

**Circumstances surrounding the death of a man in a
hospice whilst a prisoner
at HMP Frankland in 2007**

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

July 2007

This is the report of the investigation into the death of a man, who died at the age of 54 on 14 January 2007 at a hospice. At the time of his death, the man was a prisoner at HMP Frankland. He had been ill for some time with cancer and was receiving palliative care at the hospice.

I extend my sincere condolences to the man's family and friends for their loss.

This investigation was undertaken by my colleague. I would like to thank the Governor of Frankland, and his staff for their help and assistance with this investigation. I am also grateful to a doctor who was commissioned by County Durham Primary Care Trust to undertake a clinical review into the man's medical care while in custody.

I make two recommendations in this report and note three housekeeping points. I also record six points of good practice, two of which focus on the exceptional palliative care the man received at Frankland. In sad circumstances, my report reveals the excellent partnership working between healthcare at Frankland and the external health providers.

In this final report one recommendation has been partially accepted and the other recommendation accepted.

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

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Prisons and Probation Ombudsman

July 2007

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SUMMARY

The man was a life sentenced prisoner. A category A prisoner, he was located at HMP Frankland. He died from cancer at the age of 54 in a hospice.

In March 2002, the man had developed rectal cancer. Despite repeated counselling, he refused to undergo major surgery for a total excision of the rectum. He did agree to surgery for a more local excision of the tumour, but unfortunately when this was attempted the tumour was too large for removal.

He was then referred to a cancer treatment centre where he underwent a combination of radiotherapy and chemotherapy between May and June 2004. The man progressed reasonably well, but by May 2005 he had developed rectal pain and his prognosis was poor.

In October 2005, the man's pain was proving difficult to manage and he was seen and assessed by a consultant in palliative care, supported by Macmillan Nurses. In January 2006, the man was transferred from his residential wing to Frankland's healthcare unit where his illness could be better managed in a more appropriate environment.

The man was visited regularly by the consultant in palliative care whilst he was in Frankland. The consultant offered advice and support to both the man and healthcare staff.

A review of the man's security categorisation on 21 November 2006, concluded that he should remain a category A prisoner. He did not make any representations to the review board and refused consent for medical records to be disclosed to the board. He also indicated that he did not wish to leave Frankland for palliative care until he was actively dying.

Planning for the man's final stages of life was undertaken. A security assessment of the hospice was completed. It was noted that the man would need to be re-categorised to category B for admittance to the hospice.

On 20 December 2006, he signed a 'Do Not Attempt Resuscitation' form. By 27 December, his condition had deteriorated significantly. He was re-categorised as category B prisoner and transferred to the hospice. The man was escorted by two officers and not restrained. Following the transfer, the escorting officers wore civilian clothes. A two officer escort remained at the hospice, in an adjoining room, until the man's death on 14 January 2007.

My investigation concludes that the man received appropriate care at Frankland with good levels of partnership with the palliative care consultant and Macmillan Nurses. However, his family has raised many issues concerning the lack of communication with Frankland and their brother's time at the hospice. I judge that the appointment of a Family Liaison Officer to link between the family and the prison on the man's admittance to the hospice would have helped to resolve those issues as they arose. As it is, the family has felt angry and distressed, and without appropriate support. I

make a recommendation on this matter. In addition, I identify six examples of good practice

THE INVESTIGATION PROCESS

The investigation into the man's death was opened by my colleague on 29 January 2007. She visited Frankland and met with the Governor and the prison's Family Liaison Officer. Representatives from the Independent Monitoring Board (IMB) and the local branch of the Prison Officers' Association (POA) were informed of the investigation, but declined to see my colleague. Notices and terms of reference were sent to Frankland in advance of my colleague's visit.

My colleague reviewed the man's prison and medical records. She requested copies of relevant documents to be forwarded to her. A review of the man's healthcare was carried out by a doctor on behalf of County Durham Primary Care Trust (PCT).

My colleague returned to Frankland, on 16 March and spoke to a friend of the man.

One of my own office's Family Liaison Officers, made contact with the man's sister on 30 January. The man's sister raised some initial issues, which she wished to be considered as part of the investigation. On 15 March, my Family Liaison Officer and colleague visited the man's two sisters. Both sisters raised further questions about the death of their brother.

