A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Frankland in February 2014

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 man, who died of lung cancer in February at HMP Frankland. He was 54 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Frankland. The prison cooperated fully with the investigation.

The man had been in prison since March 2011 and transferred to HMP Frankland on 15 September the same year. He had a number of chronic conditions, including back pain, which caused him mobility problems. In May 2013, the man began to experience night sweats and chest pain and was diagnosed with mild chronic obstructive pulmonary disease. On 12 August, the doctor noticed a lump on the man's chest and requested an urgent X-ray which was not done until a month later. The results showed a mass in the man's chest and the doctor made an urgent referral for a scan for suspected cancer. Further tests were carried out and, on 1 November, healthcare staff told the man that he had lung cancer and secondary cancers on his spine. He began a course of radiotherapy and chemotherapy.

On 29 November, hospital staff informed the man that he was likely to have only a matter of months left to live and he moved to the palliative care suite at Frankland. In January 2014, he was told that radiotherapy had reduced the primary tumour but the chemotherapy had not reduced the secondary cancers and no further active treatment was possible. The man remained in the palliative care suite at Frankland for end of life care. The man's son, who was also a prisoner at Frankland, was given the cell next to him for extra support. In the early hours of 7 February, the man called for assistance after he fell trying to get into his wheelchair. His health deteriorated quickly and he died shortly afterwards.

I am satisfied that, overall, the man received a good standard of care at Frankland, especially in relation to his palliative and end of life care. Although the clinical reviewer says this did not impact on his eventual diagnosis, I am concerned that a mix up in the referral process meant an initial X-ray took longer than it should have done. Risk assessments for earlier hospital escorts were inconsistent and with limited healthcare input, but I am pleased to note that the man was not restrained for hospital appointments towards the end of his life.

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

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

CONTENTS

Summary	5
The investigation process	6
HMP Frankland	7
Issues	8
Recommendations	17
Action Plan	19

SUMMARY

1. On 21 March 2011, the man was remanded to prison and, in September, was sentenced to life imprisonment for kidnap and murder and sent to HMP Frankland. The man had undergone back surgery before he went to prison and had ongoing back pain and could only walk short distances. He smoked cigarettes, but initially turned down advice about giving up smoking.

2. In May 2013, the man reported having night sweats and a cough. He was diagnosed with mild chronic obstructive pulmonary disease (COPD – lung disease). He continued to suffer from chest and lower back pain and in August 2013, a prison GP found a lump on his chest and requested an urgent in-house X-ray. The X-ray was not completed until 19 September and the results showed a mass in the man's chest. On 26 September, a prison GP referred the man for an urgent CT scan for suspected cancer and he attended the chest clinic for a scan on 9 October.

3. On 21 October, the man was admitted to hospital as an emergency with acute breathlessness. He was diagnosed with a chest infection and discharged back to prison the same day and was given a cell in the prison healthcare centre. A week or so later his son moved to the cell next to him for extra support. On 29 October, the man had further detailed scans of his chest and spine.

4. On 1 November, healthcare staff informed the man that the results of the MRI and CT scan confirmed he had lung cancer with secondary cancer in his spine. On 4 November, the man began a course of radiotherapy at the Freeman hospital, Newcastle. On 26 November, he moved to the prison's palliative care suit with his son in the cell next door. On 10 December, the man began a course of palliative chemotherapy to relieve his symptoms and to reduce the size of the tumour.

5. On 24 January 2014, after a further CT scan, the oncologist informed the man his life expectancy was between three and six months. The man continued to be cared for in the palliative care suite at Frankland

6. At 1.15am on 7 February, a nurse responded to the man's cell bell alarm. He had fallen in his cell and the nurse helped him to bed. The man's condition began to deteriorate rapidly and the nurse arranged for his son to join them. The man died at 2.30am.

7. The clinical reviewer stated that the man received a good standard of care at Frankland and that his palliative and end of life care was excellent. The correct use of a referral template would have avoided the delay in carrying out the initial X-ray, but the delay is unlikely to have affected the outcome. We are pleased to note that restraints were not used for later hospital appointments. However, there was no healthcare input into the risk assessment for the use of restraints for earlier appointments when the man's health and mobility were poor. We make two recommendations about these issues.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and inviting anyone with relevant information to contact her. The man's son, a prisoner at Frankland, contacted the investigator as a result.

