

**Investigation into the circumstances surrounding the  
death of a man on 15 February 2010 while in the  
custody of HMP Frankland**

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

**March 2011**

This is the report of an investigation into the circumstances surrounding the death of a man while he was serving a sentence at HMP Frankland. A post mortem and the subsequent Inquest found that his death was due to laryngopharyngeal ulceration and haemorrhage brought about by Crohn's disease. The man was 45 years old. I offer my condolences to his family, friends and all those touched by his death.

One of my investigators led the investigation and an independent review of the man's medical care in prison was commissioned from County Durham Primary Health Care Trust. I am most grateful for their assistance. I would also like to thank the management and staff at HMP Frankland for their co-operation during the course of this investigation.

The man who died was convicted in September 1999 and sentenced to life imprisonment. He spent the early years of his sentence at several prisons, arriving at Frankland in June 2005. After reporting abnormal weight loss and mouth ulcers in August 2006, his symptoms were investigated and he was diagnosed with Crohn's disease in October 2006. Following the diagnosis he was continually reviewed by healthcare staff and his medication and treatment were altered according to his changing needs. As the disease progressed, his pain relief included morphine. I have found that the morphine was dispensed erratically and raises issues about the Primary Care Trust policy at Frankland for dispensing controlled drugs. The Governor should work with the Primary Care Trust to ensure that very poorly prisoners can receive their medication even if they are too unwell to collect it themselves.

The man who died was admitted to hospital on 6 February 2010. During the early morning of 15 February he suffered an unexpected and ultimately catastrophic haemorrhage which led directly to his sudden and unexpected death.

I conclude that the man's death could not have been prevented. It is evident that for the most part he received equitable and responsive care throughout his time at Frankland, except for dispensing controlled drugs for pain relief. I make eight recommendations, of which four are to the Primary Care Trust about communication between healthcare staff and recording information. The other recommendations are jointly addressed to the Governor and the Primary Care Trust about administering controlled drugs, recording information and health and safety assessment reviews of the healthcare centre waiting rooms.

I am pleased to record that my recommendations have all been accepted. Three have already been implemented and the remaining five are due to be implemented in April 2011.

I apologise for the delay in issuing my report and any additional distress this may have caused.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**March 2011**

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## **SUMMARY**

The man who died was a prisoner at HMP Frankland. He died of complications brought about by Crohn's disease on 15 February 2010 in hospital. He was 45 years old and was serving a life sentence imposed in September 1999. Within a year of coming into prison the man complained of mouth ulcers and inflammation of the inside of his mouth. This periodically recurred over the following few years and he was referred to an Ear, Nose and Throat specialist.

The man transferred to HMP Frankland in late June 2005, where he had no immediate medical concerns other than an ongoing knee problem. In May and June 2006, he was treated for a perianal abscess and later a sore throat. Because of the extent of his sore throat, he was referred for diagnosis and treatment at an outside hospital under the two week rule for suspected cancer. The pain in his throat continued and he was prescribed appropriate medication including morphine, a controlled drug. A period of investigation at local hospitals by specialist doctors followed and a gastroenterology specialist diagnosed Crohn's colitis in October 2006.

Following the diagnosis, the man's treatment became more focussed and included regular assessments by prison healthcare and NHS hospital professionals. His condition fluctuated over the months and the use of adalimumab, an expensive drug which required specific authorisation from the Primary Care Trust Exceptional Cases Committee was approved. After some initial difficulty, adjustments to his diet were also made to ensure that he received food appropriate to his needs.

Throughout his time at Frankland the man's hygiene proved problematic. He did not always cooperate with his treatment regime and regularly refusing to be admitted to Frankland's in-patient department. Although, when his condition did necessitate it, he was admitted to healthcare or outside hospital for treatment.

By 23 July 2009, the man was being prescribed daily morphine for pain relief, as well as additional small doses to combat breakthrough pain. The main doses were initially dispensed at acceptable time periods, around 12 hourly, with a number of smaller doses given for breakthrough pain during the day and at night. This situation lasted for about one week until 30 July. Following admission to hospital for a few days, he returned to Frankland on 6 August and was given morphine doses twice a day. The administration of those doses was governed by the Primary Care Trust policy on controlled drugs. Healthcare staff interpreted the policy as meaning that the drug should only be issued if the man came to the healthcare centre. Administering the drug became erratic when he did not always attend.

Because of the progress of his illness and the severe inclement weather during the winter of 2009/2010, the man often felt unable to walk the distance from his wing to the healthcare centre. On those occasions, he was either taken by wheelchair, an uncomfortable experience for him given the poor

state of the prison's wheelchairs, or he remained on his wing until he felt able to make the journey. If he was unable to reach healthcare, his medication was not dispensed. The explanation for the failure to dispense his morphine on those occasions was not documented.

The man's condition continued to deteriorate and he was admitted to hospital on 6 February under prison escort. Proper risk assessments were made regarding the use of handcuffs and were periodically re-assessed. He remained at the hospital and, on the morning of 15 February, he suffered a severe haemorrhage and died soon afterwards. His death was sudden and unexpected and a later post mortem examination found that his death was due to laryngopharyngeal ulceration and haemorrhage due to Crohn's disease.

On the morning of his death, two family liaison officers from Frankland visited the man's family at their home to break the news. They spent time with the family, explained the processes following a death in prison custody and gave advice. They also gave the family a letter of condolence from the Governor and offered a financial contribution to the funeral expenses. A debrief was held at the prison and the officers who had been escorting the man were offered support.

Money and property belonging to the man who died was returned to his family at their request in mid-March 2010. Concerns raised by the family included that not all of his property was returned to them. Other concerns about aspects of his care were raised by three prisoners who were interviewed for this investigation.

An Inquest on 16 November 2011 returned a verdict that the man died of natural causes due to laryngopharyngeal ulceration and haemorrhage due to Crohn's disease.

I make eight recommendations all of which have been accepted and are to be implemented by April 2011. Two concern the policy for dispensing controlled drugs, two refer to communication between healthcare staff, three are about recording information and one concerns health and safety assessment reviews for the healthcare centre waiting rooms

## THE INVESTIGATION PROCESS

1. My investigator first visited HMP Frankland on 25 February 2010 and met the duty governor and other relevant staff. He was given a briefing about the circumstances surrounding the man's death. One of Frankland's family liaison officers was nominated as the liaison officer. An offer to meet representatives of the Prison Officers' Association was accepted. No members of the Independent Monitoring Board (IMB) were available at that time but a representative of the IMB saw my investigator during a later visit. (Every prison in England and Wales has an Independent Monitoring Board. The members are volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. The IMB also deals with complaints by prisoners and is required to produce an annual report on the prison to the Secretary of State, highlighting good practice and raising any areas of concern.)
2. Notices to staff and prisoners were published inviting anyone with information about the man who died to make themselves known to the investigator. One prisoner wrote to my office and was interviewed at HMP Woodhill some weeks later. Two others were interviewed at Frankland during the course of the investigation. The investigator also interviewed relevant prison staff. A post mortem examination took place and the police conducted an initial investigation. They found no suspicious circumstances.
3. Frankland provided copies of the man's prison and medical records. County Durham Primary Care Trust (PCT) commissioned a clinical review. The report was received on 3 August 2010 and updated on 14 September.
4. One of my family liaison officers (FLO) spoke on the telephone to the man's sister. She asked a question about the circumstances of her brother's death and later raised an issue with another of my FLOs about the return of his property. The man's sister also wanted to record that the FLO at Frankland, had been "really kind to her family and could not do enough for them".

## HMP FRANKLAND

5. HMP Frankland is a high security training prison on the outskirts of Durham. It was opened in 1980 and has an operational capacity of 859 prisoners held in seven accommodation wings. The prison holds high and standard risk category A prisoners, including those remanded in custody by the courts, and category B prisoners serving four years and over. Prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category B prisoners are people for whom the highest security conditions are not necessary but for whom escape must be made very difficult.
6. G wing, where the man who is the subject of this report lived, is an accommodation unit at the top end of Frankland. It is remote from the healthcare centre (HCC) which adjoins the main administration buildings near the front gate of the prison. In common with other wings, G wing prisoners walk or, if necessary, use a wheelchair to get to the HCC. The journey is several hundreds of metres and takes between eight and ten minutes at a normal walking pace. The route is mainly in the open air and involves going through nine separate gates all of which have to be unlocked by prison staff. The last part of the journey is under cover within the main buildings.
7. Healthcare at Frankland is provided by the County Durham Primary Care Trust. The healthcare centre is a general practitioner (GP) led 24 hour facility with an in-patient department (IPD). It runs numerous clinics from Monday to Friday.
8. HMP Frankland has an active Safer Custody Unit which is responsible for the prison's Anti Bullying Policy which was published in February 2010 and the Violence Reduction Strategy which was issued a month later.
9. HM Inspectorate of Prisons published an inspection report in February 2008. The following comments are of relevance to this report:

“4.6 The PCT had introduced a no smoking policy throughout healthcare and there had since been a dramatic drop in the number of prisoners admitted. Smokers were offered smoking cessation support. The reduced numbers held in healthcare meant that the number of beds did not reflect need.

“4.24 Prisoners with chronic diseases were managed well. A dedicated nurse was compiling registers following a review of all clinical records that had identified 240 prisoners with chronic disease.

