Investigation into the circumstances surrounding the death of a man at HMP Frankland in January 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2010

This is the report of an investigation into the death of a man at HMP Frankland on 17 January 2009. He arrived at Frankland on 27 April 2005 after being sentenced to 15 years imprisonment at a local Crown Court on 17 March that year.

The man suffered from diabetes and depended on insulin. He had asthma, smoked and had two heart attacks in 2004 which resulted in angina. He was obese, had raised blood pressure and high cholesterol levels. He was taking a large quantity of medicines as a result.

Throughout his time at Frankland, the man frequently declined offers of help from doctors and nursing staff, both within the prison and also at the local hospitals. He did not fully comply with the medicines that were prescribed for him which had an adverse impact on his general health. He deteriorated over time, but would still refuse further investigations recommended by the doctors treating him.

On 17 January 2009, one of the man's friends found him slumped in his chair in his cell. There had been no obvious problems just 15 minutes before. Staff endeavoured to revive the man but were unsuccessful. I would like to offer my sincere condolences to the man's family and friends for their loss.

An investigator conducted the investigation on behalf of the Ombudsman. I thank the Governor of Frankland and his staff for their co-operation and assistance. In addition, a review of the man's medical care in prison was carried out by a doctor on behalf of the County Durham Primary Care Trust (PCT). I am grateful to the clinical reviewer for his assistance. I would also like to apologise for the delay in providing this report.

I find that the man's diabetes and mental health were well managed by staff at Frankland, with appropriate and timely referrals to the local hospitals. Unfortunately, the man did not always heed the advice of healthcare staff, and this, coupled with his general ill health, undoubtedly contributed to his death. I make one recommendation in my report.

Jane Webb
Deputy Prisons and Probation Ombudsman **January 2010**

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SUMMARY

On 17 March 2005, the man was sentenced at a local Crown Court to 15 years imprisonment for serious sexual offences. He arrived in prison with health problems including insulin dependent diabetes, asthma and angina following two heart attacks the previous year. He was an obese smoker with high cholesterol levels in his blood.

The man threatened to overdose on his insulin shortly after he arrived in prison and staff decided to put him on special observation measures, known as F2052SH. (F2052SH was the Prison Service's system for supporting and monitoring prisoners in crisis. This has been superseded by the ACCT process. An Assessment, Care in Custody and Teamwork (ACCT) document is now used to monitor prisoners in crisis who are at risk of suicide or self harm.) These special measures were no longer considered necessary shortly after the man arrived at Frankland.

The man transferred to HMP Frankland on 27 April. He started work in the Braille workshop despite having been essentially unemployed for the previous 20 years. Unconnected to this, the man had some heart problems in July and August 2005. He had further problems in September and was admitted to hospital on 26 September. The tests were inconclusive and he was discharged on 27 September. He refused any further follow up appointments at the time.

About a year after arriving at Frankland, at a routine health check of his diabetes, staff were concerned about the man's low mood and thought he might be suffering from depression. He was assessed by the mental health team and started taking antidepressant medication on 25 April 2006.

Throughout the following years, the man was monitored and treated for his diabetes and other medical conditions, but would often refuse to go to hospital despite advice from doctors in the prison. He would sometimes alter his own medication, and it would appear he did not always take the medicines prescribed by his doctors.

On 17 January 2009 one of the man's friends, accompanied him as he collected his breakfast meal. When he returned to his cell, the man asked his friend to look out for him if his door was closed (an arrangement they made so that they did not miss meals). A little while later the man's friend went to the observation hatch of the man's door and looked in to check he was alright. He gave him a 'thumbs up' sign to indicate he was well. The friend returned some 15 minutes later and saw the man slumped in his chair. He did not respond to his friend's shouts, so he sought staff assistance.

Staff went into the cell and endeavoured to resuscitate the man, but it was not possible to achieve this. Paramedics also attended. They instructed staff to end their resuscitation efforts and the man was certified dead at 12.44pm.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from this office. He first visited the prison on 10 February when he spoke to staff who had come into contact with the man. Notices were posted to staff and prisoners about the investigation, inviting contributions if necessary. The investigator interviewed four members of staff and three prisoners.

2. The investigator met members of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on the prison.) Neither the IMB nor the POA had anything specific to bring to the investigator's attention at this time, but both said they would help wherever they could.

3. The investigator studied all the relevant prison records relating to the man. They included his main prison record, medical records and statements made by staff. The Investigator also visited C wing, the unit where the man was housed when he died.

