

**Investigation into the circumstances surrounding
the death of a man at HMP Frankland
in November 2006**

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

June 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Frankland. The man died in his cell on the afternoon of 15 November 2006. He was 57 years old.

A post mortem report into the man's death has not yet been completed. However, I understand that this will likely indicate that he died of natural causes as a result of heart failure.

I offer my sincere sympathy and condolences to all of the man's family and to his friends for their loss.

This investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison was carried out by the County Durham Primary Care Trust. As on past occasions, I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Frankland for their full and ready co-operation during the course of the investigation.

I make two recommendations and also highlight one example of good practice.

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June 2007

CONTENTS

Summary	4
The Investigation Process	6
HMP Frankland	7
Key Findings	8
Issues	14
Recommendations and Good Practice	18

SUMMARY

The man who is the subject of this report was received into HMP Manchester on 29 July 1997, having been convicted of a serious offence that day. A little over three months later, he was sentenced to 15 years imprisonment.

The man had been diagnosed as an insulin dependent diabetic many years previously. He was an intelligent man, and had a good knowledge of his condition. Nevertheless, he declined to attend the regular diabetic clinics that were held at Manchester prison. From his records, it would appear that this was because he thought he knew more about the condition than did healthcare staff. Indeed, the man continued to miss the majority of clinics following his transfer to Frankland on 28 October 1998. However, in December 2001, he appeared to change his mind. It is not clear why this was the case, but from then on he attended far more clinics than he missed.

Nevertheless, the man had a number of disagreements with healthcare and catering staff at Frankland with regard to what constituted a suitable diet for diabetics. On 8 May 1998, an F2052SH (a form then used by the Prison Service to monitor and support prisoners deemed to be at risk of suicide or self-harm) was opened when he began to refuse food and medication in protest at the diet that he had been given. The form was closed a week later, after which the man began to settle into prison life at Frankland.

In January 2004, the diabetic milk supplement was changed from skimmed to semi-skimmed milk. Following this, the man submitted a number of complaint forms concerning the diet available to diabetics. On 19 October 2004, a meeting was held between a dietician, healthcare staff and the catering manager to discuss matters. The changes made to the diet after this meeting were communicated to the man, and appeared to satisfy him.

Despite his concerns about his diet, the man's diabetes was generally well controlled during his time at Frankland. He had no other serious health problems, although he briefly suffered from dizziness and an increased heart rate in September 2006 following the death of his mother.

On the afternoon of 15 November 2006, prisoners at Frankland were locked in their cells due to a staff training day. A few seconds after unlock at 5.05pm, a prisoner entered the man's cell and found him to be unresponsive. The prisoner thought that the man was dead, as did the staff whom he alerted. Healthcare assistance was called, and the nursing staff who attended attempted cardio-pulmonary resuscitation (CPR). Sadly, this was without success.

The man's death on the afternoon of 15 November 2006 was sudden and unexpected. One prisoner and one officer told my investigator that he had been looking unwell that morning, but others said that he was laughing and joking as normal and seemed to be okay. He had not asked for healthcare assistance at any time that day.

The clinical review concludes that the man's diabetes was well managed during his time at Frankland. However, I make one recommendation with regard to the diet available to diabetics, and one regarding staff training.

I also draw attention to one example of good practice.

THE INVESTIGATION PROCESS

The investigation was opened on 17 November 2006 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. Six prisoners came forward as a result.

My investigator was given access to the man's prison files, including his medical record. He visited Frankland on 24-25 January 2007, and again on 22 February. He interviewed six members of staff during the course of the investigation.

An independent clinical review of the man's health needs whilst he was in custody was carried out by the County Durham Primary Care Trust. Unfortunately, the clinical reviewer was not provided with a copy of the medical record until nearly the end of January 2007. I understand that he has had similar problems following a more recent death at Frankland. This is disappointing, and has been a matter of great frustration to the clinical reviewer. Although I have chosen not to make a formal recommendation, the Governor should ensure that such delays do not occur in future.

One of my family liaison officers contacted the man's daughter, who was his next of kin, on 6 December 2006. His daughter's main concern at this stage was that she did not yet know the cause of her father's death.

HMP FRANKLAND

HMP Frankland is one of the eight maximum security establishments within the Directorate of High Security Prisons. Frankland holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. Four of the six wings hold vulnerable prisoners (those whose offences or behaviour mean they may be at risk of attack from other prisoners). The operational capacity of the prison is 734.

