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

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Frankland. He died in his sleep in November 2009, following a lengthy period of illness. He was 62 years old.

I offer my sympathy and condolences to the man's son and daughter. I am pleased that they were able to visit their father shortly before he died, as he had previously chosen to limit contact with his family. I apologise for the delay in issuing this report and for any additional distress caused.

An investigator carried out the investigation on my behalf. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to her for her assistance. I would also like to thank the Governor and staff at Frankland for their help during the investigation.

The man had been in prison for nearly 23 years. He chose to have limited contact with others, including healthcare staff for the majority of his time in custody. Staff first noticed that he was unwell in May 2009, but he refused to go to hospital for any treatment. A post mortem examination confirmed the cause of his death as ischaemic heart disease and an underlying coronary artery atheroma. He was also found to have diverticular disease and colonic fistulae.

The clinical reviewer concludes that, whilst he was challenging to care for in the last months of his life, staff were dedicated to making him comfortable. I, too, note the care taken by healthcare staff to manage his medical condition over a considerable period and acknowledge their dedication in spite of his lack of cooperation.

I judge that his death could not have been prevented given his reluctance to be treated and that the care given by staff was at least to the standard a person would expect to receive outside of prison. However, I endorse three recommendations by the clinical reviewer concerning adherence to policies relating to assessing mental capacity, treatment of pressure sores and record keeping.

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 **June 2011**

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SUMMARY

The man was convicted on 16 February 1987 and sentenced to life imprisonment. He spent time in several prisons before moving to Frankland. He had little contact with healthcare staff until May 2009, when they became concerned about his health and his unwillingness to engage with them. After initially refusing over two weeks to allow the doctor to examine him, he agreed to an examination in mid-June. He had a large swelling below the umbilicus (navel), which he said had been present for several months. They immediately arranged for him to be taken to hospital as an emergency admission, where he was x-rayed. He discharged himself the following day. On his return to Frankland, staff advised him on several occasions that his condition was potentially serious and needed further investigation. However, he declined to go to hospital.

His refusal of treatment led to staff monitoring him under the suicide and self-harm prevention provisions for nine days in June. It was stopped as he agreed to remain resident in the healthcare centre and accept nursing care and assistance.

In August, he agreed to go to hospital for a scan. It showed that he was probably suffering from inflammatory bowel disease but the consultant would need to see him again. He subsequently refused to see the consultant to discuss the diagnosis.

In October, one of the prison doctors was concerned about his mental state. An attempt was made to carry out a dementia screen but he would not cooperate. A few days later, arrangements were made for him to be examined by a consultant forensic psychiatrist but he again declined to allow this.

Doctors and healthcare staff told him several times that he probably had cancer and needed treatment in hospital but each time he declined medical intervention. Towards the end of October, he agreed to go to hospital. However, he discharged himself the following day, despite being told by the consultant that his condition would deteriorate and his prognosis was poor. Doctors in Frankland reinforced this message. He repeatedly made it clear that that he did not wish to go to hospital and continued to refuse treatment.

During the evening of 9 November, a nurse noticed that he had not moved since he had checked him half an hour earlier. When clinical and discipline staff went into the cell, they found no signs of life. Around an hour and a half later, an out of hours doctor confirmed that he had died. The news was broken to his family that night. A debrief was held and staff were offered support. A post mortem subsequently showed the cause of death as ischaemic heart disease and an underlying coronary artery atheroma.

I am satisfied that his death could not have been prevented, particularly as he refused to accept treatment. However, I make three recommendations in respect of procedural weaknesses identified by the clinical reviewer. They are to ensure that clinical staff follow guidance in respect of mental capacity assessments and the treatment of pressure sores as well as maintaining a complete record of all of their discussions and actions.

THE INVESTIGATION PROCESS

1. The man died in November 2009. Notices were issued to staff and prisoners to inform them of the investigation process and give them the opportunity to speak with the investigator. In the event, no one responded.

2. The local PCT commissioned a review of the man's clinical care and treatment at Frankland on my behalf. I am grateful to the clinical reviewer for her report.

3. She spoke to the investigator at the start of the review. She examined the medical records, including those on the computerised system. They both jointly interviewed a number of staff during a visit to Frankland on 7 June.

4. Given that the man spent many years in prison, I have taken the decision not to investigate events over the whole of his sentence. My report focuses on the period from mid 2009 when concern was first expressed about his physical health.

