PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at University Hospital of North Durham while a prisoner at HMP Frankland

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a prisoner at HMP Frankland, on 30 May 2013. The man, who was 65 years old, died of bronchial pneumonia caused by advanced mouth cancer. I offer my condolences to the man's family and friends.

An investigator carried out the investigation. Two Clinical reviewers were appointed to review the man's clinical care in prison.

In May 2012, the man was examined by the doctor because he complained of throat pain. He had dental work to remove some teeth and was referred to an ear, nose and throat (ENT) consultant, but was eventually diagnosed with an infection of the salivary gland. the man was still in pain, which spread to his tongue in February 2013, and he was referred for an urgent scan. The scan showed that the man had advanced cancer of the tongue. His condition was terminal but he received palliative radiotherapy and chemotherapy treatment. The man developed pneumonia, and died in hospital on 30 May.

The clinical reviewer is satisfied that there was no undue delay in the man's diagnosis and that his subsequent treatment was equivalent to that which he could have expected to receive in the community. While an earlier referral for a scan might have resulted in a more prompt diagnosis, the prison appropriately referred the man to secondary services and test results did not indicate a need for an earlier referral. There were some occasions shortly after his diagnosis when his pain relief does not appear to have been optimal and I consider that more could have been done to provide him with a suitable diet earlier, but overall the man appears to have received supportive palliative care at Frankland.

However, it is disappointing that the possibility of a further application for compassionate release was not reconsidered when the man's condition deteriorated, this might have allowed him to die in hospital no longer in prison custody. I am also concerned that the man's medical condition was not adequately taken into account when assessing his security risk, resulting in him being chained to an officer in hospital until shortly before his death. This was distressing for him and his family and I do not consider this was a proportionate response to his risk.

The issue of inappropriate use of restraints on terminally ill prisoners has been raised with Frankland several times previously. We have been assured by the Deputy Director of Custody that he has raised the matter with all high security estate governors and the Governor of Frankland needs to take active steps to avoid reoccurrence.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was sentenced to 26 years imprisonment for importation of drugs on 8 March 2002. He transferred to HMP Frankland in June 2005. The man had a number of conditions that were treated with medication, but otherwise he was generally in good health.

2. The man first complained of having a sore throat in May 2012. He was referred to the dentist, had a number of teeth extracted, but was still in pain. He was prescribed pain relief and referred to an ENT consultant. Nothing untoward was discovered, despite several tests. The man was seen by the dentist, prison doctors and the ENT consultant on many occasions. He lost a significant amount of weight but this was ascribed to his difficulty in eating, because of his dental problems. In October 2012, he was diagnosed with a diseased salivary gland.

3. In January 2013, the man was in significant pain. He was admitted to the prison inpatient unit on 14 January for assessment. The man had an X-ray of the salivary glands at Darlington Hospital on 22 January. The visiting ENT consultant referred the man for an urgent MRI scan on 14 February because he suspected cancer. In an acknowledged error, a hospital consultant radiologist incorrectly changed the request to routine, but the ENT consultant re-organised the scan for 5 March – outside the target of two weeks for urgent referrals. The man was admitted to hospital on 27 February as his condition had deteriorated. He had a scan and biopsies on 5 March and, on 8 March, a specialist oncologist confirmed that the man had cancer of the tongue.

4. The man appeared to respond well to a course of radiotherapy and chemotherapy and his tumour shrank. However, on Sunday 26 May, the man was readmitted to hospital as he was struggling to breathe. He was diagnosed with pneumonia in both lungs. Throughout his hospital stay, as on previous occasions, the man was handcuffed by a chain to a prison officer. At 5.00am on 30 May, the man had a cardiac arrest. Hospital staff stabilised him, but during the 40 minutes that they were treating him, the chain was removed for only about five minutes. Sadly, the man's condition deteriorated rapidly. At 7.00am, the duty governor authorised that officers should remove restraints. Shortly afterwards, the hospital notified the man's family of his deterioration and one of his daughters arrived at the hospital at 7.25am. The man died at 9.10am.

5. In light of the clinical reviewer's findings, we are satisfied that the clinical care the man received at Frankland was equivalent to that which he could have expected in the community. However, the investigation has identified a need for better communication between healthcare professionals about complex cases and the use of the electronic medical record. The use of restraints was not always be justified by a properly considered risk assessment and appears particularly inappropriate in the period after the man was diagnosed with pneumonia. This was distressing for him and his family. An application for early release on compassionate grounds was rejected on 12 April and a new application was not made when the man's condition deteriorated.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Frankland of the investigation and asking anyone with relevant information to contact her. Six prisoners were interviewed as a result.

7. The investigator visited HMP Frankland on 12 June and went to the wing where the man had lived and spoke to prisoners and relevant staff. She collected copies of the man's prison and medical records.

8. NHS England (Durham, Darlington and Tees Area Team) appointed a clinical reviewer to review the man's clinical care. The clinical reviewer and investigator carried out joint interviews on 10 and 11 July at HMP Frankland. In addition the investigator interviewed three members of prison staff by telephone. The investigator gave her initial findings to the Governor during the investigation and followed this up in writing on 18 July.

9. The investigator informed Her Majesty's Coroner for Durham and Darlington District about the investigation. The Coroner has been sent a copy of this report.

10. One of the Ombudsman's family liaison officers telephoned the man's daughter on 4 July to explain the purpose of the investigation. During a meeting on 25 July, the man's family provided evidence for the investigation to consider, including copies of correspondence and complaints about the man's care, and photographs of the man restrained in hospital. They had the following concerns:

    - Why were medical records not accurate and e-mails recalled?
    - Why did it take so long to diagnose the man?
    - Why did the significant length of time the man was prescribed pain relief not prompt sooner investigation into the cause of his pain or the affect on his mental health?
    - Why was breakthrough pain relief not better managed?
    - Why was communication between the Prison Service, Care UK and the hospital difficult and did this affect the man's treatment?
    - Why were the man's dietary requirements, and things to make him more comfortable, not arranged quickly?
    - Why was the man restrained while he was in hospital and during treatment?
    - Why were care planning meetings arranged when the man was having chemotherapy, which meant he could not attend?
    - Why was the man not recategorised and released on compassionate grounds?

11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, whether palliative care was provided, liaison with his family, his location and security arrangements and whether compassionate release was considered.