The most recent full inspection report by HM Chief Inspector of Prisons, dated March 2003, describes Frankland as offering a safe environment based upon good relationships between staff and prisoners. The inspection found good staff understanding of individual prisoners and their needs.

Following a short unannounced follow up inspection on 25 October 2005, the Chief Inspector recorded that healthcare services at Frankland had improved since the full inspection. However, primary care still needed development and staffing shortages had hindered progress. Of the 12 healthcare recommendations made during the full inspection, nine had been fully achieved, one partially achieved, and two had not been achieved.

Healthcare services at Frankland are commissioned by the County Durham Primary Care Trust. The prison's healthcare centre has 18 beds, all of which are linked to the office with a call bell system. The healthcare centre runs a number of clinics, including a monthly diabetes clinic.

KEY FINDINGS

The man was convicted on 29 July 1997 and remanded to HMP Manchester on the same day to await sentencing. A first reception health screen (a routine health screen for all new arrivals into prison) was completed following his arrival at the prison. The screen recorded him as have been an insulin dependent diabetic for 40 years, but that his diabetes was stable at present. He was also recorded as possibly suffering from carpal tunnel syndrome (a condition affecting the nerve function in the wrist).

The man's mental health was also assessed at his reception health screen. He said that he had cut his wrists nine months previously as a result of depression. He said that he had not expected to be sent to prison, but that he was not feeling suicidal now. The assessor decided that he was not at risk of suicide or self-harm at that time.

Diabetic clinics were held regularly at Manchester, around once a month or once every two months. The man rarely attended these during his time at Manchester. An entry in his medical record on 23 March 1998 indicates that this was because he thought he knew more about diabetes than the healthcare staff. He also complained about diabetic food supplements on the same day, and on two further occasions later the same year.

On 28 October 1998, the man transferred to Frankland. It was recorded at his reception health screen that he was an insulin dependent diabetic, and a high fibre and high carbohydrate diet was recommended. Shortly after his arrival at Frankland, the man was referred a Consultant Diabetologist at a local hospital. At a follow up on 5 February 1999, the man complained to the consultant about his diet. However, the consultant concluded that his diabetes was under good control, and recommended no change to his regime.

At a review on 9 April, the man's dietary needs were considered further. A doctor at Frankland, wrote to the Principal Officer in the kitchen on 13 April and clearly set out the man's dietary requirements. The emphasis was that a high fibre/high carbohydrate diet was required.

The man remained discontented with his diet, however. On 8 May, he was placed on an F2052SH (a form then used by the Prison Service to monitor and support prisoners deemed to be at risk to suicide or self-harm) because he had been refusing food and medication for two days. The nurse who opened the F2052SH noted that the man had said to staff on his wing that he "wanted to end it all". However, on 10 May he was seen by a Healthcare Officer (HCO), to whom he said that he was "not refusing food to harm himself, but to get his correct diet as per letter from (the prison doctor) to catering department." On 15 May, the F2052SH was closed as the man had begun to eat and was taking his medication correctly.

Following the closure of the F2052SH, the man began to settle more easily into prison life. In August, he started work as a library orderly. Numerous entries in his wing record indicate that he was a good worker who was quiet and had no problems. Nevertheless, he continued not to attend the diabetic clinic. No reason was given for

his non-attendance, although it is clear from the records that it was his own choice not to participate.

On 6 June 2000, the man suffered a hypoglycaemic attack (when blood sugar falls to a dangerous level) whilst in the gym. He was given glucose by the gym staff. The nurse who attended felt that the attack was due to the man taking an extra gym session and not having had enough food. The man soon recovered, and was escorted back to the wing.

On 4 December 2001, the man attended a diabetic clinic. This was almost the first clinic that he had attended since his arrival at Frankland three years previously. It is not clear why he began to attend the clinics, but for the remainder of his time at Frankland he attended far more than he missed. At the clinic on 4 December, the man had a long discussion with the nurse with regard to his diet. He felt that his needs were not being met in terms of the provision of wholemeal bread. The nurse agreed to discuss this with a dietician, and an appointment was made for 19 March 2002. However, the man did not attend this appointment. An entry on 20 May indicates that his diabetes was well controlled at the time, and that the man agreed with this judgement.

At a clinic on 25 June, the man requested referral to a diabetologist. It is not recorded why he wished to see the diabetologist. The nurse noted that she would discuss his request with the prison GP. An unidentifiable entry on the following day said, "there is no reason to refer this man to waste the time of a busy diabetologist".