4. The Durham Primary Care Trust identified a doctor to carry out a clinical review of the man's clinical care whilst he was at Frankland. I am grateful to him for undertaking this review. The investigator discussed aspects of the man's treatment with the clinical reviewer, in particular relating to the large amounts of medication found in the man's cell. The clinical reviewer has provided an additional opinion on this matter.

5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries into the man's death.

6. A family liaison officer (FLO), spoke to the man's daughter-in-law. She did not raise any concerns for the investigator to consider. She felt that the prison had looked after her father-in-law well and kept in good contact with her. The man's daughter-in-law did ask if the investigator could identify a prisoner who was described as a close friend to the man. She wanted to contact him and thank him for his kindness to the man. I believe this has been facilitated through the prison's family liaison services.

HMP FRANKLAND

7. HMP Frankland is one of the high security prisons in the north of England. Its main function is to keep some of the most dangerous prisoners in the system in custody. It holds both Category A (the highest security level) and Category B (a slightly lower security level) prisoners. The man was a Category B prisoner. It was built in 1983 and had further accommodation added in 1998. It now holds approximately 740 prisoners, half of whom are likely to be serving life sentences.

8. Throughout a prisoners time in custody, Prison Service staff have to assess that person for risk (risk they posse to themselves and others as well as risk of security breaches such as escape). They do this in a variety of ways and at various times, depending on circumstances relating to a prisoners security category. With Category B prisoners, it is assumed that they have the ability to escape or cause problems for the Prison Service, and that if they did escape the public would be in some danger. When such prisoners need to go to outside hospitals the prison assesses the risk they posse and decides what level of security measures to take to safeguard the public (usually two members of staff with the use of handcuffs). Later in this report I talk about hospital escorts and the use of handcuffs for the man.

9. Frankland has been recognised as a consistently good performing prison in the Prison Service performance rating scales. In the report of an announced inspection in 2008, Her Majesty's Chief Inspector of Prisons, described Frankland as "drifting" in some key areas, most worryingly in relation to safety. There were good relationships between staff and prisoners in some areas, most notably the vulnerable prisoner areas. However, she was critical of relationships between black and minority ethnic prisoners and prison staff. Her Majesty's Chief Inspector of Prisons report also said that it was

   > 'disappointing, given the prison's relatively elderly population, that some good work on disability had been discontinued, following the departure some months ago of the disability liaison officer, and the failure to find a replacement.'

   Health services were described as generally good.

10. The Independent Monitoring Board issued an annual report covering the period December 2007 – November 2008. In that report, the IMB praise a recently appointed Principal Officer responsible for the needs of disabled prisoners. They also highlight that a small elderly prisoners unit had been set up in E wing, which has shown itself to be very useful. All prisoners at Frankland are held in single cell accommodation with toilets and hand washing facilities.

11. At the time of the man's death there had been 19 deaths at Frankland since the Ombudsman became responsible for all deaths occurring in custody in 2004. Of these, 17 were due to natural causes. Four of the deaths (including the man's) were due to heart attacks. Two were similar in that they

concerned prisoners who, at times, did not comply with their medication. Three of the four cardiac related deaths were also sudden and somewhat unexpected.

KEY FINDINGS

12. The man was found guilty on 16 February 2005 at a local Crown Court of serious sexual offences. He was sentenced to 15 years imprisonment and held first in HMP Durham. He transferred to HMP Frankland on 27 April 2005.

13. The man was an insulin dependent diabetic, and had been for 15 years prior to his arrival in prison. He had had two heart attacks in 2004 and was left with angina as a result. He was obese with raised blood pressure and raised cholesterol levels in his blood. He suffered from asthma and was a smoker.

14. When the man first arrived at Durham, he was identified as being at risk of potential suicide or self harm. He told staff that he had taken an overdose of his insulin. The staff placed the man on the F2052SH (a regime designed to support those prisoners in crisis to prevent them from self-harm). He was kept on F2052SH until 4 May 2005, just after his transfer to Frankland.

15. Healthcare staff at Frankland referred the man for follow up care, but he would often refuse appointments or help. Details of the specific episodes of referral and refusal are contained within this report and the clinical review undertaken by the clinical reviewer.

16. The man started working in the Braille workshop on 4 July. The wing history sheet for him says that he was a quiet prisoner who kept himself much to himself. By early August entries in the history sheet say that he had started to mix with a small group of prisoners.