12. The man's family received a copy of the draft report. They raised a number of issues and questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. However, information provided has resulted in some clarity in this report.

HMP FRANKLAND

13. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 convicted and remand male prisoners. There is 24 hour inpatient care. NHS County Durham commissions Care UK to provide healthcare services.

HM Inspectorate of Prisons

14. The last report published on Frankland by HM Inspectorate of Prisons followed an unannounced inspection in December 2012. The report noted that security intelligence informed proportionate risk assessments. Healthcare services, including dental provision, were considered generally good although a significant number of vacancies inhibited their delivery. Some prescribing practices were poor. The Care Quality Commission took part in the inspection, and found that the services operated by Care UK were of a good standard and working relationships with other partners helped them to deliver effective care. Inspectors noted that arrangements for end of life care for terminally ill prisoners were of a high standard.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. The IMB annual report for the year to November 2012, noted that healthcare services were generally timely but staffing levels had caused some problems and there were delays with appointments to see a GP. Security arrangements for outside hospital appointments were noted to be appropriate. The IMB was very positive about palliative care at the prison.

Previous deaths at Frankland

16. The man's death was the ninth death from natural causes at Frankland since January 2012. Four of the other prisoners also died of cancer. We have previously found that the risk assessment process for seriously and terminally ill prisoners at Frankland was not sufficiently robust and did not take into account how the person's condition affected his actual risk of harm. It is a serious concern that we are again critical of Frankland in this report for the inappropriate use of restraints.

ISSUES

17. The man was born in July 1947. He was sentenced to 26 years imprisonment for importation of drugs on 8 March 2002. The man transferred to HMP Frankland in June 2005. The man was examined on a number of occasions during 2007 for heart palpitations and was prescribed medication to correct his heart rhythm. The man was prescribed medication for high blood pressure, high cholesterol and an enlarged prostate. He was examined and monitored for a number of age-related conditions (joint pain, coronary heart disease and skin ulcers thought to be related to poor circulation caused by smoking). The man had been given help to stop smoking between 2008 and 2010 and was prescribed nicotine patches but it is not clear from the records how successful this was.

The diagnosis of the man's terminal illness

18. In March 2009 a dentist at the prison, advised the man that he needed to have some teeth removed, but he declined. In November 2011, the dentist repaired the man's upper bridge, but again advised him that removal of his teeth was the best option.

19. On 14 May 2012 a prison GP examined the man when he reported a pain in the left side of his throat. The GP noted that the man had an enlarged submandibular gland (a major salivary gland under the floor of the mouth) and prescribed antibiotics. Another dentist examined the man on 18 May, agreed that the antibiotics should help, and reviewed him for dentures. The man weighed 113.8kg at that time.

20. On 6 June a doctor examined the man who was still suffering from pain in his jaw. The doctor concluded that the pain was as a result of the man's dental problems, but referred him to an Ear, Nose and Throat (ENT) specialist who held clinics at the prison, for another opinion. On 8 June, the dentist removed some of the man's teeth. He was still complaining of pain on 18 June and a dentist examined him on 22 June. The dentist fitted him for dentures but recorded nothing of concern.

21. On 9 August the ENT associate specialist, examined the man at the prison and found a firm lymph node. He referred him to a ENT consultant at Darlington Memorial Hospital, for further investigation. At the direction of the ENT specialist a prison GP prescribed the man another course of antibiotics and augmentin for bacterial infections. The man did not go to his dentist appointment with the doctor the next day as he was in too much pain.

22. On 20 August, the dentist extracted some more of the man's teeth. The man said he felt unable to attend Darlington Memorial Hospital later that day for tests, because he was still in pain from his tooth extraction. Healthcare staff recorded this as a failed appointment, indicating that he had deliberately refused to go. The healthcare staff said that it was not until the man wrote to Care UK to complain about this that they realised he had had such significant dental work earlier that day. The man received a written apology from Care UK.

23. The dentist examined the man on 10 September, and he continued to complain of a sore throat. The man had more dental work, and the dentist referred him to the GP. The GP examined the man later the same day and noted that his throat was red and sore, and urgently referred him to the ENT associate specialist. The ENT specialist saw the man at the prison on 13 September, although there is no corresponding entry in his electronic medical record about this. The doctor prescribed a further course of antibiotics after this appointment. The ENT specialist is one of several specialists who hold clinics at Frankland but who do not have access to the SystmOne electronic medical record. Therefore, their clinical notes are often received in writing weeks after a prisoner's appointment. We agree with the clinical reviewer that this does not help a holistic approach to medical treatment. We make the following recommendation:

    The Head of Healthcare should ensure that all clinicians working regularly in the prison have access to SystmOne to record their consultations with prisoners.

24. On 24 September, the man went to an appointment with the ENT consultant at Darlington Memorial Hospital where he had a fine needle aspiration (FNA – when tissue/fluid is taken for analysis) and neck examination. There was no sign of malignancy

25. The ENT specialist examined the man on 11 October, and told him that the pain was due to an enlarged salivary gland, but it was a benign (non-cancerous) condition. The ENT specialist told the man that surgical removal of the salivary gland was being considered. The GP examined the man on 25 October, and noted that he had been routinely referred by The ENT specialist for a sialogram (examination of the salivary glands). The GP referred the man to maxillofacial department (specialists in head, neck, face, jaws and the hard and soft tissues), to rule out an infection in the bone.

26. The man had four appointments with prison doctors and six other appointments with healthcare staff over the next few months. While it was noted that he was losing a significant amount of weight, all the clinical staff involved in the man's care thought this was due to his difficulty eating because of problems with his teeth. The man's pain relief medication was reviewed and increased but appeared to have little effect. The man had blood tests in October, all of which were normal. The clinical reviewer accepted that, the man's weight loss and pain could have led to an urgent referral, but noted that he already been referred to secondary services and the staff attributed the continuing difficulties to his ongoing dental problems.

27. In January 2013, officers and prisoners noticed that the man was in more pain, and his speech was slurred. The man's family submitted letters and complaints to Care UK, Frankland and the Offender Health Division at the Department of Health, as they were concerned that he was not receiving satisfactory care. In response to these concerns, the man was admitted to the prison's inpatient unit on 14 January for a pain and nutrition assessment. The man weighed 91kg (he

had lost 22.8kg over eight months). His blood pressure, oxygen levels and pulse were within an acceptable range. The head of healthcare created a care plan on 15 January focussed on nutrition and pain management. The man went to an appointment at the maxillofacial unit at Sunderland Royal Hospital. A specialist in oral & maxillofacial surgery concluded that the man's pain was due to a diseased salivary gland and that he should continue treatment with the ENT consultant.