“4.33 The level of opiate prescribing was high. About 150 prisoners were receiving opiate-based medication and there was the potential for prisoners to be bullied for it. More in our survey than the comparator said they had been victimised by other prisoners because of drugs. There was no structured approach to pain management and cell searches by healthcare staff suggested HMP Frankland that a significant proportion of medication, legitimately obtained, was finding its way on to the illicit market.”

The Inspectorate recommended that:

“4.78 A step-wise approach to pain management, such as the WHO [World Health Organisation] analgesic ladder, should be introduced. The clinical need and rationale for the use of opioid analgesics and adjunct therapy should be clearly documented for each patient and periodically reviewed.”

(The World Health Organisation analgesic ladder is a three-step approach to pain relief whose concept is to administer the right drug in the right dose at the right time.)

## KEY EVENTS

10. In September 1999, the man who died was convicted and sentenced to life imprisonment. He was later given a tariff (the period which must be served in custody before release can be considered) of 18 years. He refused to take part in any sentence planning or offending behaviour programme work throughout his sentence. He was a category B prisoner.
11. As part of his sentence progression, the man transferred to HMP Swaleside in November 1999. His Continuous Medical Record showed that on 10 July 2000, he reported sick and was diagnosed with stomatitis (an inflammation of the mucous lining in the mouth), aphthous mouth ulcers (painful sores that occur inside the mouth) for which a mouthwash and multivitamins twice daily were prescribed.
12. Three weeks later, he transferred to HMP Gartree. On reception, he had a sore left ankle and mentioned the recent mouth ulcers. He received ibuprofen and physiotherapy for his ankle pain, which improved markedly over the following two months. During 2002 and 2003, he was treated as both an inpatient and outpatient by an orthopaedic specialist and discharged in late December 2003.
13. The prison doctor at Gartree, examined the man on 14 October when he complained about a lump on the right side of his face. The doctor suspected parotitis (an inflammation of the salivary glands), and prescribed a seven day course of antibiotics and analgesia. He also referred him to the Ear, Nose and Throat (ENT) specialist at the local hospital's Department of Otolaryngology.
14. On 2 January 2004, the man complained of aphthous ulcers and was treated with Adcortyl (a corticosteroids paste for treating common mouth ulcers). He weighed 54.5kg. On 19 January, he complained of an infected spot in his anal area and investigative blood tests were carried out. Copies of the blood results are filed in his medical record but no interpretation of them is evident.
15. A Consultant ENT Surgeon reviewed the man who died on 11 February and agreed with the prison doctor's diagnosis. In a letter about the consultation, the ENT surgeon wrote that the man had complained of ulcers in his throat which were suspected to be aphthous ulcers. The man was treated by the dentist in December, who extracted a tooth and noted a small superficial ulcer on his lower gum which was treated with antibiotics and a mouthwash.
16. In late June 2005, the man transferred to HMP Frankland, where he underwent the normal induction procedure. He had no immediate medical concerns other than his ongoing knee problem and he weighed 57.6kg. He continued to refuse to take part in remedial work, sentence planning or targets. Two days after his reception, he

underwent a drugs test, which proved positive for opiates. He was charged and found guilty under the prison disciplinary code and was confined to a segregation unit cell for 14 days. (A segregation unit provides temporary accommodation for prisoners who have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.) Over the following months the man spent time in the segregation unit for disciplinary matters. During that time, he was reviewed daily by doctors and nursing staff, in line with normal segregation procedures.

17. In early May 2006, the man was diagnosed with a perianal (around the anus) abscess. He was admitted to outside hospital and the abscess was drained. He underwent tests which showed that his lower rectal mucous membranes were normal. His discharge letter identified that he was anaemic and would be investigated, including a colonoscopy (investigation of the bowel and lower gut using a flexible camera). He returned to Frankland and by 24 May, his wound had healed sufficiently for him to be discharged from the dressing clinic and advised to contact the HCC if further problems occurred.
18. In the meantime, the man who died reported "special sick" (a process whereby prisoners can get medical attention without an appointment) on 30 June, complaining of a very sore throat. The nurse recorded a green/white patch on the left side of his throat. He saw the visiting dentist the same day who noted that he had a large ulceration on the left side of his palate and prescribed a seven day course of antibiotic drugs. Ibuprofen analgesics were also prescribed and an oral rinse to be used three hourly. His diet was adjusted to include soup every day. The dentist noted that the man should see him in seven days and, if the response to the medication was poor, he would be referred immediately for an oral pathology report. The dentist saw the man on 7 July and referred him for diagnosis and treatment at an outside hospital under the two week rule. (The two week rule refers to an urgent referral to hospital for patients with suspected cancer to ensure that they are seen by a specialist within two weeks.)
19. Reporting special sick again on 11 July, the man who later died complained of feeling unwell and being in a lot of pain. The nurse recorded that he looked very unwell, was thin and had a large ulcer on his palate. His tongue had also split down the centre. Both she and the wing senior officer tried unsuccessfully to persuade him that admission to HCC overnight, until he saw the doctor the following morning, would be in his interest. The prison doctor assessed the man the following day and recorded that he was still experiencing pain in his mouth and had difficulty drinking. The doctor prescribed Oramorph (a morphine based painkiller) four times daily and Fortisip (a dietary supplement). The man again refused to be admitted to HCC and the offer was repeated on 16 July when staff thought he looked significantly worse, but was again refused.

20. Morphine sulphate, and a number of other prescribed medicines, are categorised as “controlled drugs”. They are defined as “Any drug whose production, possession, importation, and distribution is strictly regulated or outlawed.” Their use is regulated under the Misuse of Drugs Act 1971 and its subsequent amendments. Primary Care Trusts (PCT) have policies to regulate the security and administration of these drugs. Prison healthcare provision at Frankland is the responsibility of County Durham PCT and their policy requires that controlled drugs may only be dispensed by suitably qualified medical staff which must be witnessed by a second person. A signature is required from both parties to confirm that the medication has been dispensed. The drugs must be kept securely in a locked cabinet within a locked cabinet. In practice, at Frankland controlled drugs are administered by a nurse and witnessed by another healthcare worker. They are stored in locked cabinets within the HCC.
21. After receiving his lunchtime dose of Oramorph on 18 July, the man asked for his prescription to be increased to reduce the pain he was still experiencing. The nurse had no authority to do so but offered to add him to the doctor’s list for the following morning. The next day, the prison doctor recorded that the man’s weight was 51.2kg and that he was in pain. The doctor prescribed 30mg morphine sulphate tablets (MST) twice daily and Oramorph. Later the same day, the man was reported by wing staff to be vomiting and the doctor prescribed Cyclizine (to reduce nausea). During the evening, he was reviewed by healthcare staff who again tried to persuade him to come into the HCC. He refused and became agitated so the healthcare staff told him to report further problems and let staff know if he changed his mind.
22. During the afternoon of 20 July, at about 1.45pm, the man complained of increased pain and being unable to swallow. He agreed to be admitted from G wing to the HCC and was assessed by a duty Staff Nurse at about 2.15pm. She contacted the on-call doctor who examined him at around 3.00pm and made a plan for the man’s future care. General clinical observations (temperature, pulse, blood pressure and fluid balance) were ordered twice daily. The MST 30mg was prescribed three times daily, with a further prescription for 10mg of the same medication for any breakthrough pain (pain which is not fully controlled by the main painkilling prescription). This action was to be reviewed the following morning by the doctor.
23. At 4.20pm, a nurse recorded in the Continuous Medical Record that she telephoned the doctor with regard to his earlier prescription for MST. She noted that there had to be a 12 hour gap between each administration of the MST. Therefore, that evening, it was necessary to give the man 40mg of MST and Oramorph for the breakthrough pain until the prescription could be re-written. The night staff reported that he complained of pain throughout the night even after taking the medication.

24. The next day the man was admitted to outside hospital, under prison escort, for an emergency laparotomy (a surgical procedure which involves the insertion of a camera and tube to examine the abdomen) to establish a diagnosis. His pain became more controlled and he was fed, from 4 to 7 August, using naso-gastric tubes (a method of feeding a patient direct into the stomach, bypassing the mouth, using tubes through the nose and throat). He was also prescribed methadone (a pain reliever) twice daily. From 8 August, his condition was reported to have improved and he was eventually able to eat, drink and walk around the ward. The hospital doctors had not made a definitive diagnosis. However, the man was well enough to be discharged back to Frankland on 15 August. His ulcers were healing and he had gained weight. The hospital provided a comprehensive discharge letter which detailed the treatment and tests he had received and identified appropriate follow up treatment. A management plan was to be formulated as soon as possible. It should include fluid management, oxygen and drug therapies and whether he should be resuscitated if he deteriorated again. No follow up appointments were necessary but some test results were still pending.
25. When he returned to Frankland, the man went back to the HCC. The prison doctor reviewed him on 16 August. He noted that no malignancy had been found while he was in hospital and that the man should return to his wing in two or three days. Later that day the man became anxious about remaining in the HCC and signed a disclaimer refusing medical treatment. He later changed his mind after speaking to a nurse and decided to remain there. After making good progress and not being in pain the doctor considered that he was clinically stable. The doctor discharged him back to his cell on G wing on 18 August. The doctor gradually reduced the man's methadone prescription over a period of four days when it was discontinued. As his weight had reduced to 46kg, regular weekly checks were planned and the man was also scheduled for weekly reviews by the prison doctor, the next being on 25 August.
26. During the following week, the man gained a little weight. He was keen to go back to work and the doctor, on 23 August, designated him labour grade 2. (Prison work is graded for health and safety reasons and is allocated to those who have the required medical or mental fitness to perform the task.) The man said that he was "rattling" (suffering drug withdrawal symptoms) after he stopped taking the methadone. The doctor prescribed zopiclone (a short term medication for insomnia) to reduce the withdrawal effects and loperamide for diarrhoea. He was allowed to keep both drugs in his cell (known as in-possession).
27. On 1 September, the man's weight was 50.2kg and he was concerned about being without methadone. The prison doctor prescribed tramadol (an analgesic for moderate to severe pain) for two weeks and zopiclone for one week, again in-possession, after which he was to be

given no more. A further review was scheduled for one week later. However, on 3 September after a spot check, healthcare staff found that the man had no medication left. He said that he had taken them all, his ulcers had returned and he wanted to see the doctor as soon as possible. The healthcare staff made an appointment for him to see the doctor the following day for an examination and review of his medication. The man did not attend the appointment and an unsigned note was made in his medical record which said, "Avoid analgesic medication other than paracetamol."