9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. The investigator interviewed eight members of staff and one prisoner at Frankland on 9 April and carried out one telephone interview on 6 May. She gave the Governor initial feedback about the preliminary findings of the investigation, and followed this up in writing.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

11. We informed HM Coroner for Durham and Darlington of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's ex-wife, his nominated next of kin, to explain the investigation. The man's family had a number of concerns and questions about the man's care at Frankland which we have taken into account in the investigation. These included:

    - They had been promised better access to visits but this did not happen.
    - They had been told that the man's cell door would be left open for his son to have access to him but this was not done until the man was extremely ill.
    - Why were the man's X-ray results not forwarded to his hospital appointment with the oncologist?
    - What happened when the compassionate release applications were made?
    - Why was the man's next of kin not invited to his medical appointments?
    - Why was the man's medication prescribed by the oncologist changed by the prison doctor?
    - How timely were hospital referrals and health assessments?
    - The man's family were concerned his pain relief was poor.
    - They said that the man had been promised a meal with his family and wanted to know why this had not happened.

13. The family are happy with the content of the report. The questions they have are predominantly about the transcripts and they have some questions regarding the clinical review which they will pursue at Inquest.

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

15. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP FRANKLAND

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

HM Inspectorate of Prisons

17. The most recent inspection of Frankland was in December 2012. The report noted that security was normally applied proportionately. Health services provided a high quality of care for patients with chronic diseases and life-long conditions, but waiting times for the GP and some specialist services were too long. Staff shortages inhibited the development of services. 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.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to November 2013, the IMB stated the quality of healthcare services was good and the number of staff vacancies that had been inhibiting delivery earlier in the year had been reduced. The IMB was very positive about palliative care at the prison and noted that a chemotherapy pilot scheme, linked to the palliative care project, had just been successfully completed to provide in-house intravenous treatment.

Previous deaths at HMP Frankland

19. The man is the eleventh prisoner to die from natural causes since 2012. We have raised the issue of the use of restraints without appropriate risk assessments before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

20. The man was serving a life sentence and had been at Frankland since September 2011. He had suffered consistent lower back pain for some time and had undergone three operations on his back before his prison sentence. As a result of his pain, the man had reduced mobility and often used a wheelchair. The man smoked cigarettes and initially refused smoking cessation advice. He also had angina. Healthcare staff saw him frequently regarding his pain management, which continued to be problematic.

21. Records show that between 30 December 2011 and 25 October 2012, the man complained of increasingly severe back pain. On 7 December, a visiting orthopaedic consultant examined the man and considered that adequate investigation had taken place in the past, including an MRI scan in 2010, and pain management should continue. He requested a repeat MRI scan to be carried out in 2013 as a precaution.

22. On 20 May 2013, a prison GP saw the man for a routine health screen. He had raised cholesterol and complained of night sweats and a productive cough. A sputum specimen was sent for testing and he was referred for a nurse appointment for cholesterol management.

23. A clinical manager saw the man on 28 May to discuss ways to reduce his cholesterol. He noted that the man had been a heavy smoker from a young age and referred him for advice about giving up smoking.

24. On 10 June, the sputum test results indicated that the man had mild chronic obstructive pulmonary disease. He was prescribed a salbutamol inhaler to help open the airways and ease breathing.

25. On 24 June, the prison GP examined the man who complained of intermittent sharp pains in his chest. The GP diagnosed a chest infection and prescribed antibiotics and a short course of steroids which cleared the infection. Later that month, the man complained of ongoing back pain and another prison GP examined him and noted that the man was waiting for an MRI scan. He recorded that the man's pain relief was adequate.

26. On 7 August, the man attended a smoking cessation appointment with a pharmacist. He complained of chest tightness and difficulty breathing. A nurse saw him later that day. He said he had night sweats, pain on movement and had a pain in his chest, which was different to the pain he experienced from angina. The man did not have a cough and thought his pain could be muscular from pushing himself in his wheelchair. The man told the nurse that he would make an appointment with the doctor if the pain persisted.