28. The man had a diagnostic sialogram at Darlington Hospital on 22 January. The head of healthcare spoke to the man on 8 February and he told her that he wanted to have his salivary gland surgically removed. She referred him to the ENT specialist.

29. The ENT specialist examined the man on 14 February when he complained of pain and swelling in his tongue. He reviewed the results of the sialogram test and urgently referred the man for an MRI scan because he suspected cancer. The man then weighed 85kg.

30. Over the next few days the man was seen by a number of healthcare staff. The appointment for the urgent MRI scan was chased on 20 February and the hospital was told that a routine appointment had been arranged for 11 March instead. The referral for the MRI scan was recorded as having been received by the radiology department at the University Hospital North Durham Hospital on 18 February, although The ENT specialist said he hand-delivered the referral on 14 February. A consultant radiographer, changed the referral from urgent to routine. The ENT specialist was unhappy that his urgent request had been changed and rearranged the appointment for 5 March. In a letter dated 18 June, in response to Care UK's investigation, the radiographer accepted that changing the request to routine was an error.

31. Over the next few days, the man told healthcare staff that the swelling in his tongue had improved slightly but he was still in pain. On 26 February, the man was having difficulty swallowing and his tongue was swollen. The head of healthcare and doctor examined him and arranged for the man to go to the University Hospital of North Durham for an urgent assessment. For apparent security reasons the assessment was postponed until the next day and changed to another hospital.

32. The man was admitted to Sunderland Royal Hospital on 27 February. He had a scan that day and biopsies for suspected cancer of the tongue were taken on 5 March. On 8 March, an oncologist confirmed that the man had cancer.

33. The clinical reviewer concluded that, while an earlier referral for an MRI scan might have identified cancer sooner, the man had been appropriately referred to specialist secondary health services none of which identified the need for a scan at an earlier stage. While there was a delay in the man having a fine needle aspiration (due on 20 August 2012 but completed on 24 September), the results identified no malignancy. The routine referral to maxillofacial specialist on 11 October was appropriate, given The man's clinical history and the results of the earlier investigations. On 14 February, when the man's

condition changed, an urgent referral was made. Although the hospital wrongly changed his referral for an urgent scan in February to routine, the healthcare administration manager noticed this error and notified the ENT specialist's secretary and it was rectified without significant delay.

34. The clinical reviewer was satisfied that there was no undue delay in the man's diagnosis caused by healthcare staff at the prison. The man was quickly referred for secondary care and subject to intensive investigation by different specialists. Although these investigations highlighted problems with his salivary glands, cancer was not detected. The clinical reviewer concluded that the man received care equivalent to that which he could have expected to receive in the community.

35. Although he concluded that the care the man received was reasonable, the clinical reviewer noted that, while healthcare staff discussed the man's case at morning meetings, there were no similar case management meetings at which visiting specialists were included. This would have been helpful for all concerned:

The Head of Healthcare should ensure that healthcare staff and visiting specialists have the opportunity to discuss complex cases as part of routine case management meetings, so that all aspects of the symptoms and treatment can be considered.

Informing the man about his condition and treatment

36. The man suspected that he had cancer after his test on 5 March. He said he did not want his family informed until the diagnosis was confirmed and he knew the extent of his condition.

37. On 6 March the man met the head of healthcare, the prison family liaison officer and a clinical manager. He told them that he and his family would be submitting a complaint about the care he had received from the ENT consultant and the dentist and that he should have been diagnosed earlier. Care UK later responded to these complaints and conducted their own investigation to identify any learning. The staff discussed pain management with the man who asked that his daughters should be present when he was given his diagnosis at the hospital multi-disciplinary meeting (MDT) scheduled for 8 March.

38. On 8 March the man saw a consultant oncologist and a consultant head and neck specialist at Sunderland Royal Hospital. Healthcare staff from Frankland attended but the man's family were not present. The doctors confirmed the man's diagnosis was as squamous cell carcinoma (cancer of the tongue) which had spread to the glands in his neck. The man was told that his condition was terminal and surgery was not a viable option. He could have a high dose treatment of radiotherapy (30 sessions daily, Monday – Friday for six weeks) and chemotherapy (one session per week for six weeks) at Newcastle Freeman Hospital to shrink the tumour and help prolong his life. The man was told that a feeding tube would be inserted into his stomach.

39. The hospital consultants had no objection to the man's family being present when he was given his diagnosis. However, the prison told the investigator that they did not have sufficient notice to consider the request because it was an early morning appointment. A family visit was arranged that afternoon at the prison when the man and healthcare staff, informed his family.

40. Hospital staff ensured that the man was fully informed about his condition and treatment and provided information to him and healthcare staff at Frankland about his treatment options. However, we consider that the prison should have prioritised the man's request to have his family with him when he received such a serious diagnosis. We make the following recommendation:

    The Governor should ensure, unless there are overriding security concerns, that prisoners are able to have the support of their families at hospital appointments when receiving news of a serious diagnosis.

The man's medical appointments and treatment

Appointments

41. Before he was diagnosed, the man's urgent scan was scheduled for 26 February, but was cancelled for what were described as security reasons as the man's solicitor knew about the appointment. The assessment was rearranged for the next morning, but was again rescheduled as it was thought his family knew about the arrangements. The appointment was moved to a different hospital the same afternoon, which the man attended.

42. The Prison Service's National Security Framework, which governs prisons' security arrangements, does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that prisons often do this without sufficient reason. The national security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision and, if necessary, additional security arrangements can be put in place rather than cancelling appointments.

43. We accept that Frankland re-arranged the appointments quickly and the man had his scan within 24 hours of his original appointment. However, the man had been ill for some time and had been referred for an urgent scan for suspected cancer, and this should have taken priority. His risk assessment at the time indicated that he was considered a low risk of escape and there was no security intelligence suggesting this risk was heightened or that it was likely he would be assisted to escape. It is therefore difficult to see how cancelling the original appointment was justified. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.