28. Healthcare staff examined the man on G wing on 8 September when he complained of the return of an ulcer in his mouth. The prison doctor saw him and referred him to the oral consultant. Although his tramadol dose was increased, a note indicates that the prescription would be reduced and stopped although no firm time scale was given. Paracetamol was also given three times daily.
29. The man who later died saw a consultant ear, nose and throat specialist at outside hospital in late September. He wrote, in early October, to the prison medical officer that the man had a massive ulcer in his oropharynx (the part of the throat behind the junction of the soft and hard palate) which affected his tonsils, soft palate and the base of his tongue. He said that the man would have to be re-admitted for re-investigation and would contact the prison the following week. He also asked for the man's weight to be recorded at least twice weekly and recorded that he currently weighed 51.4kg.
30. On 4 October a consultant in gastroenterology, performed an endoscopy (a visual examination of the bowel using a camera via the rectum) on the man. He wrote the following day that he had multiple ulcers in his rectum and colon suggestive of Crohn's disease (a condition, in which sectors of the digestive tract become inflamed, thickened and ulcerated). He took samples of the ulcers for further examination but wrote that the gastroscopy was otherwise normal. The consultant prescribed a course of steroids, a calcium intake supplement and medication to heal the ulcer. He also included the man on his patient list to be seen at his inflammatory bowel disease clinic the following Wednesday (11 October) to assess the sample results and his response to the treatment started following the colonoscopy. An entry in the medical records on 12 October showed that the consultant confirmed a diagnosis of Crohn's colitis.
31. The consultant reviewed the man again on 18 October and considered he was responding well to steroid therapy. He noted that the man said that he had suffered insomnia, a common side effect of steroid therapy, and had asked for sleeping tablets. The doctor thought this was a reasonable request but left the decision to the prison doctor. The consultant arranged a follow up education session at the hospital clinic for the man regarding the diagnosis.

32. Two days later, the prison doctor noted that the man's mouth ulcer was healing, he was eating well and his weight had increased. His corticosteroid medication was reduced and given weekly in-possession. Later that week, his weight was found to have risen.
33. The man's prescription included zopiclone, for his insomnia, a reducing dose of prednisolone (a corticosteroid anti inflammatory drug) and tramadol to treat the pain. After complaining that he had been given only half the tablets he should have received, he was suspected of giving away or trading the tramadol to other prisoners. The pharmacist confirmed that the correct number had been dispensed and said that this was not the first time the man had made this claim. No further action was taken.
34. The man continued under the overall supervision of the gastroenterological consultant and the prison doctors regularly reviewed him. Adjustments to his medication and care regime were made according to those reviews. His diet was modified (blended food and regular fortified nutritional drinks) to ensure that his nutritional intake was sufficient. His weight rose during late 2006 but fell again at the turn of the year. The man attended the gastroenterology clinic at an outside hospital on 2 January 2007, where a specialist nurse reviewed him. She found that he felt unwell and had a large mouth ulcer which made his appetite poor and he was experiencing difficulty sleeping. She advised that he should continue to take prednisolone on a reducing dose, with mouth washes and a mild sleeping tablet. By 12 January, his ulcer was healing although he frequently refused to take the prednisolone. The same day a prison doctor reported to the security department that she believed that the man was trading the prescribed fortified drinks.
35. The prison doctor wrote to the gastroenterological consultant on 19 January, identifying the problems healthcare staff were having with the man's medication and suggested that Asacol (an anti inflammatory medicine) should be considered. The consultant responded in a letter dated 21 February disagreeing with the suggestion and suggesting alternative therapies that would allow the prison doctor to wean the man off prednisolone.
36. During early February, staff on G wing noted in the man's wing history record that his health appeared to be improving but that he constantly had to be reminded to clean his cell and improve his personal hygiene. Later in the month, staff entries document that his health was again in decline and his cleanliness was not up to standard. Throughout the rest of the man's sentence, staff regularly had cause to remind him of the need for better hygiene.
37. The duty prison doctor noted on 23 February that the man had lost two kg of weight in the previous two months. She wrote to the gastroenterological consultant on 26 February with an urgent request

for an appointment or advice about his treatment. She restarted the prednisolone but was concerned that the reducing dose, once it fell to a low level, triggered the recurrence of extensive mouth ulcers. She asked that the review date given by the nurse specialist for 17 April should be brought forward and further investigations made. On 2 March the man refused to restart the prednisolone and take steroid pastilles recommended by the consultant. A week later he was looking and feeling a little better and agreed to take the pastilles but continued to refuse other oral steroids.

38. On 16 March, the man was again looking better but complained that his voice had become hoarse. As a result, the prison doctor again wrote to the consultant suggesting a change of medication to include azathioprine (an immunosuppressant used to treat active Crohn's disease). Over the following weeks, the man improved but refused to take the steroid pastilles.
39. During a mandatory drugs test on 13 April the man tested positive for buprenorphine (commonly known by the brand name of Subutex and used to treat heroin addiction). He was subsequently charged under the prison disciplinary code and confined to the segregation unit for five days.
40. The gastroenterology nurse specialist reviewed the man on 17 April while he was in the segregation unit. After discussion between the nurse, the man and the gastroenterological consultant a new medication regime was agreed using Adcortyl paste for his mouth ulcers and azathioprine. The side effects and need for regular tests were explained. During May, the man complained of muscle aches but remained on the wing.
41. Following the discovery of a bladed weapon in the man's possession on 8 June, he was considered fit to undergo the disciplinary process and punished with cellular confinement for three days. The man did not attend healthcare for his blood tests again on 18 June but became abusive to healthcare staff when told that his medication would be delayed until later in the day. He was again assessed for adjudication on 22 June and was found physically and mentally fit to undergo the process.
42. During the following month, the man's muscles ached less and he was better able to walk but continued to refuse to have blood taken for testing. On 20 July, the prison doctor recorded the man's weight as 51.7kg and noted that he was "feeling bad" and did not think he was improving. She also said that he had a large ulcer at the back left side of his mouth which was affecting his eating. The man and the doctor discussed the options. She noted that he would restart mouthwashes and take calcium lozenges but was not keen to accept steroids (prednisolone) because of the sleep disturbance which was a side effect. She wrote a prescription for the medication and blood samples

were taken for analysis. The results were returned on 9 August and were described in a note to the man from a prison doctor as “perfectly satisfactory”.

43. The prison doctor wrote in the man’s medical record on 27 July that he was still not well. She re-prescribed zopiclone and prednisolone and concluded that he was to be reviewed weekly. She also wrote to the gastroenterological consultant updating him on the man’s condition and asked for suggestions to help him. Another prison doctor saw the man on 3 August and made a note that he was doing reasonably well.
44. On 14 September, the prison doctor examined the man noting that he showed marked symptoms of his Crohn’s disease. He wrote in EMIS, the electronic medical records system, that he must be reviewed after the weekend when the blood test results were available. The doctor added a c-reactive protein test (CRP detects a protein produced by the liver which is present during episodes of acute inflammation or infection). He also made a note in the Continuous Medical Record, “I am alarmed to find that I have not reduced his prednisolone”. He went on to order the gradual reduction of the medication. On 21 July, he wrote another note documenting that the man felt fine and to “reduce further” although the note does not specify what is being reduced. EMIS records for the same date that the reduction rate should continue. The doctor noted that the man was to be seen in four weeks time and listed his medication.
45. The man saw the prison doctor on 21 December, who noted that he had “dreadful mouth ulcers”. He intended to re-start the cortisone and mouthwashes and would review him in three weeks to check if he was amenable to alternative treatments. On 4 January 2008, the man was examined by another prison doctor who again noted his sore throat and prescribed antibiotics (amoxicillin) and an anti-fungal drug (nystatin). The doctor also noted that the man was reluctant to be re-referred to the gastroenterological consultant.
46. After examination and a medication review on 11 January, the prison doctor referred the man to the ENT department raising concerns about the condition of his throat. An appointment was arranged for 28 February. In the meantime, the man’s condition was closely monitored. He was seen by a Consultant ENT Surgeon, who wrote to the prison doctor that the man was much better than when he had been previously admitted to hospital. In the ENT consultant’s opinion, he did not need any specific treatment as far as his mouth or pharynx (part of the throat) was concerned. He also wrote that the care of his mouth and throat conditions was essential to control the Crohn’s disease.
47. On 25 April following the ENT consultant’s response the man was re-referred by a doctor at Frankland to the gastroenterological consultant as he still had a sore throat and mouth ulcers. His weight was recorded at 50.1kg. Following an appointment on 19 May, the

gastroenterological consultant wrote to Frankland observing that the man appeared extremely emaciated and that his weight was now 48kg. As well, because he complained of bone pain, the doctor commissioned a bone density scan which took place on 10 June. No results of the scan are recorded in the man's medical record.

