Investigation into the death of a man in June 2011 at HMP Frankland

Report by the Prisons and Probation Ombudsman for England and Wales

February 2012

This is the report of an investigation into the death of a man who died in his cell in the healthcare centre at HMP Frankland. The cause of death was congestive cardiac failure (heart failure) due to myocardial scarring (scarring on the heart) which was caused by coronary artery atheroma (blockage of the vessels that take blood away from the heart). I offer my sincere sympathy and condolences to his family and friends.

The investigation was carried out by a Prisons and Probation Ombudsman Investigator. A review of the man's clinical care in custody was carried out by the clinical reviewer on behalf of County Durham Primary Care Trust. We are grateful to the clinical reviewer for his assistance. We would also like to thank the Governor and staff at Frankland for their co-operation during the course of the investigation.

The man had suffered from heart failure for a number of years. He refused much of the treatment recommended to him. When his condition worsened he agreed to hospital admission, but discharged himself without receiving the full recommended treatment. As a result, end of life care was planned. Despite the man's unwillingness to access some of the proffered healthcare, HMP Frankland made considerable efforts to care for him effectively and according to his wishes. This care was commended by his next of kin and, indeed, by the man himself shortly before he died.

Notwithstanding the generally very good care which the man received, there remains scope to learn lessons from his case. We therefore make three recommendations for improvement regarding: arrangements for moving prisoners to healthcare at weekends, referral to the disability liaison officer and checks on the in-cell medication of those prisoners with a history of vulnerability.

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

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Prisons and Probation Ombudsman **February 2012**

CONTENTS

Summary

The investigation process

HMP Frankland

Issues

Conclusion

Recommendations

SUMMARY

1. The man was sentenced to life imprisonment in 1998. He was diagnosed with a number of significant health problems over the following years, including heart disease. In his first years in custody, he refused the treatment recommended to him on several occasions. He moved to HMP Frankland in October 2007.

2. During his time at Frankland, the man's health fluctuated. His mobility was sometimes affected by oedema (fluid accumulation in the limbs, which can be caused by heart failure) and he experienced some periods of chest pain and shortness of breath. The man refused to participate in several hospital investigations and tests during this time. However, he also went through periods in which he was in relatively good health and was able to work as a wing cleaner.

3. After a deterioration in his health, the man agreed to be admitted to the University Hospital of North Durham on 6 June 2011. He was diagnosed with acute kidney failure and cardiac failure, before discharging himself against medical advice on 10 June. Prior to discharge, he was assessed by a psychiatrist who determined that he had the capacity to understand the potential consequences of his decision. On his return to Frankland, he was advised to move into the healthcare centre, but preferred to return to his cell on C wing.

4. As a result of the serious nature of his condition and his refusal of treatment, it was determined that end of life care should be planned. A Macmillan nurse visited the man and made suggested changes to his medication. Both discipline and healthcare staff continued to try to persuade the man of the benefits of moving into the healthcare centre, but he insisted on remaining on the wing. As a result of his deteriorating mobility, healthcare staff began to visit him man on a daily basis to deliver his medication and offer assistance with his personal hygiene. He also received help from other prisoners with activities such as cleaning his cell and collecting meals. The prison's family liaison officer arranged for him to speak to his sister over the telephone.

5. The man's health deteriorated further and he agreed to move into the healthcare centre on 28 June. The following morning he was found to have stopped breathing. Healthcare staff administered cardiopulmonary resuscitation and an ambulance was called, but their attempts to resuscitate him were unsuccessful.

6. Caring for the man was challenging for staff at Frankland, on account of his refusal of treatment and preference to remain in his cell on C wing rather than move to the healthcare centre when his health deteriorated. Nevertheless, his wishes were respected and the clinical reviewer concludes that healthcare staff went to great lengths to ensure that he received care equitable to that which he might receive in the community. We make four recommendations, regarding procedures for moving prisoners to healthcare at weekends, handling of 'Do Not Attempt to Resuscitate' requests, referrals to the disability liaison officer and checking in cell medication for prisoners who might be vulnerable.

THE INVESTIGATION PROCESS

7. The investigation was opened on 30 June 2011, when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to his death to make themselves known to the investigator. No one came forward as a result.

8. The investigator visited Frankland on 5 July. During the visit he met a clinical manager, the prison's family liaison officer, and a representative of the prison's Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison). The investigator was provided with copies of the man's prison records, including the medical record.

9. On 18 August, 23 August and 1 September, the investigator returned to Frankland. During the course of these visits he interviewed eight members of staff. The initial findings of the investigation were fed back in writing to the Governor.

