

**Investigation into the circumstances surrounding the
death of a man, who was a prisoner at HMP Frankland,
in November 2007**

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

August 2008

This is an investigation into the circumstances surrounding the death of a man who had been in prison for several decades. He died in his bed at HMP Frankland, in November 2007. The cause of death was recorded as acute bronchopneumonia due to dementia.

The man had not been in contact with his family for many years and none of his relatives could be traced following his death. Nevertheless, I offer my sincere sympathy and condolences to all those touched by the man's death for their loss.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by a medical reviewer on behalf of the Northumberland Care Trust. I am most grateful to the medical reviewer for his assistance.

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. I am particularly indebted to the head of the business unit for the assistance she provided my investigator in her role as liaison officer.

I apologise to those affected by this report for the delay in producing it.

I make three recommendations.

Jane Webb
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man was in prison for several decades, He had lived in a number of different prisons throughout the country in his first 20 years in custody, before spending most of the rest of the prison term at HMP Long Lartin.

Following a deterioration in his health, the man was diagnosed with dementia in 2001 and Alzheimer's Disease (the most common form of dementia) in 2003. As a result he transferred to HMP Frankland in July 2004 to live on the elderly and disabled prisoner's wing, where he could receive more specialist care.

At the time of his transfer, the man's memory was already very poor. He was reluctant to have a bath or shower and would often engage in bizarre behaviour. His condition deteriorated over time and the man became increasingly challenging for staff to deal with, particularly with regards to his personal care.

In June 2006, the man had deteriorated to the extent that staff at Frankland began to look at alternative care outside of the Prison Service. A number of different opinions were held as to the most suitable accommodation for the man, ranging from a low secure dementia unit to the high security facilities at Broadmoor Hospital. What was agreed, however, was that the man would never be suitable for release into the community, on account of the underlying risk factors present.

The man was referred to Broadmoor Hospital in October 2006. After a lengthy assessment process, he was deemed unsuitable for admission in June 2007. However, the man was recommended to St Andrew's Hospital, Northampton, where, following an assessment, he was offered a place on the Foster Unit, a medium secure unit for older adults, in August 2007. By this time, the man had moved to a cell in the healthcare centre inpatient's unit at Frankland, on account of his deteriorating condition.

However, before he could take up his bed at St Andrew's, funding for the place had to be arranged. Given that the man had been in prison for several decades, there was some debate over who was responsible for providing the necessary funding. The Primary Care Trust from his home area agreed to fund the place, and a contract was sent to them by St Andrew's early November. Sadly, the man died mid November, before the contract could be signed.

The deceased was a difficult and challenging patient for staff at Frankland to deal with. Nevertheless, I am satisfied that the care that he received was respectful and, in the main, appropriate. I make three recommendations in total, including one regarding the future application of a scoring tool to determine the likelihood of those with non malignant (a severe and progressively worsening disease) conditions developing a terminal illness.

THE INVESTIGATION PROCESS

1. The investigation was opened in November 2007 when my investigator issued notices announcing the investigation 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 my investigator. No prisoners came forward as a result.
2. My investigator visited Frankland late in November. He was given access to the man's prison files, which were substantial, and toured the prison, including visiting the cell in the healthcare centre where the man lived. My investigator returned to Frankland in February 2008, when he interviewed four members of staff.
3. A clinical review, examining the medical care that the man received at Frankland, was carried out by a medical officer on behalf of the Northumberland Care Trust. I am most grateful to the medical officer for his assistance.
4. Given the time that the deceased has spent in custody, I have taken the decision not to investigate events over the whole of his sentence. The focus of my report will be on the time that the man spent at Frankland, following the diagnosis of Alzheimer's Disease.