The man's diabetes was well controlled over the course of the next year, although he was advised to increase his carbohydrate intake to take account of the rigorous gym sessions that he liked to undertake. However, at a review on 14 July 2003, the man said that his blood glucose was now poorly controlled. He blamed this on the wing regime, in particular the restricted timings for meals (his insulin had to be taken 15-20 minutes prior to eating). At his next review on 29 July, it was agreed to change the man's insulin to pre-filled pens. The benefit of this change was that insulin could be taken either with or following meals, and hence brought greater flexibility. At a review on 17 September, it was noted that his diabetes was now under much better control.

In 2004, the man began to raise regular concerns about his diet. He submitted a complaint form on 15 January because his daily ration of skimmed milk had been stopped (he had received one pint of skimmed milk as a daily dietary supplement since March 2000). The catering manager responded. He said that the doctor and Head of Healthcare had deemed the nutritional benefits of skimmed milk to be negligible and that it had therefore been stopped as a supplement. Diabetics were recommended to take semi-skimmed milk, which was available as a breakfast choice.

The man did not accept this, and appealed against the reply to his complaint on 21 January. In his appeal, he said that he had been drinking skimmed milk for 30 years, following recommendations from his NHS consultant. The appeal was replied to by the Senior Medical Officer (SMO), who said that advice given 30 years ago might not

be relevant nowadays. Nevertheless, an appointment was arranged for the man to see a dietician for definitive advice on his needs.

On 10 February, the man met with the Senior Dietician at the local hospital. At the meeting, the dietician assured him that semi-skimmed milk was suitable for his needs. She also spoke to him about the need to supplement his meals with regular snacks of fruit and bread, and to try to reduce the amount of cheese that he ate. However, the dietician did not note in the medical record the advice that she had given him with regard to snacks and his cheese consumption.

On 6 March, the man submitted a further complaint form in which he indicated that he was unable to follow the dietician's advice due to the lack of choice available from the menu. The response from a Senior Healthcare Officer said that no recommendations had been made regarding snacks, and suggested that the man write to the dietician and ask her to put her recommendations on paper.

The man subsequently wrote to the dietician. She replied on 13 May, saying that she had spoken to the catering manager who had assured her that fruit and bread was available to all diabetics to be eaten as snacks throughout the day. The dietician again wrote to the man on 22 June, apparently after he had written to the Head of Nutrition and Diabetics at the local hospital. In this letter, the dietician set out formally the advice she had given the man on 10 February. The letter was copied to the SMO at Frankland.

Following receipt of this letter, the man submitted a further complaint form on 8 July. In this, he requested that the kitchen provide him with the recommended snacks. The response from an HCO was not completed until 20 August. In his response, the HCO said that the man was "supplied with dietary supplements in accordance with prison kitchen protocol", and that the dieticians suggestions were "guidelines only".

The man appealed against this response on 24 August. In his appeal, the man wrote that the menu was insufficient in the dietician's opinion for his dietary needs. As a result of this ongoing dispute, a meeting was arranged for 19 October between a Clinical Nurse Specialist, the dietician and the catering manager, to discuss the man's dietary needs and formulate an action plan. In the meantime, the man raised a further complaint on 7 October with regard to his snack provision.

Following the meeting on 19 October, the Clinical Nurse Specialist wrote to the man to set out the points that had been agreed. These included the provision of an extra half-pint of semi-skimmed milk to type 1 diabetics (insulin dependent diabetics) and replacing the provision of a cheese sandwich for overnight lock-up with a healthy alternative. At a review on 4 December, it was recorded that his dietary needs were now fulfilled.

The man did not raise any complaints with regard to his diet in 2005. At a review on 29 July 2005, the Consultant Diabetologist changed his insulin dosage and, at a follow-up on 16 December, noted that the man was doing fairly well on the new dosage. By his next review, on 9 June 2006, the consultant felt that the man had "excellent glycaemic control".

The man spent time in the segregation unit in January and February 2006, after evidence of cannabis use was found following a mandatory drugs test. After initially pleading not guilty, he eventually did plead guilty at an adjudication hearing on 11 April. This was his first proven adjudication since his reception into custody nearly nine years previously.

On 28 September 2006 at around 7.15am, a nurse was called to the wing to see the man after he complained of dizziness, headaches, a “heavy feeling” in his throat and a rapid heartbeat. The nurse took observations which proved normal. The man told the nurse that his mother had been cremated the previous day. She therefore advised him that he could be suffering from stress or a panic attack, and advised that he rest in bed and contact staff if his condition worsened.