5. One of my family liaison officers made several attempts by telephone and in writing, to contact the man's daughter, his next of kin. After the investigation had been completed, it came to light that his daughter had moved house and the correspondence had not been forwarded to her until October 2010.

6. After reading the draft report, the family contacted to make two points:

    - A diagnosis of mental illness was made very early in his prison sentence. However, they feel this was never sufficiently followed up. They acknowledge their father could be difficult and disengaged but questioned the correlation between his behaviour and his mental health. They understand this matter is not directly linked with the circumstances of their father's death but they are deeply concerned by what they believe was a failure by the authorities to provide appropriate mental health intervention.

    - The family would like to have been able to re-establish contact with their father at a much earlier stage. Then they could have provided a valuable source of support for their father. The daughter wrote to the prison in June 2009 asking for information about her father's health. She was upset to receive a brief response suggesting she would have to take this up with her father directly. She later found out he was in the infirmary at the time and not able to respond himself. She felt that had staff checked his records, they would have seen that he had received no visits for years. This could have been an opportunity to establish contact with his family when his health was in decline. She feels that staff could have let her know, without betraying any medical confidence, that her father's health was poor.

HMP FRANKLAND

7. HMP Frankland is one of eight maximum security prisons in England and Wales. Frankland holds convicted category A and B adult male prisoners, as well as high risk remand prisoners. On arrival in prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D. Category A are prisoners whose escape would be highly dangerous to the public or the police or to the security of the state. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The operational capacity of the prison is 859.

8. Healthcare services at Frankland are provided by the local Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two wards with capacity for four and three prisoners respectively and ten furnished rooms. The man lived in one of these rooms for the last months of his life.

9. The most recent full inspection of Frankland by HM Chief Inspector of Prisons, dated February 2008, describes the prison as "drifting in some key areas, notably in relation to safety with a lack of evidence of a robust reduction strategy and effective staff-prisoner relationships".

10. In regard to the healthcare unit and caring for the health of prisoners, the inspection found that healthcare services were, in general, good although staffing levels were low. The inpatient unit was a good environment and patients were well cared for, although a new day centre to support mentally ill prisoners was much needed. There was excellent collaborative work between the local Primary Care Trust and the prison, with prisoners able to access equitable NHS services whilst in prison.

11. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The Board's report for the year 2008 to 2009 does not contain any issues which are relevant to the circumstances of the man's death.

12. Since my office took responsibility in 2004 for investigating deaths in prison custody, there have been a number of deaths at Frankland which are attributed to natural causes including the man's death. The circumstances of his death are different to those previously investigated but there are similar themes.

KEY EVENTS

13. The man was born in 1947 and brought up in Cheshire. He was the second youngest of six but also had five half-siblings from both of his parents' previous marriages. His mother committed suicide when he was 15 years old. He joined the army at the age of 20 where he remained for three years. He married whilst he was in the army. He and his wife had a son and a daughter but decided to separate in 1985 and subsequently divorced. In 1976 he established his own property repair business which he ran for ten years before getting into financial difficulties.

14. A few months before he committed his offence, he was assessed by a psychiatrist who suggested that the appointments should continue, but he declined. After his trial, a consultant forensic psychiatrist diagnosed that he was mentally ill and recommended that he should be transferred to a high security psychiatric hospital, but this was later withdrawn.

15. He was convicted of murder and sentenced to life imprisonment by a Crown Court on 16 February 1987. He was initially detained at HMP Manchester (then called Strangeways) and spent short periods in a number of prisons before transferring to HMP Frankland in February 1992. He isolated himself from staff and other prisoners. On several occasions staff expressed concern about his mental health but he declined to allow any assessments to be made. He also regularly declined, most recently in 2008, to participate in Parole Board hearings and Sentence Plan Boards or to cooperate with the Probation Service in planning his future.

16. He had little contact with the healthcare department until May 2009, when staff expressed concerns that he was neglecting his personal hygiene. Nurse A told Prison Doctor A on 28 May that she was concerned as he appeared to be unwell, losing weight and had bowel problems. When the doctor visited him in his cell but he refused to be examined or be admitted to the healthcare centre. He told the doctor that he had lots of problems but did not wish to discuss them and had been feeling better in the last two days. The doctor noted in the medical record that "The man did not mention any particular problem, seemed to have mental capacity to make decisions, will refer to Mental Health Team for assessment". To assess mental capacity, the individual is initially asked a series of simple questions to establish whether their level of awareness regarding who and where they are, their condition and treatment etc. Depending on their response, a more formal assessment would then be made.