HMP FRANKLAND

5. HMP Frankland is one of eight maximum security establishments in England and Wales. Frankland holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. Four of the six wings hold vulnerable prisoners, including B wing (where the man lived prior to his permanent move to the healthcare centre in May 2007). The operational capacity of the prison is 734.
6. Healthcare services at Frankland are provided by the County Durham Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two six-bedroom wards and eight furnished rooms. The man lived in one of these rooms for the last six and a half months of his life.
7. The most recent full inspection report by HM Chief Inspector of Prisons, dated March 2003, describes Frankland as offering a safe environment based upon good relationships between staff and prisoners. The inspection found good staff understanding of individual prisoners and their needs.
8. Following a short unannounced follow up inspection on 25 October 2005, the Chief Inspector, recorded that healthcare services at Frankland had improved since the full inspection. However, primary care still needed development and staffing shortages had hindered progress. Of the 12 healthcare recommendations made during the full inspection, nine had been fully achieved, one partially achieved and two had not been achieved.
9. The latest Independent Monitoring Board (IMB) report, for the year 2006-07, found that healthcare had improved during the course of the year. The IMB reported that morale amongst healthcare staff, which had previously been low, had stabilised and improved. They also reported that all sections of healthcare appeared to be working well.
10. This is the 15th death to have occurred at Frankland since April 2004, when I began investigating all deaths in custody in England and Wales. All but two of these have been due to natural causes, as has the one subsequent death at Frankland.
11. Of those cases that I have previously investigated one involved a man who, like the subject of this report, would have presented formidable problems for the nursing team at Frankland. In my report, I concluded that the care that the man received was "as good as could have been achieved in the community". Another case also involved a man with challenging behaviour. I reported that I was "impressed by the extent to which healthcare and discipline staff responded to (the man's) illness and made his life as comfortable and dignified as possible".

KEY FINDINGS

12. The man arrived at Frankland in July 2004. He was given a cell in the elderly and disabled prisoner's unit, on B wing. A reception health screen took place on the following day, at which the man's appearance was noted to be unkempt and frail. He said, however, that he felt "fit and well". The nurse who completed the form noted that the man's Alzheimer's meant that he had a very poor memory.
13. Over the following months, wing staff raised concerns regarding the man's ability to look after himself. In October, it was reported that he was unable to bath himself and was often incontinent of urine and faeces. In January 2005, staff reported that the man would sometimes walk around the landing naked and that he mixed his food inappropriately (by, for instance, putting custard over chicken).
14. In January 2005, the man was assessed by a locum consultant forensic psychiatrist. On the following day, the consultant forensic psychiatrist referred the man to a consultant geriatrician at a local unit specialising in psychiatry of old age. In his referral letter, the consultant forensic psychiatrist reported that the man had deteriorated in the last 18 months. He was now disoriented and his short term memory and knowledge of current events was poor. The man was, however, still able to recall historical events, such as the dates of the Second World War and the year of his imprisonment.
15. The consultant geriatrician replied in March. He reported that there was no funding in place for psychiatry of old age in-reach into the Prison Service. The consultant geriatrician therefore said that he was unable to take on the work "without official recognition and resources".
16. In April, the man was examined by the mental health team at Frankland. He undertook a mini mental state examination (MMSE, a brief questionnaire to test cognition and screen for dementia). The man scored 9/30 on the questionnaire, indicating severe dementia. It was noted that this represented a dramatic deterioration since the man's previous MMSE three months previously (the result of which does not appear to be in the medical record). The care plans that were in place for memory, orientation and personal hygiene were discussed with the man, and he signed them.
17. The man continued to deteriorate over the summer. In July, after a mental health review, wing staff reported that he was becoming increasingly violent and aggressive. An example given was that he had recently hit a member of staff with a bundle of newspapers.
18. In October, the head of prison healthcare services at Durham and Chester-le-Street PCT, wrote to the chief executive of the PCT. The PCT chief executive raised the issue of there being no funding in place for psychiatry of old age. He added that he considered that the man (and

another prisoner who had also been referred) should be treated the same as any other patient in the catchment area and that his care should therefore be covered by the existing contracts that were in place.

