". It is not clear whether he received advice on the effects that smoking might have on his medication.

34. The following day, the man refused to go to the Infirmary for his scheduled surgery. As part of the preparation for surgery, he was required to take a laxative. However, he refused to travel once he had taken the laxative and refused to sign a disclaimer that he took responsibility for his non-attendance. Two days later, the clinical team leader in the prison's inpatient facility saw him in his cell to talk about his future treatment. He refused to discuss his treatment options and insisted that he should not have been given a laxative before travelling to hospital.

35. However, on 3 March the man saw Prison Doctor B and said he now wanted the catheter inserted. An appointment was made at the renal unit for 7 March. On the day of the appointment, however, he again refused to attend. The reason for his refusal is not recorded. He also refused to sign a disclaimer.

36. Towards the end of March, the man's incentives and earned privileges (IEP) level was reduced from standard to basic. (IEP is a three tier system designed as an incentive to reward good behaviour in prison. Incentives include access to in-cell television, more private cash to spend and more time out of cell.) The reduction followed several warnings to him about his failure to follow prison rules and regulations and his threatening and abusive behaviour towards staff.

37. The man's conduct continued to be disruptive and, on 15 April, he was moved to the segregation unit for two days after setting fire to his cell. He was reportedly unhappy with the medical treatment he was receiving and said he did not take his medication because it "disagreed with him". Four days after he returned to F wing, his IEP level was upgraded to standard to encourage him to improve his conduct. The following day, however, he was segregated for seven days after being found guilty at an adjudication hearing of using threatening and abusive language towards an officer. Shortly after arriving in the segregation unit, he flooded his cell.

38. The then healthcare manager wrote to the man on 2 June regarding his future treatment. The manager acknowledged that the man was unhappy with his treatment at the Infirmary and said it would be possible to refer

him to another renal unit. However, he asked the man for assurance that he would engage in his treatment and asked him to respond in writing before a referral was made. It does not appear that he replied.

39. Prison Doctor A talked with the man about his treatment on 10 June, the day after he had moved into a new cell on G wing. He again said he did not think he should have been given a laxative before his appointment in January. He also complained about a swab that was taken in hospital around that time. He thought this was a DNA swab, taken as part of a conspiracy against him. The doctor advised that the swab was taken as standard practice to check for MRSA (methicillin-resistant staphylococcus aureus, a bacteria that often occurs in people who are ill in hospital). He repeated the healthcare manager's offer of referral to another local renal unit and advised him that he was in severe danger because of his high blood pressure and kidney failure. However, he declined the offer of referral to another hospital. The doctor noted his belief that the man had the mental capacity to make this decision. The following day the psychiatric nurse asked to see the man to formally assess his capacity to refuse treatment. He said he did not wish to participate.

40. In early July, the man's condition began to deteriorate. He said he had vomited and felt short of breath. He was given an inhaler to use as required. When he did not improve, he was admitted to hospital on 11 July. On the same day he moved to the Infirmary so that he could be assessed in their renal unit.

41. The following day, the man underwent a procedure to insert a neckline in preparation for hemodialysis. (A neckline in this case is a permanent access site in the patient's chest for the purpose of dialysis.) He started dialysis on 13 July. However, on 16 July, he discharged himself from hospital against medical advice.

42. The man was expected to return to the Infirmary for dialysis three times a week, on Tuesdays, Thursdays and Saturdays. He attended the first four appointments but, on 29 July, refused to attend. He said this was because he had to wear a high visibility suit when he attended hospital as part of the prison's security measures to prevent an escape. The risk assessment was reviewed and it was decided that he did not need to wear the high visibility suit. It remained the case that three staff should accompany him to hospital, including a senior officer who was in charge of the escort. He was double cuffed on his way to hospital but, during dialysis, the handcuffs joining him to the officer were replaced by an escort chain (a long chain with a handcuff at each end). He subsequently went to his next dialysis appointment which was on 31 July.

43. On 6 August, the man's IEP level was reduced from standard to basic. This followed several recent warnings about his behaviour, including one the previous day for being abusive to nursing staff at the Infirmary. The following day, he refused to attend hospital for dialysis. He said he was unwell as he had been vomiting and had diarrhoea. He was told that his

dialysis was important and he should attend if he could, but he said he did not feel up to it.

44. A week later, the man again refused to have dialysis. On this occasion he went to hospital but changed his mind following his arrival. It is not clear why he declined dialysis on this occasion. On 21 August, he refused to attend hospital. He said this was because he did not like the staff who were escorting him. The potential consequences of refusing dialysis were explained to him by healthcare staff, but he did not change his mind.

45. The man missed two dialysis sessions in a row on 30 August and 2 September. On both occasions he was taken back to the prison before dialysis started on account of what was described as abusive and aggressive behaviour towards staff. (It is not clear from the records whether he was abusive towards escorting staff, hospital staff, or both.) At the request of the renal consultant, healthcare staff attempted to take a blood sample so the effects of missing the sessions could be monitored. However, he refused to provide a sample.

46. After these two missed sessions, the man had dialysis as scheduled during the next fortnight. He again missed two sessions on 18 and 20 September. On the first occasion he threatened one of the escorting officers and refused to be taken to hospital. It is not clear from the records why he did not attend the second appointment.

47. The day after the second of these missed dialysis sessions, the man complained of shortness of breath and feeling “terrible”. His blood pressure was very high, at 221/148. He was admitted to the Infirmary for monitoring. He was discharged two days later when his condition had stabilised.

48. The man again refused to have dialysis on 27 September. He told a nurse at the hospital that the treatment made him feel suicidal. One of the escorting officers therefore opened an Assessment, Care in Custody and Teamwork (ACCT, the process used by the Prison Service to monitor and support prisoners assessed as at risk of suicide or self-harm). On his return to Frankland, he saw a member of staff trained in the ACCT procedures for the mandatory opening assessment. He expressed concerns regarding his health problems and being on an indeterminate sentence with no sign of release. He also said his mental health problems were exacerbated by being on the basic regime as he did not have a television or stereo.

49. An action plan (known as a caremap) was written by Senior Officer (SO) A, who was appointed as the man’s ACCT case manager. The caremap included the request that he see a member of the prison’s mental health in-reach team. He subsequently saw Community Psychiatric Nurse B, on 29 September. He told her that it was not his dialysis that made him feel low. He said it was because he had nothing to stimulate him as he was not allowed a television and stereo whilst he was on the basic regime. He

was concerned that he could not therefore listen to his religious music. At a review later that day, SO A gave permission for him to be provided with a stereo.

50. Prison Doctor C discussed the man's care over the telephone on 30 September with a consultant nephrologist at the Infirmary. They discussed the possibility of reducing the frequency of dialysis to twice a week. (It remained at three sessions a week.) They also discussed the potential of a kidney transplant. The consultant said that the man was not on the transplant list because he had high blood pressure.

51. On 10 October, the man was taken to the segregation unit after he threatened to set fire to his cell if he was not unlocked for association. (As he was on the basic IEP level, he received limited association compared to prisoners on standard or enhanced levels.) On the same day, he was found guilty at an adjudication hearing of assaulting a prison officer on 30 August. His punishment was ten days cellular confinement, which he served. However, the guilty verdict was later quashed by the Briefing and Casework Unit of the National Offender Management Services (NOMS). The verdict was quashed because, whilst he had refused to attend the hearing, there was no clear record that he had been advised that it would proceed in his absence.