48. The gastroenterological consultant agreed with the ENT consultant's opinion and recommended the use of adalimumab (a medicine used to induce and maintain remission of Crohn's disease). The doctor first established that the man had not been exposed to tuberculosis (TB) as the drug can compromise the body's ability to fight infections. The gastroenterological consultant explained the dosage and asked to review the man four to six weeks after starting the medication. He was aware of funding issues regarding prescribing adalimumab and was willing to write to the Exceptional Cases Committee at the Primary Care Trust in support. The prison doctor and the gastroenterological consultant then took the necessary steps to do so.
49. Another prison doctor at Frankland reviewed the man twice in August, noting his symptoms and medications. The man asked about interferon therapy (thought to be effective in some patients with Crohn's disease) which the doctor said he would discuss with his colleague.
50. The man continued to consult the prison doctors, principally about inflamed skin and other tissue conditions. A prison doctor discussed the risk of osteoporosis and whether reducing the prednisolone might protect him. She noted that, should he need another course, it would be accompanied with a bisphosphonate, used to prevent the loss of bone mass. She prescribed diclofenac (a non steroidal anti inflammatory drug) and lansoprazole to decrease the amount of gastric acid produced.
51. The man refused to attend an appointment with the gastroenterological consultant at the outside hospital on 29 September, or to sign a disclaimer to that effect, saying that he had not been given sufficient notice of the appointment. The gastroenterological consultant wrote to the prison doctor that the man did not want further assessments or follow up appointments and, in line with his wishes, no appointments had been made. Another prison doctor discussed this with the man on 28 October. He explained that he refused the earlier appointment because he believed it was intended to be a follow up appointment to the anti TNF therapy (the use of adalimumab). Because the therapy had not started, he thought that the appointment was a waste of time. The doctor wrote to the gastroenterological consultant the following day to ask him to see the man and this appointment took place on 17 December. The request for use of adalimumab was discussed by the Exceptional Cases Committee on 29 January 2009.

52. Staff discussed the man who later died at a multidisciplinary case conference on 11 February, where it emerged that he did not want to receive his medication daily in-possession because he was afraid of being bullied by other prisoners. (No record of a complaint of bullying is evident in either the man's record or the Safer Custody Unit at Frankland.) To alleviate his worries, the medication was held in the healthcare centre.
53. The gastroenterological consultant wrote on 23 February to the prison doctor that the funding was now available for adalimumab. He advised her of the dosage and arranged a follow up appointment six to eight weeks after starting the therapy.
54. During a review on 9 March, the man complained to the prison doctor of severe pains in his throat. On examination, she noted large ulcer craters in his throat and that he looked thin and emaciated. She continued his existing medication and prescribed Ddiflam oral rinse (a non-steroidal anti-inflammatory drug containing a painkiller used to relieve mild to moderate pain). The doctor also wrote an instruction to wing staff for the supply of a soft diet to the man. His weight remained at 50kg. Two days later, the doctor discussed with a nurse specialist in rheumatic disease, the administration of adalimumab. The nurse, who is a registered prescriber, agreed to order the medication. She suggested that a full blood count be taken, a liver function test and a further x-ray be performed prior to starting the medication. The doctor noted on EMIS that the x-ray would not be performed for several weeks because of refurbishment work and would be done after the treatment had started.
55. On 18 March, because he was unable to eat and had difficulty taking liquids, the man was offered admission to HCC. He declined, preferring to remain on G wing. Blood test results on 23 March showed that his haemoglobin count was again low and there were indications that he may be deficient in iron. The prison doctor prescribed a further 14 day prescription of zopiclone and, after a request from the man, issued a medical instruction for a soft/liquid cold diet (such as yoghurts and ice cream). A further more specific blood test was scheduled for the following day to be followed by remedial medication to raise his blood iron level. The man refused the blood test as he had not yet started the adalimumab medication.
56. The first adalimumab injection was given to the man on 27 March and the nurse administering it identified 10 April (Good Friday) for the second injection. It was, in fact, administered on 13 April (Easter Monday). The following day, the man refused to attend an appointment with the gastroenterological consultant because he did not want to wait in a reception holding cell prior to the escort leaving Frankland. He refused to sign a disclaimer.

57. Further blood tests in April confirmed that the man was lacking iron and he was prescribed appropriate medication. On 24 April, he was given his third adalimumab injection. Three days later, he complained of a cough and was given antibiotics by the prison doctor who noted that his throat appeared less sore. The man said that he felt and was eating a little better. He had his fourth injection on 1 May and was reviewed by the doctor on 13 May when he felt that his throat was worse and reported that he was not eating. The doctor thought that he was more alert and active and had put weight on, but this was not borne out by his recorded weight. Monitoring his condition and the adalimumab injections continued. On 29 May, he told a nurse that his stools were black and she obtained samples for analysis.
58. On 1 June, the man saw a doctor at the gastroenterological consultant's clinic, who wrote that after a partial response to the injections the man was again troubled with severe ulceration in his throat, which affected his ability to eat and drink. The man mentioned the black stools and the doctor thought they may be the result of bleeding into his digestive tract. He also told the doctor that he had recently missed one of his injections although there is no confirmation of this in the medical record. The gastroenterological consultant also reviewed the man and advised an increase of the adalimumab injection and a gastroscopy to look for gastroduodenal Crohn's disease. In response to the man's blood results, he requested that the prison doctor prescribe a folic acid supplement to help his oral ulceration. On 12 June, due to a malfunction of the equipment, the man was not given the adalimumab until a further supply was received on 18 June and the next injection was given on 2 July.
59. The prison doctor reviewed the man again on 7 July, who said he was feeling better but still had difficulty eating. On examination, the doctor noted that the ulceration, which she described as a huge crater, in his throat was worse. One week later, she discussed the man with one of the nurses who had reported that he was increasingly depressed and having more difficulty swallowing. The doctor wrote to the gastroenterological consultant on 14 July for an urgent review of the man, expressing concerns that he was getting worse and the potential complications of such a large ulceration of his throat. She also discussed with the man whether he would accept antidepressant medication. He was initially resistant but eventually agreed to a small dose of gabapentin.
60. On 16 July, the man was reviewed by another prison doctor. In an effort to make him as comfortable as possible until his appointment with the gastroenterological consultant, the doctor prescribed a benzydamine hydrochloride spray (a non-steroidal anti-inflammatory drug), glandosane (to relieve dryness of the mouth), Fortisip and zopiclone to help him sleep. However, on 22 July, he was examined by a nurse following concerns by wing staff about deterioration in his health and mental condition. She noted that he was quiet and

withdrawn and thought he had an infection in his throat. He was offered a place in healthcare but refused, signing a disclaimer to that effect.

61. The following morning, the man was asked to go to the treatment room for his clinical observations to be taken. He attended but refused to wait while the patient before him was treated. The man saw the doctor later that morning who, because he was suffering pain, prescribed morphine sulphate (MST) in tablet form and in solution (oramorph) to be taken as required for breakthrough pain. According to the Controlled Drugs Charts, during the six days between 23 and 29 July, oramorph was administered six times during the day and evening and on seven occasions during the night hours.
62. A Staff Nurse talked with the man on 29 July about his apparent inability to cope with life on the wing. She repeated the offer of admission to the HCC but he declined, preferring to stay on the wing with his friends who, he said, would help keep him and his cell clean. She told him that the offer remained open should he feel he could no longer cope on the wing. During the same conversation, the man said that the pain relief medication was effective.
63. The following day at 5.10am a nurse went to the man's cell after staff reported that he had vomited blood. The bleed was not as serious as was first feared and, apart from a minor pain in his throat he said he felt alright. He elected to stay in his cell and use paracetamol to control the pain. Later that morning, the doctor examined the man who he thought looked pale and dehydrated. The man again said he felt all right but was not receiving a soft or liquid diet from the prison kitchen which he thought had caused the bleeding. The doctor thought that surgical intervention might be necessary and referred him to the gastroenterological consultant. He also requested urgent blood samples for a range of tests and advised the man that admission to the HCC would allow better monitoring but again he declined.
64. Two days later, during the early afternoon of 31 July, the man was taken to the Accident & Emergency (A&E) Department at a local hospital. They immediately referred him to the ENT department who admitted him for assessment and further treatment. A dietician advised Frankland on his dietary needs, provided prison staff with information and ideas for his continued support and advised that his weight should be monitored weekly. The man returned to Frankland on 6 August. Later in the month, an entry on his EMIS record shows that the man went to hospital on 19 August but was unable to undergo the planned procedure (which was not identified) because he had not been told to fast prior to the appointment.
65. On 25 August a consultant microbiologist, informed the gastroenterological consultant and medical staff at Frankland that while the man was in hospital he had been exposed to a patient with

tuberculosis. He was aware that the man's immune response was compromised and advised that he should have chest x-rays at three and six months after exposure. The gastroenterological consultant wrote to Frankland's medical officer on 3 September advising that, because of his exposure, the man's adalimumab injections should cease and he would review him on 8 September when he was due for a gastroscopy. The gastroscopy did not take place because again the man had not been told by prison staff that he should not eat beforehand. The appointment was re-booked for 25 September. Results from the examination received at the prison on 1 October indicated that he was suffering from "active chronic gastritis" (inflammation of the lining of the stomach).