19. Around a month later, in November, a mental health support worker, was told by staff on B wing that the man's physical health had deteriorated. The wing staff reported that he was eating very little at present and on some days was eating nothing. A mental health support worker raised this with a prison doctor the following day and suggested that the man might benefit from Ensure (a nutritional supplement). The prison doctor felt that this wasn't necessary as long as the man was eating something. It was, however, decided to weigh the man regularly.
20. Following the chief executive's letter, a consultant geriatrician was able to visit Frankland in January 2006 to assess the man. He concluded that the man was too impaired to be considered for treatment with a cholinesterase inhibitor (a drug designed to help treat symptoms resulting from the early and middle stages of Alzheimer's). However he did consider that the man was able to cope well with the prison life, due to its unchanging regime.
21. During an evening in late February, the man slipped in his cell and banged his head. He suffered no injuries other than a graze to his forehead. A mental health support worker saw the man the following day to dress his wound. She discussed his care with wing staff, who told her that the man refused to bath or shower and only changed his clothes occasionally. The health support worker said that healthcare staff were unable to force the man to bathe against his will and that he had no other problems with his day to day living. They would, however, continue to monitor the situation.
22. The man was admitted to the healthcare centre about mid March, after developing a chesty cough. He was seen the next day by a prison doctor, who diagnosed a chest infection and prescribed amoxicillin. The man experienced another fall during the early hours of four days later. As previously, he sustained no injury other than a graze to his head.
23. Ten days after the second fall and having considered the man's case, the Parole Board recommended that he should not be released on licence and should remain in closed conditions. In their report, the Board remarked that

"there is no real way of addressing the risk factors which were certainly present at the time of (the man's) index offence and which are still seen as posing an unacceptable risk.....given his history and perceived level of risk, a continued stay in closed conditions seems the only realistic option".
24. It was reported that, during evening association on a day late in March, the man held a blanket over another prisoner's mouth and told him to shut up. The man had been heard to shout abuse at this particular prisoner in

the previous few days. He denied the allegation and was warned not to enter the other prisoner's cell at any time. Two days later the man returned to B wing from the healthcare inpatient's wing. After a couple of days back on the wing he was said to be coping well with the regime.

25. The man was reviewed by the mental health worker in mid May 2006. She gave the opinion that he had deteriorated little since she had last seen him late in February. The mental health worker noted that the man's short term memory was poor (he was unable, for instance, to recall what he had eaten for breakfast that morning) and that he needed continuous prompting and persuasion to meet his personal hygiene needs.
26. In the spring of 2006, the man's solicitor instructed a professor of psychiatry, to prepare a psychiatric report on the deceased for the Parole Board. After twice assessing the man, the professor wrote to Frankland in May. In his letter, the professor argued that the man's dementia was not as severe as the consultant geriatrician had concluded in January. He therefore recommended that an anti-dementia drug be commenced. The professor also recommended that the man should no longer be in category A conditions as his condition meant that he was not an escape risk.
27. The professor of psychiatry completed his report early June, and forwarded a copy to Frankland. On the same day he again wrote to the senior medical officer at the prison. The professor requested that the man be referred to St Andrew's Hospital, Northampton, where there is a low secure dementia unit. He argued that this was the best place for the man, given his condition. The letter was copied a consultant psychiatrist at St Andrew's, who replied on 19 June. The medical officer wrote that the man may be suitable for their low secure unit for older men and that they would be happy to carry out a pre-admission assessment to confirm this. However, he said that it was first necessary to establish the appropriate funding authority and to reach an agreement to fund any potential place taken by the deceased.
28. The prison healthcare development manager at Durham and Chester-le-Street PCT, replied to the professor of psychiatry's letter in July. She said that she had asked the Healthcare Manager at Frankland, to liaise with the prison doctors and the consultant geriatrician to ensure that the man received the recommended anti-dementia drugs. The prison healthcare development manager also wrote that any decision to transfer the deceased out of the prison environment would rest with the Prison Service.
29. In mid August, the man was assessed by a second consultant forensic psychiatrist at Frankland. The man was able to recall the year and place of his birth, although he did not detail his offence correctly. The consultant forensic psychiatrist noted that the man was abusive about the prison officers and said that he did not like to adhere to the rules. The man also

claimed that he was able to manipulate and influence officers and governors.