Treatment

44. Before his radiotherapy and chemotherapy treatment could start, the man had to be fitted for a specialist face mask and have further scans. This preparation was necessary to ensure that his treatment could be delivered safely, and Macmillan nurses reassured the man that it was not being unnecessarily delayed. Treatment started on 3 April.

45. The man's family were concerned there had been a delay in the man starting his treatment and that his daily appointments were not at a specific time each day. The man had asked to be given notice of when he was due to go to hospital. The security governor told the multi-disciplinary meeting on 16 April that the man would be told when he was locked in his cell the evening before whether his appointment was in the morning or afternoon the following day.

46. In response to whether missed appointments or lateness attending appointments would have affected the man's condition and recovery the consultant oncologist, said:

> "There were no missed appointments; the timing of treatment has no impact on the outcome – it doesn't matter if radiotherapy is administered in the morning or in the evening. The only factors influencing the outcome are total dose, overall treatment time and quality of planning."

47. The man received intensive treatment with a view to extending his life expectancy, rather than curing his illness. We think withholding information about the timings of his appointments until the night before was not a considerate approach. As the appointments were daily at the same hospital we do consider that there were reasonable security grounds not to let him know. However, we are satisfied that the man's received the treatment he needed for his condition and he received it at the appropriate time without delay or cancelled appointments.

The man's pain relief and medication

48. Before he was diagnosed with cancer, the man was prescribed diclofenac, tramadol and gabapentin to manage his pain. The dosages were increased but seemingly did not always control his pain. After he was diagnosed with cancer in March, medication was prescribed as directed by the hospital consultant with advice from the Macmillan nurses.

49. On 27 September 2012, the man was recorded to be verbally aggressive to healthcare staff, as he was frustrated that he had not been prescribed sufficient pain killers after tests at Darlington Memorial Hospital three days earlier. It appears that this was understandable as the doctor examined the man later the same day, and increased his pain relief.

50. A nurse examined the man on 17 February 2013 when he was having bad headaches. The nurse explained to the man that he should not self-medicate by taking greater pain relief than prescribed as there was a danger of overdose.

51. There was some delay in providing breakthrough pain relief during the weekend of 10 March. The man was in too much pain to attend the healthcare centre at 10.00am, and healthcare staff went to his wing at 12.30pm, when they dispensed pain relief (healthcare staff had been attending another medical emergency). There was another delay the next weekend, when officers thought he wanted pain relief before attending a visit, but he had needed it immediately. The need to ensure effective pain relief quickly was discussed at the weekly multi-disciplinary team meeting and the problems were resolved, by ensuring that nurses and prison staff were briefed about the importance and that night orderly officers understood that medication might need to be delivered urgently at any time. On 28 March, The man told a Macmillan specialist nurse in palliative care, and the clinical manager that he was comfortable and his pain was now under control.

52. The man had chosen to remain living on his wing and there was no established protocol for managing pain relief for a terminally ill prisoner on the wing which caused the initial problems. However, with advice from hospital staff and Macmillan nurses, the prison then ensured pain relief was administered appropriately. While there were some initial difficulties, these were quickly identified and resolved. In light of the clinical reviewer's comments, we are satisfied that the man's medication and pain relief was adequately managed. However, we are surprised that the possibility of issuing the man with pain relief medication in his cell to self-administer overnight and return next morning, which we have seen happen in other prisons, does not appear to have been considered. It is possible to supply medication to a terminally ill prisoner at night after lock up and collect again the next morning without a security risk.

Palliative care

53. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. The head of healthcare and the dentist, the specialist Macmillan nurse met the man to prepare him for the diagnosis and a senior officer was appointed as a family liaison officer. The man gave consent for them to be present when he was given his diagnosis. He was offered input from the mental health team, but he declined.

54. After he was diagnosed, the man was under the care of two doctors. Prison healthcare staff liaised with a Macmillan palliative nursing care specialist, to help ensure that the man received all the appropriate treatment and pain relief.

55. The man was placed on the prison's palliative care register on 8 March and his care was discussed at weekly multi-disciplinary team meetings which started on 13 March. (Initially they were held on Wednesdays but then they were moved to Tuesdays). They were well attended by prison and healthcare staff and supported by Macmillan palliative care specialists. The man was unable to attend the multi-disciplinary team meetings, because he had to attend hospital

appointments each day for his treatment. He told staff that he was content with his wing managers relaying any issues on his behalf. On 7 May, the meeting time was changed to the morning so that the man could attend (his hospital appointment was in the afternoon). He told staff that morning that he wanted more time to prepare for his hospital treatment and did not wish to attend the meeting. The man attended only one multi-disciplinary team on 21 May, but was given the minutes of all the meetings and appeared to be satisfied with the arrangements. Nevertheless, as the multi-disciplinary team meetings are an important aspect of a prisoner's end of life care we consider that where possible the timings of the meetings should be scheduled to allow the prisoner to attend if he chooses.

The Governor and Head of Healthcare should ensure that, so far as possible, multi-disciplinary team meetings for terminally ill prisoners are held at times which allow the prisoner to attend.

56. At The man's request, two of his friends from his wing were briefed by the dentist and a Principal Officer (a palliative care champion at Frankland) about what to expect with the man's condition. They discussed anticipated problems and explained what support would be available to them to help the man. Officers on the wing were also briefed about palliative care.

57. The clinical manager asked the prison's kitchen to provide the man with a suitable soft diet and fresh full fat milk. A dietician prescribed fortisip nutritional drinks on 20 March. However, there were some initial problems getting an adequate amount of fresh milk and nutritional drinks (in the man's preferred flavours). At the multi-disciplinary team meeting on 9 April, it was noted that the man did not wish to use a blender that the prison had bought for him and officers again asked the kitchen to provide suitable foods and supplements. After another week, the wing manager and the man's personal officer told the kitchen that they were frustrated that appropriate food was still not being supplied. At the multi-disciplinary team meeting on 16 April, the wing manager confirmed that the kitchen now gave the man daily packs of ice-cream, yoghurts and milk. The man had requested ice cubes to ease his discomfort, but the head of healthcare had advised him that this was likely to exacerbate his pain so they were not supplied.

58. We are concerned that it took so long to organise a sufficiently nutritious soft diet and drinks for the man's health and comfort. This should have been achieved with relative ease and the delay was unacceptable.