The nurse then visited the man in his cell at around 10.30am on the following day (29 September). She noted that he was still in bed and he said that he had not been eating. The man thought that he might have had food poisoning, although the nurse noted that he had not experienced vomiting or diarrhoea. She encouraged him to eat a small amount of food, and saw that he adjusted his insulin accordingly.

At 2.30pm that afternoon, the nurse received a telephone call from the wing. The man had apparently told staff that he was seriously ill and needed to see a doctor. The nurse visited, and the man spoke to her of a “buzzing” in his ears. She escorted him to healthcare, noting that he was able to walk across “quite rapidly”. Once at healthcare, the nurse examined his ears and found nothing untoward. His blood pressure was also taken. It was normal. The nurse subsequently advised he man to return to the wing and to contact staff if he felt it necessary. He did not seek any further medical assistance at this time.

The man attended a diabetic clinic on 13 October at which he was noted to be doing very well. He then attended a review with the Consultant Diabetologist on 3 November, at which he said that he was feeling better on his current insulin regime. There is no record of the man being seen by healthcare staff on any further occasions prior to his death.

The day of the man’s death (15 November 2006) was a staff training day. Prisoners were therefore locked in their cells during the morning and afternoon. They were unlocked in the morning for breakfast, and again at around 11.00am for lunch.

My investigator spoke to a number of staff and prisoners with regard to the man’s health at this time. One prisoner said that he saw the man in the shower the previous evening, when he said that he was “feeling terrible”. The prisoner said that he was “slower and pale” on the morning of 15 November. The officer who was in charge of the servery that morning, saw the man at around 11.45am when he collected his lunch. He remembered that the man was looking very pale, but did not appear to be sweaty or in distress. The officer recalled that the man was moving alright and engaging in conversation with other prisoners, and he did not feel that there was a need for him to be seen by healthcare staff at the time.

At around 11.50am, a Senior Officer spoke to the man with regard to a legal visit that his solicitor was arranging. He recalled that the man appeared to be his normal self

at the time. My investigator also spoke to three prisoners who had seen or spoken to the man at around the same time. Each of them said that he seemed to be alright and gave no cause for concern.

At around 11.55am, the prisoners were locked up for the afternoon. At around 1.00pm, the officer who had earlier been in charge of the servery carried out a roll check (an officer checks each cell to ensure that the correct number of prisoners are on the wing). He recalled that the man appeared to be asleep at this time. A further roll check was carried out at around 3.45pm by a different officer, who noticed nothing untoward. At around 4.45pm, a third officer carried out the final roll check of the afternoon. His recollection was that the man was lying on his back at the time and appeared to be asleep.

At around 5.05pm, an officer unlocked cells 6-18 on the man's landing for tea (he lived in cell B3-10). He opened each cell door by approximately three to four inches in order to check that the prisoner was there. The officer recalled that the man was lying on his bed. He did not consider this to be unusual and thought that the man must be asleep.

A few seconds later, a prisoner went to the man's cell to say hello to him. At first glance, the prisoner thought that he was asleep. However, on entering the cell, he realised that the man was dead. The prisoner immediately called the officer who was manning the landing alarm bell, to the cell. At interview, this officer recalled that, when he arrived at the cell, it was obvious to him that the man was dead. The officer then went to the wing office and made a 'code black' call for healthcare assistance. (A code black call means that someone is unconscious and not responding.)

At the same time, a second officer entered the man's cell, followed shortly afterwards by a third. The second officer checked for a pulse, but found none. The two officers did not attempt cardiopulmonary resuscitation (CPR). At interview, the second officer said that this was because it was fairly obvious to them both that the man was dead at that time.

At around 5.10pm, a nurse and HCO arrived at the cell, followed by a Healthcare Support Worker (HCSW). The nurse and HCSW attempted CPR, but were unsuccessful. Paramedics arrived at around 5.35pm and chose not to continue with CPR. At around 5.55pm, the duty doctor confirmed death.

An examination of the man's insulin pens immediately after his death by the duty doctor indicated that he may have taken his week's supply of insulin two days early. However, closer examination of the pens at a later date by an expert in diabetes ruled these findings to be incorrect. The man had, in fact, taken the correct amount of insulin at the time.