17. The man complained of chest pains on 22 August and he was moved to the healthcare centre for further investigations. He returned to his own cell later that day. He felt unwell again on 31 August and a nurse who visited him in his cell told him to rest there. An entry in the man's wing history sheet from 3 September says 'moves as little and as slowly as possible because of his health, has few associates, should be on B wing really (closer to healthcare)'.

18. On 26 September the man was admitted to the cardiac unit at University Hospital of North Durham complaining of chest pains. He underwent various tests including an electrocardiograph (ECG) and blood tests, but they were all inconclusive. He was discharged from hospital on 27 September, refusing further follow up and investigation.

19. The man went to the prison healthcare centre on 25 February 2006, and had some routine blood tests for his diabetes. Healthcare staff felt at the time that he seemed a bit low in mood and wondered if he was depressed. He was referred to the mental health team for their view. The man was offered antidepressant medicine on 25 April, having been seen in the interim by the mental health team for cognitive behavioural therapy. He also refused a referral to the local hospital for a renal function test as part of his diabetes monitoring on 17 March.

20. Towards the end of May, the man had a chest infection that required antibiotics, and then on 17 June he became unwell with diarrhoea and vomiting. He refused to be admitted to healthcare at first, but on 18 June he was admitted, though only for about six hours.

21. The man reduced his own insulin dose around 6 July because he said the insulin was causing his depression. He was referred to the diabetic nurse specialist. It is not clear from the records whether he resumed his normal dose.

22. The optician saw the man on 11 July as part of his diabetic monitoring (a consequence of diabetes can be loss of vision) and referred to a consultant ophthalmologist at a local Eye Infirmary. However, when his appointment was due on 8 August, he refused to go.

23. On 16 September, the man's application for Enhanced status on the prison's Incentives and Earned Privileges (IEP) scheme was refused because a sentence plan had not yet been completed. (IEP is a system to reward good behaviour in prisons. There are three tiers – basic, standard and enhanced, with enhanced being the highest level of rewards available. Incentives can include more visits and opportunity to spend more private cash.)

24. The man was moved to the segregation unit on 18 November because he failed a mandatory drugs test (all prisoners are subject to random urine testing for drugs). It seems that he was unable to provide a urine sample. The adjudication was eventually cancelled on 18 December. (An adjudication is an internal hearing into alleged breaches of prison discipline by prisoners.)

25. The man had an angina attack on 2 December which resulted in him being admitted overnight to the in-patient unit at Frankland. The prison doctors wanted him to go to outside hospital, but he refused. He returned to his own unit on 3 December.

26. On 7 December, the man was found in possession of a large quantity of his prescribed medication that he had not been taking. Healthcare staff reminded him of the importance of taking his medication properly, as prescribed. He was allowed to keep his medication in possession. It is not clear from the records what, if any, monitoring was undertaken of his compliance with this guidance.

27. One month later, on 5 January 2007, the man again threatened to take an overdose of his insulin because he was unhappy about access to his grandchildren being made difficult. An ACCT document was opened on him (ACCT is the Prison Service's replacement for F2052SH) and all medicines in his possession were removed.

28. The man was seen by the prison doctor on 30 January. The doctor wrote in the clinical record that the man was suffering angina attacks about five times a week, but had refused permission for a referral to a cardiologist at the local hospital. The man did however allow the doctor to refer him back to the

consultant ophthalmologist and for an ultrasound to check if he had trouble with gallstones. (This was because the man was also suffering abdominal pain.) He remained on an open ACCT until 2 March and received support and counselling in the interim from the mental health team.

29. The man was seen by the ophthalmologist on 8 May and had an ultrasound on 15 May. The ophthalmologist said that he needed further treatment on his eyes, but the ultrasound showed that he did not have gallstones.

30. On 20 May, the man had chest pain that lasted several hours, but he refused to see the prison doctor about it. The pain eventually reduced whilst the man was in the healthcare centre, but he refused to be admitted and was taken back to his cell after the pain passed.

31. The man was seen by the prison doctor on 4 June because he had been short of breath for a couple of days. The doctor prescribed antibiotics. The man saw the doctor again on 11 June because of his continued shortness of breath. The doctor thought that this might be due to problems with the man's heart and prescribed a diuretic after carrying out an ECG and blood tests. When the doctor saw the man again on 22 June, he felt that the man was definitely worse and was suffering from heart failure. The man was referred to the cardiologist and the prison doctor also prescribed an increased dose of the diuretic Frusemide.