52. At an ACCT review on the day he moved to the segregation unit, the man said he "hates" every officer on G wing. He refused to go to hospital for his next two planned dialysis sessions. On the evening of the second of these refusals, 14 October, he was short of breath and told healthcare staff that his lungs were full of fluid. The renal unit at the Infirmary was contacted, who advised that he should attend hospital urgently for dialysis. He agreed, and remained as an inpatient until 17 October. During his stay he was warned by the consultant that if he carried on missing dialysis sessions at his current rate there would be a "significant impact on his prognosis".

53. Despite the consultant's warning, the man asked for his dialysis session on 21 October to be terminated after just ten minutes. It is not clear why he refused to continue. However, he returned to hospital in an emergency admission later that day when he became short of breath and required oxygen. He remained in hospital as an inpatient for four days. He was advised to stay in the prison's healthcare centre on his return, but preferred to go back to his cell on G wing.

54. An ACCT review was held on 27 October, led by SO A. Prisoners should be invited to the reviews and, although he often declined to attend, the man did attend on this occasion. He said his situation had not changed and asked to see a member of the mental health in-reach team. The SO noted in the caremap that he made a referral on 29 October, although it does not appear that a member of the team saw him for some time. The SO also noted that the next ACCT review should be more comprehensive,

with representatives of the Independent Monitoring Board and mental health in-reach team present. This did not happen.

55. At a review on 7 November, it was noted that the majority of entries in the man's ACCT document were positive. He had made no mention of thoughts of suicide or self-harm and the only unresolved issue was a return to standard IEP. After a period of improved behaviour, his IEP level was upgraded to standard on 19 November.

56. The man also attended more of his dialysis sessions in November and only missed two during the month. It is not clear why he refused to attend the first of these. On the second occasion he said it was because he did not wish to be restrained by an escort chain during dialysis. (An escort chain is a long chain with a handcuff at each end. During dialysis the cuff between him and the escorting officer was replaced by an escort chain.) On both of these occasions, he was subject to an emergency admission to hospital the following day when his symptoms exacerbated. He was discharged the same day both times, although on the second occasion he reportedly became angry and claimed he was being refused treatment.

57. The ACCT document was closed on 28 November, when the man was described as "more positive of late" and it was noted that he had attended most of his dialysis sessions. He said he was happier now he was back on the standard IEP regime.

58. On 4 December, however, the man again refused to go to hospital for his dialysis session. Later that day he felt pain in his chest and an ambulance was called. He refused to remain in the healthcare centre and returned to his wing. He did not wish to be seen by the paramedics when they arrived. Three days later, he again complained of chest pain and, on this occasion, agreed to go to hospital. He was diagnosed with unstable angina. Although he was advised to remain in hospital for treatment, he discharged himself and returned to Frankland.

59. The following day, the man returned to the Infirmary for a scheduled dialysis session. He started dialysis but, about half way through, said he wanted to stop and return to the prison. An ACCT post-closure review was held the same day, at which he said he felt better now he was on the standard regime and had a television.

60. SO A opened a new ACCT document on 10 December, as he was concerned that the man had missed a number of dialysis sessions and was not taking his prescribed medication. The man did not agree that ACCT procedures should be opened and refused to take part in the assessment interview. The caremap listed just one issue which was to be addressed, that is his compliance with his dialysis treatment.

61. The man agreed to attend an ACCT review the following day. He said he had no thoughts of harming himself and could not see why the document had been opened. He said he wanted to attend his dialysis sessions but

he “had issues” with certain senior officers and would not go if they were on the escort. He attended his first dialysis session after this review but at the next, on 16 December, he refused to go to hospital when he discovered the identity of the senior officer in charge of the escort.

62. Following his refusal to have dialysis on 16 December, Prison Doctor C wrote to him. She reminded him of the significant risk to his health if he continued to miss dialysis sessions. She strongly encouraged him to ensure his medical treatment took preference over any other issues he might have.

63. On the same day, an enhanced case review was held to discuss what was recorded as the man’s “difficult and challenging behaviour and refusal to accept kidney dialysis treatment”. The meeting was chaired by the residential manager with responsibility for G wing. It was also attended by the head of healthcare and representatives from the mental health team and safer custody teams. The panel concluded that he should remain on an open ACCT document as long as he did not co-operate with his treatment. They also agreed to try to arrange a group of escort staff who he would agree to go to hospital with. A mental health assessment was also arranged.

64. During a dialysis session on 22 December, the man complained of chest pains and was therefore admitted to the hospital’s coronary care unit (CCU). When the escort staff changed over in the evening, he asked to be discharged and taken back to the prison as he did not like the SO who was now in charge of the escort. This was against the advice of the consultant in the CCU.

65. The following day, Community Psychiatric Nurse A visited the man to assess his capacity to refuse treatment. He said he did not wish to attend the interview as he considered himself to be mentally well. His next dialysis session was scheduled for 24 December. On the morning of the appointment, he said he would not go unless he was taken by ambulance as he still had chest pain. (It was usually the case that he was taken to hospital in a taxi.) Healthcare staff did not agree this was necessary and he therefore refused to attend the appointment. However, his condition later deteriorated and he agreed to go to hospital for dialysis. On account of his worsening condition, an ambulance was called. He remained in hospital until he was discharged on 27 December. During his inpatient stay he had an angiogram (a scan of the chest and heart) which showed nothing unusual.

66. On 31 December, the man wrote to healthcare staff at Frankland to say that he no longer wished to attend the Infirmary for treatment. He said this was due to “medical negligence and serious breach of patient doctor confidentiality”. He said he was happy to receive treatment at any hospital except the Infirmary. The following day, he said he would not co-operate with blood pressure checks until the transfer of his care to a hospital was arranged.

67. A case conference was held at Frankland on 2 January 2009 to discuss the man's request. It was agreed to refer him to another hospital and he was subsequently put on their waiting list for treatment. It was noted that Prison Doctor C had discussed him with the local Primary Care Trust's legal advisors, who judged that prison healthcare staff had fulfilled their legal obligations to him and his treatment. In the meantime, staff were advised to try to persuade him to attend his scheduled appointments at the Infirmary. It does not appear as though he received an appointment for the other hospital.

68. The man refused to attend his scheduled dialysis appointment at the Infirmary on 3 January. However, later that day, he was admitted to a hospital after suffering chest pain. After his admission, he agreed to move to the Infirmary for dialysis. He was discharged from hospital the same day.

69. Two days later, the man was again admitted to a hospital. After admission to healthcare with shortness of breath, he pulled out his Hickman line (a tube inserted into the chest for various treatments, in this case to perform dialysis) as the cell he moved into for observation did not initially have a radio. On the advice of the consultant, he was admitted to hospital so the Hickman line could be correctly inserted. He was discharged the same day.

70. The head of healthcare contacted the local NHS Trust on 7 January to discuss the man's regular refusal of treatment from a legal standpoint. She was advised that the key factor was the patient's ability to understand the decisions they were making and, if they had the capacity to make such a decision, their wishes should be respected. She was also advised that staff should clearly record all attempts to convince him to accept treatment. Following this discussion, Community Psychiatric Nurse A visited him to assess his capacity. He did not engage fully and the nurse was therefore unable to make a full assessment.

71. The following day, the man refused to attend hospital for dialysis. He later complained of chest pain but refused to stay in the healthcare centre for observations. On 9 January, he again complained of chest pain and shortness of breath. He was admitted as an emergency to the Infirmary before being discharged the following day.