27. On 8 August, a nurse saw the man as he had upper body ache and cough. She took a sputum sample for testing and requested a doctor's appointment for the next day. It is not clear from the medical records whether the man attended a doctor's appointment the next day.

28. On 14 August, a prison GP examined the man who was complaining of ongoing chest pain, severe night sweats, weight loss and coughing up brown phlegm. The man also had a skin inflammation on his the left of his chest wall. The doctor noted that underneath was a soft lump around 10cm in diameter. The man said the lump had been there for a number of months and he thought it had grown. The GP referred the man for an urgent chest X-ray.

29. On 15 August, the man declined to attend hospital for an MRI scan for his back condition as said he had muscle spasms. Records show that the hospital planned to rearrange this, but the man's condition deteriorated before this happened.

30. On 19 September, a visiting radiologist carried out the man's X-ray at Frankland. This was over a month after the GP has asked for an urgent referral. Seven days later the results showed a mass in his chest. The prison GP told us that there appeared to have been some confusion about the urgency of the referral. Although the GP had clearly noted the X-ray was urgent in the medical records and used the standard template for referrals, she had not circled or highlighted the word 'urgent' on the template. It therefore appears the referral was processed as a standard priority.

31. On 26 September, after reviewing the X-ray, the GP noted the man had pain in the right side of his chest, radiating around and through to his back. The man told him he was still coughing green, blood streaked sputum. The GP made an urgent referral for a CT scan for suspected lung cancer under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. The man attended his first outpatient appointment at the respiratory clinic on 9 October at University Hospital North Durham. The man's X-ray results were not available at the hospital although the consultant had requested them several times before the appointment. The GP said that he had specifically asked for the X-rays to be sent to the hospital, and this is evident on the referral form. We have not been able to ascertain whether the problem was with the administration at Frankland or the hospital, but the clinical reviewer says that this did not impact on the man's scare and the hospital completed the CT scan as requested.

32. At 11.58am on 21 October, the man was admitted to University Hospital North Durham as an emergency due to acute shortness of breath. He was diagnosed with a chest infection, prescribed medication and returned to prison at 6.43pm the same day.

33. On 29 October, the man attended the hospital for an MRI scan and on 1 November, the hospital informed Frankland's healthcare department that the test results confirmed that the man had lung cancer and secondary cancers to his spine. The GP, two nurses and a Macmillan Nurse informed the man and

his son of the diagnosis. Prison staff supported the man to break the news to his wider family.

34. The clinical reviewer noted that symptoms of back pain are difficult to assess and track, particularly in patients with complex case histories where the presentations are varied. She found that the man was appropriately referred to an orthopaedic surgeon who was satisfied that his back pain had been appropriately investigated, but requested a future MRI scan as a precaution. The clinical reviewer considered that the man was referred to secondary services appropriately and, while the delay in obtaining the first X-ray delayed his initial diagnosis a little, it did not affect the outcome. However, it is important that urgent referrals are appropriately prioritised. We make the following recommendation:

The Head of Healthcare should ensure that clinical staff clearly indicate the priority for referrals on the appropriate template.

The man's medical treatment

35. On 1 November, after he had been told of his diagnosis, the man attended University Hospital North Durham for an urgent chest scan. On Saturday 2 November, The man attended the Freeman Hospital in Newcastle, for an appointment with his oncologist to discuss his treatment options. The oncologist prescribed dexamethasone (an oral steroid) and metoclopramide (a medication to relieve feelings of nausea). Later that day, the oncologist contacted healthcare staff at Frankland to ask them to increase the dexamethasone prescription over the weekend. There is no evidence that the prison doctor changed his medication, as his family believed, other than at the request of the oncologist. The man began a course of radiotherapy on 4 November over four consecutive days.

36. The man often complained about his pain management. Records show that he was given oramorph and MXL (both liquid morphine pain relief) frequently. The nurse told us that the man had difficulty with pain after treatment and that it took time to get this under control with gradual increases in pain relief. The man had a pain management plan which the Macmillan nurse and GP reviewed regularly. A nurse said the man always took his prescribed medication and had pain relief available as and when he asked.

37. On 11 November, the man and his son attended a multidisciplinary meeting which discussed the man's wishes about resuscitation. On 13 November, he signed an order agreeing that in the event of cardiac or respiratory arrest no attempt at resuscitation would be made.