30. The man was found guilty, at an adjudication hearing in mid September, of using abusive words or behaviour. No details of the specific offence are available. A segregation algorithm (a means to test whether a prisoner is suitable to be segregated) was completed by a community psychiatric nurse. The psychiatric nurse noted that "at the current stage of dementia he would very quickly deteriorate (if segregated)". As an alternative punishment, the man's earnings were stopped for one week.
31. A consultant forensic psychiatrist at Frankland wrote to the medical director of Broadmoor Hospital (a high security psychiatric hospital) early October, to request an assessment. He gave the opinion that the man was not suitable for conditions of low or medium security, but also presented the professor of psychiatry's alternative view. A reply was sent from Broadmoor's Referrals and Admissions Panel late October. The reply said that Broadmoor's policy was that they could not proceed without first getting an opinion from the man's catchment area's regional secure unit. They suggested that Frankland should write to the forensic case manager at a regional secure unit in the man's home catchment area. He did so early November.
32. An assessment was subsequently carried out by a consultant forensic psychiatrist at the regional secure unit in mid December. The psychiatrist wrote to his counterpart at Frankland in late January 2007 with his findings. His opinion was that the man's dementia was moving from a moderate grade to severe. The consultant at the regional secure unit was supportive of a move to a therapeutic environment, as he felt that staff at Frankland were struggling to cope with the deceased and he would only decline further in future.
33. The consultant at the regional secure unit also wrote about the risk that the man posed. He felt that the motives for the man's crimes were still a matter of speculation and it was therefore difficult to assess the likelihood that he would carry out similar acts in the future. He went on to say that he did not think that a transfer to St Andrews was appropriate. He concluded that the most appropriate location for the man was a high security therapeutic environment. The consultant forensic psychiatrist at Frankland subsequently referred the man to Broadmoor Hospital, for a second time, early February.
34. At adjudication hearings held on two separate dates in February, the man was found guilty of three offences of using abusive words or behaviour. He was again found unfit for segregation and instead received a two week reduction in earnings.
35. The man was assessed by a member of the nursing staff in April, regarding his current level of personal hygiene. The nurse was told by wing staff that the man had been sleeping more lately. He was also

- declining all offers of a bath or shower. The man was able to walk to the healthcare centre, where he again declined the offer of a bath. He became verbally abusive to healthcare staff and refused to stay for the assessment.
36. On the following day, the man did agree to go to healthcare and allowed staff there to help him take a bath. He needed assistance to get in and out of the bath. It was requested that he be brought to healthcare on Sundays for regular personal hygiene assessments and a bath.
 37. Around two weeks later, on 1 May, the man transferred from B wing to the healthcare centre inpatients wing. His physical and mental health was continuing to deteriorate and the man was reportedly not eating and had lost weight. The move was initially a temporary one for assessment and to monitor the man's nutritional status. However, he did not return to B wing and remained as an inpatient in healthcare for the remainder of his life.
 38. The man was assessed by a prison doctor on the day after his transfer to inpatients. The prison doctor noted that the man was not managing on the wing due to poor self-hygiene and poor diet. He also noted that the deceased looked emaciated (extremely thin through illness or lack of food). Despite this, however, the first prison doctor remarked that the man was in good spirits and was chatty and alert. He recommended that the man take a course of fortisip (a nutritional supplement).
 39. The man settled reasonably well into the inpatients wing. He was noted on a number of occasions to be enjoying the fortisips and to be bright and alert. However, he was still refusing baths and showers on most days and, on 18 May, he refused to have a blood sample taken for testing. In the next fortnight it was noted on two occasions in his medical record that the man's legs were swollen. He made no complaint about this, however, and said that it was normal for him.
 40. In June, the chair of Broadmoor Hospital's admissions panel wrote to the consultant forensic psychiatrist at the regional secure unit in reply to his letter of January 2007 and the subsequent referral to the hospital. His letter was copied to the consultant forensic psychiatrist at Frankland. The consultant forensic psychiatrist wrote that the admissions panel had decided not to offer the deceased a bed at Broadmoor, as they could "see no value in a short term admission to high security, particularly in the light of his dementia". He went on to say that the panel's view was that the man should be assessed by St Andrew's Hospital for their opinion on his suitability for admission there. The consultant forensic psychiatrist at the regional unit subsequently wrote to St Andrews, in early June, to request that they assess the man for a potential admission to the hospital.
 41. A review of the man's security category was held late June, at the request of the director of high security prisons. A report was prepared, which included a summary of the man's current circumstances. The Local

Advisory Panel at Frankland recommended to the director that the man should remain a category A prisoner. Their reasoning for this was that the man had undertaken no offending behaviour work, due to his mental incapacity. The Panel referred to the incident of March 2006, from which they concluded that the man was “still highly dangerous”.