32. The clinical record does not say whether the man actually saw the cardiologist, but does indicate that he was seen several times over the next three weeks by prison healthcare staff. Eventually, on 16 July, the man was so unwell that he had to be taken to the local hospital, where he was admitted. He remained there until 28 July when he discharged himself because, according to the specialist registrar in cardiology at the local hospital discharge letter, he could not endure being chained to prison officers.

33. The hospital diagnosed that the man had an enlarged heart due to the shortage of blood supplying the heart and the pumping action of the heart was not efficient. The man's lungs were becoming congested and fluid was gathering in the lungs as a result. The clinical reviewer's review says that continued use of diuretic medicines helped reduce the fluid on the lungs, but it led to a deterioration in his kidneys' ability to work properly.

34. When the man returned to Frankland on 28 July, he was moved to B wing because the staff on C wing felt that was a more appropriate place for him to be looked after. (B wing has more cells which are suitable for disabled and elderly prisoners and is closer to available nursing staff.) The man was not happy about this move and it seems he was not allowed to go to work either as staff thought that he was no longer fit enough. He stated that he would refuse to take his insulin medication if he was not moved back to C wing where his social support was. He moved back to C wing on 23 August.

35. On 17 September, the man was seen at a local hospital for laser treatment. At about this time he also officially retired from prison work (he was 64 years old).

36. Further tests for the cause of the man's abdominal pain (already investigated in May, when gallstones were suspected) were organised. On 29 October the man had a gastroscopy which confirmed he did not have any problems with his gallbladder. The prison doctors were still concerned about his kidney function.

37. The entry in the man's wing history sheet for 3 November says that he 'continues to attend work as and when required', so it seems the man was able to go to work occasionally despite being officially retired.

38. The cardiologist who saw the man on 8 November said that his heart problems were much as they had been before. He recommended that the prison doctor refer him to a diabetic specialist and a urologist for further consideration of his kidneys. The prison doctor sent letters of referral to the hospital as advised.

39. The man was admitted to a local hospital on 14 November because he had chest pain and was vomiting. He returned to prison on 15 November.

40. The man was due to go to the eye hospital again on 20 November but he declined to go. He also refused to see the diabetologist on 21 February 2008 and the renal physician on 7 March because he disliked being 'dragged through the hospital in handcuffs' (according to the entry in his wing history sheet).

41. The man was seen in the healthcare unit at Frankland on 10 March as he had been vomiting daily for three weeks. He was seen again on 31 March but had not improved. He was diagnosed with pneumonia on 1 April and advised that he needed to go into hospital for antibiotic treatment. He refused to go to hospital, but agreed to be admitted to the prison healthcare unit.

42. He discharged himself back to his wing the next day, against medical advice. Two days later (on 4 April) he agreed to go to outside hospital and was admitted to the local hospital for treatment of his pneumonia. He discharged himself again the following day and returned to prison. On 8 May, the man was due to attend the local hospital for an appointment with the cardiologist but he refused to go.

43. The clinical records say very little about the man's general medical condition over the following months, save that he had chest infections in August and again around Christmas. His kidney function continued to be a cause for concern. He was diagnosed as having chronic kidney disease on 23 December and referred urgently to the kidney specialist.

17 JANUARY

44. On the morning of Saturday 17 January 2009, the man and his friend were unlocked and walked together to get their breakfast. On their return, the man said that he wanted to 'bang up' (lock his cell door) for a while. The friend did not see this as unusual as they had an arrangement to look out for each other. When one of them wanted to 'lock up', the other would keep his door open and keep an eye out to ensure that the other was not forgotten for meals and the like. On this occasion, the friend was keeping watch for the man.

45. The friend remembered staff making security checks of all the cells, including the man's. He recalled that the man had a laugh and a joke with the officer who was doing locks, bolts and bars (LBB's). (LBB's are daily checks made by landing staff to ensure that the fabric of each individual cell is intact and that it has not been tampered with or defaced by prisoners.) The friend told the investigator that he left his cell at one point that morning to go and see the principal officer. When he returned, he said he opened the observation flap in the man's cell door and asked him if he wanted to be unlocked. The man put his thumbs up to say he was alright and did not want to be unlocked. The friend then returned to his own cell.

46. Some 15 minutes later, the friend went to the man's door to put a newspaper cutting through the top of the door. He again opened the observation flap in the door, and saw the man collapsed in his chair. He immediately recognised that something was seriously amiss. The man was sitting in his chair with his head lying against the back rest in a manner that suggested he had collapsed. The friend went down the landing and asked a member of staff to come with him to the man's cell.

