INVESTIGATION INTO THE DEATH OF A MAN, SHORTLY AFTER HIS RELEASE FROM HMP FRANKLAND ON COMPASSIONATE LICENCE ON 29 NOVEMBER 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

SEPTEMBER 2005

This is the report of the investigation into the death of a man who was in the custody of HMP Frankland when he died due to natural causes on 29 November 2004.

My office investigates the deaths of all prisoners in custody, including those due to natural causes. In this case the investigation was carried out by one of my team leaders, Jane Webb. She also commissioned an independent clinical review which is much appreciated.

The man died in a hospice, four hours after his release on compassionate licence and after years of treatment for lung cancer. I share the concerns of my investigator and the clinical reviewer about the late stage at which compassionate release was considered.

The man had no contact with his daughter or partner whilst in custody and they have not participated in my investigation. However, I would like to extend my condolences to them as they come to terms with their loss. I also commend the prison and the authorities for making it possible for him to see his daughter shortly before he died.

I am grateful to the Governor of Frankland, and to the liaison officer, for their assistance during the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2005**

CONTENTS

Annex

SUMMARY

1. The man was convicted of wounding with intent and sentenced to seven years imprisonment on 18 February 2003. The victim of the offence was his long term partner, with whom he had a child. The offence breached the terms of a County Court order, and in prison the Protection from Harassment Act applied and he was forbidden to have contact with either his partner or his child.

2. For many years the man suffered from a psychiatric condition (bi polar affective disorder) and he also abused alcohol. At the time of his sentence he had already been diagnosed with lung cancer.

3. He began his sentence at HMP Durham, before being transferred to Frankland in January 2004. Both prisons ensured that he regularly attended hospital for out-patient treatment. For much of his sentence, he was monitored under the prison's suicide and self harm arrangements. His physical health improved for twelve months from March 2003, but unfortunately the symptoms returned and continued treatment was unsuccessful. He became increasingly poorly and frail, serving most of the last months in the Healthcare Centre at Frankland.

4. As well as the psychiatric and general nursing staff within the Healthcare Centre, the man was also supported by other professionals including Macmillan nurses. Whilst each brought their own specialist expertise to bear, it is not apparent that there was a co-ordinated multi-disciplinary approach to his situation which could have considered both the security and medical issues.

5. In October 2004, the man asked about compassionate release and the following week his request was supported by an entry in the medical record. The following month the Macmillan nurse raised a number of concerns about the man's care and well being. Nearly a fortnight later he was moved to the Listener suite. On 29 November, a Board met and recommended compassionate release to a hospice. He was released the same day at 16.05 and died later at 20.30.

BACKGROUND

6. Little information about the man's background is available but it is clear that his mental health had a profound effect on his ability to maintain relationships. The psychiatric report for his last offence describes bipolar affective disorder as "*a serious mental illness, which is characterised by extreme abnormalities of mood. In severe cases patients can also become psychotic as he has done in some past episodes."* The report goes on to refer to his abuse of alcohol: "*also relatively severe and amounts to a diagnosis of a dependence syndrome."* As well as the assault on his partner, the man had committed an earlier, similar offence against his brother.

7. When he assaulted his partner, he had stopped taking the medication for his psychiatric condition and was in the early stages of relapse. By the time of his arrest he had no fixed address and throughout his sentence he had no support from family or friends. He gave his details as a single man with one child and no next of kin.

HMP FRANKLAND

8. HMP Frankland is a maximum security establishment holding category A and category B adult male prisoners. It is part of the high security directorate of the Prison Service.

9. Frankland opened in 1980 as a temporary prison staffed by the army. It closed for further modifications and reopened as a fully operational high security prison in 1983. Two further wings were added in 1998, bringing the certified normal accommodation to 653. Prisoners are held in single cell accommodation in six wings, four of which hold vulnerable prisoners.

10. The prison's Healthcare Centre has 18 beds, eight in four bed wards and the rest in single cells all of which are linked to the office with a call bell system. Adjacent to the centre is the Listener's Suite which is a large and comfortable two bedded room. The prison's Safer Custody team, rather than healthcare, determine access to this room. When the man used the Listener's Suite he was provided with an alarm to summon assistance.

11. A doctor attends the prison each morning and afterwards a GP is on call for the Durham cluster of prisons. Nursing staff, with a range of general and mental health qualifications, and care staff are on duty day and night.

12. Prisoners in the Healthcare Centre have the same regime as the rest of the prison and are locked up for the same periods. If they need attention during this time, they call for staff who obtain permission to open the cell. The prisoners' medical needs are mixed, including physical and mental illness. The Healthcare Centre also houses prisoners whose behaviour is such that they are considered unsuitable for normal location.