38. On 14 November, the man complained of a sore mouth (a side effect of his cancer treatment) and was prescribed gelclair to help relieve the pain. A clinical team manager referred him to the Macmillan dietician and contacted the Freeman Hospital for treatment advice, who advised an increase in his medication.

39. On 20 November, the Macmillan dietician saw the man, along with his son and a healthcare support worker. The man said he had eaten very little over the past two weeks, but his sore mouth had improved with medication. The man's diet was adjusted to include soft foods and Complan, a food supplement.

40. On 22 November, the oncologist saw the man at University Hospital North Durham. At the man's request, two nurses accompanied him. The oncologist discussed treatment options with the man, but said he needed a bronchoscopy (a procedure to examine the airways and lungs) before a decision on further treatment could be made.

41. The man underwent a bronchoscopy on 27 November and attended a follow up outpatient appointment on 29 November. Nurses offered to attend this appointment with him, but the man refused. Hospital staff informed the man that he had a life expectancy of six months and the only treatment would be palliative, to relieve symptoms. On 10 December, the man began a course of palliative chemotherapy to relieve his symptoms and reduce the tumour. He attended chemotherapy appointments on 10, 27 and 31 December and 17 and 24 January.

42. Records show that the man received regular pain relief medication. On 29 December, he told a nurse that he did not consider his pain was being appropriately managed. The next day, he told another nurse the same and she arranged for a pain review. The Macmillan nurse, saw the man on 2 January 2014, but the man said he did not want his morphine prescription or other pain relief increased because of the side effect of nausea. The Macmillan nurse reminded him that he could request oramorph as and when he required it. She referred him to the physiotherapist to relieve his lower back pain and ordered a heat pad.

43. On 17 January, a chemotherapy nurse from University Hospital North Durham informed healthcare staff that the man needed a CT scan before his next chemotherapy treatment. He went to hospital for the scan on 22 January. On 24 January, the oncologist saw the man, who was accompanied by his ex-wife who was his nominated next of kin, a family liaison officer and nurse to discuss the results. The oncologist said the radiotherapy had reduced the primary tumour but the chemotherapy had not made any difference to the secondary cancer in the man's spine. He told him that his life expectancy was between three and six months. The oncologist and the palliative care team from Frankland discussed an end of life care plan with the man.

44. On 3 February, the clinical team manager saw the man, who said his left leg was numb and his vision was blurred. The clinical team manager contacted the hospital and the man was admitted for tests. The man had an MRI scan, which did not show any new disease and he was discharged back to prison the next day.

45. At 6.45am on 6 February, nurse responded to the man's cell bell, and found he was distressed and short of breath. She encouraged him to keep his

oxygen on and offered him his prescribed pain relief, which he initially declined but later agreed to take. A nurse asked if the man's son could be unlocked to sit with him, but the duty governor declined. Records show the man settled down after this incident and ten minutes later he was sleeping. The next day, at a multidisciplinary meeting, the nurse asked for clarification about the man's son having access to his cell during the night (patrol state). A protocol, agreed by the deputy governor, clearly stated the man's son would be unlocked only when healthcare staff notified the Governor that the man had reach the end of life stage and death was expected within a few hours or following a sudden deterioration and death was expected.

46. At 9.13am that day, the man asked to see a GP because he thought he had a chest infection. A nurse increased his oxygen therapy to help alleviate his symptoms. At 4.26pm, the prison GP saw the man who complained he was short of breath and said his current pain relief was not working. The prison GP recorded there were signs of mild pleural effusion (a collection of fluid next to the lung). He increased the man's pain relief and prescribed medication to alleviate his symptoms.

47. At 5.11pm, a nurse reviewed the man and noted that he appeared to be more unwell. She discussed an open door policy with the palliative care nurses. This would allow staff easy and quick access to the man's cell, and his son could be unlocked during the night to be with him. A risk assessment was completed that day and a security manager agreed that this could begin the next evening.