17. Nurse B wrote to the man on 29 May to tell him that staff were concerned about his health and his refusal of treatment. He reminded him that a note he had written previously, saying that he would not wish to be resuscitated in the event of collapsing, was not legal and would need to be validated by a solicitor. He was told that, in these circumstances, staff would intervene and provide treatment.

18. A week later, on 3 June, Nurse A visited him in his cell to weigh him. Staff had reported that he appeared to have suffered further weight loss and were concerned that he might be throwing away his meals. The staff also believed that he had become incontinent. He allowed himself to be weighed (which was 62kg) but was otherwise uncooperative about any further examination. The medical record noted that, "I believe the man received a letter from the mental health team wishing to discuss certain matters but he immediately put it in the bin." The nurse proposed that a member of the mental health team (Nurse B) should visit him as she considered that he would not initiate any contact with the team. (There is no record as to whether this visit took place.)

19. The following day, 4 June, he refused to go to the general practitioner (GP) clinic, allow his blood pressure to be taken or give blood and stool samples. He did not give a reason for refusing to cooperate with medical staff.

20. On 10 June, he asked to see a nurse as he was experiencing a lot of pain. He was examined by Prison Doctor B in the healthcare wing and agreed to go to hospital as an urgent admission. In her referral letter to the hospital of the same day, she reported that he had previously declined any medical intervention. He had lost significant amounts of weight and had a large reddened and inflamed irregular swelling below the umbilicus (navel) which was protruding on the abdominal wall, and he had told her had been present for several months. He also had diarrhoea and blood in his faeces. She suspected that he had a tumour.

21. He was admitted to hospital on 10 June. The consultant surgeon reported to Frankland's doctor that he was clinically anaemic and cachectic. (Anaemia is the result of not having enough red blood cells in the blood. Cachectic is a general physical wasting resulting from any debilitating chronic disease.) The consultant radiologist confirmed that the x-ray of his chest showed that his lungs were clear. However, the x-ray of his abdomen showed soft tissue density in the pelvis above the abdomen which suggested erosion of the sacroiliac joints bilaterally (that is wearing away of the joints in the pelvis area). The radiologist recommended further investigation by way of a computerised tomography (CT) scan of the abdomen or pelvis area. (A CT scan uses x-rays and a computer to generate detailed images of the inside of the body.)

22. The following day, 11 June, he discharged himself from hospital before the CT scan could be taken. On return to Frankland, he was admitted to the healthcare centre but discharged himself. He signed a statement that he did not wish to have any nursing contact when he returned to the wing, his decision was taken against the advice of nursing staff and he understood the potential adverse consequences for his health. Nurse A told him that, if he needed any assistance from her or any other nursing staff, he should let staff on the wing know. He told her that he would not take up the offer.

23. Later that day, he fell when collecting his meal. The clinical record described the injury as "a red area on his forehead". He told staff that he had lost his balance before falling. He declined the offer made by Nurse A to be admitted

to the healthcare centre, and again signed that he understood he was refusing treatment against medical advice. He agreed to staff collecting and bringing his meals for him. On the following day, the nurse visited him in his cell to offer any help but he declined and told her to leave.

24. On 13 June, Officer A noticed that his condition appeared to have worsened. Faecal fluid was running from the mass on his abdomen and he said he was in pain. He agreed to go to the healthcare centre where he was examined by Prison Doctor B, who prescribed codeine phosphate (a pain killer) and domperidone (which regulates nausea and vomiting). The following day, he refused to have the dressings changed on the open wound on his abdomen and so dressings were left with him to use.

25. The next day, 14 June, staff put in place an Assessment, Care in Custody and Teamwork (ACCT) plan because of his refusal to accept any treatment at hospital or in the healthcare centre despite medical advice. (ACCT is used to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner is subject to regular case reviews that will decide the level of observations/conversations to be carried out at intervals determined by their perceived level of risk.) As part of the process, staff were required to conduct observations on him once an hour and have quality conversations with him four times a day. An assessment interview took place the following day, 15 June.