42. However, the director disagreed with the Local Advisory Panel and therefore directed that the man’s security category be downgraded to category B. This meant that the man would, theoretically, have greater freedom to move around the prison and reduced security on hospital visits. The following reasoning was given:

“Whilst the director agreed with the local panel’s view that the man remained highly dangerous and insightful (and he could not foresee a time when it would ever be considered safe to release him into the community), he considered that the man’s overall circumstances – particularly those relating to his age and infirmity – were such to suggest that he could now be adequately managed and contained as a category B prisoner.”

43. The man continued to decline showers nearly every day throughout July and August. There were complaints from staff that he was becoming more abusive when refusing baths and showers in July, although he seemed to become more settled in August. Nevertheless, it is apparent that it was extremely difficult to get the man to engage with personal hygiene.
44. Late July, the man was assessed for a second time by a consultant geriatrician, at the request of the healthcare manager. The consultant geriatrician wrote to the healthcare manager in early August with his findings. He felt that the man appeared to have changed little since his last assessment and was very institutionalised. The consultant geriatrician concluded that it was difficult to see the man ever being managed outside of prison or a special hospital.
45. The consultant psychiatrist at St Andrew’s Hospital, wrote to the consultant at the regional secure unit in August, following his referral two months earlier. The man had been assessed in July by two medical officers from St Andrew’s. As a result, the consultant psychiatrist at St Andrews offered the man a place on a medium secure unit for older adults. He added that a full assessment and treatment plan would be drawn up and forwarded. It would also be necessary to arrange funding for the man’s place before he could take it up.
46. The man was reasonably settled through September, although he complained of abdominal pain and headaches towards the end of the month. It was established that he had been unable to open his bowels for some time, and he was prescribed a laxative.

47. In early October, the community psychiatric nurse at Frankland, spoke to the consultant psychiatrist at St Andrew's with regard to the man's transfer. She was told that he would be transferred as soon as the next bed was available.
48. One afternoon late in October, a nurse found the man sitting on the floor of his cell. He told her that he had missed the bed when trying to sit down. The man was helped up by staff and examined for injuries, of which there were none.
49. Around a week later, still in October, the man was again found on his cell floor in the afternoon, on this occasion by second nurse. The man told the nurse that he had slipped and had hurt his right arm and shoulder. On examination, the man was found to have limited movement in his right arm. He was given a sling by the nurse and an appointment was made with the doctor.
50. On the following day, the man attended the Accident and Emergency Department at a local hospital. An x-ray revealed a fracture at the top of the humerus (the long bone in the arm running from the shoulder to the elbow). A consultant orthopaedic surgeon decided against an operation. The man was subsequently discharged with a 'collar and cuff' style sling. However, he usually refused to wear the sling and would take it off as soon as it was put on.
51. At around 3.00am on 2 November, the man was found lying on the floor of his cell. He was unable to explain how he had got there. He was helped back into bed and it was noted that he had received no further injuries.
52. The man was again found lying on the floor of his cell in the early hours of the morning on both 9 and 10 November. On both occasions he was helped to his feet and said he had no pain and no further injuries. In the afternoon of 11 November, he was found sitting on the floor of his cell and said that he had missed his chair when sitting down. A nurse examined him and found no new injuries. However, the man said that he had pain in the same area that he had fractured previously. The nurse made him an appointment with a prison doctor due to a "deterioration in mobility, increase in incontinence and general condition".
53. As a result, the man was seen by a prison doctor on 12 November. The prison doctor recorded that the man was "non-specifically unwell" and that, for unspecified reasons, he was unable to examine the man that day.
54. Three days later, the man saw a prison doctor for a second time. He recorded that the man was "not 100%". The man refused even a basic examination and was noted to be alert and pushing the doctor away when he tried to examine him. The doctor advised that they "watch and wait".
55. On 16 November, a "named patient agreement" was sent by St Andrew's Hospital to the Primary Care Trust covering the man's home area, who

had agreed to fund the man's place at the hospital. This agreement is essentially a contract which, once signed, would commit the Primary Care Trust to funding the place.