The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

59. At the man's request the pagan chaplain at Frankland, was notified of his illness. She visited him and attended the multi-disciplinary team meeting on 25 March. Although she was unable to go to any other meetings, the chaplain was kept updated on the man's progress.

60. As the man's condition worsened, his ability to speak and be clearly understood reduced, so he was given special equipment to help him communicate. The man was given a 'litewriter' electronic notepad (as well as paper/pen) to communicate with staff and family, although there is no evidence that the litewriter was provided when the man was admitted to hospital on 26 May. He was given access to a laptop, usually restricted for use by prisoners in connection with legal proceedings, so he could continue a book he was writing. The man was given additional pillows and cushions, and had a suction machine in his cell to help clear his throat.

61. The clinical reviewer comments:

> "There was regular contact between prison healthcare staff and palliative care agencies and weekly Multi-Disciplinary Team Meetings. The man was managed on a palliative care pathway and his treatment needs were reviewed daily. The Multi-Disciplinary Team Meetings were very well documented and there was good communication with the man."

62. We are satisfied that, with the exceptions noted, healthcare and prison staff provided a good overall standard of palliative care, with attention to the man's physical, emotional and spiritual needs when he was at Frankland. We agree with the clinical reviewer that the man received exceptional support from other prisoners on F wing, particularly the man's two friends until his final admission to hospital.

The man's location

63. The man lived on the second floor landing of F wing at Frankland. He told staff and his friends that he wanted to remain living on the wing and did not want to move to another cell or to the healthcare centre. Frankland respected the man's wishes and his personal officer acted as first contact for any issues associated with his accommodation.

64. As the inpatient unit at Frankland was closed for refurbishment between 4 March and 1 July, it was planned that the man would move to HMP Holme House, a nearby prison, if his clinical needs could not be met on his residential wing. The suitability of the man's continued location on F wing was kept under review and discussed each week at the multi-disciplinary team meeting.

65. On 8 May, the man was admitted to Sunderland Royal Hospital as he had an infection in his salivary gland, although he still attended Newcastle Freeman Hospital for his treatment. He was discharged back to F wing on 13 May.

66. The clinical reviewer noted that respecting the man's wish to remain on his wing was in line with the approach taken in the community and we are satisfied he was appropriately accommodated during his illness.

Compassionate release

Early Release on Compassionate Grounds

67. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS). The decision over whether to release a prisoner on compassionate grounds is made by the Secretary of State for Justice taking into account medical opinions on the prisoner's condition and information provided by NOMS staff. A clear medical opinion on life expectancy is required.

68. An application for compassionate release was instigated by Frankland and submitted to the public protection casework section on 15 March, with additional information sent on 19 March. The Governor did not fully support release until issues relating to a Confiscation Order (the man was required to pay £1,899,200 or, in default, serve an additional three years custody) and with UKBA about the man's citizenship were properly understood and there was a sufficiently robust release plan.

69. The doctor had indicated that the man's life expectancy without treatment was one to two months, but with treatment could be six to twelve months. A medical adviser in the Offender Health Division of the Department of Health, reviewed the application on behalf of the public protection casework section the next day, but due to insufficient information about the man's weight loss, the medical adviser asked for a specialist report.

70. In response to the medical advisers request, the hospital consultant, prepared a report outlining the man's diagnosis and treatment plan dated 8 March, which was submitted to the public protection casework section. The medical adviser again asked for more information. On 26 March, a clinical summary from the consultant oncologist was submitted. The next day, the public protection casework section requested an update on the man's treatment and progress, which was submitted on 2 April, and referred back to the medical adviser. On 9 April, the medical adviser indicated that he had no clear prognosis for the man as his treatment had only just started and he needed more information. The medical adviser spoke to the head of healthcare at Frankland and the hospital consultant submitted a further report to the medical adviser on 11 April with the same prognosis, one to two months without treatment, but up to a year if treated. The medical adviser concluded on 12 April, that he did not support the man's application for release, because there was not a clear prognosis. The public protection casework section refused the application for compassionate release on 24 April, but requested that Frankland keep the case under review. The public protection casework section sent a memorandum to the Governor of Frankland on 24 April:

"Please would you carefully monitor the man's condition and refer the case to us again if there is any significant deterioration in his [the man's] health or significant change in his circumstances"

71. In addition to the prison's application, the man's family submitted an application through their legal representative to the Ministry of Justice, which was referred to the public protection casework section. The application was received by the casework section on 19 March.

72. The decision to refuse early release on compassionate grounds was challenged by the man's solicitor on 26 April, and reviewed by the Treasury Solicitor on behalf or the Secretary of State for Justice, but remained the same. Frankland notified the public protection casework section when the man was admitted to hospital between 8 and 13 May, but it was concluded that the decision did not need to be reviewed, as there had not been a significant change in the man's condition.

73. On 22 May, the man's solicitor submitted an undated medical report from the consultant oncologist to the Treasury Solicitor asking for an urgent review of the application for early release on compassionate grounds. The public protection casework section sent this information to the medical adviser who responded on 27 May, stating that the information had not changed his opinion and he did not support release. On 29 May, the man's solicitors asked for the case to be referred back to the medical adviser for consideration, as the man had then been diagnosed with pneumonia in both lungs. The public protection casework team confirmed that Frankland did not resubmit the application, and the public protection casework section did not refer the application back to the medical adviser before the man's death on 30 May.

74. The man was admitted to hospital on Sunday 26 May, which was a bank holiday weekend, and died the next Thursday. The public protection casework section is not staffed at weekends or bank holidays, although there is an out of hours' service for emergencies, which the prison could have contacted for advice. The public protection staff told the investigator that the prison should have resubmitted the application when the man was diagnosed with pneumonia on 26 May, in line with the advice in the memorandum of 24 April. Nevertheless, the public protection casework section had been alerted by the man's solicitors on 29 May, and did not reconsider the case themselves.

75. The original application for compassionate release appears to have been dealt with very cautiously with repeated requests for reports but we accept that at that stage there was no clear prognosis that the man had less than three months to live, which is the usual test applied. However, we consider that the decline in the man's health on 26 May, and the diagnosis of pneumonia should have prompted the application for early release on compassionate grounds to be resubmitted urgently to the public protection casework section. While approval of an application at that stage would not have resulted in the man being released to the care of his family, it would have meant he was able to die in hospital no longer in prison custody.

The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are kept under review and reconsidered when a terminally ill prisoner's condition deteriorates.