26. It is recorded in the medical note for 15 June that Prison Doctor B had tried to explain to him about the result of the x-ray taken at hospital and that his condition was potentially serious. He told the doctor that he believed he was suffering from an abscess, although he also said it might be cancer. Nurse C, Clinical Team Leader, and Nurse A spoke to him about returning to hospital for further investigation of his abdomen. However, he refused and also declined to remain in healthcare.

27. Nurse C led an ACCT case review on 16 June, which was attended by him and Officer B. She recorded that he had been "admitted to healthcare for observation and support due to his deteriorating condition". She added that he was very selective about accepting any care. Although he had accepted help with some aspects, he refused any intervention from the doctor.

28. Over the next few days, nursing staff changed his dressing each day and helped with his personal hygiene. He was offered but declined the opportunity of a Macmillan nurse to visit him. (Macmillan nurses provide support for people diagnosed with cancer.) He refused to allow Prison Doctor B to examine him on 23 June. He told the nurses that he was aware that the discharge from his abdomen was abnormal but did not want any treatment or further input from the doctor. In regard to his mental state, the clinical record shows "He appears to have the capacity to make this decision [to refuse treatment] and can recall events from past conversations that we [with Nurse C] have had".

29. An ACCT review took place on 25 June. He was deemed not to have any active thoughts of suicide or self-harm and had never expressed such thoughts. He had accepted most of his care but continued to decline treatment for or investigation of his condition. Detailed entries of events and observations were made in the ACCT plan. The clinical record shows "Appears to have the capacity to refuse treatment." The ACCT was closed and he remained in the healthcare centre to be "observed and supported". A post closure review of the ACCT took place on 2 July and it was recorded that he continued to be nursed within the healthcare department.

30. On 7 July, Prison Doctor B told him that his diagnosis was unresolved and therefore required further examination, but it was thought that he had cancer. He refused to allow her to examine him on that occasion but did agree to be examined when she saw him two weeks later on 21 July. A further reddened small swelling was noted below the umbilicus cord. He was told that the underlying lesion was serious and needed further treatment in hospital, which he declined.

31. When seen by Nurse C on 25 July, he accepted that he would need treatment in hospital and agreed to go there. He expressed anxiety about the number of discipline staff who would be required to accompany him and was told it would be the same as when he attended hospital on 10 June for an x-ray.

32. Prison Doctor B reviewed him on 28 July and a referral note was faxed to the hospital on the same day. In her letter to the consultant surgeon, the doctor asked whether arrangements for a CT scan could be fast tracked with admission on the same day as she thought this would encourage him to agree to treatment. She decided to see him again the following day as she had been told by staff that he was non committal about having the CT scan and, if required, an operation. He confirmed that he remembered speaking to her the previous day and still wished to have treatment in hospital. As there had been no response from the hospital by 5 August to the request for an urgent scan, she asked staff to check progress with the hospital. The hospital explained that the relevant staff were both on holiday.

33. He was checked by an out of hours doctor on 16 August as staff had reported that he had not eaten anything over the past four days and had only drunk minimal amounts of fluid. The doctor reported that he was stable, well hydrated, not in any obvious discomfort and responded appropriately to questions.

34. On 18 August, he appeared to staff to be in a lot of pain, but he denied this and initially refused to see a doctor. Later in the day, he agreed to be examined by Prison Doctor B who noted that the holes in his abdomen wall continued to discharge faecal matter. He accepted codeine and domperidone.

35. He was taken to hospital on 19 August for the CT scan. When the consultant colorectal (bowel) surgeon contacted Frankland on 26 August to confirm that the result of the scan was available, he refused to agree to see the consultant

either at hospital or Frankland. Instead, the consultant was asked to put the results in writing.

36. On 1 September, he asked for medication to relieve abdominal pain. Pain relieving medication (codeine and domperidone) was prescribed and he continued to take the medication on most days afterwards. He refused to be examined by Prison Doctor B on 7 September but agreed to see the consultant colorectal surgeon provided that the appointment was not at a meal time. The doctor broached the subject again with him on 9 September as she had understood from staff that he had implied that he would not see the consultant. He would not commit to seeing the consultant.

37. Healthcare Assistant (HCA) A noted on 12 September that he appeared a little confused. He was not cooperative with Prison Doctor B when she tried to examine him on 14 September. Later that day, he told Officer C he would see the consultant colorectal surgeon at some point, and on 28 September and 5 October told her he would see the consultant if he visited the prison, but was not keen to go to hospital.