Their concerns were:

- What happened to the private cash and tobacco apparently held for the man by escort staff?
- Why were escort staff visited by uniformed officers?
- Why was communication with the man's family by the prison so limited?
- Why was the man sent out with so few toiletries and basic items?
- What happens now to the compensation due to the man?
- Why were there such differences in the behaviour of escort staff?
- Why was there no contact offered by the chaplaincy?
- Why was there no offer of flowers or any prison representation at the funeral?
- Why was there no up to date prison next of kin details?
- Had the man asked that his family should not be informed of his deteriorating health?

I hope that I have been able to provide answers to these matters in this report.

HMP FRANKLAND

HMP Frankland is one of eight maximum-security establishments within the Directorate of High Security Prisons. The prison holds category A and B adult convicted prisoners, and high-risk remand prisoners. Four of the six wings hold vulnerable prisoners. The operational capacity is 734.

The most recent full inspection report by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, is dated March 2003. It 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.

Following a short unannounced follow up inspection on 25 October 2005, Ms Owers recorded that healthcare services at Frankland had improved since the full inspection. Primary care still needed development, but 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.

County Durham Primary Care Trust is commissioned to deliver healthcare services at Frankland. The healthcare centre has 18 beds, all of which are linked to the office with a call bell system. A palliative care plan was developed to ensure the man received appropriate care, treatment and medication whilst he was located in the healthcare centre.

KEY FINDINGS

In December 1991, the man was sentenced to life imprisonment at Crown Court. In 1994, he transferred to Parkhurst so he could have surgery for bowel cancer in a secure environment. Following his return to Frankland, he underwent chemotherapy in hospital as the pathology report had indicated a spread of the tumour to his lymph nodes. The man continued to receive regular follow-ups at the local hospital.

In March 2002, the man was found to have abnormalities in the lower part of his rectum. Hospital doctors recommended further surgery. He refused this treatment because he said that no cure could be guaranteed.

In January 2004, his consultant surgeon, wrote to the prison's medical officer. The surgeon had reviewed the man following indications that there was a recurrence of his cancer. The surgeon informed the prison's medical officer that the man had developed rectal cancer. The surgeon was concerned for the man's symptom control, as he still refused major surgery. A compromise of removal of the tumour with follow up radiotherapy was being considered by the surgeon. This treatment was considered to be more low key, with minimal surgical intervention.

In February 2004, the man underwent an examination under anaesthetic at hospital. The tumour was extensive and could not be removed transanally. A biopsy was taken for further examination. The man was discharged back to prison later the same day. The surgeon wrote to a consultant in clinical oncology. The surgeon requested that consultant in clinical oncology consider the man for radiotherapy. The surgeon felt that the man would still decline surgery.

In March, the consultant in clinical oncology wrote to the surgeon. The consultant in clinical oncology had discussed the treatment of radiotherapy with the man. HE had told the consultant that he did not want to undergo surgery, but consented to chemotherapy in an effort to increase the response to the proposed radiotherapy. In April, the man refused the offer of further surgery.

Between May and June 2004, the man underwent chemotherapy and radiotherapy in hospital. In September, the surgeon saw the man at Frankland. The surgeon noted that the man was doing reasonably well. The man was interested to know whether the radiotherapy had made any difference to his illness. The surgeon was considering whether a computerised tomography (CT) scan or an examination under anaesthetic would be appropriate. The surgeon decided to liaise with the consultant in clinical oncology.

In October, the man was seen by the consultant in clinical oncology but refused to be examined. In December, healthcare recommended he be admitted to the healthcare centre as an inpatient, but he refused.

In February 2005, the consultant in clinical oncology wrote to the medical officer at Frankland. The consultant said that the man had refused a CT scan and that no more appointments had been made. He added that he would be happy to see the man if he was agreeable.

A letter to consultant from the prison medical officer on 3 March, said that the man had refused the CT scan as he did not wish to attend the appointment wearing prison clothing. The man was now in agreement for the scan to take place. An appointment for a CT scan was therefore made for 27 April. The results of that scan indicated that the man had some diffuse concentric thickening of the rectal wall, but there was no evidence of any secondary cancers.

On 16 June, the surgeon visited the man at Frankland. The surgeon noted that the man's major complaints were pain and what sounded like tenesmus (pain when passing stools). The surgeon also documented that the man was being well looked after in prison and was receiving a variety of pain killers. He was still adamant that he did not want surgery, and the surgeon felt this would no longer be appropriate.