CONDUCT OF THE INVESTIGATION

13. As well as gathering information from the prison and medical records, the investigator and clinical reviewer carried out formal interviews with the prison's Head of Central Services and the Healthcare manager. A further interview was carried out with the Macmillan nurse employed by Derwentside Primary Care Trust who visited the man at Frankland prison.

14. Staff and prisoners at Frankland were informed of the investigation but none of them responded to the invitation to contact the investigation team.

15. The Ombudsman's Family Liaison Officer made contact with the authorities responsible for the man's daughter, who in turn consulted her to establish that she did not wish to participate in the investigation.

KEY FINDINGS

16. The man was remanded in custody to Durham on 6 November 2002 and was sentenced to seven years imprisonment on 18 February 2003. It was his second custodial sentence and he began it at Durham. He was a category C prisoner. The healthcare reception interview identified his mental and physical illness. Whilst in police custody, he had drunk a noxious fluid and the prison opened its suicide and self harm monitoring form (F2052SH).

17. The F2052SH remained open and there were several occasions when either ligatures were found in his cell or he was found to have been secreting medication. Reviews took place regularly and set detailed objectives which were allocated to specific departments and which made the connection between his physical and mental health, together with the stage of his sentence. The F2052SH was closed at the beginning of March 2003 when it was considered that he was more settled since he was sentenced. The comment was made in his personal record that he felt happier as the radiation treatment was complete and he was able to go back to work. There are some entries in his security record, but he was given enhanced status as he had begun to keep his cell in better condition.

18. The man transferred to Frankland on 23 January 2004 and was initially located on a wing. The records describe him as vague and withdrawn, but not presenting any discipline problems. He was admitted to the Healthcare Centre in March after complaining of feeling unwell. There were signs of deterioration, which suggested a recurrence of the cancer, and this was confirmed by the hospital after tests the following month. His mood was low, such that at one point he asked if staff would hasten his death if the cancer was confirmed. As a result, a F2052SH was reopened on 30 April and he was also referred to the Macmillan nurses. The F2052SH and IMR records show that he was a man in considerable distress with entries such as "*awaiting compassionate release, does not wish to die in prison. Afraid of pain".* Support for compassionate release came from the prison doctor and the Consultant Oncologist but it was decided not to grant the request as his condition stabilised in June 2004. He returned to the wing at his own request, hoping that a change of routine and social contact would help his mood. This only lasted for a few weeks before his return to the Healthcare centre.

19. The F2052SH was closed but reopened soon afterwards with entries such as "*wished he had never been born, wished himself dead."* He was seen by the mental health team and psychiatrist, and his mental health was taken into account as well as his physical wellbeing. In September, he was suspected of storing medication and said that he was scared of pain. At the end of the month, the man was described

by a Macmillan nurse as having deteriorated physically, lost weight and having difficulty walking.

20. The Macmillan nurse was interviewed as part of this investigation. She described the difficulty she faced in nursing the man within the prison where security requirements conflicted with her own professional values and standards. She believed that there were:
    - delays before the dietician and the physiotherapist were cleared for visits
    - delays before pillows, pressure relieving mattresses and cushions were allowed in
    - lack of variety in the food supplements available
    - information written in his records and passed to the staff on duty but not consistently carried out.

21. The man had hospital out patient appointments throughout his sentence and attended them regularly. Each escort from the prison should have been preceded by an assessment of the risk he would present to himself and to others. It is the risk assessment that should provide the opportunity for medical staff to indicate whether there are any medical objections to the use of restraints. 15 escort forms have been examined for the period when he was at Frankland, three of which were accompanied by a risk assessment and only the latter ones include objections to restraints. Records for a month before his death show that he was still being strip searched on leaving the prison and wore handcuffs and a closeting chain. Entries in both the forms appear to have been made by rote, and without an appropriate assessment which took into account his increasing frailty. For example, although his conviction was for an assault on his partner, the forms regularly stated that he "*was a danger to women"* although his offence was against a specific individual. There was no evidence from his criminal or prison record that he presented a risk to other women.

    The Governor should review the use of escort and risk assessment procedures to ensure that restraints are used appropriately.

22. The man was being monitored and reviewed as required by the F2052SH arrangements, as well as by a range of professionals from the prison and the community. However, it does not appear that his wellbeing was looked at holistically, that his state of mind was linked to his diagnosis, or that counselling was considered. Had he been able to receive the specialist services of the hospice at an earlier stage, he might have benefited from its compassionate environment.