38. In the course of the doctor's examination on 5 October, he told her that the holes in his abdomen had been caused by being stabbed recently. She was concerned about the comment and arranged for him to undertake a dementia screen. Arrangements were made for Nurse A, who is a registered mental health nurse, to conduct a "mini mental health test". However, he refused to complete the test as he did not want to recall certain earlier parts of his life. The doctor researched his medical history in regard to previous mental assessments. The record showed that in 1987, before his trial, there had been some concern about his mental state but no mental disorder had been diagnosed. After his trial, he was considered for transfer to a secure hospital but his mental state was found to have stabilised. Further concerns about his mental state were occasionally raised but the doctor did not identify any further references after 1998. She recorded that she would discuss the matter with the mental health team.

39. The consultant colorectal surgeon wrote to Frankland's doctor on 6 October, confirming that the CT scan (taken on 19 August) showed that the man was probably suffering from inflammatory bowel disease and diverticular disease (abnormal pouch in the colon) and that an underlying malignancy (cancer) could not be ruled out. He added that it was difficult to be sure of the exact cause of the problem and he would need to see him again.

40. Prison Doctor B saw him on 9 October as he had been vomiting during the previous night. He told the doctor that he felt better and denied experiencing any pain. He declined medication to treat nausea and told her that he did not wish to see her again.

41. Following a review of his medical notes on 9 October, arrangements were made for a psychiatrist to examine him. A consultant forensic psychiatrist assessed him in Frankland on 15 October. He did not give straight answers to questions from the psychiatrist and shouted and swore at him, before the

interview was terminated. The medical record notes “No evidence of formal mental illness detected. No follow up required.”

42. Nurse C had a meeting on 20 October with a specialist palliative care consultant and a palliative Macmillan care nurse. The palliative team noted that there was no definitive diagnosis but nevertheless felt that, due to his deteriorating condition, their services might be needed in the future. Nurse A tried to assess his mental state but he told her that he was too tired to cooperate.

43. The consultant colorectal surgeon saw him on 21 October and told him that without surgery the outcome was poor. He said he would not agree to have any surgery to his stomach. The consultant was asked to provide an early written report.

44. Prison Doctor B told him on 26 October that surgery would help but he said he was not interested in any further intervention. The doctor, with Officer D, asked him whether he would wish to be resuscitated in the event of becoming unconscious and he was adamant that he would not wish to be.

45. The following day, he was referred to the same doctor as he had fallen. He refused to let her examine him in regard to the fall or go to hospital for treatment of his abdominal problem. On 28 October, he was reviewed by Prison Doctor C and confirmed that he did not wish any further medical intervention. Nurse C contacted the Macmillan nurse to report on the man’s general deterioration.

46. Prison Doctor A examined him on 29 October, though he was not keen to be examined. He said that was in pain all over and agreed to be admitted to hospital for treatment. The doctor spoke to a surgical registrar at the hospital and they agreed that he should be urgently admitted to the accident and emergency department. He was taken to hospital by ambulance later that day. Whilst awaiting a CT scan, he accepted antibiotics and was given four units of blood as he was anaemic.

47. The following day, he discharged himself from hospital. The consultant general surgeon told him that without treatment the prognosis (likely outcome) was poor. He replied that he understood the risk and did not want treatment. It is noted in the clinical record that he was ”deemed competent by the team and therefore discharged back to healthcare [Frankland]”.

48. In the course of giving him a shower on 31 October, the staff noticed that he had a “small 5p size sacral [pressure] sore”. He initially refused any dressing for the sore but agreed to one on 2 November.

49. On 2 November, he was noted to have a swollen left ankle and a lump on his left hip. He refused to allow medical staff to examine him and was aggressive, threatening to bite anyone who came near to him. The following day, he asked to go to hospital but would not confirm that he would remain

there and Prison Doctor B was reluctant to refer him to hospital without an assurance that he would accept treatment.

50. Prison Doctor A examined him on 4 November and discussed the management of the pain he had been experiencing in his left hip and thigh during the previous two days. He refused to go to hospital for an x-ray which the doctor considered necessary to identify whether there had been any injury. The doctor also raised the matter of treatment of the wound on his abdomen, advising him that without treatment the wound would worsen. The medical record shows "seems to be mentally competent to make decision, refusing to go out for any further investigation and intervention".