On 15 July, staff in the healthcare centre wrote to the Macmillan Nursing Service for advice on the provision of care for the man, making him comfortable, and how rapidly he could deteriorate. On 31 August, a case conference was held at Frankland to discuss his future care needs. The conference was attended by prison staff, healthcare staff and a Macmillan Nurse. This multi-disciplinary meeting agreed that a Macmillan Nurse would discuss pain relief with the man, would ascertain from him what else the prison could do to help, and would speak to the Governor with reference to his category A status.

The man's security categorisation meant that he would have to be escorted by three prison officers. Some local hospices were willing to take him whilst he was still a category A prisoner, but had reservations about the security of their rooms (for example one hospice expressed concerns that all their rooms were on the ground floor with immediate access to the garden area).

On 6 October, a Consultant in Palliative Medicine, wrote to the GP at Frankland. The palliative care consultant had assessed the man's care needs. The palliative care consultant reviewed the man's medication including his painkillers. The palliative care consultant had discussed with the man his prognosis, he was aware of his illness, but had raised concerns about where he would spend his final days. The man had indicated he hoped to be with his family or failing that he would agree to care in a hospice. It was noted by the palliative care consultant that if a compassionate discharge was appropriate, then it would be important to put the wheels in motion. The palliative care consultant would see the man in about one month's time.

On 21 October, the surgeon saw the man at Frankland. The surgeon noted that the man was receiving palliative care interventions. The surgeon recorded that he would see the man in three to four months time. On 18 November, the palliative care consultant saw the man and reviewed his care and medication. The palliative care consultant felt that the man should move onto the healthcare centre for closer monitoring and for rapid provision of breakthrough medication. On 13 December, the then Governing Governor wrote to the palliative care consultant, informing him that the prison would endeavour to facilitate appropriate care plans for the man. The updated medical reports would assist in the decision to review his categorisation and other security matters.

On 1 January 2006, the man was admitted to the healthcare centre from B wing. The move was to facilitate better care and observation of him, ensuring his illness, pain control and palliative care could be delivered in appropriate surroundings.

On 13 January, the palliative care consultant wrote to the Governor. The palliative care consultant said that a hospice would not be appropriate for the man as a category A prisoner for security reasons. The palliative care consultant felt that palliative care would be better managed at UHND. The palliative care consultant concluded that if the man no longer remained a category A prisoner, towards the end of his life, then the hospice could provide care.

On 6 February, the palliative care consultant visited the man in the healthcare centre to assess his care and medication needs. On 22 February, the man was admitted to UHND as a day patient. He was seen by the surgeon for further investigations and pain assessment. The man declined a surgical procedure to create an opening of the bowel to a body surface, forming a stoma. He wanted to return to the prison.

On 3 March, the man was seen once more by the palliative care consultant. The man had decided that he did not want any further surgical or anaesthetic intervention and wished to continue with conservative treatment. On 30 March, a Senior Dietician wrote to healthcare staff. The dietician advised that the man should have extra milk for drinks and, if his nutritional state deteriorated, supplementary drinks should be considered.

On 29 June, the man attended the Pain Management Unit at hospital. On 18 August, the palliative care consultant saw the man for an assessment of his palliative care needs. On 26 September, the palliative care consultant again saw the man, noting that he had a perianal infection for which antibiotics were prescribed. The palliative care consultant also noted that the man had been started on morphine. The palliative care consultant suggested the prescription of a single dose of morphine for severe pain. A full care plan had been implemented by healthcare staff on 1 August.

On 2 October, the man was admitted to hospital with upper abdominal pain and vomiting. He was observed overnight and discharged the following day. His pain management was helped by the involvement of the hospital palliative care team.

On 4 October, the palliative care consultant wrote to the prison GP, recommending the prescribing of a syringe driver for the man's pain control. This was agreed by the GP.

On 5 October, the palliative care consultant reviewed the man. His general condition was deteriorating. Security clearance was already in place at the hospice and another hospice near Newcastle that might be deemed appropriate for the man's final days. A full risk assessment had been undertaken at the hospice by prison staff.

On 10 October, the palliative care consultant again visited the man and noted that his symptoms were well under control. The man indicated to the palliative care

consultant that he wished to stay at Frankland until he was in the last stages of life and then transfer to a hospice, where his family would be happy to visit him.

On 21 November, the Deputy Director General of the Prison Service and Director of High Security reviewed the man's category A status. He considered all reports prepared by prison staff, noting that the man did not submit any representations nor consent for the board to consider his medical record. The deputy director decided that the man was to remain a category A prisoner.