66. The man's medical record contains a note dated 5 October signed by an out of hours GP that 10mls of morphine sulphate could be given to the man at four hourly intervals instead of the previous prescription. A copy of a supporting prescription document also exists but no entry was made in the medical record and there is no indication of why it was necessary.
67. Soon after 9.20am on 13 October, the man was taken to hospital in an emergency ambulance having suffered a substantial bleed from his throat. He remained there until 16 October. He underwent an endoscopy which showed he had two pharyngeal ulcers, one of which showed evidence of a recent bleed, that his oesophagus (the tube between the throat and stomach) and the duodenum (the tube leading from the stomach) were normal. A discharge summary also indicates that his medication was adjusted and included omeprazole (to reduce the acid produced in the stomach) and prednisolone which was to be reduced and reviewed two weeks later.
68. On 26 October, the man complained of a pain in his throat and coughing up spots of blood. Although the prison doctor was unable to see him personally, she prescribed two antibiotics (co-Amoxiclav and metronidazole) in combination to reduce the risk of him suffering another serious bleed and zopiclone to help him sleep. The doctor did however see him the following day when he complained of extreme pain in his throat and she increased his morphine prescription. The doctor noted that this should be in tablet form at the man's request because liquid morphine burned his throat as he swallowed it.
69. Owing to a clerical error at Frankland on 16 November, the man missed an appointment with the gastroenterological consultant, which was re-scheduled for 1 December and, because he felt unwell, he refused to attend. The gastroenterological consultant wrote to a consultant gastroenterologist colleague, on 18 November seeking advice on whether adalimumab injections should be restarted following his exposure to TB. The consultant colleague responded on 2 December that the man should take a three-month course of Rifinah (an antibiotic treatment for TB) provided his weight was over 50kg.

That treatment should be followed by a three-month course of pyridoxine (vitamin B) and throughout monthly liver function tests were necessary. He also said that, if the course of action was acceptable to the man, then adalimumab could restart. The gastroenterological consultant forwarded the advice on 18 December. The prison doctor discussed the proposal with the man who agreed to start the treatment for TB but refused adalimumab because he was unimpressed with the previous results.

70. In the meantime, on 23 December, the Staff Nurse sought advice as to whether the man should start the proposed treatment for TB. A specialist advised not to start the treatment until it could be discussed with the gastroenterological consultant on his return from annual leave on 5 January 2010. Therefore, the treatment was withheld.
71. A Nursing Sister responded to a telephone message from G wing staff on 24 December that the man felt unwell and was not able to go to HCC for his controlled drugs. She took a wheelchair to G wing. He still refused to go to HCC, but did go in the wheelchair later in the morning.
72. The man told the prison doctor on 4 January that, because his throat was troubling him again, he wanted to restart the adalimumab injections. On 12 January, the doctor discussed the case with a specialist TB nurse and, following this, a series of tests and a chest x-ray were conducted mid-January. The results later showed no evidence of old or active TB.
73. Nursing staff assessed the man on 28 January, after G wing staff reported that he looked unwell and listed him for the prison doctor the following day. The doctor saw him and re-prescribed gabapentin and Fortisip Extra dietary supplement. On 30 January, he again felt unwell but declined an offer to remain in the HCC over the lunch period to discuss his problems with the doctor. However, he did see a doctor that afternoon who prescribed antibiotics and recommended that he should be added to the doctor's list for Monday 1 February as a matter of urgency. When the Nursing Sister took the antibiotics to G wing on 31 January the man refused them because he thought they were not effective.
74. On 1 February, the man told another prison doctor that he had been feeling unwell for the past week and was taking all his medication except the antibiotics. He was alert, in pain and looked tired but his temperature was normal. He did however have inflammation at the back of his throat. The doctor prescribed zopiclone, co-amoxiclav and metronidazole and set a further review for Thursday 4 February.
75. A Staff Nurse was asked to see the man on G wing because he felt unwell and was unable to walk to HCC to collect his controlled drugs. She saw him just after 9.00am on 3 February when he appeared frail, lethargic and unable to talk very much. He told her that he could not

make the journey to HCC and she explained that she was not allowed to bring the controlled drug to the wing because of the PCT policy governing its issue. The nurse offered to admit the man to HCC but he declined although he agreed to go in a wheelchair.

76. A prison doctor reviewed the man at about 10.30am that morning. During the appointment, he said he was unable to swallow the antibiotic tablets and asked for oramorph to be prescribed for pain. The doctor recorded that the man looked tired and dehydrated. He had a fistula (an abnormal channel between a hollow organ and the outer surface often caused by an infection) on the back left side of his throat and white exudates (a liquid that escapes from intact blood vessels and is part of the healing process) on his tongue.
77. The doctor altered the man's prescription for co-amoxiclav and metronidazole tablets to liquid forms and added oramorph to be taken as required but at a rate no more than 5ml every four hours. He also prescribed nystatin (an antifungal medication) in liquid form. The doctor advised nursing staff that, if his condition deteriorated, he might need to go to outside hospital for treatment.
78. After the consultation, healthcare staff tried to persuade the man that admission to the HCC would make his care and the administration of his drugs easier. He adamantly refused, preferring to remain on G wing with his friends where smoking was allowed. During the late afternoon another Staff Nurse saw the man on G wing after wing staff became concerned that he looked unwell. He said he was all right and after discussion told the nurse that he would consider coming into HCC.
79. During separate interviews with the investigator, the Staff Nurse and Nursing Sister said that the man, in common with other patients requiring treatment at HCC, was brought there by internal escort staff. He came twice daily to HCC to receive his medication, normally at about 11.00am and 6.00pm. Sometimes he walked and other times he was pushed in a wheelchair. The Staff Nurse estimated the journey would take about ten minutes at a normal walking pace and a few minutes longer if using a wheelchair. She also said that, depending on how busy the HCC was during the morning, he would be seen within a few minutes. She estimated that the longest he would have to wait was between ten and 15 minutes. Prison staff are responsible for escorting prisoners back to their wings after treatment. She said that this can result in waits of up to half an hour in the waiting room. She explained that there are four waiting rooms of differing sizes. The number and category of prisoners in each room is determined by prison staff after a risk assessment and consideration of the numbers involved. During the afternoon appointments, escort staff took the man who is the subject of this report to HCC and brought him back immediately after treatment as it was quieter at that time of day.

80. Provision of wheelchairs at Frankland, until after the man's death, was that each wing had a wheelchair of a basic design which was available for prisoners. The Staff Nurse said that some had missing footrests. No staff interviewed could remember whether the G wing wheelchair was complete. (I am pleased to learn that all the wheelchairs have recently been replaced with new models complete with footrests.)
81. The prison doctor saw the man on 5 February who said that, whenever he swallowed, he became nauseous. He appeared gaunt and, in an attempt to alleviate the sickness, the doctor prescribed an injection of prochlorperazine mesilate and prochlorperazine maleate buccal tablets.
82. The following day the man was still unwell. He had difficulty speaking and was unable to keep his dietary supplement liquid down. A male Staff Nurse telephoned the prison doctor who recommended that the man should be taken to outside hospital. The duty governor was initially reluctant to allow him to go without the doctor seeing him personally but relented after speaking to the doctor himself.
83. The man remained at Frankland for the remainder of the day until 4.15 pm, when an emergency ambulance was called. A full security risk assessment had been made during the early afternoon and escorting staff were briefed. At about 5.00pm, the man was taken in handcuffs by ambulance to a local hospital. He was examined, x-rayed and given treatment. At 10.30pm the decision was made to transfer him to the hospital where he arrived just after 11.30pm. He was admitted at about 3.40am on 7 February and remained there until his death eight days later. The man was in contact with his family by telephone whilst he was in hospital.
84. The security risk assessment required that the man was subject to the use of restraints, either handcuffs or an escort chain. (This is a length of chain with a handcuff at either end to allow a level of privacy when receiving medical treatment, using the lavatory, bathing etc.) The level of restraints was varied in line with the requirements of the risk assessment. One escorting officer queried the level of restraint in use on 9 February, noting that the risk assessment had not been reviewed since the man came into hospital. A Senior Officer at Frankland's security department confirmed that the risk assessment had been reviewed and remained valid. Prison managers visited the man daily and the police checked his progress periodically by telephone.
85. On the morning of Sunday 14 February, the man was told by a doctor that there was a possibility that he would undergo an operation on the following Tuesday. He slept fitfully during that night.
86. At around 7.30am the following morning the day shift prison officers, one male and one female, took over as escorting officers. At about 8.20am, the man was sitting up in bed watching television and talking

with the officers. During their conversation, he began to vomit, suffered a serious loss of blood and collapsed.