47. The officer went to the man's cell with the friend and opened the cell door. The officer went inside and saw the man slumped in his chair with his mouth open, looking very white. He tried to rouse him by shaking him and calling his name but got no response. He checked to see if the man was breathing, or if he could detect a pulse in the man's wrist. He could not feel a pulse or determine that the man was breathing. He asked the friend to go to the wing office and tell staff that there was a 'code black' in C1 – 30. The friend left to do this.

48. When the friend reached the wing office, he informed staff of the code black in cell C1-30. An officer went down the landing and saw the officer with the man. The officer told the officer that arrived that the man was not breathing. The officer second on the scene went to the end of the landing and called for staff on other landings to come and assist. At this point an officer from C2 landing raised the alarm using the radio.

49. A senior officer and staff from other parts of C wing arrived very quickly. The senior officer asked his colleagues to lock all the prisoners up in their cells. Three members of the healthcare staff arrived with emergency equipment. They moved the man on to the floor in order to start cardio pulmonary resuscitation (CPR). Two nurses had been undertaking CPR for a while,

when an officer came past and offered to take over chest compressions from a nurse who agreed.

50. The officer remembered that the defibrillation machine was attached to the man. It assessed the man's condition and instructed staff to continue CPR. They continued CPR with the defibrillation machine assessing the man regularly for approximately 25 cycles of CPR. The defibrillation machine then indicated that the man had a heart rhythm that would allow the machine to give an electric shock to his heart. The machine did this and then, on reassessment, instructed staff to recommence CPR. Staff followed this procedure until the paramedics arrived at 11.25am. They made a further assessment and advised that everyone should stop CPR. The man could not be resuscitated and had died.

51. The prison staff put the death in custody contingency plan into operation and telephoned the police and the coroner. They also telephoned for the on-call doctor to attend, which she did. The doctor certified the man's death. Debriefing sessions were held and staff were offered support from the staff care and support team. The man's friend who had found him collapsed in his chair was offered help and support by many different staff. Indeed he said that he found the offers of help a little overwhelming.

52. The man's family were informed of his death by a personal visit from the prison's family liaison officer and a member of the chaplaincy team later that afternoon.

53. When the man's cell was cleared of his possessions, the staff discovered a large quantity of medicines that had been prescribed for him but not taken.

ISSUES

54. The man kept himself to himself. He talked to people he liked, but he had only a small circle of friends with whom he associated. The man that found him was one of his friends, and he told the investigator that he would see his friend at least four times every day. When the man was working in prison workshops, they would walk together to those work areas. The man's friend would accompany him to collect his food at mealtimes. This was in part because the man was unsteady on his feet at times and his friend would act as support for him should the need arise.

55. When the man first arrived on C1 landing, he used to stop at his friend's cell to catch his breath on his way to get his meals. Later, the man moved to a cell closer to his friend, again in part to be closer to his friend and also because it meant he did not have so far to go when collecting his meals.

56. For a while, the man moved to B wing, because that was thought to have better facilities for less mobile prisoners. He did not settle there because he missed his friends. The senior officer that answered the alarm when the man was found saw him one day on B wing, and agreed that he would help organise his return to C wing.

57. The man's wing history sheet had many entries in it which said that he never left his cell, except to go to work occasionally and get his meals. He liked to sit in his cell, with a few friends visiting him, watching television and reading whilst enjoying a cigarette. He did receive visits from his son and his daughter-in-law, but the issue of his grandchildren being denied visits was the source of unhappiness and depression in his early years in prison.

58. On two occasions when the man's depression became so bad that he threatened suicide by either overdosing or refusing to take his insulin, prison staff acted swiftly and monitored him using the F2052SH or ACCT system. After a period of a couple of months on these special observation conditions, he settled down to his usual sedate lifestyle. On both occasions, the man's in-possession medication was removed from him and he was required to take his medicines under supervision. At the end of both episodes of enhanced observation, staff assessed the man to judge whether he could have his medicines back in possession. He was allowed them after both risk assessments.

59. However, it is clear from the significant amount of medicine in his cell when he died that the man was not taking his medicine as prescribed by the doctors. This was not the first time as, on 7 December 2006, the man was discovered with excess medication in his cell. There does not appear to have been any satisfactory procedure for checking whether he took his medicine properly. All prisoners would have regular cell checks for the property in their cell and the man was no exception. The last recorded volumetric control check on the man's property was made on 14 October 2008. (Volumetric control is used to control the amount of property a prisoner has in his cell. Each man is allowed the contents of two standard-sized boxes.)