On 1 December, the palliative care consultant saw the man. The palliative care consultant reviewed him and noted his physical condition was rapidly deteriorating and that he had declined a blood transfusion. The man had reiterated to the doctor his desire to stay at Frankland until near his death. The palliative care consultant was going to make contact with a governor to discuss arrangements for the man's re-categorisation for the transfer to a hospice. The palliative care consultant saw the man on 14 December and noted he was comfortable.

On 15 December, a governor wrote an email to the Governing Governor setting out the circumstances relating to the man's deterioration, with an update on the present situation. On 21 December, the Head of Category A Policy and Review at the Prison Service's Directorate of High Security, suggested that the re-categorising of the man would require a medical report, a review of the prisoner's medical record and a recommendation from the Governor of Frankland. The Head of Category A Policy said that the decision to maintain the man's category A status could be kept under review, with any reports being updated in the event of significant changes to his condition.

On 20 December, healthcare staff started to implement an integrated care pathway. The care pathway set out information for the man's care needs as his illness was reaching its final stages. He signed a 'Do Not Attempt Resuscitation' form the same day.

On 22 December, the Deputy Governor, wrote a report to the Governor, outlining the present situation with regard to the man's deteriorating condition and his transfer to a hospice. The Deputy Governor indicated that the use of restraints would not be required as the man had limited mobility. The Deputy Governor also noted that escort staff would wear civilian clothes whilst on bed watch duties in the hospice.

On 27 December, a medical officer at Frankland, wrote a memo to the prison's senior management. The medical officer said that the man was near to death and that a transfer to a hospice was urgent. The medical officer asked for the man to be allowed to go to the hospice without restraints. Later that day, a downgrading of his category A status was received at the prison from the Directorate of High Security Operations Unit. At 3.50 pm, the man was transferred to a hospice. The risk assessment had been completed and the man was re-categorised to category B with a two officer escort. Restraints were not applied.

The two officers escorting the man to the hospice were in prison uniform. This was the only occasion when escort staff wore uniform. All subsequent escorts were

carried out by staff in civilian clothing. A two officer bed watch was maintained throughout the man's stay at the hospice.

The man continued to receive palliative care at the hospice. His family was allowed to visit when they wished. Regular prison management checks were carried out at the hospice.

On 14 January 2007, the man was in the last stage of his life. With his family by his bedside, he passed away at 10.45 pm. His death was confirmed at 11.05 pm.

On 15 January, the Governor wrote to the man's family offering his condolences and letting them know the contact details for the Family Liaison Officer.

The man's family was offered financial assistance towards his funeral expenses. This was gratefully accepted.

ISSUES

Clinical review

A review of the man's medical care was carried out by a doctor on behalf of County Durham Primary Care Trust.

The doctor reviewed the man's prison medical record and documents from external health providers. He summarised the man's illness from 1993 when he was identified by a specialist department at an university as having an inherited predisposition to develop various cancers, in particular bowel cancer.

The doctor noted his key findings and conclusions as follows:

The man was both fortunate to have been traced by the specialist university department in relation to the family's inherited tendency to develop cancers and in particular bowel cancer. This undoubtedly improved the man's prognosis and his life expectancy.

There is no doubt that everyone involved in healthcare at Frankland, and the hospitals, went the extra mile in ensuring the man received optimal care.

The man's needs were high and as a category A prisoner this must have represented a very considerable challenge for the prison management at Frankland. Despite this, they seem to have managed to ensure that he reached most of his appointments as planned and those missed were largely a result of his refusal to attend.

Towards the end his palliative care needs were conscientiously and sensitively managed and his wishes were respected.

The man was unfortunate in having a genetic predisposition to malignancy that caught up with him the end. Nonetheless, he contributed greatly to the research and the understanding of his condition. In consequence, his children will be regularly screened to afford them the best opportunity of a healthy life.

The doctor identified the following points of good practice.

- 1. Human Genetic tracing, advice, follow up and research.**
- 2. Sensitive management and prompt treatment both in Frankland and at the various hospitals, including Parkhurst.**
- 3. Collaborative prison management approach and involvement in pro-active palliative care.**
- 4. Excellent palliative care co-ordination and management.**

Family Issues

One of my Family Liaison Officers and my investigator visited two of the man's sisters. The man's sisters raised several issues they wanted the investigation to look at in relation to their brother's death.

What happened to the private cash and tobacco apparently held for the man by escort staff and why was he sent out with so few toiletries and basic items?