56. On the following day, the man was noted to be "very poorly" and not walking about (as he usually did) or talking to anyone. The next morning he had a shower, but was noted to be very withdrawn and unable to attend to his own needs. He sat in his chair all day, refused his medication and had very little to eat. At around 9.00pm that evening, the man was found lying on the floor of his cell. He was checked over by a nurse and helped back into bed.
57. At around 9.00am on a day in November, a healthcare support worker took the man's medication to his cell. She found the man looking unwell and unable to speak clearly. The healthcare support worker took the man's blood pressure which, at 67/43, was low. She offered him oxygen, which he declined, and asked the second prison doctor to attend.
58. A prison doctor saw the man in his cell at around 9.05am. He noted that the man was pale and his breathing was shallow. The doctor suspected that the man may have a chest infection or urinary tract infection. However, the man would not allow the doctor to examine him. The prison doctor referred the man to a local hospital and was told that he could be admitted in one to two hours once a bed was available.
59. Shortly before 11.00am, the man's condition deteriorated and he stopped breathing. The prison doctor was called, and pronounced death at 11.05am.
60. A post mortem examination revealed the cause of death to be acute bronchopneumonia due to dementia. The man had not had any contact with his family for a number of years, and no relatives could be traced. As such, his funeral was arranged by prison staff.

ISSUES

The man's proposed move to St Andrew's Hospital

61. The possibility of the man moving to St Andrew's Hospital was first raised by the professor of psychiatry in his report of June 2006. He recommended that the man be considered for transfer to a low secure dementia unit at the hospital.
62. A consultant forensic psychiatrist at Frankland did not agree with the professor. He was concerned about the risk that the man posed, and referred him instead to Broadmoor Hospital, a high security psychiatric hospital, in October 2006.
63. In line with Broadmoor's admissions policy, the man was assessed by a consultant forensic psychiatrist from a regional secure unit in his home catchment area in December 2006. The psychiatrist agreed with his counterpart at Frankland that a transfer to St Andrew's was inappropriate and concluded that a high security therapeutic environment was the most suitable location for the man. As such, the man was referred to Broadmoor for a second time.
64. In June 2007, the admissions panel at Broadmoor decided not to offer a place to the man. They suggested that St Andrew's might be suitable and a referral was subsequently made. After an assessment in July, a consultant psychiatrist at St Andrew's wrote to offer the man a place on a medium secure unit for older adults, in mid August.
65. Given the amount of time he had spent in prison, the man represented a unique case. Once his dementia reached the stage where it became appropriate to consider transferring him to an environment outside of the Prison Service, it is inevitable that there would be differences of opinion over the most suitable place for him to live. Whilst the professor of psychiatry advocated a low secure unit at St Andrew's, others disagreed with this view. Given these differences of opinion, and considering that the man was still a category A prisoner at the time, it was reasonable to use caution and initially refer to Broadmoor, a hospital with the highest recommended security level.
66. When the man was declined admission to Broadmoor, a prompt referral was made to St Andrew's Hospital. Once he was assessed and offered a place, it then became necessary to acquire the necessary funding to pay for the man's care.
67. In his clinical review, the medical reviewer, for the Northumberland Care Trust, says that:

"Where it is clear there is a need for a transfer to a different environment for terminal care, such a transfer should be arranged

promptly with a minimum delay to enable appropriate planning of terminal care.”

68. Unfortunately the man was unable to take up his place at St Andrew’s due to the length of time it took to organise funding for the place. The medical reviewer describes this delay as “regrettable”. The difficulties in the man’s case stem from the length of time that he had spent in prison. The usual scenario would be that the Primary Care Trust (PCT) covering the home probation area would pay for the placement. However, as the man had not lived in his home area for over 50 years there was some debate as to whether the PCT was still responsible for funding.
69. The PCT covering the man’s home area did eventually agree to fund the place at St Andrew’s. An agreement was sent to them by the funding co-ordinator at the hospital, in November 2007. Sadly, the man died before the agreement could be signed.