72. The man went to his next dialysis session on 13 January, but refused to attend two days later. On 16 January, he complained of chest pain that was spreading to his left arm. He refused to go to healthcare for observation as he could not be guaranteed a cell with a television. He was later admitted to hospital when his symptoms worsened. He discharged himself the following day against the advice of the consultant.

73. On 20 January, the man went to the Infirmary for dialysis. However, he refused to begin the procedure as he was not happy with the arm on

which his handcuffs were placed. He wanted the escort chain to be placed on his left arm, but was told that it had to be on his right arm due to the position of the dialysis machine. Later, following his return to Frankland, he changed his mind and said he wanted to return to hospital for dialysis. He had now missed his appointment slot and therefore dialysis could only be provided in an emergency. Blood tests had to be taken in order to determine if this was appropriate. He refused to provide blood as he thought he should still be eligible for his routine appointment. He did not therefore receive dialysis.

74. Two days later, the man again refused to go to the Infirmary for dialysis. On this occasion he said it was because of the presence of a particular senior officer on the escort. Again he changed his mind later in the day. The hospital was contacted to see if they had room for him, but they did not. The consultant told Frankland that they had a number of new dialysis patients and therefore could not provide any degree of flexibility in future.

75. The man declined to attend his dialysis session on 27 January as he had a legal visit booked for the same time. Three days later, he said he was feeling light headed. His blood pressure was taken and had fallen to 100/78, lower than the normal range. It was thought this might be related to verapimil (medication for high blood pressure and angina), a drug he had recently started taking. This medication was stopped. His blood pressure was checked overnight and, by the following morning, had increased to 139/107. Later that day, he refused to go to the Infirmary for his scheduled dialysis session.

76. An ACCT review was held on 2 February, at which the man reiterated his view that he should not be subject to ACCT procedures. However, it was noted that he continued to miss treatment sessions for various reasons and the ACCT therefore remained open. The following day, he again refused to attend his dialysis session. He said it was because he wanted the escort chain to be on his left wrist rather than his right.

77. At a mental health assessment with Community Psychiatric Nurse A on 9 February, the man said that he felt “panicky” and anxious on account of his illness. The nurse recommended the use of an anti-depressant and fluoxetine was subsequently prescribed by a prison doctor. On the same day, Prison Doctor C wrote to a consultant nephrologist at the Infirmary. She noted that a number of anti-hypertensive medications (to control high blood pressure) had been tried but, for various reasons, the man had declined them all at some stage. She went on to say that it was difficult to prescribe a medication that he would accept and he was not currently taking any such medication.

78. Three days later, the man declined to attend hospital for dialysis as he had a legal visit booked. On the same day, his IEP level was reduced from standard to basic. This followed a “lengthy period of poor and abusive behaviour [meaning that he] no longer met criteria for standard prisoner”. He was downgraded for a minimum of 28 days. His behaviour

did not improve through the remainder of the month. However, other than one session on 24 February, he accepted his dialysis sessions.

79. A dietician saw the man on the dialysis unit at the Infirmary on 17 February, as he had recently lost some weight. She recommended that he should be given a course of nutritional supplements, and take four per day.

80. The improvement in the man's compliance with dialysis was noted at an ACCT review on 23 February. There was some discussion as to whether he should be allowed a television to improve his state of mind. (It is normally the case that prisoners on the basic IEP level are not allowed a television in their cell.) SO A, who led the review, agreed to look into this further but, seemingly, he did not get a television.

81. Two days later, the man was taken to the healthcare centre in the early hours of the morning after complaining of shortness of breath. The out of hours doctor was contacted, who advised that he should be observed overnight but did not need oxygen therapy. He refused to stay in healthcare unless he was given oxygen, and returned to G wing. Later that day, he complained to Prison Doctor C that he was not allowed a television. She explained that she could not affect this decision.

82. Other than on 3 March, when he said he did not like the escorting officers, the man went to the Infirmary for all of his scheduled dialysis sessions in March. He also started to take medication to control his blood pressure, namely perindopril and aliskiren. However, his general conduct did not improve. He was discharged from the mental health team's caseload on 6 March after he was described as threatening and abusive to Community Psychiatric Nurse A during an assessment. There were also reports of him being abusive towards wing staff during the month.

83. At an ACCT review on 17 March, the man said he had been going for dialysis recently because the staff on duty were ones whom he liked. At his next review, on 23 March, it was confirmed that he had not missed an appointment for three weeks and the "issues surrounding his non-compliance have now been resolved". The ACCT document was closed on the same day.

84. On 29 March, the man made a serious threat against an officer. The officer said that he felt "extremely threatened and intimidated" in the aftermath. As a result of this incident, and a general deterioration in the man's behaviour over the month, he was moved to the segregation unit on 30 March. The post-closure ACCT review scheduled for the same day did not take place.

85. It was noted on 1 April that he was not taking the nutritional supplements that were recommended in February. Around 40 portions were removed from his cell. He was encouraged to eat more. His blood pressure was noted to have improved.

86. The man continued to attend most of his dialysis sessions in April, when he was in the segregation unit. (The sessions were now on Mondays, Wednesdays and Fridays rather than Tuesdays, Thursdays and Saturdays.) He missed one session on 3 April, for reasons that are not recorded. He missed another session on 10 April, apparently because he refused to comply with the normal searches that take place before a prisoner can leave the establishment. At around this time, he began to refuse to take his medication again. His general conduct was reported as poor and his weekly basic IEP reviews described threatening behaviour and a poor attitude.

87. During his dialysis session on 13 April, the man was warned by the consultant that his condition had deteriorated to the extent that he risked "sudden collapse" were he to refuse any further sessions. This was reiterated by Prison Doctor A the following day, who noted in the medical record that his opinion was that the man had full mental capacity to refuse treatment if he wished.

88. On 17 April, the dietician from the Infirmary provided a suggested meal plan for the days when the man went out of the prison for dialysis. This included a packed breakfast (as he often left before breakfast was available). The dietician also advised that the packed lunch must include a protein filling (such as meat, egg or cheese).

89. The consultant nephrologists wrote to Frankland on 23 April with an update on the man's progress. His blood pressure continued to improve, to the extent that the consultant was prepared to consider creating an arteriovenous fistula. (An AV fistula is the surgical process by which an artery and vein in the forearm are directly connected, allowing the vein to grow larger and stronger. As a result, repeated needle insertion for hemodialysis treatment is easier. The fistula can take some weeks or months to develop following surgery.) An appointment for him to undergo this procedure was subsequently made for 12 May.

90. Before the treatment could be given, the man's condition deteriorated dramatically on 27 April. He was successfully resuscitated by nursing staff after he stopped breathing. He was taken to hospital by emergency ambulance, and returned two hours later. At 4.00am the following morning he again stopped breathing and was again successfully resuscitated by prison staff. As before, he was taken to hospital by emergency ambulance and returned later.

91. Despite the deterioration in his health, the man refused to attend his scheduled dialysis session on 29 April. He also refused to sign a disclaimer. He attended his next session, on 1 May.

92. After suffering chest pain in the early hours of 3 May, the man was taken to healthcare for an ECG (a test to measure the electrical activity of the heart). The test was faxed to the out of hours GP, although the advice

given is not recorded in the medical record. He refused to wait in healthcare for the results of the ECG. He reportedly threw furniture at a door and was verbally abusive to staff after demanding that they give him extra milk.