48. At 1.15am on 7 February, a nurse responded to the man's cell bell. He had slipped out of his wheelchair and onto the floor. The man told the nurse he had not hurt himself from the fall but he did have chest pain. She helped him back into bed and gave him his prescribed pain relief. The man settled, but his breathing was laboured and his condition was deteriorating rapidly. The nurse contacted the duty officer at 1.50am to contact the man's next of kin and for the man's son to be unlocked so he could be with him. The man passed away at 2.30am, his son was with him.

49. We agree with the clinical reviewer that the man's treatment was equivalent to that he could have expected in the community. There was evidence of exemplary practice in respect of his palliative care management. The clinical reviewer says that pain management was a core feature of the man's care planning and it was apparent that pain management was considered almost daily by nurses and GPs. The man was prescribed strong opiate medication for pain and treatment for nausea and there are documented discussions and responses to the man's pain status in the pain management plan. The man received well-structured, evidence based, holistic care with specialist input from a palliative care specialist nurse and there was close communication with Macmillan and the secondary care palliative care teams. His palliative care needs were appropriately discussed with him and his son and addressed. Records show there were regular multidisciplinary meetings to which the man and his son were invited and mostly attended. There were no problems with attendance at hospital appointments and appropriate clinical

checks and observations were made when he returned. There was good communication between the healthcare at Frankland and the hospital

The man's location

50. The man wanted to remain in his cell on the wing where his son also lived and every effort was made to respect his wishes for as long as possible. However, his health began to deteriorate, and after he was discharged from hospital on 21 October, he was moved to the prison's healthcare centre. On 3 November, staff arranged for the man's son to have a cell next to him in the healthcare centre to enable him to have extra support.

51. On 26 November, the man agreed to move to the palliative care suite at Frankland for end of life care. His cell had a walk-in shower, hospital bed and easy chair. The man was given a portable cell bell so he could summon help easily when he needed it. His son was moved to the cell next door and was able to assist the man and be with him for most of the day and evening. The man's family was concerned that his son had not been allowed access to him at all times which they believed had been promised. We are satisfied that the prison intended to arrange this for end of life stages but the man died very suddenly. We consider that the prison made commendable efforts to locate the man's son next to him which allowed him to support his father for most of the day. The man told staff he was comfortable in his accommodation and, if it was not possible for him to be released from prison, he wanted to die there.

52. The palliative care suite allows terminally ill prisoners to be nursed in an appropriate setting. We agree with the clinical reviewer that the man was located appropriately, especially towards the end of his life, and that the prison took account of his preferences.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as 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 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 about the prisoner's ability to escape must be considered as part of the assessment process. It also deemed that restraining by handcuffs of 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.

54. Between 9 October 2013 and 3 February 2014, the man was escorted to hospital 21 times; for appointments, as an inpatient and for treatment including radiotherapy and chemotherapy. He was restrained for the first fourteen occasions ranging from an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer), single cuff (this means the prisoner is cuffed to one of the escorting officers) and double cuff (double cuffing is when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs). We asked the security manager for clarification of how the man was double cuffed. He said that because the man was in a wheelchair, double cuffing meant both his hands were restrained by a set of standard handcuffs, and one wrist was attached to an escorting officer using an escort chain. Records show that the man was double cuffed in this way five times: on 21 October, when taken to hospital as an emergency, 22 November for an oncology appointment, 27 November when attending hospital for a bronchoscopy, and on 28 November and 3 December when seeing the oncologist. He was restrained with an escort chain and a single cuff twice - on 9 October, for an appointment with the chest clinic and 29 October, when attending for an MRI scan (when the restraints were removed for treatment).

55. Every risk assessment shows that the man was considered a low risk of escape and low risk to hospital staff, with no previous concerns raised in regard to behaviour in prison, previous escorts or previous time spent on escort or bedwatch. On each occasion he was assessed as a medium risk of hostage taking due to the nature of his offence. (The circumstances of his index offence suggest this was unlikely particularly taking into account his poor state of health.) Healthcare staff recorded no objections to the use of restraints, but noted the man used a wheelchair. There is no healthcare assessment on any of the risk assessments to indicate how and whether the man's deteriorating health or lack of mobility impacted on his risk of escape.

56. The man had five appointments in early November, for radiotherapy. On each occasion he was accompanied by two officers and restrained with an escort chain which was removed for treatment. The man had five appointments in late December and early January for chemotherapy, we are pleased to note that he was not restrained for any of these appointments. The risk assessments completed by an operational manager noted that this was because of his declining health.