At the time of submitting my report, a report following the post mortem examination had not yet been completed. However, it appears that the post mortem report will indicate that the man died of natural causes as a result of heart failure.

The man's next of kin was recorded at the prison as being his mother. She had visited him on a number of occasions whilst he was at Frankland. However, she had died in September 2006 and the prison did not hold address details for any other members of the man's family. The Head of Secretariat, therefore telephoned the man's brother to break the news of his death (the man's brother had telephoned around two months previously to inform the prison of his mother's death, and it is from this record that the Head of Secretariat obtained his telephone number). The man's brother was able to provide contact details of the man's daughter. As she was heavily pregnant at the time, the Head of Secretariat was keen to avoid undue distress and so wrote to her to offer help with the funeral expenses (the news of the man's death was broken to his daughter by her uncle).

Communication between the Head of Secretariat and the man's daughter was open and effective. The man's daughter described the help given to her by the Head of Secretariat as "fantastic".

The man's funeral was held on 11 December, and all of the costs were met by the prison. A collection by the prisoners on his wing raised £150 for flowers, with a donation also made to Diabetes UK.

ISSUES

Management of the man's diabetes

The clinical reviewer concludes that the man's diabetes "appears to have been reasonably well managed during his stay in prison." He notes that, as a diabetic for around 40 years, the man had a good knowledge of the day to day management of his condition including the risk factors present. It is surprising, therefore, that he chose not to attend diabetic clinics on many occasions, particularly in the first four to five years of his imprisonment.

Part of the problem, in the clinical reviewer's view, is that the man "appeared to take the view that healthcare monitoring was of no value because he knew more about diabetes management than they did." The reviewer concludes that this was "not in his best interests".

The man made numerous complaints with regard to his diet during his time in prison, and it is clear that this was an issue of some concern to him. This was particularly the case in 2004, when the changing of his milk ration from skimmed to semi-skimmed appears to have acted as a catalyst for further worries about the quality of the snacks provided for diabetics. The clinical reviewer takes the view that, in this case, there was fault on both sides.

As the reviewer notes, it is difficult to fulfil individual needs in a mass catering establishment such as a prison. However, in his clinical review he concludes that medical staff at Frankland gave contradictory guidance to catering staff in the early part of the man's time at the prison. On the other hand, the clinical reviewer considers that the man had fixed ideas about his dietary requirements, dating from the early days of his diabetes, and was "resistant to advice on modifications to them".

The clinical reviewer concludes that the multi-disciplinary meeting held on 19 October 2004 was the right approach. Healthcare staff, caterers and the dietician were present, and the findings were clearly communicated to the man afterwards in writing. This approach appears to have been successful, as there is little evidence of the man making either formal or informal complaints with regard to his diet for the remainder of his time in custody.

The clinical reviewer suggests that such an approach should perhaps have been tried earlier. I agree. The man had made numerous complaints with regard to his diet (particularly in 2004, as well as earlier). Some of the replies he received were not particularly helpful, and poor communication following his meeting with the dietician on 10 February 2004 did not help matters.

The Head of Healthcare should ensure that the diet available to diabetics is regularly reviewed by a dietician, and that multi-disciplinary meetings with individual prisoners are held when necessary.

Care provided on 28/29 September 2006

A number of prisoners approached my investigator to say that, around one or two months before his death, the man was ill in his cell. Each of them described similar symptoms: that he was unable to get off his bed, had no strength and could not move. The consensus was that it was as if he was paralysed. One prisoner told my investigator that the man was simply told to rest, and that he did not agree with this. Another prisoner said that the man wanted to go to hospital but was refused. Each of the prisoners whom my investigator spoke to felt that this incident needed highlighting and that the care provided to the man needed examining.

Although none of the prisoners was able to provide a date on which these events occurred, they all gave a timeframe of around one to two months before his death. It would appear therefore that the prisoners are referring to the events of 28-29 September 2006 when a nurse was called to see the man on the wing when he complained of dizziness, headache and a rapid heartbeat.

My investigator asked the clinical reviewer to consider these events and the care provided to the man at the time. The clinical reviewer notes that the man “was not paralysed, and all his observations were normal when he was seen and assessed on both days.” In fact, the man was taken to healthcare and walked there quickly and easily. Moreover, the reviewer says that the man “obviously fully recovered” and notes that he was described as being well at subsequent diabetic reviews. He goes on to say that he does not consider that “this management was unreasonable or that further investigation was indicated at that time.” I agree with the clinical reviewer’s assessment.