51. The Macmillan nurse and Nurse C spoke to him on 5 November. He refused investigation or treatment and told them that he preferred to stay in healthcare rather than go to hospital. The Macmillan nurse agreed to liaise with the palliative care consultant regarding placing him on the end of life pathway. (The purpose of the pathway is to provide high quality care for people approaching the end of life.)

52. Prison Doctor A saw him twice on 7 November. The doctor told him that he was probably suffering from abdominal cancer and that his condition would deteriorate without treatment. The doctor asked him whether he would wish to be resuscitated in the event of his heart stopping or if he stopped breathing. He now said that he would wish to be resuscitated and the doctor informed the governor of his wishes. (This was a change from his earlier wish not to be resuscitated.) His son and daughter visited him which he appeared to appreciate. They were upset about his long term prognosis, but thanked the staff for the care which they were giving their father.

53. On 8 November, he appeared confused as to where he was, the time and what he was doing. He gave incoherent answers to basic questions. He cooperated with staff when they sought to make him comfortable in bed and change his clothes.

54. The following day, he seemed to be confused and tired. He was seen twice by Prison Doctor B and confirmed that he did not want to be admitted to hospital. She discussed his deteriorating state with his daughter, who thought that, if her father was not going to get better, then he should not be resuscitated. In a subsequent conversation with the doctor, the daughter said she was upset about having the responsibility for any decision regarding resuscitation and might visit her father again as he had improved as a result of her previous visit. The doctor explained that, medically, he did not meet the criteria for resuscitation as he was unlikely to recover from his illness and was not fit for surgery (which he had refused), which was the only treatment that would help. The doctor signed a "Not for Resuscitation" document.

55. At 7.00pm, he was in a semi-conscious state and unable to talk or react to being spoken to. Earlier in the day, he had been able to drink small amounts of fluid but by the evening could not swallow sips of fluid or medication in

tablet form. Staff then decided to begin the end of life pathway, to ensure that he was comfortable and was not in pain.

56. Nurse D started night duty at 7.15pm and took over from the day staff. He told the investigating team that at approximately 7.30pm he carried out a routine check of prisoners and the man "appeared to be asleep on his bed. I did note some movement in him". When he checked again at approximately 8.00pm, he noted that the man had not changed position from the previous check. He summoned a colleague from the healthcare department, HCA B. The HCA called for assistance from the principal officer acting as Oscar 1. (Oscar 1 is the senior officer on duty who can be contacted by radio to respond to emergencies.)

57. Nurse D told the investigating team that the Principal Officer, the Oscar 1 officer, arrived within two or three minutes of the call and unlocked the room. The nurse went into the room with the HCA and, on checking him, found no signs of life. The nurse confirmed that he was aware that the medical notes stated that he should not be resuscitated. An out of hours doctor was called who attended at 9.30pm and, after examining him, confirmed his death.

58. The family was told of his death later that evening. The family had expressed a preference to be notified by telephone. The Macmillan nursing team was informed the following morning. The prison paid for the funeral and their family liaison officer attended with a colleague.

59. A debrief was held at 10.30pm and the prison care team was asked to provide support for staff. Police attended Frankland and found nothing suspicious about the death. A subsequent post mortem examination revealed the cause of death to be ischaemic heart disease and an underlying coronary artery atheroma.

ISSUES

60. The clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust. She identified areas where improvements to the delivery of care could be made. She adds that it is important to note that there is no reason to believe the issues she identifies in any way contributed to the death of the man and she concludes that he received "much more care than he would probably have accessed if living at home".

Treatment of the man's anaemia

61. The clinical reviewer was unable to find any evidence of his anaemia either being treated or treatment discussed with him. She adds that effective treatment might have resulted in him experiencing higher energy levels and less confusion, dizziness and risk of falls. She asked Prison Doctor B whether she had prescribed any medication to treat his anaemia. The doctor recalled that she could not remember precise details of consultations and that treatment might have been discussed. The doctor acknowledged that a record was not kept and that, in the scheme of his overall condition, treating his other conditions was more important but was still refused.

62. I endorse the following recommendation made by the clinical reviewer.

The Head of Healthcare should remind clinicians that all conversations with patients about medication must be recorded in the clinical record, even if the patient refuses the treatment proposed and it is subsequently not prescribed.