The man's family had to purchase toiletries and clothing for their brother when he was admitted to the hospice. This was an added expense for the family who were not aware that the man had made a request for his property to be held at the prison.

A friend of the man, told my investigator that he had assisted in packing his friend's belongings on 27 December 2006 when the man was ready to transfer to the hospice. My investigator was told that the man's property did not accompany him to the hospice but was stored at the prison.

A Prison Escort Record (PER) form that accompanies all prisoners on transfer from prison was completed for the man's relocation to the hospice. It did not record any property, cash or tobacco.

My investigator spoke to an officer who escorted the man to the hospice. Responding by email on 28 March, the officer said that the man requested that his belongings from his cell be packed, sealed and left at the prison, for his family to collect at a later date. No cash or tobacco was taken from the man by the escort staff. The officer told a member of senior management and healthcare staff of the man's request. His property was collected by his family from the prison following his death.

On 30 March 2007, my investigator received an email in response to a request she had made to Frankland's Family Liaison Officer. the Family Liaison Officer noted that there was £24 still held in an account for the man at Frankland, and she would forward a cheque for this amount to his sister. This 11 week delay in transferring the cash held at the prison to the next of kin is unfortunate. The Governor will wish to ascertain that systems are in place to ensure such a delay does not happen again and I make the following housekeeping point:

Monies held in a prisoner's accounts should be sent to the next of kin as soon as possible following a prisoner's death.

Why were the escort staff visited by uniformed officers and why were there such differences in the behaviour of escort staff?

Prison staff carrying out escort duties at the hospice wore civilian clothes. Escort staff were placed in a room adjacent to the man's room, the door connecting the two rooms remaining open at all times. The man was not restrained whilst he was a patient in the hospice. Management checks at the hospice were carried out on a daily basis by senior staff at Frankland. The man's sisters were upset that, on occasions, these checks were carried out by staff wearing prison uniform. Relatives

visiting patients in the hospice could recognise the prison staff undertaking the management checks, and this embarrassed the man's family.

I understand the point raised by the man's family. However, I must also acknowledge that a uniformed member of the staff carrying out a brief management check might well be returning to work in the prison later that day. I would not expect that person to change clothing several times. However, I do ask that the Governor consider, as a point of housekeeping, asking such staff to wear a civilian outer jacket or jumper on such occasions so that their uniform is not obvious to a casual observer.

Officers undertaking bed watch duties should be reminded to respond sensitively to relatives, particularly when escorting terminally ill prisoners.

The man's sisters commented that on occasions escort staff failed to display sensitivity towards them as visiting relatives. I am sorry to learn this. It should be perfectly possible to show support and sensitivity, whilst still maintaining security. Nevertheless, The man's family were extremely grateful to two escort staff. They said these officers were supportive and helpful to the family whilst carrying out their bed watch duties.

I commend the officers for their sensitive approach whilst undertaking bed watch duties at the hospice.

The family also commented that hospice staff often referred to the escort officers as 'guards'. This term is not appropriate and should be discouraged. As a point of housekeeping, I believe that hospital and hospice staff should be advised of the correct way to describe prison staff and to avoid condescending or embarrassing terms of address being used.

I suggest that when officers are undertaking bed watch duties they inform hospital/hospice staff of their names so these are used when the escorts are being referred to.

Why was communication with the man's family by the prison so limited?

The man's family would have been considerably aided by the appointment of a family liaison officer when he was admitted to the hospice on 27 December 2006. Good communication between the family and the prison would have ensured that any issues could have been dealt with as they arose, rather than at a later time. This would have helped to alleviate some of the concerns the family has brought to my attention weeks after the man's death.

An investigation I mounted at Frankland, just weeks before the man's death found excellent family liaison. Whilst the man's family was grateful for the support offered, a more pro-active response would have been appreciated.

A Family Liaison Officer should be introduced to the prisoner's family when a prisoner is taken to an outside hospital or hospice for terminal palliative care.

What happens now to the compensation due to the man?

I am unable to comment on the compensation the man was in the process of claiming. I suggest that the family contacts his solicitor to ascertain whether the claim is still available to them and any legal issues arising.

Why was there no contact offered by the chaplaincy?