93. Prison Doctor D wrote to the man on 7 May after they had earlier discussed his dietary requirements. He reminded him of his responsibility to make meal choices from the menu based on the advice he had been given from the dietician. He added that kitchen staff were also aware of this advice and were able to supply packed meals to meet the requirements on the days that he attended hospital.

94. The man refused to go to the Infirmary on 12 May for the surgery to create a fistula. No reason for this refusal is recorded in his notes. He also refused to sign a disclaimer. Although he declined to have the surgery, he attended all of his scheduled dialysis sessions in the first two weeks of May. However, he continued to reject his prescribed medication.

95. On the morning of 18 May, the man suffered a bout of diarrhoea and said he felt generally unwell. He went to the Infirmary for his scheduled dialysis session and was admitted as an inpatient due to his weakness. He was diagnosed with sepsis (blood poisoning) and treated with intravenous antibiotics. He continued to deteriorate and an ECG showed he had endocarditis (inflammation of the inner lining of the heart, usually as a result of a bacterial infection).

96. The man therefore moved to the hospital's coronary care unit on 22 May. He was told on the same day that his prognosis was "very grave". However, on 25 May, he discharged himself from hospital despite being advised that he should remain and continue the course of intravenous antibiotics. On his return, he moved into a cell in the prison's healthcare centre.

97. When he moved to the coronary care unit, the then head of business unit and Frankland's family liaison officer, telephoned his mother to update her on his condition. She updated his mother on her son's condition for the remainder of his life. (Telephone records show that the man himself contacted his family regularly during his time at Frankland, often several times a week.)

98. Following his return to Frankland, the man discussed his treatment with the clinical team leader in the prison's inpatient facility. He said he would not accept any treatment at Frankland and thought he should be treated in hospital. When she asked why he had therefore discharged himself from hospital, he said it was because he did not agree with the use of restraints in hospital.

99. The man went to the Infirmary on 27 May for his scheduled dialysis session and for a course of intravenous antibiotics. However, he refused to start the session as he thought his handcuffs were too tight. The cuffs

were checked by the escorting staff, including a senior officer, who considered them to be reasonable. It was noted that the handcuffs had already been loosened by a principal officer prior to departure from Frankland, after which he had said they were comfortable. He subsequently became verbally abusive to hospital doctors and nurses, as well as the escorting staff. The senior officer in charge of the escort, after consulting the duty governor, decided to take him back to Frankland immediately.

100. Later that evening, the man complained of chest pain and shortness of breath. An ECG was taken with the result faxed to the out of hours doctor. He recommended that the man be admitted to hospital. After undergoing tests at hospital, he was discharged and returned to Frankland at 5.30am on 28 May.

101. On the morning of 28 May, the man sustained an injury to two fingers on his left hand. Healthcare Officer (HCO) A described the events at interview with the investigator. The HCO said that he went to the man's cell to answer a call bell. As is standard practice when the door is locked, he spoke to him through the observation flap in the cell door. He said that the man asked "for something he wasn't entitled to". He went on to say that when he told him he was unable to provide this item, he "stepped forward and threw a punch". The HCO said he instinctively stepped back and pushed the flap shut. The man's fingers became trapped in the flap. He sustained lacerations and damage to the nail on the middle and ring finger of his left hand. The wounds were treated and dressed by a nurse.

102. On the same morning, the man continued to complain of chest pain and requested re-admission to hospital. Prison Doctor D discussed the symptoms with a nephrologist at the Infirmary, who advised that the man should be admitted for review. He remained in hospital until 22 June and was treated with intravenous antibiotics as well as his usual dialysis. Towards the end of his stay in hospital, he was prescribed warfarin (medication used to thin the blood to prevent it from clotting). His conduct in hospital was said to be disruptive. He was described by the doctor in charge of his care as being "verbally abusive and aggressive to staff".

103. On his return to Frankland, the man again stayed in the healthcare centre. The day after his return he refused to take his medication as he did not have a carbonated (fizzy) drink to take it with. He said he would not drink water or milk. The following day, he declined to go to hospital for dialysis as he wanted to make a legal telephone call. He also refused to have his International Normalised Ratio taken (INR, a measure of the effectiveness of warfarin treatment) and was not therefore permitted his dose of warfarin. (Clinicians are not allowed to give warfarin without first checking the INR as otherwise they might give an ineffective or dangerous dose.)

104. On 27 June, the man requested to go to hospital for dialysis to make up for his missed session the day before. This was not possible as the

dialysis unit at the Infirmary was already fully booked. He again refused to have his INR taken and was again not given his dose of warfarin.

105. Two days later, he again refused to attend hospital for his dialysis session. He had earlier "demanded" to see the Governor of the prison. When he was told that this was not possible, he said he would not go to hospital. He later changed his mind and said he was prepared to go out for dialysis. However, he had by now missed his slot and the unit was full.

106. The man went to the Infirmary for dialysis on 1 July. This was the last session he attended. He refused to attend his next session, two days later, as he had a legal visit planned. Later that day, he told Principal Officer (PO) A and the then Head of the Business Unit that he was losing weight and did not have enough food. After discussing the matter with a prison doctor, it was agreed that he should receive extra portions. However, he declined the extra portions and said he considered the food to be "slop".

107. On 4 July, the man vomited and said he felt "hot and sweaty". He refused to take his evening medication. He was more settled the following day, but vomited twice in the early evening. He refused to attend his dialysis session on 6 July and again refused his medication. On 7 July, he refused his morning medication as he did not have a carbonated drink to take it with.

108. The following morning, the man refused to go to hospital for dialysis and did not sign a disclaimer. He again declined his morning medication. At around 11.11am, Healthcare Assistant (HCA) A went to check on him in his cell. She looked in the cell and saw that he was "slouched" on his bed. Upon entering the cell, she examined him and found that he had no pulse. She began cardio pulmonary resuscitation (CPR) and was joined by a prison nurse. A radio call for an emergency response was made by HCO B.

109. An ambulance was called, and paramedics arrived at the prison at 11.30am. Prison Doctors C and D also attended, and took over CPR from the nursing staff. Their efforts were unsuccessful, and the man's death was pronounced at 12.02pm by one of the paramedics.

110. A family liaison officer from HMP Birmingham, which is nearer to the man's family home, was asked to break the news of his death to his mother. She visited the man's mother at her home on the afternoon of 8 July. No other family members were told of the death by prison staff.

111. The funeral took place on 23 July. Although the man had converted to Islam some years previously, he had not left a will or any indication of his wishes following his death. At his mother's request, the funeral consisted of a Christian service and burial. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a

death in custody).

ISSUES

Acceptance of dialysis treatment

112. After suffering from deteriorating kidney function over a number of years, the man began dialysis treatment in July 2008. The treatment involved thrice weekly outpatient visits to the Infirmary. Each dialysis session lasted for several hours.

113. The man's compliance with his dialysis treatment was variable. Although there were some periods where he attended most of his scheduled sessions, notably in February, March and April 2009, he missed a session a week on average. These missed sessions were often followed by emergency hospital admission.

114. The man gave a number of different reasons for missing the dialysis sessions. He often said that he did not like the senior officer in charge of the escort or the level of restraints used (I discuss this in more detail later). He also declined dialysis because, he said, the treatment was not helping him or he thought the hospital staff were "negligent". A number of prison staff told the investigator at interview that he would refuse dialysis for what they thought were trivial reasons, such as disliking the content of his packed lunch. It is also recorded that he sometimes refused dialysis because he had a telephone call scheduled.