10. A review of the man's clinical care in custody was undertaken by the clinical reviewer on behalf of County Durham Primary Care Trust. The clinical reviewer joined the investigator on his visit to Frankland on 1 September.

11. The Ombudsman's senior family liaison officer spoke to the man's sister, his nominated next of kin, on 25 July. She explained the purpose of the investigation and provided the opportunity for the man's sister to ask questions or raise any concerns she might have. The man's sister said that he had told her that he was "very well looked after" and "treated well" by staff at Frankland. She went on to say that the prison's family liaison officer had been "brilliant" and had arranged for him to speak to her over the telephone shortly before he died. The man's sister also thanked the prison's family liaison officer for arranging her brother's funeral and the return of his property to her. The man's sister was offered an opportunity to comment on the draft version of the report however, to date, has chosen not to do so.

HMP FRANKLAND

12. Frankland is one of eight high security prisons in England and Wales. It holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. The man was a category B prisoner (those who do not require the maximum security but for whom escape must be made very difficult). C wing, where the man lived for most of his time at the prison, is for vulnerable prisoners (those who need to be or request to be separated from other prisoners for their own safety). The operational capacity of the establishment is 859.

13. Prior to April 2011, healthcare services at Frankland were provided by County Durham Primary Care Trust. The contract has subsequently been awarded to Care UK, who provide healthcare services across a number of prisons in the area. The healthcare centre provides 24 hour inpatient care, consisting of a mixture of wards and single cells. The man moved into one of the centre's single cells the day before his death.

14. All prisoners are risk assessed by a member of the healthcare team to determine whether they can keep medication 'in-possession'. (This means that they are issued with several weeks supply at a time to keep in a lockable cabinet in their cell and take as prescribed.) The risk assessment considers factors such as whether the prisoner is vulnerable to bullying for their medication, whether there is intelligence that they might be selling it to others, and the prisoner's understanding of when and how to take their medication. Some medications, including those known as 'controlled drugs', cannot be held in-possession and must be taken in front of staff on account of their high potential for misuse. As we will explain later, the man sometimes kept his medication in-possession but at other times collected it on a daily basis.

15. HM Chief Inspector of Prisons conducted an unannounced full follow up inspection in November 2010. The Chief Inspector found that, after recent staff shortages, health services had improved. However, waiting times to see a prison doctor were described as "unacceptably long". The Chief Inspector also reported poor monitoring of prisoners with life long medical conditions.

16. The IMB report for 2009-10 considered that a good standard of healthcare was provided at Frankland. They highlighted a concern that some prisoners were selling their prescription medication to others.

17. This is the ninth death that the Ombudsman has investigated at Frankland since January 2010. All but one of these previous deaths were due to natural causes. Many of these reports concern prisoners with long term illnesses and several comment on the high standard of care received by the men in question. One report recommended that regular risk assessments should be carried out for all prisoners holding in-possession medication, so as to reduce the risk of such prisoners being bullied or harassed for their medication.

ISSUES

The diagnosis of the man's terminal illness

18. The man was remanded in custody to HMP Preston on 25 July 1998. The man was later convicted of serious sexual offences and sentenced to life imprisonment with a tariff (the minimum time that must be served before parole can be considered) of six and a half years. This was his fourth time in prison, having most recently received a four year sentence in 1989 for similar offences to his latest conviction.

19. Over the following three years the man spent time in various prisons in the south of England. During this time he was diagnosed with type 2 diabetes (when the body does not produce enough insulin or is unable to effectively use the insulin that is produced to maintain a normal blood glucose level – usually managed by diet and medication), high blood pressure and ischaemic heart disease (reduced blood supply to the heart). The man attended regular hospital appointments with a cardiologist (heart specialist). It was noted that his mobility was poor on account of obesity and angina.

20. In March 2002, the man moved to HMP Wakefield. From 2005 to 2007, he regularly experienced chest pain and shortness of breath. However, he often refused medical intervention or hospital admission and discharged himself from hospital against medical advice on more than one occasion. He moved to Frankland in October 2007. He took a variety of medication at the time, including drugs to treat angina, high blood pressure and diabetes.

21. In contrast to his choices at Wakefield, the man went to two cardiology appointments at the University Hospital of North Durham in his first months at Frankland. In April 2008, it was noted that his legs were becoming more swollen, seemingly as he was refusing to take frusemide (medication to treat the accumulation of fluid in the body on account of heart failure. This accumulation of fluid often leads to swollen legs or ankles, known as oedema). No reason for this refusal is recorded. An ultrasound taken the following month showed that the man had right sided heart failure. In June, healthcare staff recommended to him that he be admitted to hospital for assessment, as he was becoming more short of breath and his legs were more swollen. He refused, and later said this was because he disliked the medical treatment he was receiving and did not like having to wear handcuffs (discussed in paragraph 76) when he went to hospital. At his request, all outstanding hospital appointments were cancelled.