Release on Temporary Licence

76. In certain circumstances, a prisoner can be allowed to leave prison on a temporary licence. The specific criteria for granting release on temporary licence (ROTL) are outlined in PSO 6300 Release on Temporary Licence; the licence can be granted by the governor of the prison, providing he or she is satisfied that the release will not undermine public confidence in the administration of justice. ROTL requires a satisfactory risk assessment and the availability of suitable accommodation for the prisoner's needs (which would include hospital admissions). The prisoner is not restrained by handcuffs once ROTL is granted, although prison officers can accompany the prisoner to provide support, manage risk and ensure that visits are managed safely.

77. The Governor noted on the application for early release on compassionate grounds that release on temporary licence did not meet the man's needs at that time (19 March) but that consideration of ROTL would be made at a later date if necessary, in line with the criteria set out in PSO 6300. While ROTL consideration is noted on the weekly MDT minutes, there is no evidence that ROTL was fully considered again, despite the change in the man's condition.

The Governor should ensure that release on temporary licence is considered for terminally ill prisoners in hospital who meet the criteria.

Liaison with the man's family

78. During the meeting between the man and the head of healthcare on 8 February, the man gave permission for his medical details to be disclosed and discussed with his family.

Family liaison officer

79. A senior officer was appointed as the prison's family liaison officer (FLO) on 5 March 2013, before the man's terminal diagnosis. The family liaison officer arranged for the man's family to visit him and facilitated weekend visits. Staff from F wing provided cover during their breaks to ensure these visits could go ahead. The family liaison officer attended multi-disciplinary meetings and tried to resolve issues raised by the man and his family such as the supply of fresh milk and purchasing a blender.

80. The man had extra family visits during his treatment. At the multi-disciplinary meeting on 21 May, wing managers reported that the man thought the decision that he would resume normal visits with his family when his treatment ended was 'cruel and unfair'. It was agreed that the security governor should review this decision, but this was not done before the man died.

81. When the man was admitted to hospital on 26 May, the escort risk assessment notes that the man's family were not to be notified. There was no explanation for this. However, at 11.15 am the family liaison officer was informed that the man was being taken to hospital (the man left Frankland at 11.18am) and she immediately contacted his family to tell them. The family liaison officer was not on duty over the bank holiday weekend, but she kept in contact with the man's daughter and updated her on his condition.

82. On 28 May, the family liaison officer arranged to meet the man's daughter at the hospital and spent over four hours with his family. She visited the man the next day, bought him phone cards and recorded that he looked brighter than the previous day.

83. At 5.00am on 30 May, the man had a cardiac arrest in hospital but neither the family liaison officer nor the man's family were informed as it was considered that his condition had then stabilised. Just over two hours later, at 7.05am, the family liaison officer received a call to say that the man's condition had worsened and he was not expected to live. Hospital staff telephoned the man's family at 7.08am to tell them he was dying. The family liaison officer went directly to the hospital, where she met the man's daughter and remained there to offer support. The family liaison officer was present with the man's daughter when he died. We consider that the prison should have notified the man's family of his cardiac arrest, which was especially serious given his condition. We make the following recommendation:

    The Governor should ensure that next of kin are notified as soon as possible when the condition of a prisoner who is seriously ill suddenly deteriorates.

84. The man's daughter was not given any time alone with him before or after, his death. The man's daughter arrived at the hospital at 7.25am and was informed that her father had very little time to live. Although the escorting officers and the family liaison officer maintained a discreet distance, they stayed in the room. After the man's death staff remained in the room at all times until the man's body was taken to the mortuary. The man's daughter was not allowed some time alone with him, and the officer thought that they were obliged to remain in the room with the man. We make the following recommendation:

    The Governor should ensure that staff allow family members to have private time with a prisoner when it is known that they are dying and present no risk of escape.

85. The man's property was returned to his family (with the exception of documents on the prison's laptop) and a contribution to funeral expenses was offered in line with national guidance.

Communication with Frankland and Care UK

86. The man's family considered that they had good support and communication from the prison's family liaison officer, but they did not feel that they received appropriate or timely communication with prison managers or those employed by Care UK. The man's family complained about what they perceived to be his poor care and management before his diagnosis and were frustrated that no obvious action was taken. In addition to contacting the prison and Care UK, The man's family made representations to various government departments about his treatment, specifically in relation to restraints, nutrition and pain management.

87. The investigator reviewed the correspondence, and was satisfied that each letter received a timely response, and the matters raised were looked into. Care UK started an investigation as a result of the man's family's concerns.

88. The investigator contacted a Health and Justice Manager, at the Care Quality Commission, who confirmed that the man's family had written to complain about he man's clinical care in custody. The Health and Justice Manager explained that the Care Quality Commission does not investigate individual complaints about healthcare in prisons. Instead, the Care Quality Commission reviewed Care UK's internal investigation and decided that they did not need to carry out an additional inspection into healthcare at Frankland, because they were satisfied that Care UK had appropriately responded to the concerns the man's family had raised.

Restraints, security and bed watch

89. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 (the Graham judgement) made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

90. Advice for prisons is outlined in 'Prisoner Escort and Bedwatch Function', an agreement between NOMS and the NHS. The agreement notes that using restraints on terminally or seriously ill patients should be considered inhumane except when justified by security considerations. It goes on to say:

> "Levels of restraints used on prisoners must at all times be proportionate to the perceived security risks and be balanced by consideration of care and decency for the prisoner."

91. The man was security category B at the time although the prison was considering the possibility of reducing him to category C. The head of security at Frankland, told the investigator that the decisions about restraints were carefully considered and reviewed daily. The head of security explained that the man was a high profile offender, with the resources to arrange an escape. He said that the man's telephone conversations were all monitored, and while there was no substantive information about a planned escape, concern was raised that the man had implied that he wanted to return to Antigua. The head of security said that security intelligence was shared with very few staff and would not necessarily be recorded on the escort risk assessment, but contained in a restricted file. The investigator examined the restricted file, but found it contained no confirmed security intelligence that the man was likely to, or was planning to escape. It does not seem unreasonable or unlikely that during his illness the man might have voiced a wish to return to Antigua some day, but there is no evidence to indicate any intention to escape there and it seems unlikely that someone would wish to escape from life-prolonging treatment, without which the man had been given only a very short time to live.