87. The male officer immediately called the medical staff for help and, in accordance with instructions for the removal of restraints during a medical emergency; he released the man from the escort chain. Both officers left the room with their equipment and waited outside. They reported the developments to the duty Governor at Frankland. The hospital staff treated the man for about half an hour but he died at 8.55am.
88. The male officer reported the man's death to the governor on duty at Frankland, and the local contingency plan for the death of a prisoner in custody was implemented. A Governor grade and a Principal Officer went to the hospital and sent the escorting officers back to Frankland. Another Governor and a member of the IMB debriefed the escorting officers just after midday. The officers then saw the duty care team member (a team who support staff members during stressful periods) and made statements about the events surrounding the man's death.
89. At 11.45am, Frankland's family liaison officers (FLOs) visited the man's mother at her home where they broke the news to her and other family members. While they were there, they telephoned other family members to break the news to them, at the request of the man's mother. The FLOs explained the next steps, advised the family to contact a funeral director and give their contact details so that the Governor could make a contribution to the funeral expenses. The FLOs also explained to the family the role of the Coroner and the Prisons and Probation Ombudsman. They gave the deceased man's mother a letter of condolence from the Governor and an information leaflet about the process following the death of a prisoner.
90. One of the man's friends at Frankland said that he had been told of his death by an officer and had been offered counselling. However, another close friend said he found out from another prisoner several days later and no notices of the death had been displayed on the wing.
91. A post mortem was conducted at the request of the Coroner by a Home Office Pathologist on 16 February 2010 who found indications that the man's death was due to:
  - Laryngopharyngeal ulceration and
  - Haemorrhage due to Crohn's disease.
92. The FLOs kept in touch with the family and the man's funeral took place on Tuesday 2 March 2010. The man's personal cash and property were sent to his family later that month. His friends at Frankland made a substantial collection to send flowers to the funeral and, at their request, the remainder was donated as a contribution towards the cost of a headstone.

## ISSUES CONSIDERED DURING THE INVESTIGATION

### Administering controlled drugs

93. The man who died was first prescribed morphine for pain in July 2009. From then until his death it was prescribed on seven occasions. Latterly, the morphine was prescribed twice daily until 3 February 2010 and then increased to “as required up to a maximum of four hourly”.
94. At Frankland, morphine is dispensed only from the HCC. In line with the PCT policy on dispensing controlled drugs, it is stored in an approved locked cupboard and recorded in the Controlled Drug Register when issued. During the majority of the time the man was taking morphine, he had to visit the HCC twice daily with an internal escorting officer. The walk from G wing to the HCC takes a fit person approximately ten minutes and involves negotiating nine gates.
95. Nursing staff told the investigator that the man was taken to HCC to obtain the controlled drugs between 9.00am and 11.00am and 4.00pm to 6.00pm. Also, that he might on occasions wait half an hour to be given his medicine and then, some time later, return to his wing. The man’s personal officer recalls that period might be as long as one and a half hours.
96. The pages relating to the man in the Controlled Drugs Register pages reveal that drug administration times could vary greatly. It is a reasonable assumption that when morphine is prescribed twice daily to cover a 24 hour period that the interval between doses should be as near to 12 hours as possible, but this was not the case. The man’s first daily dose was dispensed as early as 9.05am, or as late as 11.40am. The second was dispensed as early as 3.00pm, or as late as 6.50pm.
97. On 3 January 2010, the man received his first dose of morphine at 10.30am and the second dose at 3.15pm a gap of four and three quarter hours. He did not receive another dose until 11.30am the following day, a wait of just over 20 hours. This was not an isolated example, there are nine occasions when he was without pain relief medication for 17 hours; 11 occasions of 18 hours, 14 occasions of 19 hours and three occasions of 20 hours between doses. The norm was that the man was without his pain relieving medication for between 14 and 15 hours.
98. As well as the long gaps between administrations of the controlled drugs, I am also concerned that he rarely received it to relieve breakthrough pain. With the exception of the period between 23 and 29 July 2009 when he received oramorph for breakthrough pain on six occasions during the day and evening and on seven occasions during the night, there were no instances of him receiving pain relief outside the twice daily regime. I find it hard to imagine that this man was without pain during the long hours between his prescribed doses.

However, the small more frequently available doses prescribed on 5 October 2009 and 3 February for breakthrough pain were never administered.

99. Interpretation of the controlled drug policy meant that on at least one occasion the man was left on his wing without his medication as he did not feel well enough to make the journey to HCC until later in the day. His dilemma was either to go without his pain relief or made the journey when he felt unwell and unable to do so.
100. I believe that this was an unacceptable situation. It was unclear to the medical staff interviewed what arrangements could be used to give prisoners their controlled drugs if they were unable to go to the HCC.
101. It is also unclear how, under this regime, controlled drugs could be given to this man every four hours as advised by doctors on 23 July, 5 October and again on 3 February 2010. However, it is clear from the Controlled Drugs Charts that arrangements were made between 23 and 29 July 2009 to give him morphine for breakthrough pain during the day and night hours. If arrangements could be made on those days, I think that they could have been possible at other times.
102. No copies of the man's Controlled Drug Register Charts are available for October, November and part of December 2009. There are however two Prescription and Administration Charts for 6 October to 24 December used to record the issue of morphine. During this period, the man was due to receive 250 doses of morphine and actually received 191 doses. Of the 59 doses he did not receive, six were not given because he was an in-patient at an outside hospital for three days. The other 53 doses were not given and there is no explanation why this happened.
103. I find it difficult to entertain the notion that the man refused a drug to relieve his severe pain on that number of occasions. It has been suggested by other prisoners that, when he felt he could not make the journey to HCC for his controlled drugs, he was left in his cell without them. They believed that when this happened, refusal of medication was recorded. In fact no reason was recorded. Healthcare staff did not know how prisoners receive controlled drugs if they could not collect them from the HCC which supports the contention that the man was indeed left without them, an intolerable situation.
104. It is pertinent to point out that the winter of 2009/2010 was particularly long and severe and coincided with the time when the man who died was most debilitated, towards the end of his life. That journey between G wing and the HCC, to be undertaken twice daily, must have been arduous and an unattractive prospect for him. It is fair to say that the man contributed to his problems in that he refused to be admitted to HCC, even after repeated offers over many months for him to do so, which would have obviated many of the difficulties he experienced.

Nevertheless, his experience should not be repeated for other prisoners.

**The Governor and Primary Care Trust should immediately review their policy on the issue of controlled drugs to ensure that access to them, while strictly controlled, is available at appropriate times to give effective pain relief.**

**The Governor and Primary Care Trust should develop and publish a clear strategy for secure dispensing controlled drugs to prisoners who are unable to attend the Healthcare Centre.**

### **Equity of care**

105. The clinical reviewer found that the man's treatment and care was regularly reviewed by prison medical and nursing staff who made appropriate referrals to the outside hospital team for further specialist investigation and treatment. She wrote:

“[The man] received care commensurate with similar patients in the community suffering from Crohn's disease. His disorder was constantly reviewed, reassessed, investigated, treated and documented by health care professionals both within the prison and in NHS facilities ... no reasonable request for help was rejected and ... wing staff kept nursing staff abreast of any changes in [the man's] health that gave them cause for concern. When it was found that he had lost twenty percent of his body weight a case was made to the PCT for funding for Adalimumab. This was funded because all other reasonable alternatives had been tried.”

106. Taking into account the clinical reviewer's comments and the variability of his pain management, I judge that the man generally received at least the same level of care that he could have expected had he been treated for this distressing condition in the community. However, the handling of his pain management was haphazard. This was partly due to his refusal to be accommodated in the HCC and partly to the inflexibility of the PCT policy on how these drugs are delivered to a patient who is unable to make the arduous journey from a distant wing to the HCC. To that extent, I judge that the man's treatment was only partly equitable.
107. This man was admitted on 6 February 2010 to a local hospital because of deterioration in his condition. He transferred to another hospital early the following day. He remained there until the morning of 15 February when he died suddenly and unexpectedly from a haemorrhage due to laryngopharyngeal ulceration, a consequence of Crohn's disease. During that period he was under prison escort, proper risk assessments were made and updated and staff responded to the situation as it changed.

## Record keeping and information sharing

108. The clinical reviewer observed that there had been difficulties in two aspects of record keeping and sharing of information. Firstly, the communication between departments regarding the man's hospital appointments was not effective. He missed out-patient appointments in August and September 2009. Both had to be cancelled because he had not been told to fast the night before the procedures were due. I appreciate that, for security reasons, prisoners should not be given advance notice of their appointments. However, high security prisons like Frankland should find a way to balance security with allowing prisoners to make the necessary preparations so that tests can be completed satisfactorily.
109. Secondly, the provision of the man's nutritional requirements was inadequate. The dietician at the local hospital wrote on 14 August 2009 to Frankland with information and suggestions for suitable meals and supplements for the man and suggested prison staff monitor his weight on a weekly basis. Although the meals were provided at first, by 24 November, the prison kitchen had stopped sending soft foods to the wing. It is not clear precisely when or why the soft diet was discontinued but the prison doctor re-issued an instruction the same day for the supply to be re-started and maintained indefinitely. The instruction specified a diet that the man could eat despite his throat ulcers. Ten days later, prison kitchen staff evidently remained uncertain and requested a further directive from the doctor to identify what he could eat.
110. It is unfortunate that the man's longstanding dietary needs, which were a major factor in his condition and were well known at the prison, were either not fully met or were delivered erratically. It is also a concern that kitchen staff took ten days to ask for clarification of the diet during which time the man reportedly felt unwell and, on 1 December, told the doctor that he had not eaten for a few days.
111. Regarding the advice to monitor the man's weight, no entries to that effect were ever recorded on EMIS. On 20 August 2009, the prison doctor further tasked the HCC treatment room for a weekly record of his weight. The man's weight is noted only in letters between NHS and prison staff. The clinical reviewer also noted that numerous entries were made on EMIS regarding the man's difficulty eating, drinking and swallowing due to ulceration of his mouth and throat. There is however no mention of any nursing intervention or advice such as offering straws to drink through and using a soft toothbrush. These and similar interventions may well have been suggested and discussed but they were not documented or delivered.
112. The clinical reviewer could find only one entry in the man's medical record of giving psychological care which was made following contact with a tuberculosis sufferer while a patient in hospital. Given his

immunosuppressed condition, this could have had serious consequences. He was worried and frightened and according to EMIS “given reassurance with good effect” and was told that “something would be sorted for him”. It is unclear what reassurance and advice was given or what it was that was to be done for him.