22. By October, the man began to take all of his medication again. It was noted that he had "greatly improved". He had lost weight and experienced no angina or shortness of breath. In January 2009, he reported abdominal pain and bleeding from his rectum. He was referred to a consultant colorectal surgeon (a specialist dealing with disorders of the rectum, anus or colon) who visited him at Frankland in February. The consultant placed him on the waiting list for an urgent sigmoidoscopy (examination of the rectum using a fibre optic camera). However, the man refused to attend the appointment when it was arranged. He later told a doctor that he would never go to hospital "because of the way he was treated" on

a previous escort. It was also reported that he refused to attend an appointment because he was not allowed to wear his own clothes.

23. Over the following year, the man's health was relatively good. There were some periods in which his oedema got worse and others when it improved. In May 2010, his health began to deteriorate again. His became more short of breath and his ankles became more swollen. At one stage, he indicated that he would now go to hospital and see a cardiologist. However, he changed his mind shortly afterwards. The man's dose of frusemide was increased and, by late July, he had improved to the extent that he was able to continue his previous job as a wing cleaner. It was noted that he felt well and had no problems walking.

24. In 2011, the man's health began to deteriorate again. In April and May, he experienced lengthy periods of constipation and his ankles were again noted to be swollen. On 6 June, he reported that he had vomited four times in the last day and that his vomit contained some blood. After assessing the man, a prison doctor, advised that he be admitted to the University Hospital of North Durham for further investigation. On this occasion, the man agreed to admission.

25. The man was admitted to hospital as an inpatient. The day after his admission he was told he was seriously ill. Various tests were undertaken at hospital and he was diagnosed with acute renal (kidney) failure and cardiac failure. It was envisaged that he would remain in hospital for treatment of these potentially serious conditions. However, on 10 June he said he wished to discharge himself and return to prison without treatment.

26. The clinical reviewer notes that the man was diagnosed with a number of different illnesses over time. We agree with his view that these illnesses were all diagnosed in a "timely and appropriate manner".

The man's continuing treatment and end of life care

27. As discussed later in the report, prison staff made consistent efforts to persuade the man to engage with his treatment plan. However, as a result of the serious nature of his condition and his refusal of treatment, it was determined that end of life care should be planned. It was noted that he was aware of the severity of his condition and he said he had told his family that he could die. Three days after his return to Frankland, a referral was made to the local Macmillan service for assessment. We consider this to have been the appropriate time to make this referral.

28. The Macmillan nurse visited on 15 June, and saw the man with the clinical team manager. The man told them he was aware he was dying and "feels he has given up". He said he was less able to carry out activities of daily living (meaning self-care activities such as collecting meals and cleaning his cell) than previously and needed help from his friends on the wing and from staff. The man was advised that end of life care would be better delivered on the healthcare inpatient unit, but he said he preferred to say on C wing for as long as possible. The Macmillan nurse suggested changes to his medication, as he complained of a

"discomforting ache" to his legs, neck and arms. A second visit was arranged for 29 June.

29. The following afternoon, the clinical team manager spoke to the man about what would happen were his heart to stop. The man said that he did not wish to be resuscitated were this to happen. Over the following days, he declined several offers of a place on the inpatient unit. He also declined offers of help with bathing and dressing from healthcare staff, as he said that he was able to cope with help from his friends. The man's arms and legs were red and swollen, which continued to affect his mobility. He was prescribed erythromycin (an antibiotic) to treat this.

30. The clinical team manager again raised the issue of resuscitation with the man on 21 June, and he reiterated that he did not wish to be resuscitated under any circumstances. Prison Doctor B reviewed the man the following day and noted that his arms and legs were still swollen despite the prescription of the antibiotic. He prescribed a different antibiotic. They also spoke about the man's wish not to be resuscitated. The doctor told the investigator that he did not take this further at the time as he was unsure of the local policies regarding 'Do Not Attempt to Resuscitate' orders. He later spoke to a senior nurse to clarify the position. They determined that the man's next of kin should be consulted about the decision.

31. On 23 June, Nurse A established a palliative care plan, which addressed various issues surrounding end of life care. This included speaking to the man about his preferred place of death. The man again said that he was happy to remain in his cell on C wing rather than move to healthcare. The man had, however, now agreed to come to healthcare three times a week so he could be assisted to shower by a healthcare assistant.