60. A few months earlier, staff on C wing had been asked to keep an eye on who was visiting the man's cell because there was concern that the tramadol (a strong pain relief) might be tempting for other prisoners. There was an awareness amongst staff of the fact the man had a quantity of prescribed medication in his cell.

61. It is a matter of concern to the clinical reviewer and myself that the man was not taking the medication designed to improve his health. Part of the deterioration in his condition could have been attributed to him not taking his medication properly. Healthcare staff do not appear to have checked the man's cell to ensure he was taking his medication. The clinical reviewer points out that doctor's in the community do not go to their patients' homes to check if they are taking their prescribed medication appropriately. However, in the closed confines of a prison where staff are responsible for prisoners care, I would argue that checks are both possible and desirable. The man was one such patient in my view.

The Governor and Head of Healthcare should devise a system that checks the amount of in possession medication held by prisoners who might be at risk of not taking their medicines regularly.

62. The man consistently refused offers of admission to hospital and referrals to specialists in secondary care. He gave the explanation on at least one occasion that he did not want to be "dragged through the hospital" whilst handcuffed. Although I can empathise with this view, it is not reasonable for prisoners who have to attend hospital appointments to expect that they should go without some measure of security arrangements being made. Whether that is proportionate and reasonable is an operational matter for the Prison Service to decide. I observe that Frankland is part of the high security estate and the man was a category B prisoner serving a long sentence for very serious offences. He was not recommended for open conditions during his time at Frankland.

63. It is also not clear that this was the only motive for the man declining help from outside health services. He refused admission to the prison's in-patient facility on a number of occasions and discharged himself early on at least one occasion (2 April 2008). The man would not have been required to wear restraints for admission to the in-patient centre.

64. The clinical reviewer in his clinical review, described the man as 'non-compliant in taking his medication properly. The clinical reviewer judges that the man "used not taking medication or the threat of overdose as manipulative tools". The man threatened to refuse to take his medication in late July and early August 2007 if he was not moved back to C wing. Despite all of these refusals and apparent manipulations, staff at Frankland continued to advise and recommend compliance with healthcare interventions that would benefit the man. I echo the clinical reviewer's comment in his clinical review that it is to the credit of the clinical staff that they 'stuck to their task' of encouraging his cooperation.

65. The clinical reviewer also says that these refusals of treatment undoubtedly contributed to the man's death being earlier than would have been likely, although his chronic ill health meant he was unlikely to live much longer.

66. When the man was first discovered collapsed in his cell on 17 January 2009, it is the clinical reviewer's view that he was already dead. However, it is to the credit of staff first on the scene and the attending healthcare staff, that they attempted CPR. There are occasions where it is not appropriate to attempt to resuscitate someone who is clearly dead and has been so for some time. This was not the case with the man. Indeed, following several cycles of CPR, the defibrillation machine indicated that there was a heart rhythm that would allow the machine to give an electric shock to the man's heart. Despite this, it transpired that none of the considerable efforts to revive the man were successful – though not for the want of trying on the part of prison staff.

67. The man's other medical conditions of diabetes and his mental health concerns were, according to the clinical reviewer, managed comprehensively throughout his time in prison. He was referred to specialists at appropriate times and further investigations for other medical conditions affecting the man were made. The man would often reject those interventions, but that did not stop the health services from endeavouring to assist him. His long term conditions were equally well considered as his more acute episodes of illness. County Durham PCT should compliment the clinical team involved in the man's care both in the emergency setting and throughout his time at Frankland.

CONCLUSION

68. The man was described by the clinical reviewer as a man who had multiple serious, chronic and life threatening conditions. He socialised with only a small circle of friends. He was pleasant to all staff, but would not open up to many people. He had a few periods of depression that staff identified and treated appropriately by special observation methods. He appeared to know his own mind and would, on many occasions, decline offers of assistance and referral to secondary care for his ongoing medical conditions. He received his medication, much as people in the community would, in his own possession. It appears that he did not always take his medicines as he ought to have. These factors, combined with the man's many health complications and his rejection of help from doctors and nurses, both within and outside the prison, undoubtedly led to his death occurring earlier than might otherwise have been the case. However, that having been said, the clinical reviewer is of the view that the man was unlikely to have survived much longer, in view of his multiple medical problems.

RECOMMENDATION

The Governor and Head of Healthcare should devise a system that checks the amount of in possession medication held by prisoners who might be at risk of not taking their medicines regularly.

The Prison Service have not yet responded in respect of this recommendation.