The deceased’s care at HMP Frankland

70. The medical reviewer notes that the man’s deteriorating condition was recognised in June 2006. At that point “consideration was given to his future health and well being within a prison environment”. However, he goes on to say that:
- “Given his weight loss, confusion and mobility problems, likelihood of his death might have been assessed using a specific tool for patients with non malignant conditions. Such a tool can predict the likelihood of death in patients with progressive debilitating diseases.....Given the increasing ageing population of prisoners at Frankland, it is important that the Prison Service looks at the provision of environments compatible with terminal care for those with malignant and non-malignant terminal conditions”.
71. The medical reviewer makes the following recommendations, which I endorse.

The head of healthcare should consider the application of a scoring tool to determine the likelihood of those with non malignant conditions developing a terminal illness.

An assessment should be undertaken of the suitability of the environment within the healthcare unit for the care of terminally ill prisoners.

Anti-dementia medication

72. In his letter to Frankland of 24 May 2006, the professor of psychiatry recommended that the man be started on an anti-dementia drug. In his clinical review, the medical reviewer notes that it is not clear whether this

medication was in fact commenced. From the medical record and prescription charts, it does not appear that this was the case.

73. In contrast to the professor's view, a consultant geriatrician had, five months earlier, concluded that the man was too impaired to be considered for treatment by medication. My investigator contacted the medical reviewer for his view. He replied as such:

"Given the deterioration over a number of years and the view from one doctor looking after him that his dementia was too advanced, the addition of anti-dementia drugs at that stage would be unlikely to have had any significant beneficial impact on him.....he was also poorly compliant with medication and self care, which would add weight to the argument against commencing treatment".

The deceased's numerous falls in the weeks prior to his death

74. The man was found either lying or sitting on the floor of the cell on a total of seven occasions in the month leading up to his death. On some occasions he said that he had missed his bed or chair when trying to sit down, and on other occasions he was unable to explain why or how he got to be on the floor. On one occasion, during the afternoon of October 2007, the man fractured his humerus when falling.
75. The medical reviewer notes that "it is likely that the man's falls were as a result of his deteriorating mental state, his weight loss, confusion and the probability of his development of an underlying chest infection". He goes on to say that "investigation (of the underlying reasons behind the falls) would have been unlikely to have altered the outcome, hence continuing monitoring and support in his prison healthcare environment was not inappropriate".
76. A healthcare senior officer, who is also a registered general nurse, told my investigator that a mattress was put on the floor of the man's cell to protect him from further falls. She added that they also considered attaching cot sides to the man's bed but, following a risk assessment, this was deemed unsuitable. However, neither of these actions are recorded in the medical record, nor is there any record of a formal falls assessment (a means of risk-assessing and preventing falls in older people) having taken place.

The head of healthcare should remind nursing staff of the importance of undertaking and recording a formal falls assessment for all patients who are at risk of falling.

The morning of the day of death.

77. The medical reviewer considered whether a blue light ambulance should have been called as soon as the man was taken ill on the morning of the

day of death.. His opinion is that this would have made “no difference to the outcome”. The medical reviewer explained that:

“It is clear from the post mortem report that the man had significant underlying bronchial pneumonia. Given the progressive deterioration documented in his clinical records, his death could be expected and occurring within his familiar environment was appropriate”.

78. The medical reviewer concludes that the man's death was inevitable and expected, and did not relate to violence or neglect.

RECOMMENDATIONS

1. The head of healthcare should consider the application of a scoring tool to determine the likelihood of those with non malignant conditions developing a terminal illness.

Accepted – The clinical governance lead has been contacted to ask for a copy of this document and possible training for staff will be looked into.

2. An assessment should be undertaken of the suitability of the environment within the healthcare unit for the care of terminally ill prisoners.

Accepted – Frankland are establishing assessment and guidance under the KITE standards for palliative care in conjunction with a Marie Curie consultant in palliative care. Healthcare staff at Frankland also meet regularly to discuss any cases with an external palliative care team and have a named nurse who leads on this area.

3. The head of healthcare should remind nursing staff of the importance of undertaking and recording a formal falls assessment for all patients who are at risk of falling.

Accepted – Notice to staff issued and discussed in full staff briefings. The named mentioned above has been tasked with completing this.