32. The prison's family liaison officer spoke to the man's sister on 24 June. She explained that the man did not wish to be resuscitated and that the prison would produce a document for him to sign to this effect. It was noted that Prison Doctor B had planned a consultation with the man on 29 June to establish this. The prison family liaison officer also arranged for the man to have the opportunity to speak to his sister over the telephone that afternoon.

33. The following day (25 June), the man said he was feeling much better. The clinical team manager visited him in his cell and noted that his arm was now much improved, to the extent that he was able to sweep the floor of his cell. She offered to help the man with his personal hygiene needs, but he said he was able to manage by himself.

34. However, within two days the man's health deteriorated. His testicles were now severely swollen and he said he had not passed urine for two days. He had also been incontinent of faeces. His mobility was also worse than previously and he had to be helped to shower by a healthcare support worker.

35. On 28 June, the man agreed to move into a cell on the inpatient unit. The swelling in his legs and testicles was causing him pain and he had still not

passed urine. He was given oramorph (a stronger morphine based painkiller) for his pain and was prescribed trimethoprim (an antibiotic) for a suspected urinary tract infection. The man also said that, since speaking to his sister four days earlier, he had changed his mind about resuscitation and did now wish to be resuscitated were he to collapse. Despite his change of heart with regards to resuscitation and admission to healthcare, he still did not wish to be admitted to hospital.

36. The clinical reviewer concludes as follows with regard to the period leading up to the man's death:

> "He had considerable input, care and attention from a number of healthcare professionals … It is clear that medical and nursing staff went to great lengths to provide healthcare commensurate to what the man could have expected had he been in the community."

37. Once it became clear that the man required end of life care, he was referred to the local Macmillan service for specialist advice. His wishes, including his preference to remain on C wing for as long as possible, were discussed and respected. The question of whether to resuscitate the man was first raised on 16 June, and he was initially adamant that he did not wish to be resuscitated were his heart to stop. The man maintained this view until the day before his death, when he told staff that he had changed his mind.

38. The appropriate 'Do Not Attempt to Resuscitate' form had not been completed at this stage. As a result, had the man not reversed his decision, the resuscitation attempt the following morning would have taken place against his wishes. Timely completion of these processes would clearly be beneficial for both the patient and for healthcare staff.

    The head of healthcare should ensure that documentation relating to resuscitation decisions is completed as quickly as circumstances allow.

Events of 29 June 2011

39. During his first night as an inpatient, the man was checked on a regular basis by the duty nurse, the duty nurse last checked the man at around 6.30am and recorded that he had had a comfortable night and not complained of any pain. Shortly before 7.45am, Officer A went to the inpatient cells to check on them. Officer A is a discipline officer in the healthcare centre and told the investigator that this check was one that was not scheduled, but which he decided to do on arriving at the start of his shift.

40. On his arrival at the man's cell, Officer A opened the inspection panel and saw the man "lying on his back with his right leg protruding from the sheets". The Officer told the investigator that he could not see any movement in the man's chest (to indicate that he was breathing) and got no response when he called his name and banged on the door. He therefore opened the cell. The Officer examined the man and recalled that he was "ice cold" and that he was unable to find a pulse. He told the investigator that his opinion was that the man was dead.

41. Officer A therefore returned to the nurse's station at the end of the corridor for assistance. The Healthcare Officer (HCO) and Nurse B were in the office and went to the man's cell. Their colleague went to collect the emergency trolley (containing equipment such as oxygen and a defibrillator). She arrived in the cell shortly afterwards with the clinical team manager and Nurse C. The control room was contacted to request an emergency ambulance. It is recorded that this call was made at 7.45am.

42. In contrast to Officer A and the HCO recalled that the man was warm to the touch when he arrived at the cell. However, he also could not find a pulse and said that the man was not breathing. The staff in attendance began cardiopulmonary resuscitation (CPR – a combination of chest compressions and mouth to mouth breaths), with the HCO administering chest compressions. Nurse C attached a defibrillator, which advised that an electric shock should not be administered.

43. The HCO told the investigator that they initially used a ratio of 20 compressions to one breath until an oxygen mask was in place, after which the compressions were continuous alongside the oxygen. I understand that current Resuscitation Council (UK) guidelines advise that a ratio of 30 compressions to two breaths is most appropriate. The clinical reviewer concludes that the evidence available suggests that the man was already dead when discovered by staff. It follows that any resuscitation attempt was unlikely to be successful. However, we would encourage the head of healthcare to ensure that staff are advised if the latest Resuscitation Council guidelines.