23. On 28 October, the man began to vomit and was unable to eat or drink. An obstruction to his throat was suspected and he was admitted to the hospital as an in-patient. Tests confirmed the diagnosis and he was told that his prognosis was poor. He refused further treatment and expressed the wish to have early compassionate release due to his

illness. The bedwatch records state that he "*may be contemplating ending his own life as he was informed that he would not live to his parole date".* The records of the bedwatch staff are detailed and informative. Risk assessments were completed for his in-patient stay and there were medical objections to the use of restraints. These were respected and he was nursed without them.

24. The man returned to Frankland on 1 November and, on 3 November, the Medical Officer recorded his support for compassionate release. This was not achieved until 26 days later.

25. He lived for 28 more days and all but the last four were spent in a single cell in the Healthcare Centre. His condition was what would be expected for a person at this stage of a terminal illness. He was weak, unable to bathe or move from bed to chair without assistance, needed help to drink and had difficulty eating the prison diet. On three nights he complained of loud music from other patients. On another night he asked for assistance to go to the toilet and fell whilst waiting for help to come. On another occasion, he had to wait for an hour before staff were available to bathe him. It is some comfort that, as far as can be told from the records, the man does not seem to have been in pain and he was lucid and able to communicate his needs.

26. Record keeping is an integral part of nursing practice and is a tool that should help the care process. Good record keeping helps protect the welfare of patients by promoting high standards of care, continuity of care and better communication and dissemination of information between members of the multi-disciplinary team. Furthermore it should provide an accurate account of treatment, care-planning and delivery, with the ability to detect changes in a patient's condition at an early stage.

27. All medical records therefore form a vehicle for communication amongst the team. There is an absence of records, for example he was admitted to healthcare on 16 April 2004 until 26 June 2004, but there is no evidence of a care plan or daily nursing notes. Again in July he is admitted but the medical records do not make this clear and once again there is no evidence of an appropriate care planning process. There are entries in the medical record, but these fall short of evidence of an appropriate care planning process.

28. I am also disturbed about the apparent failings on occasions of staff to act on instructions entered in the medical record, in a timely manner. On 5 May 2004, it was identified that the compassionate release process should be commenced; on 25 May a letter was received from his consultant supporting this. However, the entry in the medical record states '…physical condition has settled at present, consideration for compassionate release is not being actively pursued at this time.' As the weeks went by it is evident that his condition deteriorated. There is

no evidence that this was again considered by healthcare or prison managers.

Healthcare staff must be reminded of the need to keep accurate and contemporaneous records to promote the welfare of patients by promoting high standards of care, continuity of care and better communication and dissemination of information between members of the multi-disciplinary team. Furthermore, it should provide an accurate account of treatment, care-planning and delivery, with the ability to detect changes in a patient's condition at an early stage.

27. Each prison is required to develop its own Palliative Care policy which should be a comprehensive approach to the treatment of serious illness and focusses on the physical, psychological, spiritual and social needs of the patient. The document in use at Frankland was developed with North Durham Health Care Trust and the Macmillan nursing service. It defines the ideal management for terminally ill prisoners but does not state how the shortcomings of nursing in a secure environment should be addressed. The facilities of the Healthcare Centre mean that they receive prisoners transferred from elsewhere in order that they can have 24 hour nursing care and so it is likely that this man's case will not be unusual.

28. It seems to me it would also be helpful if there were a protocol between the Macmillan nursing service and the prison to set out the arrangements for nursing terminally ill prisoners. This should lead to further improvements in working relationships.

The Primary Care Trust in partnership with the prison and Macmillan nursing service should develop a multi-disciplinary protocol for nursing terminally ill prisoners reflecting the NHS Cancer Plan and which should include:

- **Access to the prison by professional visitors**
- **Timely access to specialist services**
- **Procedures for compassionate release and release on temporary licence**

29. On 25 November, nearly a fortnight after it was first requested, the man was moved to the comparative comfort and safety of the Listener suite where he was given a radio baby alarm so that he could summon assistance. The same day a Release on Temporary Licence Board, convened for other matters, had its agenda extended to consider the man's release on compassionate grounds. The Board recommended his release and he was transferred to the hospice with the conditions that he was:

1) not allowed to visit his home locality
2) not to leave the hospice.

The prison probation officer had made contact with those responsible for the man's daughter and confirmed that she wished to say goodbye

to her father. Arrangements were made for this to happen and she visited during the few hours that he was at the hospice.

All prisoners who are diagnosed with a terminal illness should be regularly reviewed by the multi-disciplinary team and considered for early compassionate release or Release on Temporary Licence in a timely manner.

RECOMMENDATIONS

National

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Local

The Governor should review the use of escort and risk assessment procedures to ensure that restraints are used appropriately.

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