115. There were also occasions when the man would go to hospital for dialysis, only to change his mind immediately or shortly after the procedure started. Some sessions were terminated by the escorting staff on account of his abusive behaviour towards hospital staff. On other occasions, he would refuse to go to hospital in the morning, only to change his mind later in the day. On such occasions he was accommodated by the hospital where possible, subject to a free slot being available.

116. It is clearly recorded in his notes that the man was warned on a number of occasions that his refusal of treatment was likely to result in serious consequences to his health. These warnings came from a variety of sources, including the consultant nephrologist at the Infirmary and prison doctors. I am satisfied that hospital and prison staff made numerous attempts over a significant period of time to persuade him to cooperate with his treatment plan.

117. The man's mental capacity to refuse treatment was formally assessed on a number of occasions, although he often refused to participate in the assessment. Indeed, he was discharged from Frankland's mental health team caseload in March 2009 after being described as threatening and abusive during an assessment. Nevertheless, all those interviewed by the investigator who expressed a view on the subject, including Community Psychiatric Nurse A and prison doctors, were confident that he had full capacity to refuse treatment and full understanding of the likely consequences.

118. The clinical reviewer refers to National Institute of Clinical Effectiveness (NICE) guidelines, which state:

> "Treatment and care should take into account people's needs and preferences. People with chronic kidney disease should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals."

119. She goes on to say:

> "Good communication between healthcare professionals and the man was evident throughout [his] time in Frankland and every effort was made to engage him in his clinical care and subsequent management plan."

120. It is clear from prison records and interviews with staff that they found the man to be a difficult and challenging patient to manage. She concludes that he received a "very high standard of care" at Frankland. I am satisfied that staff at Frankland could have done nothing further to encourage him to engage in and comply with his treatment plan.

Provision of in-house dialysis at Frankland

121. Over the same period that the man attended the Infirmary for dialysis, another prisoner at Frankland was also going to the same hospital for dialysis three times a week (on different days to the man). These visits and the escorts involved for both prisoners used considerable resources and the prison therefore looked into the possibility of providing in-house dialysis in the healthcare centre.

122. The healthcare manager told the investigator that a cell was prepared to house a dialysis unit. However she described several obstacles to progressing the work further. Firstly, the commissioning team at the Primary Care Trust were unable to secure specialist consultants to carry out the work. Secondly, a number of healthcare staff would have to be trained to carry out dialysis, which would be time consuming and costly. Thirdly, the other prisoner was discharged from custody and it was not considered feasible to run the scheme for just one patient. She added that the man's non-compliance was not a consideration in this decision, although Prison Doctor A said he thought it unlikely that the man would co-operate with dialysis in prison.

Hospital escorts

123. One reason that the man regularly gave for not attending his scheduled dialysis sessions was that he did not like the staff who were escorting him in hospital, particularly some of the senior officers who were in charge of the escorts. He also refused dialysis on some occasions because the

escort chain was attached to his right wrist, whereas he sometimes preferred it to be attached to his left.

124. The level of security required when a prisoner attends an outpatient appointment at hospital is determined by means of an 'escort risk assessment' form, which is authorised by a senior manager. In the man's case, the judgement was that three staff should accompany him to hospital, including a senior officer who was in charge of the escort. He was double cuffed on his way to hospital (meaning that his hands were handcuffed together, with another pair of handcuffs joining his wrist to that of a prison officer). During dialysis, the handcuffs joining him to the officer were replaced by an escort chain (a long chain with a handcuff at each end).

125. Given the man's long history of abusive, violent and threatening behaviour both in prison and, on occasion, towards nursing staff at the hospital, I think that the security procedures in place were reasonable. Whilst he might have had a preference for having the escort chain on his left rather than right wrist this was, apparently, not feasible due to the position of the dialysis machine in hospital. (The machine is positioned to the patient's left, hence the officer on the escort chain had to sit to the man's right.)

126. On several occasions, the man refused to go to dialysis on account of the particular staff who were assigned to escort him. Principal Officer (PO) B, who said he got on well with him because of a shared interest in keep fit and the gym, told the investigator that the number of staff that the man did not get on with far outweighed those that he did. SO A, who knew the man well on G wing, said that it was usually staff who had placed him on report or had been involved in 'control and restraint' procedures that he did not like. I have considered the evidence carefully and found nothing to suggest that staff escorting him to hospital behaved in anything other than a professional manner.

127. A case review was held in December 2008, to discuss the man's behaviour and his frequent refusal to participate in dialysis. This identified the need to create a group of staff who he got on with. This is seemingly one of the reasons why his compliance with his dialysis sessions improved in February, March, April and May 2009. Indeed, he said himself at an ACCT case review in mid March that he had been going more often because the staff he did not like had not been on duty. It was only following his return from a four week hospital admission on 22 June that he began to consistently refuse dialysis again.

128. Ultimately, it is not for a prisoner to decide which staff accompany them on a hospital escort. Numerous factors have to be considered in determining which officers are available for escort on a particular day, most notably the shift patterns at the establishment. It is commendable that Frankland were able to provide escort staff on a regular basis with whom the man was prepared to co-operate.

129. The man's family raised other issues about his treatment whilst on escort. His mother said there were several occasions on which her son was treated unfairly by prison staff at the hospital. She described an occasion when he asked if he could have dialysis in a different arm to normal, as his usual arm was hurting him. She said that the escorting officers refused this request.

130. Although dialysis is often administered through the forearm, the man's dialysis was through an entry point in his chest. As I have already explained, he sometimes requested that the escort chain be moved from his right wrist to his left. This was not practical because of the position of the dialysis machine. The decision about which arm to use for dialysis would have been made by medical staff at the hospital rather than the prison officers.

131. A second incident described by the man's mother referred to her son being taken back to prison straight after his arrival at hospital, having been told he had "assaulted the nurse". She does not give a date when this incident was supposed to have happened. The closest similar incident described in the prison records occurred on 27 May 2009. On this occasion, he reportedly refused to start the dialysis session because he felt his handcuffs were too tight. The handcuffs were checked by escorting staff, who thought they were acceptable. The handcuffs had earlier been checked and loosened by a principal officer prior to departure from Frankland, after which he had said they were comfortable. He became verbally abusive to doctors and nurses at the hospital. After consulting the duty governor, the senior officer in charge of the escort took him back to Frankland. Given that he had been verbally abusive to hospital staff, I believe that this decision was reasonable.

132. The man's mother described an occasion on which her son took £10.00 to spend in the hospital canteen before dialysis. She said that the money was taken off him by the escorting officers, who told him he could not buy food or drink. She said that her son told her that the officers proceeded to eat and drink in front of him.

133. Prisoners at Frankland are not allowed to take any money with them on external outpatient appointments. The man was provided with a packed breakfast and packed lunch in order that he had something to eat and drink on his dialysis days. Moreover, given the length of the appointments, it is not unreasonable to expect that the escorting staff would also want to eat and drink during these hospital visits.

134. The man's mother described another occasion that she said occurred when her son was an inpatient at hospital. He had six bottles of fruit juice with him but, when he returned to the hospital room following a dialysis session, he said that the juice was gone. In these circumstances, the prison escorting staff would have accompanied him to the dialysis suite and would not have remained in his hospital room. Thefts from within the hospital are a matter for the hospital and are outside the Ombudsman's

remit. It should be noted, however, that he did not submit a 'request and complaint' form (the prison's internal complaints system) on this occasion or on any of the others I have described above.