113. Given the length of the man’s illness, his distressing and uncomfortable symptoms, and no hopeful prognosis, I am surprised that more attention was not given to his emotional and psychological wellbeing throughout and not just in relation to the risk of contracting TB. He was clearly visibly poorly and having difficulty coping with normal daily activities of eating and walking. It does not take the benefit of hindsight to imagine that he might well have been worried about himself. Nursing attention which considered his emotional and psychological wellbeing would undoubtedly have been appropriate and appreciated.

The clinical reviewer commented that:

“When giving psychological care (which I’m sure the care staff must give) this must also be documented. This documentation however must describe exactly what was done, i.e. listened to the inmate to identify his concern(s) and ‘details of information given about care and treatment’.”

Also:

“Meaningless phrases i.e. ‘looks unwell’ need to be eliminated as they only give the perception of the person making the statement. Additionally, if it is recorded that the inmate ‘looks as if he has lost weight’, this should be corroborated through documenting the weight of the person.”

114. The clinical reviewer made several recommendations about medical record keeping that provide a basis for the following recommendations:

**The Primary Care Trust should ensure that verbal or written communications are more effective between staff so that prisoners are told about the requirements, such as fasting, when attending appointments at NHS clinics. The Nursing and Midwifery Council Guidelines on Record Keeping: Guidance for nurses and midwives numbers 7, 9 & 33 apply.**

**The Primary Care Trust should ensure that changes in care regimes suggested by NHS staff are fully documented for dissemination between prison care staff. Once started or completed they must also be recorded in accordance with the Nursing and Midwifery Council Guidelines on Record Keeping: Guidance for nurses and midwives numbers 7, 9 & 33.**

**The Primary Care Trust should ensure that nursing interventions are properly recorded so that other healthcare staff are aware and can take them into consideration when planning or administering other treatments.**

**The Primary Care Trust should ensure that information recorded about patients is factual and complies with Nursing and Midwifery Council Guidelines on Record Keeping: Guidance for nurses and midwives number 5.**

### **Prescription and Administration Record Charts**

115. Within the man's medical record, there were paper based Prescription and Administration Charts until 2007 but no further charts for the years after that. The clinical reviewer commented that these charts carried only the surname and number of the prisoner on the first sheet of the chart, no other personal data was completed and in some cases the name of the prison was omitted. The reviewer also wrote:

“The charts pertaining to the time from July 2009 when [he man] was first prescribed morphine (for pain management) to his death in February 2010 were requested from prison health care. Two copies covering the times from 6 October 2009 to 23 December 2010 were sent, however, copies of the Controlled Drug register for the dates not covered by the prescription charts were received. From the record charts it was noted that when the medication was apparently not given no codes were used to explain the reason for this i.e. R = Refused.”

116. Since Prescription and Administration Charts are no longer used at Frankland and have been replaced with electronic recording systems, I do not make a formal recommendation on this point and the need for proper record keeping has been addressed elsewhere in this report.

### **Documents referring to a prisoner's risk of self-harm**

117. The man's medical record contains five self-harm/attempted suicide (F213SH) documents which refer to acts of self-inflicted injuries. Four refer to incidents in March 2008 and the other to an incident in October 2009, which was also recorded in EMIS. With the help of Frankland's safer custody staff, the investigator established that none of these incidents related to the man who is the subject of this report. They all refer to a fellow prisoner with a similar surname.
118. I am concerned that these documents found their way into the man's medical record, yet were never queried by medical or nursing staff that knew or were closely monitoring him. This is particularly pertinent as there were no linked documents referring to the formal suicide and self-harm procedures which should have been triggered by the incidents. The prisoner to whom the documents refer is still resident at Frankland

and, fortunately, alive and well. Although safer custody staff are now aware of the error in respect of the man who died, the Governor might wish to seek reassurance that those documents have now been properly filed and, if necessary, appropriate steps taken in respect of that prisoner's ongoing management.

119. My office investigates self-inflicted deaths of prisoners as well as those, like this man which are due to natural causes. Accurate and proportionate investigations rely on the full disclosure of prison and healthcare records. Had this prisoner gone on to take his life, I regret to say that the PPO would have been unable to fulfil its duties properly. Fortunately this error is rare. Nevertheless I have decided to make a recommendation about the safety of records with the aim of avoiding a repetition of these errors.
120. The man suffered a long, debilitating and, at times, extremely painful illness. In July 2009, unsurprisingly he was described as being depressed but was never assessed as being at risk of deliberately harming himself. It is to his credit that he bore his illness with fortitude and, by all accounts from those staff and prisoners who knew him, with a fair amount of good humour.

**The Governor and Primary Care Trust should ensure that prisoners' records are filed accurately and, when obvious mistakes are discovered, they are rectified quickly.**

#### **Waiting rooms in the healthcare centre**

121. In common with other prisoners receiving planned medical attention in the HCC, the man who is the subject of this report was held in one of the waiting rooms where he could remain for up to half an hour before receiving his medication. The four HCC waiting rooms vary in size and, depending on the demand and the mix of prisoner categories, prison staff allocate prisoners to the most appropriate room. The waiting rooms are not popular with prisoners and some complained verbally to the investigator and clinical reviewer that they are overcrowded and hot with limited ability to open windows for ventilation.
122. The investigator and clinical reviewer visited the waiting rooms and found them stark but serviceable. There were few people waiting in them at the time but even so the atmosphere was stale. When the rooms are full and the heating is on, I expect that they are uncomfortable and hot. On completion of treatment, prisoners are again held in the waiting room until escorting staff take them back to their wings. It was not possible to estimate the average waiting time for return. However, during the afternoon, because clinics had ceased for the day, waiting times for the man who died were said to be minimal.

123. The health and safety assessment for the HCC waiting rooms identifies the maximum number of prisoners to be held in the rooms but makes no real evaluation of the physical and environmental conditions within them.

**The Governor and Primary Care Trust should review the health and safety assessment for the healthcare centre waiting rooms, with particular emphasis on heating and ventilation arrangements and the numeric capacity of each room.**

124. Part of the reason for the man's regular refusal to be accommodated in the in-patient department (IPD) at Frankland was that he would be unable to smoke and he was, by all accounts, a heavy smoker. The Inspectorate report identified that the PCT had adopted a no smoking policy throughout HCC and commented that this had led to a drop in admissions to IPD which did not in fact reflect the need. She did not make any recommendation on the subject but I draw a conclusion that the IPD is underused because of that policy.
125. The policy of not permitting smoking in the IPD was not the only reason for the man's refusal to be admitted, but it appears to be one of the main reasons. Although it cannot be argued that smoking in the IPD should be allowed per se, it must be feasible, as it is in NHS hospitals, for mobile patients to do so. Within the prison environment there are necessary restrictions, however the IPD has a secure open air exercise area. To allow smoking in that area might help to overcome the problem of underuse of the IPD. I encourage a review of the strict no smoking policy in IPD within this context. As well, there is no evidence that the man was offered smoking cessation support at Frankland.

### **Provision of wheelchairs**

126. When he felt too unwell to walk to the HCC, the man was occasionally taken by wheelchair. The wheelchairs in use at the time were old and in a poor state of repair which, according to other prisoners, sometimes included the absence of footrests. Two prisoners told the investigator that this resulted in the man who died having to hold his feet off the ground, an uncomfortable position for someone in good health let alone someone in his condition. None of the prison or healthcare staff interviewed could remember this happening. The issue has now been resolved as new, fit for purpose, wheelchairs have been bought and are now available on all wings. It is regrettable that any prisoner should be transported in this unsafe, uncomfortable and undignified manner. I suggest that regular maintenance checks are carried out on the new wheelchairs and any deficiency quickly made good.

### **Concerns raised by the man's family and friends**

#### Information given to the family

127. Soon after the man's death, the solicitor acting for his family questioned why the family had not been told the seriousness of his condition when he was admitted to hospital.
128. The man's condition deteriorated in early February 2010 and led to him being taken to the local hospital accident and emergency department during the late afternoon of 6 February. After tests, he transferred to another hospital during the early hours of 7 February. He underwent further tests and, when it became clear that he would be detained in hospital longer than first thought, the man asked the prison to contact one of his sisters. The duty governor did so in the early afternoon of 7 February.
129. The man was given cash from his account at Frankland and a Governor gave authority for him to contact his family by telephone from the hospital on 8 February. He spoke to his sister in the early evening of 9 February and twice in the evening of 12 February. He also telephoned and spoke to his mother on the afternoon of 13 February. Visitors (unnamed) were expected at the hospital on 11 February but apparently did not arrive. The man's death in the early morning of 15 February was sudden and unexpected. Shortly before he collapsed and died, he had been talking normally to the escort staff. I am satisfied that prison staff were not in a position to know the extent or seriousness of his condition and accept that they could not have alerted his family in time for them to arrive at his bedside.

#### Personal property belonging to the man who died.

130. Another of the man's sisters contacted one of my family liaison officers in August 2010, complaining that some of her brother's personal property had not yet been returned to them. Following enquiries by the investigator and the family liaison officer, the prison were able to provide my investigator with documentary evidence establishing that the man's property had been returned to his family in a timely manner, delivered by the method agreed by his family. There appears to have been a misunderstanding between the man's sister and Frankland's FLO about the quantity of property to be returned. I am satisfied that all property and money belonging to him has been returned to his family.