44. In addition, CPR was administered whilst the man was lying on his bed. Best practice recommends that it be administered with the patient placed on a hard surface, such as the floor. The clinical reviewer considers this question and concludes that, given the man's frailty, it might not have been practical to move him to the floor and that this could have resulted in further harm. He adds that the mattress in the man's cell (which he viewed) was "hard and robust".

45. The paramedics arrived at the prison's main gate at 7.52am, and took around three minutes to reach the man's cell. On arrival, they took over resuscitation from prison staff. At 8.29am they determined that any further attempt would be unsuccessful and declared that the man had died.

46. A debrief was held later in the morning, chaired by a developing prison service manager. The aim of this meeting was to support staff following the man's death and offer them the opportunity to speak to the Care Team (members of staff who have been trained to support their colleagues) or other services. One member of staff who was distressed by the events was able to go home for the day. The HCO told the investigator that he thought the staff involved were given adequate support.

47. The clinical reviewer concludes that the emergency response on the morning of 29 June was appropriate. We agree, with the proviso as detailed above that Resuscitation Council guidelines are considered. We also note the contrast

between Officer A and the HCO's recollection of the man's body temperature. We are unable to confirm either account, but note the clinical reviewer's view that evidence suggests the man was already dead when discovered by staff.

Informing the man about his condition and treatment

48. As previously described, the man refused various offers of medical treatment or hospital admission during his time in prison. When he refused hospital admission in June 2008, two members of the mental health team met with him to assess his capacity to understand his decisions. They reported that he appeared fully aware of the potential consequences of refusing treatment and had the capacity to make informed decisions regarding his future treatment.

49. Over the following three years, the man continued to refuse medical intervention on an intermittent basis. There is evidence in his records that staff regularly discussed with him the importance of receiving the recommended treatment.

50. When he became ill in June 2011, the man agreed to go to hospital for further investigation of his symptoms. He remained in hospital for four days before discharging himself against medical advice. He reportedly told hospital staff that he did not wish to have any further treatment and "wants to die". Prior to his discharge from hospital, he was assessed by a member of the hospital's mental health service. They determined that he had the capacity to make and understand his decision.

51. Over the remaining two and a half weeks of the man's life, healthcare staff continued to encourage him to engage with his treatment. As previously noted, the man's end of life care was discussed with him and it is clear he was aware that he might die imminently. Nurse D, a mental health nurse, told the investigator that the man was "well aware of how his refusal to accept healthcare would affect his long term prognosis". She added that she had always considered the man to have the capacity to understand his decisions.

52. The clinical reviewer comments as follows:

    "[The man] had considerable input, care and attention from a number of healthcare professionals … Robust attempts were made by healthcare staff to keep the man fully informed and involved as much as possible with his care and treatment plan."

53. We agree with the clinical reviewer's view and are satisfied that staff did all they could to inform him of the choices he had and the potential outcomes of these choices.

The man's location

54. The man had been in prison since 1998 and was serving a life sentence with a six and a half year tariff. Once his tariff was completed he became eligible for release, subject to the recommendation of the Parole Board. At his most recent hearing, in October 2010, the Parole Board recommended that he should not be released or move to a lower security prison.

55. At Frankland, the man lived on a cell on C wing, part of the prison's vulnerable prisoners' unit (VPU, for those prisoners who need to or have requested to live separately from the main protection, usually on account of their offence). His personal officer, (each prisoner is allocated a named officer to whom they can go for advice or to resolve complaints) told the investigator that the man had several friends on the wing and, when his health permitted, worked as a wing cleaner carrying out lightweight duties.

56. In late May 2011, the man suffered from constipation. He was given laxatives but by 29 May these had not worked. Nurse D was concerned and contacted the out of hours doctor (as 29 May was a Sunday there was no doctor on duty in the prison), who prescribed an enema. This is a fast acting laxative that is inserted into the rectum. On account of the way this medication is administered and the expected speed of results, the nurse asked that the man move to a cell in healthcare. The man agreed to this, but Nurse D was told by wing staff that it was not possible due to "security issues". The specific issue is not clear, but it is possibly on account of the limited numbers of staff who work at the weekend (as a result of which, prisoners spend much of the weekend locked in their cells).

57. Nurse D told the investigator that she was unaware of any other occasion when a prisoner could not be brought to healthcare when requested. We note that this was not an emergency admission and the man was given lactulose, an alternative laxative, and was able to take the enema the following day. However, we do not consider it good practice that the man was unable to receive the specific treatment recommended.