92. On an escort risk assessment dated 21 March, the man's risk of escape was recorded as low, but medium with outside assistance. Two officers escorted the man and used double cuffs (double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs). The man's risk of escape was raised to medium on 2 April without an explanation why this was thought to be the case, and three officers escorted him with a single handcuff restraint (due to the man's medical condition). These assessments were endorsed by the head of security.

93. Handcuffs were removed when the man was receiving radiotherapy because of the risk to staff from radiation. However, when the man received chemotherapy treatment, officers used an escort chain (a two metre long chain with a cuff at one end attached to the man and the other attached to an officer. On 18 April, the risk assessment was reviewed and the man was allowed to sit next to the door during the car journey to the hospital to make him more comfortable. At all times throughout his treatment, the man was escorted by three prison staff.

94. When the man was admitted to hospital on 26 May, two officers escorted him using a single cuff. A residential manager at Frankland told the investigator that he visited the man on 29 May and said that he appeared much better than he expected. The manager said he had asked a nurse whether the man could walk out of hospital if he was not restrained and both officers were absent or distracted. (He accepted when interviewed that this scenario was very unlikely.) The man's nurse said that she did not consider that he would be able to get as far as outside the hospital, but she telephoned a consultant who said that he thought it was possible the man would be able to leave the hospital in such circumstances. The manager intended to discuss the escort arrangements the next day at the management meeting, but said he had no idea that the man's condition would decline so quickly.

95. On 30 May at 5.00am, the man had a cardiac arrest and hospital staff spent 40 minutes stabilising him. The escort chain was removed for just five minutes during this time to allow doctors to use a defibrillator (an electronic device that diagnoses heart rhythms and can administer a shock to restart the heart). The man regained consciousness and hospital staff told officers that the man's condition was stable, so they re-applied the handcuff and chain. However, over the next hour, the man's condition declined seriously and it was recognised that he was dying. Escort staff contacted the duty governor, who, at 7.00am, agreed that they should remove the escort chain. He was not restrained again.

96. The clinical reviewer is concerned that the man's medical care was compromised by restraints, as medical staff at the hospital had to request their removal for treatment. Escort officers have the authority to remove restraints when it is considered a life threatening situation and this is clearly stated on the escort document. However, the investigator interviewed escort officers and discussed this issue with other officers at the prison, and concluded that none of the staff felt confident, or believed that they would be supported, in making such decisions without first seeking senior management approval.

97. While some medical opinion about the man's condition was taken into account as part of a risk assessment, there is limited information about his physical condition or mobility and the impact this had on his actual risk while outside the prison. The escort risk assessment when the man was receiving chemotherapy and radiotherapy shows that 'Part 1 – Medical Officer/Healthcare Manager' was not updated daily (as required) but signed off weekly. Healthcare staff told the investigator that their input on the risk assessment was to assess whether there were any injuries that might be affected by the use of restraints, but that is not what the court judgement requires. There is expected to be an assessment of how health and physical condition impacts on the ability to escape rather than just a contra-indication for the use of restraints.

98. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are concerned that the man was restrained when he was receiving chemotherapy treatment. National guidance to prisons makes it clear that restraining a prisoner receiving chemotherapy would be regarded as degrading and that the use of such restraints would be likely also to be regarded as inhumane unless justified by other relevant considerations in line with the Graham judgement. The man's family showed the investigator a photograph of him in hospital, restrained by his right arm, attached to a drip (and oxygen) which prevented him from writing easily, which was his only means of communication. We have seen no persuasive evidence to justify the use of restraints during life saving treatment and during the latter part of the man's illness and consider his treatment degrading and possibly inhumane.

99. We conclude that the man's physical health was not sufficiently taken into account on the escort risk assessments. The use of restraints was not justified during treatment and particularly after his diagnosis of pneumonia.

100. This case is the latest in a number of cases at Frankland where we have been concerned that risk assessments for seriously and terminally ill prisoners did not follow the guidance arising from the Graham judgement. In another recent investigation into a death at Frankland, we recommended that the Deputy Director of Custody responsible for high security prisons should ensure that there are appropriate arrangements and guidance in all high secure prisons about risk assessments. We have been assured that the Deputy Director has raised this matter with senior managers at Frankland who have implemented a new risk assessment procedure which takes into account the individual circumstances of prisoners who are seriously ill or at the end of their life. Our investigation report into that case was not issued until some time after the man's death and it remains to be seen whether the new arrangements result in better outcomes. In the meantime, we repeat a recommendation we have previously made to Frankland:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all clinicians working regularly in the prison have access to SystmOne to record their consultations with prisoners.

2. The Head of Healthcare should ensure that healthcare staff and visiting specialists have the opportunity to discuss complex cases as part of routine case management meetings, so that all aspects of the symptoms and treatment can be considered.

3. The Governor should ensure, unless there are overriding security concerns, that prisoners are able to have the support of their families at hospital appointments when receiving news of a serious diagnosis.

4. The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.

5. The Governor and Head of Healthcare should ensure that, so far as possible, multi-disciplinary team meetings for terminally ill prisoners are held at times which allow the prisoner to attend.

6. The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.

7. The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are kept under review and reconsidered when a terminally ill prisoner's condition deteriorates.

8. The Governor should ensure that release on temporary licence is considered for terminally ill prisoners in hospital who meet the criteria.

9. The Governor should ensure that next of kin are notified as soon as possible when the condition of a prisoner who is seriously ill suddenly deteriorates.

10. The Governor should ensure that staff allow family members to have private time with a prisoner when it is known that they are dying and present no risk of escape.

11. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all clinicians working regularly in the prison have access to SystmOne to record their consultations with prisoners.	Accepted	With the exception of visiting consultants, all visiting healthcare professionals have access to and record all clinical entries on SystmOne. As secondary care provision is commissioner led, the Head of Healthcare has made contact with Head of Commissioning for NHS England Health and Justice to explore the possibility of promoting this element of delivery.	Head of Healthcare 31 December 2013	
2	The Head of Healthcare should ensure that healthcare staff and visiting specialists have the opportunity to discuss complex cases as part of routine case management meetings, so that all aspects of the symptoms and treatment can be considered.	Accepted	In order to ensure that all aspects of a prisoner's symptoms and treatment can be considered, the Head of Healthcare has established multi-disciplinary team (MDT) meetings for those prisoners that are 'considered' to be a complex cases, and who have multiple contacts with healthcare / prison, etc. Visiting specialists will be consulted in relation to MDTs and, if appropriate, meetings will be scheduled to enable attendance. In addition, the Head of Healthcare and Senior Nurse have attended clinical MDTs with specialists at hospitals providing treatment for patients. This is in the early stages of development and will continue to be reviewed.	Head of Healthcare 31 December 2013	
3	The Governor should ensure, unless there are overriding security	Accepted	Liaison will take place between the Head of Healthcare and Head of Security when a prisoner is to receive a diagnosis of a serious	Head of Healthcare and Head of Security	

	concerns, that prisoners are able to have the support of their families at hospital appointments when receiving news of a serious diagnosis.		medical condition. Wherever possible, unless there are overriding security concerns, the escort risk assessment will identify who will attend to support the prisoner. This could be a family member or other identified source of support for the prisoner. The risk assessment will take into consideration input from Public Protection Unit. Where any overriding security concerns exist, consideration will be given to the feasibility of the diagnosis being received in the establishment to enable appropriate support to be available. Once again this could be a family member or other identified source of support for the prisoner.	and Intelligence Completed and ongoing.	
4	The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health.	Accepted	Where hospital appointments may be cancelled the Head of Security will liaise with the Head of Healthcare to ensure that there is no detriment to the prisoner's health. In accordance with national security guidance additional security measures, where necessary will be put in place. In the event that there are overriding security concerns, justification for the cancellation of hospital appointments will be fully documented.	Head of Healthcare and Head of Security and Intelligence Completed and ongoing	
5	The Governor and Head of Healthcare should ensure that, so far as possible, multi-disciplinary team meetings for terminally ill prisoners are held at times which allow the prisoner to attend.	Accepted	The Head of Safer Custody and Diversity will liaise closely with the Head of Healthcare and the family liaison officer (FLO) to ensure that where possible prisoners on the palliative care register who are undergoing external treatment, are able to attend MDT meetings. The FLO and Head of Safer Custody and Diversity will ensure that prisoners are notified of each MDT meeting. For those prisoners who indicate that they do not wish to attend, a record of the reason will be recorded in the	Head of Safer Custody and Diversity Completed and ongoing.	

			minutes of the meeting.		
6	The Governor and Head of Healthcare should ensure that prisoners with serious illnesses receive an appropriate diet to meet their needs without delay.	Accepted	The Head of Safer Custody and Diversity will include the Catering Manager in the core membership / co-opted member of the MDT meetings to ensure dietary needs are addressed as an ongoing issue. Urgent requirements for dietary changes will be communicated to the Catering Manager as required by healthcare staff.	Head of Safer Custody and Diversity Completed and ongoing	
7	The Governor and the Head of the Public Protection Casework Section should ensure that applications for early release on compassionate grounds are kept under review and reconsidered when a terminally ill prisoner's condition deteriorates.	Accepted	The Head of Public Protection at HMP Frankland receives minutes of all MDT meetings. Applications for early release on compassionate grounds will be reviewed when a terminally ill prisoner's condition deteriorates and, where appropriate, formally resubmitted to Public Protection Casework Section. The Head of Public Protection will arrange a briefing for all duty managers to ensure they have a good understanding of the criteria for early release on compassionate grounds. The next of kin for prisoners who are terminally ill will be advised by the FLO, that any legal correspondence in relation to a terminally ill prisoner should be directed through the establishment to ensure that processes can be followed correctly. The Public Protection Casework Section will further consider every case where a prison notifies them of a change in the circumstances of a prisoner, as they are instructed to in the covering letter to the governor which	Governor and Head of Public Protection 31 December 2013 Public Protection Casework Section	

			accompanies each refusal decision.		
8	The Governor should ensure that release on temporary licence is considered for terminally ill prisoners in hospital who meet the criteria.	Accepted	Please note the points of factual inaccuracy, raised in relation to paragraph 76 that release on temporary licence (ROTL) was considered in The man's case on seven separate occasions and refused during April and May 2013.. The Head of Safer Custody will ensure that consideration of ROTL is given at all MDT meetings and that records of decisions are communicated appropriately to the Head of Public Protection. The Head of Public Protection will arrange a briefing for all duty managers to ensure they have a good understanding of the criteria for ROTL. Duty managers will be briefed in relation to individual prisoners who are terminally ill and in outside hospital to ensure that consideration of ROTL is given if there is any significant change in their condition.	Head of Safer Custody and Diversity Head of Public Protection Deputy Governor 31 December 2013	
9	The Governor should ensure that next of kin are notified as soon as possible when the condition of a prisoner who is seriously ill suddenly deteriorates.	Accepted	The Head of Security and Intelligence will ensure that hospital risk assessments reflect that notification to next of kin will be carried out by the FLO. Additional instructions will be included in the briefing section of the escort risk assessment and the bedwatch logs. Escorting staff will be required to ensure that any significant changes in the patient's health are communicated to the establishment to enable the FLO to notify next	Head of Security and Intelligence 31 December 2013	

			of kin. Amendments to documentation will be requested via High Security Prisons Group.		
10	The Governor should ensure that staff allow family members to have private time with a prisoner when it is known that they are dying and present no risk of escape.	Accepted	The palliative care MDT meetings will consider visiting arrangements and this will inform the risk assessment for prisoners who are located in outside hospital. The Head of Security will ensure that the hospital risk assessment identifies arrangements when it is known that the prisoner is dying. This will take into consideration any residual risk to either the prisoner, their visitors or the public.	Head of Security and Intelligence Completed and ongoing.	
11	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents	Accepted	The Deputy Director of Custody of High Security Prisons reiterated the implications of the Graham Judgement in relation to hospital escorts and bedwatches to all High Security Governing Governors, including Frankland, at a Senior Managers Board Meeting held on 15 August 2013. With regards to Frankland, a new risk assessment process, which includes a revised management checklist, has been introduced to ensure that risk assessments for prisoners taken to hospital are based on a consideration of the individual's circumstances and the actual risk the prisoner presents at the time. The new risk assessment process also takes into account those prisoners who are deemed seriously ill or at the end of life with the aim that security arrangements around hospital escorts will be dynamic and the use of restraints will be reviewed, as necessary, to take into account any significant changes in circumstances.	Deputy Director of Custody of High Security Prisons Completed and ongoing.	