The man's request to transfer his care to hospital

135. On 31 December 2008, the man wrote to healthcare staff and said he no longer wished to be treated at the Infirmary. He said this was due to "medical negligence and serious breach of patient doctor confidentiality". The following day he requested that his care be transferred to hospital.

136. At a case conference to discuss this request, held on 2 January 2009, it was agreed to refer the man to hospital. He was subsequently put on their waiting list. In the meantime, it was agreed that healthcare staff should continue to encourage him to attend his scheduled appointments at the Infirmary.

137. The man missed six of his scheduled dialysis sessions in January. It is not clear whether any progress was made with the referral to hospital. However, it does not appear as though he himself pursued his request to transfer his care. As I have noted earlier, he began to attend dialysis sessions regularly in February and March 2009 and did not make any more complaints about the quality of care he received in hospital.

Possibility of organ transplant

138. The man's sister said that she had offered one of her kidneys to her brother, and asked whether he was on an organ transplant list. In discussion with Prison Doctor C on 30 September 2008, a consultant at the Infirmary explained that the man was not on a transplant list because his high blood pressure precluded it. This does not appear to have changed throughout the remainder of his life. His frequent non-compliance with blood pressure medication would not have helped.

139. The clinical reviewer notes that patients with cardiovascular disease are a higher risk for transplantation. She goes on to say that the man was "thought suitable for a kidney transplant but due to his treatment non-compliance he developed severe cardiovascular disease". She concludes that had he been more compliant with his treatment "his life may have been prolonged by giving him a kidney transplant".

Management of blood pressure medication

140. The man suffered from high blood pressure in the years before his arrival in prison in 1999. His compliance with his blood pressure medication was reportedly poor prior to coming into prison. This continued from his first months in prison, and remained so for the rest of his life. A number of different medications were tried but, for various reasons, he declined them all. Even when he regularly attended his dialysis sessions, he frequently refused his medication.

141. Prison Doctor A described the man's compliance with his medication as "unpredictable". He went on to say:

> "We had some difficulty in getting him to engage with the idea of allowing us to treat his blood pressure as we thought it should be treated … I never found a reason why he didn't engage with the treatment … I strongly feel that we tried everything we could do to engage with him."

142. Prison Doctor C described how healthcare staff tried to engage with the man:

> "We all tried to be nice and we all tried to reason with him and tried to negotiate a middle position for him. But it became so impossible … he would just be so unreasonable."

143. The clinical reviewer notes that the man had "intractable high blood pressure which was very difficult to bring down and manage to an acceptable level without [his] full compliance". He sometimes kept his medication 'in possession' (meaning that one week or several weeks supply was issued for him to store in his cell and take as prescribed) and sometimes collected it on a daily basis. Although he seemingly preferred to keep his medication in possession, neither method was consistently successful in encouraging his compliance. Nonetheless, the clinical reviewer comments that his medication programme "appeared to be good practice and in line with the Nursing and Midwifery Council Standards of Medicines Management".

144. The man was warned on a number of occasions, by both prison and hospital staff, that it was important that he control his own blood pressure better. I have earlier noted the clinical reviewer's conclusion that he received a "very high standard of care" at Frankland. I am satisfied that nothing further could have been done to encourage him to comply with his medication regime.

Diet and fluid intake

145. Although he had been receiving dialysis for several months at the time, it is first recorded that the man saw a dietician on 17 February 2009. This was after he said he had lost weight. The dietician recommended that he start a course of nutritional supplements. He seemingly did not take many of his supplements as a large number were found in his cell on 1 April.

146. On 17 April, the dietician provided a suggested meal plan for the days the ma went to hospital for dialysis. Three weeks later, he met with Prison Doctor D to discuss his diet. The doctor reiterated that kitchen staff were aware of his needs, and encouraged him to make meal choices based on the advice he had been given by the dietician.

147. The man told staff on 3 July that he was losing weight and did not have enough food. After they discussed this further with a prison doctor, he was allowed extra portions of food. However, he declined this offer.

148. It was reported that the man sometimes refused to go to hospital for dialysis as he did not like the filling in his packed lunch. SO B, the catering manager at Frankland, told the investigator that the kitchen began to contact the man's wing on the morning of each dialysis session to ensure that they were able to provide the sandwich filling that he requested that day. He added that the man still refused to eat the sandwich on occasions.

149. The clinical reviewer notes that, although the multiple choice menu selections were not specific to his renal condition, "healthy options and suitable choices were available and indicated to him". She goes on to say that there is no set renal diet and:

> "Advice will vary depending on things such as [the patient's] weight, blood tests and dialysis choice … patients who are prescribed haemodialysis may require a slightly higher protein diet".

150. It is difficult to fulfil individual needs in a mass catering establishment such as a prison. However, there were indications that the man was losing weight over a period of time. Although he was offered supplements to help, he seemingly did not take them regularly. It does not appear as though his weight was recorded on a regular basis. The clinical reviewer makes the following recommendation:

> **Where dietary intervention is agreed, this should occur within the context of education, detailed dietary assessment and supervision, to ensure that malnutrition is prevented. Dietary advice should be offered to people with progressive chronic kidney disease concerning potassium, phosphate, protein, calorie and salt intake, when indicated.**

151. Towards the end of his life, the man began to refuse to take his medication unless he had a carbonated drink to take it with. He said that he did not like the prison water or milk. This was not recorded as an issue before the last few weeks of his life. Indeed, he had previously requested extra milk on occasions.

152. The clinical reviewer comments that there is "no rationale that he should receive [carbonated drinks] as part of his dietary regime". However, she goes on to say:

> "In a patient who is prescribed haemodialysis the fluid allowance often needs to be quite strictly controlled. Too much fluid accumulation will raise a patient's blood pressure and will require a longer dialysis programme to reduce the blood pressure to an acceptable level. This situation had occurred on several occasions when he continued to

drink but refused dialysis treatment, requiring the need for him to be admitted to hospital as an emergency rather than routine planned care."

153. She makes the following recommendation:

Patients receiving haemodialysis who are on a strict fluid intake regime should have their intake monitored.

Use of nursing care plans

154. The man was clearly a complex person who had several significant medical conditions and deteriorating physical health. Although he was seen virtually on a daily basis by healthcare staff, it is clear that they struggled to encourage his compliance with his treatment plan. On occasion the ACCT processes were used to encourage him to accept healthcare treatment. In addition, case conferences were held to discuss his treatment and compliance. However, he did not have a nursing care plan. Such a document would formally set out what interventions healthcare staff will deliver and what the patient could be expected to do for himself.

155. The clinical reviewer comments as follows:

"A care plan initiated by healthcare staff to address the man's medical problems that could have been transferred [around the prison] with him may have assisted the continuation of care more readily."

156. He lived in the healthcare centre inpatients unit for the last three weeks of his life. The clinical reviewer quotes Prison Service Standard 22, 'Health Services for Prisoners', which seemingly was not implemented:

"Each patient has a named doctor and healthcare worker and a care plan. The plan is initiated within 24 hours of admission [to the prison's inpatient facility] and reviewed within one week in consultation with the patient and named healthcare worker."

157. The Department of Health publication 'Guidance Notes – Prison Health Performance and Quality Indicators' also suggests that "all patients have an up to date care plan". She makes the following recommendation:

All prisoners with complex care needs should have a care plan, generated by prison healthcare, that can be transferred with the prisoner throughout the various wings of the prison to aid continuation of care.