#### Allegation that the man who died was bullied by staff

131. One of prisoners interviewed by my investigator, made a number of observations and an allegation about the man's treatment at Frankland. Principally, these covered the issues discussed above regarding collecting his medication, waiting in the healthcare centre and the discomfort caused by the poor state of the wheelchair used to assist him.

132. The prisoner alleged that some members of staff at Frankland bullied the man and named three officers. The investigator interviewed two of the three officers, but the third was on long-term sick leave following an assault. The investigator also interviewed two prisoners and senior wing supervising staff about the allegation. Neither of the other prisoners corroborated the allegation of bullying. The two available named staff members and the man's personal officer all appear to have had a cordial relationship with him. However, they all spoke of their attempts to improve his hygiene, including the use of warnings of disciplinary action, which led to some short-term friction after which they said that relationships returned to normal.
133. Frankland has a bullying reduction policy which features an appropriate definition of bullying. It is administered by the Safer Custody Unit and the process is monitored by the Violence Reduction Strategy Committee. There is no record of bullying involving the man who died by either staff or others. G wing managers confirmed that no complaints of bullying involving him had been made to them or otherwise brought to their attention.
134. During an interview with my investigator, the man's closest friend said that he was always untidy and as he became more unwell he became worse. He said staff were "fantastic" with him although there was occasional conflict between him and staff who were new to the wing who did not know his limitations. The man's closest friend helped him several times a week to clean and tidy his cell. As a friend, he said that he assisted him with other basic personal tasks, when he was unable to do them for himself, such as changing his bedding and washing him. Another of the man's contemporaries who also has Crohn's disease, portrayed the man who died as not maintaining his personal hygiene or that of his cell, which he described as an important element of combating the effects of the disease.
135. As time progressed, the man became increasingly ill. In July 2009, a nurse felt that he was not coping with the normal demands of wing life and offered him a place in the prison in-patients facility. He refused, preferring to stay on G wing with his friends and where he could smoke, something forbidden in the healthcare centre. Thereafter the offer remained open to him.
136. Allegations of bullying of a prisoner by prison staff are a serious matter which warrants close investigation. It is evident from prison records and interviews with staff and fellow prisoners that there was pressure on the man, over an extended period, to bring himself and his cell up to a reasonable level of cleanliness. It was important for him to do so in a communal environment for his, the other prisoners and staff health and welfare. I judge that the man was in part responsible for the pressure to keep him and his cell clean. It is significant that he did not complain about bullying. I am satisfied that the persuasion and pressure applied

to the man by wing staff to keep himself and his environment clean did not amount to bullying.

137. The mother of the man who died expressed views to my Family Liaison Officer that:

- The man should have been considered for compassionate early release.

Consideration for release on compassionate grounds is made under the provisions of the Crime (Sentences) Act 1997 by the Secretary of State who may release a prisoner if he is satisfied that exceptional circumstances exist which justifies the prisoner's release on compassionate grounds.

It is apparent that the man did not meet the criteria for release on those grounds. His illness while serious did not appear to be life threatening. His death occurred after a sudden and unexpected haemorrhage followed quickly by death. The circumstances of his death were such that consideration for compassionate early release was not an option.

- The man should not have been sentenced to imprisonment rather than being placed in a psychiatric hospital.

The resolution of the court case was a matter for the court and is outside the Ombudsman remit. The man's mental condition whilst he was under the care of the Prison Service raised no concerns. I have seen no indication that he came to the notice of the healthcare or mental health services at any of the prisons he was at. There is no suggestion that the man's mental health was in question or played a part in his death.

- Racial discrimination.

I have seen no evidence during this investigation that suggests that there was an element of racial discrimination in the way this man was treated. There were shortcomings in the treatment he received which have been addressed in this report and have been accepted by HMP Frankland.

138. The man's sister expressed the opinion, to my Family Liaison Officer, that there was a general lack of care regarding the management of her brother's condition. In particular she identified:

- The erratic provision of his morphine prescription and the missed medical appointments.
- The presence in his medical record of documents identifying him as at risk of suicide but in fact referred to another man.

Both of the preceding points have been examined in this report and led to recommendations that are accepted by HMP Frankland and the Primary Care Trust and are being acted upon.

- The man's sister also raised concerns that, in her opinion, prison staff showed more concern about the cleanliness of her brother's cell over his health needs and she felt he was too unwell to maintain a clean cell.

This aspect is addressed in the report and my conclusion is that the man was indeed unwell and found it difficult to maintain an acceptable standard of cleanliness in his cell. It is also true that pressure was brought to bear on him to do so which in conjunction with his refusal to be admitted to healthcare on several occasions caused it to become a recurring issue between him and some wing staff. This did not however prejudice the healthcare her brother received.

## CONCLUSION

139. The man who later died was diagnosed with Crohn's disease in 2006, following investigations by prison healthcare and NHS professionals. His condition was monitored and reviewed on a regular basis by both prison and NHS clinicians. When his condition worsened and required greater input from healthcare staff he was offered admission to the healthcare centre. On most occasions he refused, preferring to remain on the wing. He was, however, admitted to NHS hospitals on three occasions.
140. Appropriate treatment was prescribed for the man but when it was noted that he had lost about 20 percent of his body weight a case was made to the Exceptional Cases Committee at the local PCT for funding for adalimumab which was granted.
141. For the most part, I am satisfied that the man's care was responsive to his needs and comparable with that he would expect to receive had he been in the community. A more holistic approach, which considered the impact of his illness on his psychological wellbeing, would have been valuable. Pain management with morphine was prescribed and he went to the healthcare centre twice daily in order to receive this medication.
142. Unfortunately, the dispensing times of controlled drug medication could vary widely and staff had no clear idea of how these drugs should be administered to prisoners unable to attend the healthcare centre. The result was that the man's pain management was haphazard and not as effective as it should have been. I suspect that he probably suffered many hours of pain which could well have been avoided. However, it is fair to say that his refusal to move to the HCC contributed to that situation. I make several recommendations to the Governor and Primary Care Trust which I trust will ensure that other Frankland prisoners benefit especially from better management of pain relief.

## RECOMMENDATIONS

### Primary Care Trust

1. The Primary Care Trust should ensure that verbal or written communications are more effective between staff so that prisoners are told about the requirements, such as fasting, when attending appointments at NHS clinics. The Nursing and Midwifery Council Guidelines on Record Keeping: Guidance for nurses and midwives numbers 7, 9 & 33 apply.

This recommendation was accepted by the PCT who responded that:

“A full feasibility study with the Security department will be initiated to explore the possibility of informing prisoners direct of any requirements such as fasting when attending appointments and NHS clinics.”

The target date for completion of this action is April 2011.

2. The Primary Care Trust should ensure that changes in care regimes suggested by NHS staff are fully documented for dissemination between prison care staff. Once started or completed they must also be recorded in accordance with the Nursing and Midwifery Council Guidelines on Record Keeping: Guidance for nurses and midwives numbers 7, 9 & 33.

This recommendation was accepted by the PCT who responded that:

“A full review of communication streams between departments such as the kitchens, wings, security will be undertaken and any recommendations implemented.”

The target date for completion of this action is April 2011.

3. The Primary Care Trust should ensure that nursing interventions are properly recorded so that other healthcare staff are aware and can take them into consideration when planning or administering other treatments.

This recommendation was accepted by the PCT who responded that:

“Since the death of [this man] Healthcare have moved IT systems to Systemone which has detailed clinical templates which has addressed this issue.”

They report that this action has been completed.

4. The Primary Care Trust should ensure that information recorded about patients is factual and complies with Nursing and Midwifery Council

Guidelines on Record Keeping: Guidance for nurses and midwives number 5.

This recommendation was accepted by the PCT who responded that:

“A case note audit will be completed and any issues addressed direct with the relevant staff. Also, this matter will be raised at the next full staff meeting and staff reminded of their NMC Code of Conduct regarding Record Keeping.”

The target date for completion of this action is April 2011.

### **The Governor and Primary Care Trust**

5. The Governor and Primary Care Trust should immediately review their policy on the issue of controlled drugs to ensure that access to them, while strictly controlled, is available at appropriate times to give effective pain relief.

This recommendation was accepted by the Governor and the PCT. They responded that:

“Staff has been informed that individual administration of Controlled drugs should be completed on the wings if the patient is too unwell to attend healthcare. This will be provided if they are unwilling to be resident in healthcare and assessed on a case by case basis.”

They report that this action has been completed.

6. The Governor and Primary Care Trust should develop and publish a clear strategy for secure dispensing controlled drugs to prisoners who are unable to attend the Healthcare Centre.

This recommendation was accepted by the Governor and the PCT. They responded that:

“This policy work is currently underway with the development of IDTS and should be operational by April 2011.”

The target date for completion of this action is April 2011.

7. The Governor and Primary Care Trust should ensure that prisoners' records are filed accurately and, when obvious mistakes are discovered, they are rectified quickly.

This recommendation was accepted by the Governor and the PCT. They responded that:

“Head of Administration in the Healthcare department will undertake an audit of clinical records in line with PCT policy.”

The target date for completion of this action is April 2011.

8. The Governor and Primary Care Trust should review the health and safety assessment for the healthcare centre waiting rooms, with particular emphasis on heating and ventilation arrangements and the numeric capacity of each room.

This recommendation was accepted by the Governor and the PCT. They responded that:

“Head of Healthcare to liaise with Head of Estates to address this issue.”

The target date for completion of this action is April 2011.