    The Governor should ensure that there are effective procedures for moving prisoners to healthcare at the weekend when medical advice necessitates it.

58. Following his self-discharge from hospital on 10 June, the man was offered a place in the healthcare inpatients' unit, but declined and said he preferred to return to his cell on C wing. Over the following two and a half weeks staff regularly spoke to the man about the benefits of moving to healthcare. However, he was adamant that he preferred to stay on C wing and did not change his mind until the day before he died. The man's personal officer told the investigator that the man preferred to stay on the wing because he could smoke in his cell (smoking is not permitted anywhere in healthcare). He also thought that the man was a man who did not like change. Nurse D also said that he did not want to move away from his friends on C wing. The man was told that his friends would be allowed to visit him regularly in healthcare, but he did not change his mind.

59. As a result of his insistence on staying on C wing, measures were put in place to improve the quality of care that the man would receive. He received daily visits from healthcare staff to administer his medication, check on his health and offer assistance with his personal hygiene needs. In addition, the man was able to go to healthcare three times a week for assistance with a shower if he felt he required it. He received assistance from other prisoners on the wing with activities such as cleaning his cell and collecting his meals.

60. On 22 June, Nurse D recorded that she had spoken to the prison's disability liaison officer (DLO, a role that involves providing information and advice on issues of disability affecting prisoners) to ask him to carry out an assessment of the man's needs on C wing. The man disability liaison officer told the investigator that the purpose of such an assessment is to establish the needs of the prisoner and determine whether any reasonable adjustments could be made to help them lead as normal a life as possible. Unfortunately the man's disability liaison officer had no recollection of this conversation with Nurse D, and an assessment did not therefore take place. He said he would normally ask for a follow up email, but did not receive one in this case. Nurse D could not recall if she sent an email.

    The disability liaison officer should ensure there is a robust and auditable process for the referral of prisoners to him.

61. As we have noted, following his return from hospital, staff from a variety of disciplines regularly spoke to the man about the benefits of moving to healthcare. It is apparent that the man understood the decisions he made. His choice to remain on C wing for as long as he did was respected and he was given extra help from staff and prisoners. We agree with the conclusion of the clinical reviewer as follows:

    > "It is commendable how healthcare staff facilitated his care [on C wing] as best as possible within the obvious constraints of ordinary prison location, to enable his continued stay on the wing so he could be with his friends for as long as possible."

The man's pain relief and medication

62. Following his arrival at Frankland, the man initially kept his medication in-possession. In June 2008, tramadol was added to his medication. This is a painkiller used to treat moderate to severe pain. The strength of his tramadol prescription was increased occasionally over the following three years as he required.

63. On 4 July 2009, the man reported that 14 tramadol tablets had been stolen from his locked cabinet. During a cell search on 17 July, he was found to have 48 tramadol tablets missing when compared to his prescription. Conversely, the man had more tablets than his prescription specified of all other types of medication. As a result of these inconsistencies, his risk assessment was reviewed and he reverted to 'non in-possession' (meaning that he collected his

medication from the wing treatment hatch on a daily basis and took it in front of staff).

64. The man was not happy about this change and submitted several complaints about the matter. Given the evidence, however, our view is that it was a reasonable measure taken by staff to ask the man to collect his medication on a daily basis at this time. The man reverted to in-possession medication in October and managed his medication without incident for several months.

65. In March 2010, the man had a one month supply of tramadol stolen from him whilst returning to his cell from the wing's treatment hatch. As a result, he was asked to collect tramadol on a daily basis, although he was allowed to keep all other medication in-possession. In July, Nurse D discussed the man's medication with him to ensure that he understood what each tablet was for and when he had to take it. As a result of his continued compliance with his other medication, the man was allowed to have tramadol as in-possession medication again from September.

66. As a result of a new initiative at Frankland, prisoners on C wing, including the man, were not allowed to keep tramadol in-possession from November 2010. This was because there had been a number of instances of prisoners selling tramadol to others. The man therefore had to collect tramadol on a daily basis again. As previously, his other medication remained in-possession.

67. Following his return from hospital on 10 June 2011, an excessive amount of medication was found in the man's cell, some of which was issued the previous year. The man said that he sometimes forgot to take his medication. As a result, he was returned to non in-possession medication. However, because of his poor mobility, he struggled to walk to the wing treatment hatch. Nursing staff therefore delivered his medication to him in his cell to take in their presence as was prescribed.