Use of the ACCT procedures

158. Assessment, Care in Custody and Teamwork (ACCT) is the process used for monitoring and supporting prisoners at risk of suicide or self-harm. An

ACCT form was opened on 27 September 2008, when the man told a nurse at the Infirmary that his treatment made him feel suicidal. The ACCT was closed on 28 November, as he had been "more positive of late" and had attended most of his dialysis sessions. However, a new ACCT was opened on 10 December by SO A, as he had now missed a number of dialysis sessions and was not taking his medication. This ACCT was closed on 23 March 2009, as he had not missed a dialysis session for three weeks and the "issues surrounding his non-compliance have been resolved". I am pleased that staff recognised his refusal of treatment as potential self harm, and acted accordingly.

159. When an ACCT is opened, a case manager must be appointed. The case manager is responsible for leading case reviews. Prison Service Order (PSO) 2700, regarding suicide prevention and self-harm management, provides the following mandatory instruction:

> "ACCT Case Managers must be a minimum grade of Senior Officer or Nurse Band 5 and have successfully completed the training for ACCT Case Managers."

160. SO A was appointed as case manager during both of the man's periods of monitoring under ACCT procedures. However, he is not trained as a case manager and has only received the basic foundation training course. He said he was asked to lead the case reviews because the man would not participate if one of the other senior officers or principal officers was responsible. Whilst I agree that it is eminently sensible to try to encourage the prisoner's participation in the ACCT process, I am concerned that the man's case reviews were led by an untrained member of staff.

The Governor should ensure that all ACCT case managers are trained in the role, in line with PSO 2700.

161. When the man's second ACCT form was closed on 23 March 2009, a post closure review was set for 30 March. This did not take place. On the same day, he moved to the segregation unit following a period of poor conduct. SO A told the investigator that the ACCT form should have followed him to the segregation unit, and it would then be the responsibility of the unit manager to ensure that the post closure review went ahead. Seemingly this did not happen.

The Governor should ensure that ACCT post closure reviews take place as scheduled, regardless of the individual's location in the prison.

162. SO A told the investigator that he opened the second ACCT form on the advice of the safer custody team at Frankland, as the man was regularly refusing his dialysis treatment. An enhanced case review, held on 16 December, corroborated this view and recommended that he remain on an open ACCT document as long as he failed to co-operate with his treatment.

163. It appears that the man did not like being supervised under ACCT procedures. However, it is likely that the process, and its focus on improving his compliance with treatment, contributed to the increase in dialysis sessions that he attended from February to May 2009. When he began to regularly refuse dialysis again, following his discharge from hospital on 22 June, the ACCT procedures were not re-opened.

164. There seems to have been some inconsistency in whether the man's non compliance with treatment was viewed as being self harm. In practice, the use of the ACCT process as a care planning tool apparently had some success on occasion. However, a clinically-led care planning approach, as I have already recommended, may have improved consistency in his management and care which would have been good practice.

Time spent on basic IEP level and in Frankland's segregation unit

165. The man's mother said she was concerned that the time her son spent on the basic IEP level and in the segregation unit could have exacerbated his health problems. Incentives and Earned Privileges (IEP) is a three tier system designed as an incentive to reward good behaviour in prison. Incentives include access to in-cell television, more private cash to spend and more time out of cell.

166. All new prisoners to Frankland enter the IEP scheme on the standard level (unless they were an enhanced prisoner at their previous establishment). Prisoners can be placed on the basic level on the authority of a principal officer or higher grade, through not complying with the prison's expected standards of behaviour. They must receive two warnings about their behaviour before they are downgraded to basic.

167. Prisoners can be moved to the segregation unit for various reasons. The most common are as a punishment measure (known as 'cellular confinement') following an adjudication hearing, or for 'Good Order or Discipline' (known as 'GOOD', a measure which provides for the removal of a prisoner from associating with others "for the maintenance of good order or discipline or in his own interests"). Prisoners in the segregation unit may apply each day for various activities including exercise, a shower, a telephone call or visit from a prison doctor or nurse.

168. The man spent three periods on the basic IEP level whilst at Frankland. The first period was from 26 March 2008 until 21 April 2008. His second period on basic was from 6 August 2008 until 19 November 2008. He started his third period on basic on 12 February 2009 and was not upgraded before his death. He also spent several periods of time in the segregation unit. The most significant was over seven weeks from 30 March 2009 until he was admitted to hospital on 18 May.

169. During his time on the basic IEP level the man had weekly reviews of his progress, in line with the local policy. During his final period on basic,

virtually all of his weekly reviews were negative and described his poor attitude and threatening and abusive behaviour. His segregation was reviewed regularly from 30 March, all of which indicated consistent abusive behaviour.

170. The man's IEP was upgraded to standard on two occasions at Frankland, the first of which was specifically to encourage an improvement in his conduct. These upgrades were unsuccessful in the long term. Although he spent a lot of time on the basic IEP level and in the segregation unit, I have seen no evidence to indicate that the correct procedures were not followed.

171. I am satisfied that the man was a volatile prisoner who, due to his persistently disruptive and abusive behaviour, spent considerable time on the basic IEP level and in the segregation unit. A consistent improvement in his conduct was the only means by which he could avoid these penalties. Although he was made fully aware of this, he chose not to follow the advice.

172. On the basic IEP level, the man was allowed one session of exercise per day (a minimum of 30 minutes) and one session in the gymnasium per week. When he was on the standard IEP level, he was allowed the same amount of daily exercise, plus up to six gymnasium sessions per week.

173. In addition, the man spent a considerable amount of time in the segregation unit at Frankland. His longest period in the segregation unit was seven weeks from 30 March 2009 until he was admitted to hospital on 18 May. Whilst in the segregation unit he was allowed to apply for exercise on a daily basis (again, a minimum of 30 minutes) but did not have access to the gymnasium. Records show that he regularly declined exercise over this period.

174. The clinical reviewer notes that it is unclear from the records whether a particular exercise regime was identified for the man's condition. I recognise that prison and healthcare staff found him to be a demanding prisoner, and I am satisfied that decisions about his IEP level and location were made appropriately. However, it is not clear that the requirements of his health condition were considered, including the impact of a restricted regime. I agree with the clinical reviewer's recommendation and extend it slightly:

Regardless of their IEP level or their location, prisoners with chronic kidney disease should be encouraged to take exercise to help them achieve a healthy weight.

Successful resuscitation on 27 and 28 April 2009

175. On 27 April 2009, the man stopped breathing and was resuscitated by staff at Frankland. He was taken to hospital by ambulance and returned to the prison two hours later. At 4.00am the following morning, he again

stopped breathing and was resuscitated by prison staff. As previously, he went to hospital by ambulance and returned to the prison later.

176. It is commendable that staff were able to act promptly on these two occasions to save the man's life. Had he been living alone in the community, it is likely that the outcome would have been different.

Incident in which the observation flap on the cell door was shut on the man's finger

177. The man's mother described an occasion in which he was assaulted by a prison officer by having a cell door shut on his finger. This would appear to refer to an incident on 28 May 2009. Healthcare Officer (HCO) A described the events as follows:

> "We were talking through the flap in the door. I can't remember what he was asking for but it was something he wasn't entitled to, probably pop or milk. I said I didn't have any to give him. He started shouting. He then stepped forward and threw a punch … through the flap but my face was close to the flap because I was talking. I moved my face back and pushed the flap up. It was purely instinct. He then started pushing against the flap so I pushed harder. He said something like 'you hurt my fingers … they're trapped in the flap'. At that time I let the flap go and his fingers were trapped in the flap. I didn't realise at the time, I thought he was just pushing to try and get at me through the flap."