Events of 15 November 2006

My investigator spoke to a number of staff and prisoners who saw the man on the morning of 15 November. One officer said that the man appeared to be very pale at around 11.45am, but otherwise was moving well and engaging in conversation with other prisoners. One prisoner came forward to say the man was “feeling terrible” on the evening of 14 November and was “slower and pale” the following morning. However, other officers and prisoners said that they saw or spoke to him prior to lunch on 15 November and that he was laughing and joking at the time, seemed okay, and gave no cause for concern.

During the course of the investigation, my investigator spoke to a number of staff and prisoners who knew the man. Virtually all of them agreed that he was the sort of person who would raise concerns with wing or healthcare staff if he was unwell. This is certainly the impression that comes from examining his prison records. Whilst there are different recollections surrounding the state of his health on the morning of 15 November 2006, there is no evidence to suggest that the man asked for healthcare assistance at any time that morning. Indeed the clinical reviewer concludes that his death was “sudden and unexpected”.

None of the discipline staff who entered the man’s cell when he was discovered after evening unlock attempted CPR. Those whom my investigator spoke to about this

said that they did not attempt CPR as it was clear to them that the man was dead at the time. The clinical reviewer judges that it is “likely that he had been dead for some time”.

However, none of the officers who entered the man’s cell and were interviewed by my investigator had received any heartstart (CPR) training since they had joined the Prison Service a number of years previously. The officer who unlocked the man had been a first aider in a previous job and felt confident that he could use CPR if necessary. The second officer to enter the cell following the alarm being raised, on the other hand, felt that a refresher course would be beneficial to him.

As I have pointed out in many of my investigation reports following a death in custody, speedy intervention by properly trained and qualified staff can be the difference between life and death. I think it is essential that discipline staff have the knowledge and confidence to carry out CPR effectively. Such skills can only be developed by regular training.

The Governor should ensure that an appropriate number of wing staff are given the opportunity to undertake a heartstart refresher course.

Family response to the draft report

On 31 May 2007, I received comments on my draft report from the man's daughter. She was shocked to discover that wing staff at Frankland did not receive CPR training, and was supportive of the corresponding recommendation. Her other concerns centred on the afternoon of 15 November 2006 and whether staff could have done more for her father. In particular she questioned:

- Whether staff should have got an acknowledgement when checking on her father during roll checks?
- If her father had had a heart attack, would he have appeared more disturbed than if he was naturally asleep?
- Why there was no handover between staff at the end of the afternoon shift?

Roll checks were carried out on three occasions during the afternoon of 15 November, at around 1.00pm, 3.45pm and 4.45pm. The purpose of these roll checks is simply to confirm that the correct number of prisoners are on the wing. In addition, the man was unlocked for tea at around 5.05pm. On each of these four occasions, the officer concerned looked in on the man and recalled that either he looked to be asleep or that there was nothing unusual to note. The prisoner who discovered the man said that, at first glance, he appeared to be asleep.

The man was not deemed to be a vulnerable prisoner. There would therefore be no requirement to speak him, unless the officer felt that there was something untoward. Indeed, to wake him simply for an acknowledgement if he was thought to be asleep could be seen to be an affront to his personal dignity.

There was no formal handover to evening staff at the end of the afternoon shift. One officer recalled receiving an update from the afternoon staff, but no official handover. Unless there had been an event of any significance during the day, I would not expect there to be a formal handover to staff at the start of the evening shift. Information regarding any noteworthy events should have been passed on as an update and by checking the wing observation book. However, staff were unaware of any such events concerning the man that had occurred during the afternoon and there would therefore have been no need to speak about him to staff on the evening duty.

RECOMMENDATIONS AND GOOD PRACTICE

The Head of Healthcare should ensure that the diet available to diabetics is regularly reviewed by a dietician, and that multi-disciplinary meetings with individual prisoners are held when necessary.

Not accepted - the Governor does not accept the first recommendation on the grounds that an adequate policy to review and consider diabetic needs is already in place. The diabetic choice of diet was reviewed on three occasions last year with the dietician, catering manager and catering staff. They attended an advice session by healthcare and the dietician and HMP Frankland will continue to have multi disciplinary reviews, the next one due in June.

The Governor should ensure that an appropriate number of wing staff are given the opportunity to undertake a heartstart refresher course.

Accepted

Good Practice

Communication between the Head of Secretariat and the man's daughter was open and effective. The man's daughter described the help given to her by the Head of Secretariat as "fantastic".