68. Medication kept by prisoners in their cell at Frankland is checked around once every ten days. The man's personal officer told the investigator that this check does not constitute a full cell search (which would be carried out on a random or intelligence led basis) as prisoners are asked to voluntarily show staff what medication they have. This is compared against the list of medication that they have been prescribed. It is therefore the case that if a prisoner has not been taking their medication properly, either deliberately or accidentally, they could build a significant stockpile before this is discovered. The clinical reviewer concludes that the clinical risk assessment process at Frankland is satisfactory, and we note that action was taken on each occasion that doubts were raised about his vulnerability or lack of compliance. However, we do not consider it appropriate that a prisoner about whom such doubts have been raised was able to accumulate a stockpile of medication.

    The Governor and head of healthcare should ensure that those prisoners who have a history of vulnerability or non compliance, and who continue to receive in-possession medication, have their stock fully checked on a regular basis.

69. When he moved to the healthcare centre on 28 June, the man said that his oedema still caused him pain despite a recent increase in the strength of his tramadol prescription. As a result, he was prescribed oramorph (containing morphine, a strong painkiller) to take as he required, after which he reported feeling more comfortable. The clinical reviewer comments that prison doctors "acted promptly in responding to and treating his pain".

Liaison with the man's family

70. During his time in prison, the man had little contact with his family. When he was admitted to hospital in June 2011, the prison's family liaison officer, contacted his sister, who he had nominated as his next of kin. The prison's family liaison officer told the man's sister that he was in hospital and updated her about his condition.

71. Following his return to Frankland, the man told a nurse that he had contacted his family (he did not specify which family member, although other entries indicated that his sister was the only member of his family with whom he was in contact) and explained to them the severity of his condition and that he could die.

72. On 24 June, the prison's family liaison officer again telephoned the man's sister. She updated her about his condition and explained that he had asked to have a 'Do Not Attempt to Resuscitate' agreement created. The prison's family liaison officer also arranged for the man to speak to his sister over the telephone without charge. As a result of this conversation with his sister, the man thought more about his condition and eventually agreed to move to healthcare and withdraw his request not to be resuscitated.

73. Following his death on the morning of 29 June, the prison's family liaison officer contacted the man's sister by telephone to break the news to her. This was an arrangement they had agreed upon during their conversation five days earlier.

74. The man's funeral was held on 19 July, and was arranged by the prison's family liaison officer and her colleagues. The prison contributed to the costs of the funeral, which took place in Kent. The service was conducted by a prison chaplain and the prison's family liaison officer and her colleague also attended. Their commitment to travel such a distance reflects well on them and the prison, as does the complimentary manner in which the man's sister spoke of the prison's family liaison officer to the Ombudsman's family liaison officer. We consider the contact between prison staff and the man's sister to be appropriate and considerate.

Restraints, security and bedwatch

75. The Prison Service has a duty to protect the public and prevent escape, hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will

consider the offences and the risk of further offending, likelihood of escape, as well as the prisoner's health and mobility.

76. On 9 June 2008, the man told staff that he did not wish to have hospital treatment, partly on account of his dislike of having to wear handcuffs when he left the prison. In April 2009, he refused to go to a hospital appointment seemingly because he was not allowed to wear his own coat to the appointment. Both the wearing of handcuffs and of prison issue clothing are standard procedures when a prisoner goes to hospital for an outpatient appointment. We are satisfied that there was no compelling reason why the man should have been treated exceptionally to such procedures at this time.

77. When he was a hospital inpatient in June 2011, an escort chain (a long chain of around 1.8 metres with a handcuff at each end) was used to handcuff the man to an escorting prison officer. The man was a category B prisoner (a category B prisoner is one for whom the highest security conditions are not necessary but for whom escape must be made very difficult) who had been convicted of serious offences. He had completed little offending behaviour work to reduce his risk of re-offending. We acknowledge that he was unwell and his mobility was affected by oedema. However, on balance, we are satisfied that the use of restraints was appropriate in the time that he spent at the hospital. Had he chosen to remain in hospital for the recommended investigation and treatment, which could have taken several weeks, we would expect his risk to be reviewed regularly and consideration given to removing the escort chain.

78. On the night of 9 June, Officers B and C were on escort duty. Their shift ran from 7.30pm on 9 June until 7.30am the following morning. Officer B recalled that the man was quiet overnight and that he initially spent some time watching television and then had a restless night of disturbed sleep. Officer C made the following entry in the bedwatch log at 6.50am on 10 June:

    "Told nurse that he was going to sign himself out today because he was sick of the 'sarcastic comments'. The nursing staff have been excellent and these comments are totally unfounded."

79. Officer C told the investigator that this comment was specifically aimed at the hospital nurses. He said he was surprised when the man made the comment because he had been "mild and not a problem … [but] just turned and came out with it". He did not think that anything had been said to the man that could be open to misinterpretation and that the nurses had been "fantastic" towards him.