178. The man sustained lacerations to his fingers and damage to the nail on the middle and ring finger of his left hand. The wounds were treated and dressed by a nurse. He did not make a formal complaint about this incident. From the evidence available, I believe that HCO A's actions were reasonable.

Scars identified by the post mortem report

179. The post mortem report revealed a number of scars and marks on the man's body. His mother asked how he received these marks. This is not clear from his records, although the findings of the post mortem indicate that they might not have been reported anyway due to their "trivial" nature. The full finding of the post mortem is as follows:

> "The post mortem examination showed that there were no fresh injuries present. There was a small number of healing lacerations and abrasions on the back. No deep bruising was present at this site. These injuries are essentially trivial. Their aetiology [origin] is uncertain but they are entirely consistent with normal day to day activity."

Transfer from Frankland closer to the man's family

180. The man's sister asked why he was not moved to a prison closer to his family when he became ill, and added that he had not always been in a high security prison. I have explained the details of her brother's transfers earlier in my report. He moved to the high security estate in January 2007, when he transferred from Swaleside to Whitemoor. His conduct and attitude was described as very poor throughout his time in prison, despite transfers between lower category establishments to allow a "fresh start". He moved to Frankland in August 2007, following a period in which he assaulted an officer and set fire to his cell.

181. Given that the man's conduct did not improve during his time at Frankland, it is likely that, were he to move to another establishment, he would remain in the high security estate. This would restrict the options available and opportunity to transfer, as places are limited. Were he to move, it would be at the prison's prerogative. Given his medical condition and the importance of maintaining continuity of care, this would not be prudent. Alternatively, he could request a transfer. There is no evidence to suggest that he did so.

Contact with his family in the week before the man's death

182. The man's sister said that he did not speak to any members of his family in the week or two before he died. She queried whether he was asked if he wanted one of his relatives to be contacted when his health deteriorated. She also asked whether any refusal to such a request might be evidence he was suffering from dementia as a result of end stage renal failure.

183. The prison's family liaison officer telephoned the man's mother on 22 May 2009, when her son was admitted to the coronary care unit at the Infirmary. The liaison officer updated her on her son's condition. She told the investigator that she telephoned the man's mother with further updates on an average of a weekly basis for the remaining weeks of his life.

184. Telephone records show that, following his return from hospital on 22 June 2009, the man telephoned his mother's house five times. The last was on 2 July, when the call was terminated as he had run out of credit on his telephone card. He topped up his credit on the morning of 7 July, but did not make any further calls.

185. Given the above, I am satisfied that the man had reasonable opportunity to contact his family in the last weeks of his life. In addition, the clinical reviewer concludes that "there does not appear to be any evidence to support [the suggestion] that he was suffering from dementia".

Notifying his family of the man's death

186. All prisoners are asked to nominate their next of kin on arrival into prison. The man nominated his mother as his next of kin. On account of the distance she lives from Frankland, it was not practical for staff from the prison to visit her to break the news of his death. A family liaison officer from HMP Birmingham, which is near to where she lives, was asked to break the news to her. The family liaison officer visited her on the afternoon of 8 July 2009, within hours of her son's death. I am satisfied that this is in line with the practice recommended in PSO 2710, which sets out the actions to be taken following a death in custody.

187. The man's sister told one of my family liaison officers that she did not hear about her brother's death until seven months afterwards. She said she was not named as next of kin as she was estranged from her mother and another brother, and asked how the prison normally deals with such issues.

188. PSO 2710 provides the following mandatory guidance to prison Governors:

> "[They must] arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner."

189. The accompanying guidance for prison family liaison officers provides advice for managing the circumstances described by the man's sister:

> "A family may be large, split geographically, at odds amongst themselves … there may be several branches all with equal rights to information. The [prison] family liaison officer may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the family liaison officer should be prepared to deal with different sections of one family if necessary."

190. However, the above guidance is reliant on prison staff being aware of such family dynamics. There is no indication that the man asked that his sister be notified of his death or that the prison were aware that she was not in contact with her mother. Were they to be aware of this scenario, I would expect his sister to have been contacted as soon as possible after his death. I regret the delay before his sister learnt of her brother's death but believe that the prison took the appropriate actions at the time.

Return of the man's property to his family

191. The man's mother said that her son's property was not returned to the family, despite several requests. She said she was particularly keen to obtain any correspondence that her son had in his cell. His sister, on the other hand, said she was concerned that all of his property had been

returned to his mother and brother, including personal correspondence that contained her contact details. As I have said, I do not think that the prison could have been expected to know of the rift in the family.

192. Frankland's then family liaison officer told the investigator that she sent the man's mother a list of his property, with a stamped envelope in which she could return a list of the items she wanted. She said she did not receive a reply. This could have been followed up further, but this does not appear to have happened. Some time later she received a letter from the man's mother's solicitor asking for any legal paperwork. This was sent to her. As it was only legal papers, correspondence from the man's sister was not included.

CONCLUSION

193. The man's time at Frankland, particularly in the last year of his life, was dominated by his advanced kidney disease. He did not comply with his treatment plan and was regularly described as abusive and threatening. Both of these issues were a constant challenge to staff throughout the prison. I am satisfied that they did all that could reasonably be expected of them to support and encourage him to engage with his treatment. Indeed on more than one occasion I have found that staff made great efforts to provide individualised support to encourage him to accept his treatment.

194. The clinical reviewer concludes that the man was "treated to a very high standard of care" whilst at Frankland. She goes on to say that "if he had been more compliant his life may have been prolonged by giving him a kidney transplant. As such, due to his continued non compliance, there was little else the Prison Service could have done to prolong his life". I agree with this conclusion and do not believe that Frankland could have done any more to promote his wellbeing.

RECOMMENDATIONS

1. Where dietary intervention is agreed, this should occur within the context of education, detailed dietary assessment and supervision, to ensure that malnutrition is prevented. Dietary advice should be offered to people with progressive chronic kidney disease concerning potassium, phosphate, protein, calorie and salt intake, when indicated.

   Accepted – on diagnosis of a long term/chronic condition a routine referral will be initiated by nursing staff for a full nutritional assessment.

2. Patients receiving haemodialysis who are on a strict fluid intake regime should have their intake monitored.

   Accepted – due to the significant periods of unsupervised time it is only possible to maintain an accurate fluid balance with the full co-operation of the patient. In the event of a fluid balance being recommended, education will be provided to the patient that emphasises the importance of its maintenance and subsequent fluid regime.

3. All prisoners with complex care needs should have a care plan, generated by prison healthcare, that can be transferred with the prisoner throughout the various wings of the prison to aid continuation of care.

   Accepted – when a patient is discharged from healthcare, if there are continuing healthcare needs that may involve wing staff, healthcare will provide a sanitised care plan to the wing officers with the consent of the patient.

4. The Governor should ensure that all ACCT case managers are trained in the role, in line with PSO 2700.

   Accepted – all SOs and above with prisoner contact to be trained as case managers.

5. The Governor should ensure that ACCT post closure reviews take place as scheduled, regardless of the individual's location in the prison.

   Accepted – a daily list of case reviews is to be kept by the ECR, this is to be communicated to staff through the morning briefings to managers.

6. Regardless of their IEP level or their location, prisoners with chronic kidney disease should be encouraged to take exercise to help them achieve a healthy weight.

   Accepted – the importance of exercise will be highlighted at all LTC reviews.