The man was visited by the chaplain on 10 January 2007 at 10.30 am. No details of any discussion was noted in the bedwatch notes. It is also disappointing that the chaplaincy did not have any contact with the man's family following his death. Prison Service Order 2710 notes: 'Arrange for the chaplain or other religious leader to offer to hold a memorial service for the family, other prisoners and staff, both employed and contracted (subject to any specific faith considerations and the views of the family, staff and prisoners).' In fact, a memorial service for the man was held in the chapel at Frankland. In light of Frankland's position as a high security establishment, it might not have been appropriate for the family to have attended (I have not considered this issue separately as it did not in fact arise). However, the chaplaincy should have ensured that the family was offered some form of spiritual support.

Why was there no offer of flowers or any prison representation at the funeral?

The Governor wrote to the man's sister on 15 January, expressing his condolences to the family and offering support. The letter also gave details of the prison's Family Liaison Officer. The Family Liaison Officer had contact with the man's family for which they were very grateful. His property was collected by his family from the prison.

The email response from the Family Liaison Officer received on 30 March made reference to the man's funeral. The Family Liaison Officer recalled that the prison was not made aware of the funeral date until it had passed. The family had made all the funeral arrangements. The prison had assisted only with the expenses. The prison does not routinely send flowers to funerals unless requested to do so by the family.

The issue of prison representation and flowers could both have been satisfactorily resolved had a prison liaison commenced at an earlier time. I repeat my earlier recommendation regarding timely family liaison.

Why was there no up to date prison next of kin details?

The man's sister told my investigator that the letter sent to her by the Governor on 15 January 2006 had gone to an old address. She had moved three years previously. It was fortunate that the letter was forwarded at all.

The updating of prisoners' next of kin details is often raised in investigation reports by my office. It can be very distressing for families when they cannot be contacted in an emergency. Nevertheless, I do understand that the prison is reliant on the

prisoner to update this information. I repeat here a recommendation I have made on past occasions:

An annual check of next of kin details should be incorporated into the sentence planning process.

Had the man asked that his family should not be informed of his deteriorating health?

There was no formal statement in the man's medical notes that he did or did not wish his family to be kept informed of his illness or his deteriorating health. His friend referred to the man as a private man. Healthcare and hospital staff would not have been able to release any information about his physical health without his consent. Patient confidentiality is paramount, even in these circumstances.

The man's friend was allowed to visit his friend in the healthcare centre at weekends. He would spend time chatting and supporting his friend, helping with personal hygiene, cell cleaning and taking his laundry. The man's friend was also allowed to add the man's sister's phone number to his PIN card, so he could keep the family updated with their brother's condition, as he became progressively less mobile. The man's sisters greatly appreciated the assistance and kindness that their brother's friend gave to their brother.

I commend the support of the man's friend gave to the man and recommend that his prison file should reflect the help, assistance and support he gave.

The man was not restrained whilst at the hospice. This was agreed by the Governor and the Director of High Security. I am pleased that this decision was taken, allowing the man dignity during his final days.

RECOMMENDATIONS

1. **A Family Liaison Officer should be introduced to the prisoner's family when a prisoner is taken to an outside hospital or hospice for terminal palliative care.**

Partially Accepted - Frankland will consider the deployment of a family liaison officer under these circumstances, if the prisoner's family wishes this and if there are resources available to do so.

On a national level, this will be included as good practice in the revised PSO 2710 due to be published next year.

2. **An annual check of next of kin details should be incorporated into the sentence planning process.**

Accepted - Frankland intend to introduce a check of next of kin details as part of the annual sentence plan review with all prisoners. Any amendments to the details on file will also be updated on electronic and core file records.

Good Practice

1. **Human Genetic tracing, advice, follow up and research.**
2. **Sensitive management and prompt treatment both in Frankland and at the various hospitals, including Parkhurst.**
3. **Collaborative prison management approach and involvement in pro-active palliative care**
4. **Excellent palliative care co-ordination and management.**
5. **I commend the officers for their sensitive approach whilst undertaking bed watch duties at the hospice.**
6. **I commend the support the man's friend gave to the man and recommend that his prison file should reflect the help, assistance and support he gave.**

Housekeeping Points

1. **Monies held in a prisoner's accounts should be sent to the next of kin as soon as possible following the prisoner's death.**
2. **Officers undertaking bed watch duties should be reminded to respond sensitively to relatives, particularly when escorting terminally ill prisoners.**
3. **I suggest that when officers are undertaking bed watch duties they inform hospital/hospice staff of their names so these are used when the escorts are being referred to.**

ANNEXES

1. Documents considered during the investigation