Sacral (pressure) sores

63. The clinical reviewer reported that the PCT policies for the treatment of sacral sores were not followed. (A sacral sore was seen on him when he was taking a shower on 31 October 2009.) She asked Prison Doctor B whether she had been asked to treat the sore. She replied "I might well have had it mentioned in passing … I think their care [of pressure sores] is very good in healthcare". The Head of Healthcare told her that she was aware of the PCT policy for dealing with pressure sores.

64. At interview, the clinical reviewer asked HCA A how the pressure sore had been treated. She said "we used to wash it [the sore] and put a dressing on and then our manager used to come and assess it". The medical record shows that he had refused a dressing on the sore when it was first identified on 31 October but on 2 November had a dressing on his sacrum (the large bone at the base of the spine).

65. The clinical reviewer asked her whether specialists would be engaged to deal with the sore. She confirmed that would happen if the sore was "really bad, but it wasn't".

66. I endorse the following recommendation made by the clinical reviewer, slightly recast.

The Head of Healthcare should put in place processes to ensure that staff comply with the PCT policy for the Prevention and Treatment of Pressure Ulcers.

Assessing the man's mental capacity

67. The clinical reviewer considered that at no time was a formal assessment made of his mental capacity to make a decision to refuse medical treatment. She asked the Head of Healthcare whether there was a formal process for assessing a person's mental capacity. She confirmed that there was a process and she described the procedure leading up to it. Initially the prisoner would be asked simple questions to assess his awareness of where he was and other general things. If there was a concern, there are more stages which would be covered before going on to the formal assessment.

68. The clinical reviewer asked Prison Doctor B how she would assess a person's mental capacity. The doctor told her that she would make a preliminary assessment to see if the prisoner understood. With regard to the man, the doctor did not think that an assessment needed to be documented. She said that mental health staff would undertake a more formal assessment.

69. The clinical reviewer noted that references had been made in the clinical record indicating that he had the mental capacity to make decisions. Prison Doctor B took several actions to have his mental capacity assessed (including researching his medical history, asking the mental health team to carry out a capacity assessment and a dementia screen and referring him to a psychiatrist). However, the clinical reviewer considered that it would have been beneficial for the healthcare team to have assured themselves of his capacity through the use of the PCT policy procedures. She makes the following recommendation which I endorse and slightly recast.

The Head of Healthcare should ensure that healthcare staff are aware of their responsibilities in relation to the Mental Capacity Act 2005 and PCT policy and that they assess prisoners appropriately.

Compassionate release

70. Prisoners can be released on compassionate grounds. This was not considered for him and was not possible as there had been neither a formal diagnosis, nor a firm prognosis of life expectancy.

CONCLUSION

71. It appears that throughout the man's 22 years in prison he isolated himself and had little contact with others. In addition, he did not cooperate when medical staff attempted to assess his mental state. He had been in prison for over 20 years when his health seriously declined. When he was told that he would need to go to hospital for diagnosis and treatment, he persistently refused and was aware his decision would probably lead to death. It is possible he had given up on life; however he did accept a limited amount of nursing care in his final weeks.

72. By all accounts, he was a difficult and challenging patient for the staff at Frankland. Nevertheless, as my report shows, I have found that they made great efforts to encourage him to accept treatment and make him comfortable. Although the clinical reviewer has identified the need for improvements in some clinical processes, I am satisfied that these omissions did not impact adversely on the condition which led to his death.

RECOMMENDATIONS

1. The Head of Healthcare should remind clinicians that all conversations with patients about medication must be recorded in the clinical record, even if the patient refuses the treatment proposed and it is subsequently not prescribed.

   The recommendation was accepted. The response was:

   "To be raised during the next full staff meeting on 22nd February 2011."

2. The Head of Healthcare should put in place processes to ensure that staff comply with the PCT policy for the Prevention and Treatment of Pressure Ulcers.

   The recommendation was accepted. The response was:

   "PCT Policy to be re circulated to all clinical staff for review and signing of reading list.

   Template for the assessment and treatment of Pressure Ulcers to be explored for Systemone." (SystmOne is a medical computer record system used by many PCTs.)

3. The Head of Healthcare should ensure that healthcare staff are aware of their responsibilities in relation to the Mental Capacity Act 2005 and PCT policy and that they assess prisoners appropriately.

   The recommendation was accepted. The response was:

   "PCT Policy to be re circulated to all clinical staff for review and signing of reading list."