57. The man had poor mobility due to his back pain, and used a wheelchair. He also had COPD and after he was diagnosed with cancer, he became very breathless and his mobility was affected even further.

58. Public protection is fundamental, 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 pleased that the man was not restrained towards the end of this life. However, we are not satisfied that restraints on the earlier occasions were justified by fully

considered risk assessments that took into account the man's risk and condition at the time. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

59. On 31 October 2013, the man's ex-wife, his nominated next of kin, raised concerns with the prison about the lack of information she was receiving about the man's diagnosis. We are satisfied that this was out of Frankland's control as they were waiting for test results conducted at the hospital. This was explained to the man's ex-wife at the time.

60. On 1 November, a prison family liaison officer was appointed when the man's diagnosis was confirmed. The man said he wanted to inform his family himself. The family liaison officer arranged for this to take place in the prison's healthcare centre the same day, facilitated by healthcare staff.

61. The prison allowed the man extra family visits during his illness and the family liaison officer told us that all requested visits were authorised and arranged at short notice. Records show that it was also agreed that visits would be extended into patrol/night state when the man reached the end of life stage. Initially, it was planned that the man's family could visit him in the healthcare centre, but sometimes this was not possible due to the needs of other patients and because some of the visitors were children. On these occasions visits were arranged in a room off the main visits hall to allow the man and his family some privacy

62. The family liaison officer had regular contact with the man's family and plans were agreed to contact them by telephone in case the man's health declined suddenly during the night. The family liaison officer arranged for advanced security clearance for the man's ex-wife and daughter to allow access to the prison outside visiting hours. It was also agreed that the man's son should have open access to his father's cell when he reached the end of life stage.

63. On 15 and 24 January prison staff agreed and facilitated the man's ex-wife attending his hospital appointments. The family liaison officer supported her and offered her the opportunity to discuss any concerns after the appointment.

64. The man's family had asked whether it would be possible for him to have a final meal with them. The family liaison officer told us that she was in the process of arranging this, but unfortunately the man died suddenly before this could be finalised.

65. In the early hours of 7 February, when the man's became suddenly very ill, the duty officer telephoned his ex-wife as had been agreed. The man's son

was unlocked and allowed to remain with his father. Unfortunately, the man's ex-wife did not arrive until after his death.

66. Prison staff continued to support the man's son and he received visits from the chaplain and extra family visits were authorised and arranged within short notice. He was able to attend his father's funeral and a memorial service was held on 21 March in the prison chapel

67. The prison contributed towards the cost of the man's funeral, in line with national guidance. The funeral took place on 21 February and two members of staff attended from the prison.

68. We are satisfied that the man and his family were well supported during his illness, and his family were well supported after his death.

Compassionate release

69. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

70. On 11 November, the man asked for his compassionate release to be considered. The application was completed and sent to the Public Protection Casework Section of the National Offender Management Service (NOMS). The application was declined on 23 December. The reason given was that the man was very early in a sentence with a significant life tariff and was still considered a risk to others.

71. On 24 January, after the man was told his life expectancy was between three and six months, he asked for his compassionate release to be reconsidered. The application was resubmitted to NOMS that day. NOMS requested an up to date medical report and recommendations from the Governor and Offender manager which were provided. Unfortunately, the man died before a decision was made.

72. We are satisfied that the man's applications for compassionate release were processed appropriately by the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all clinical staff use the appropriate template for referrals and clearly indicate the priority.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Action Plan

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Head of Healthcare should ensure that all clinical staff use the appropriate template for referrals and clearly indicate the priority.	Accepted	All clinicians have been reminded of their professional responsibility to ensure that referral forms are completed correctly, with the priority indicator highlighted accordingly.	Completed Head of Healthcare
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	The *Graham* judgement is now explained within the hospital escort risk assessments at HMP Frankland, with the aim to always ensure that security measures are proportionate to the prisoner's individual circumstances. It is accepted that there may be a need for further refinement of this process. The relevant section of the PPO's investigation will therefore be circulated to all staff involved in the hospital risk assessment process, to ensure that they understand the legal position.	31/07/2014 Head of Security