80. Officer B said that he was not sure if the man aimed this comment at prison or hospital staff. He added that the man suggested there were "coded messages" in the conversation and specifically referred to someone saying "the grass is greener". Officer B told the investigator that he had "no idea" what the man meant by this.

81. At 7.10am, Officer C made a second entry of note:

> "He is now saying prison staff are making sarcastic comments and he is going to discharge himself and sort it out at the prison. When quizzed he just says 'wait and see'."

82. Officer B said he presumed that the man was referring to himself and Officer C when he made these comments. He added that he did not say anything offensive to the man and did not think he had said anything that could have been misinterpreted. Officer C said that he and Officer B had had a conversation about their weekend plans, after which the man said "I see your sarcastic comments coming out". Officer C added that there were "absolutely no grounds" by which he could understand why the man had said this.

83. There is no indication that the man specified what had been said to upset him, other than the vague references indicated by Officer B. After he left hospital later that day, there is no suggestion that the man made any further complaint, either formal or informal, about the conduct of prison or hospital staff. We have found nothing to suggest, from the evidence available, that escorting staff behaved unprofessionally towards the man.

Compassionate release

84. Early release on compassionate grounds is a permanent release on licence based on strict criteria. Any decision to grant early release can only be made by the Minister responsible. The criteria for early release on medical grounds for life sentenced prisoners are set out in Prison Service Order (PSO) 4700:

    - the prisoner is suffering from a terminal illness and death is likely to occur very shortly (although there are no set time limits, three months may be considered an appropriate period for an application), or the prisoner is bedridden or similarly incapacitated, for example, those paralysed or suffering from a severe stroke; and
    - the risk of re-offending (particularly of a violent or sexual nature) is minimal; and
    - further imprisonment would reduce the prisoner's life expectancy; and
    - there are adequate arrangements for the prisoner's care and treatment outside prison; and
    - early release will bring some significant benefit to the prisoner or his/her family.

85. In September 2009 and again in February 2010, the man's solicitor wrote to Frankland on his behalf to request that he be considered for early release on compassionate grounds. On both occasions they were told that the man had not been diagnosed as suffering from a terminal illness and, as such, did not meet the required criteria set out in the PSO. It is quite clear from the evidence available that this was appropriate advice at the time.

86. In addition to the criteria set out above, PSO 4700 goes on to give the following mandatory instruction:

> "Examples of cases not meeting the criteria are where conditions are self-induced, for example: following a hunger strike or where a prisoner refuses treatment."

87. It is therefore clear to us that the man still did not meet the criteria for early release on compassionate grounds when his end of life care was planned in June 2011, on account of his self-discharge from hospital and request to return to prison without treatment. In any case, it was, difficult to give an accurate prognosis of the man's life expectancy, nor is it possible to say that suitable accommodation could have been found for him outside of prison. We do not therefore consider that an application for early release would have been appropriate.

CONCLUSION

88. The man who had suffered from heart failure and related conditions for a number of years. His compliance with the recommended treatment and medication was inconsistent throughout this time. It is apparent that staff at Frankland made great efforts to inform the man of the choices available to him and the potential outcome of these choices. Although he chose not to receive the recommended hospital treatment or be cared for in the healthcare centre, his decisions were respected and staff put plans in place to help him as best as they could on the wing. The clinical reviewer concludes that healthcare staff went to great lengths to provide care equivalent to what he might expect to receive in the community. Nevertheless, we have highlighted some procedures at Frankland that might be improved.

RECOMMENDATIONS

1. The head of healthcare should ensure that documentation relating to resuscitation decisions is completed as quickly as circumstances allow.

   Accepted – This standard will be included in the regional palliative care work currently underway and all clinicians will be updated on Care UK policies regarding resuscitation.

2. The Governor should ensure that there are effective procedures for moving prisoners to healthcare at the weekend when medical advice necessitates it.

   Accepted – There are effective procedures in place for moving prisoners to healthcare at all times, including at the weekend.

3. The disability liaison officer should ensure there is a robust and auditable process for the referral of prisoners to him.

   Accepted – Full review of the referral process will be completed. Following this an auditable process will be implemented.

4. The Governor and head of healthcare should ensure that those prisoners who have a history of vulnerability or non compliance, and who continue to receive in-possession medication, have their stock fully checked on a regular basis.

   Accepted – Review of the current good practice on the Westgate Unit and for roll out to the wider prison if appropriate. This work will also be linked into the regular reviews of chronic disease patients.