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 HMP Frankland in November 2012

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 report of an investigation into the death of a man at HMP Frankland in November 2012. He was 40 years old. The post mortem report indicates that he died from bronchopneumonia. The underlying cause was his multiple sclerosis. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer conducted a review of the man's clinical care in custody. HMP Frankland cooperated fully with the investigation.

The man was diagnosed with multiple sclerosis in 2001 before he went to prison. After he was arrested in 2005, he spent three years in HMP Woodhill. Prison managers accepted that it was difficult to meet his needs there and he moved to Frankland in 2008. Frankland was better equipped to manage his degenerative condition in their inpatient centre. While at Frankland, he attended outpatient appointments with a neurologist and, after a significant delay, he had an operation to help reduce his spasms. His health deteriorated quickly in autumn 2012 and he died before suitable plans could be agreed for his release on compassionate grounds.

It is unusual - and very challenging - for prison healthcare teams to have to treat a patient for the debilitating and degenerative condition, multiple sclerosis. Woodhill evidently struggled to provide adequately for the man, although it is pleasing to learn of subsequent improvements at the prison. By contrast, staff at Frankland made considerable efforts to care appropriately for his complex needs.

In the circumstances, it is perhaps inevitable that the investigation identified a number of areas for further improvement at Frankland. For example, it is not clear that the full range of specialist help for the man's condition was considered and communication between the prison and the two hospitals involved in his care could have been better. He could also have benefited from a single healthcare lead to ensure that his ongoing treatment and access to secondary care was appropriately coordinated. Finally, there was scope to improve the support given to his next of kin. Nevertheless, I agree with the clinical reviewer that the overall care which he received in Frankland was comparable to that he could have expected in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2013**

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SUMMARY

1. The man was diagnosed with multiple sclerosis (MS) in 2001. This is a degenerative condition which gradually debilitates the sufferer. He was arrested in 2005 and subsequently sentenced to an indeterminate sentence for public protection. He spent almost three years at HMP Woodhill. The facilities were inadequate to meet his needs, although some changes were made to take account of his disability. Eventually it was decided that he needed to move to another prison which could offer an appropriate level of care.

2. In June 2008, the man transferred to HMP Frankland to live in the inpatient unit. Staff moved him between his wheelchair, bed, toilet and shower using a hoist. He attended outpatient appointments with an MS specialist about once a year and was occasionally referred to a physiotherapist. He completed the sex offender treatment programme at Frankland in 2010.

3. In 2010, the man's consultant proposed that he have an operation to have a pump fitted to reduce the spasms associated with his MS. (He eventually had the operation in July 2012.) In early 2011, he spent several months at HMP Durham while the inpatient unit at Frankland was renovated.

4. After two unsuccessful parole applications in 2009 and 2011, the man again applied for parole in mid-2012. The parole hearing was not scheduled until January 2013. A number of reports were prepared for the hearing indicating that he had completed work to reduce his risk of harm to others and that he should be released because of his failing health.

5. In October 2012, the man's health declined rapidly and he was admitted to hospital for a week. He was discharged with a 'Do not attempt to resuscitate' (DNAR) instruction, but this was not discussed with healthcare staff at Frankland. When he returned to the prison, staff confirmed his terminal diagnosis, discussed the DNAR instruction with him and notified his relatives about his recent hospital admission and deterioration. Two meetings were held to discuss his palliative care and possible release on parole. A specialist palliative care nurse saw him and his relatives visited him. A meeting to decide the best option for his eventual release was scheduled for 7 November. However, his condition deteriorated more quickly than expected and he died before that meeting could be held, with his family at his bedside.

6. The investigation has identified some communication problems between the prison healthcare team and two hospitals. It is not apparent that the full range of specialist treatment was considered to ease the man's condition and we think that he would have benefited from a single lead GP or other healthcare professional to have oversight of his care. We are satisfied that Frankland made the best efforts they could to try to arrange the man's release which were complicated by his extensive disabilities and issues of risk. We agree with the clinical reviewer that, after he left Woodhill, the care he received at Frankland was broadly comparable to that he could have expected in the community. We make six recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

7. This office was notified of the man's death on the day of his death. Notices to staff and prisoners were put up at Frankland, encouraging anybody with information about the man's death to contact the investigator. Nobody came forward.

8. The investigator visited Frankland on 13 and 14 November. He collected copies of the man's clinical record and prison record, spoke to a principal officer and the head of healthcare, and visited the cell in the healthcare centre where the man had lived.

9. A clinical reviewer was appointed by NHS County Durham to review the man's clinical care.

10. On 18 December, the investigator and the clinical reviewer interviewed three members of staff. They returned to Frankland on 10 January to interview a further three members of staff. The investigator wrote to the Governor with initial feedback from the investigation.

11. The local Coroner has been sent a copy of this report.

The man's family

12. One of our family liaison officers contacted the man's family. She and the investigator visited the man's mother, step-father and brother on Thursday 29 November. They gave the investigator copies of their relative's handwritten diaries, and subsequently also submitted copies of extensive correspondence about his care. His diaries indicated that he was often unhappy with his care. The correspondence has helped date accurately some of the complaints about his care.

13. The man's family asked for more information about his original imprisonment and sentencing and thought he would have lived longer in the community. They did not think prison was a suitable environment for a man suffering from multiple sclerosis. It is not within our remit to address sentencing decisions. The man's family were very concerned about his care at Woodhill between 2005 and 2008, which they did not think was equipped to manage his needs.

14. The man's family were concerned that healthcare staff at Frankland did not understand the nature of their relative's condition and how it could get better and worse. The clinical reviewer thinks that the man received a broadly comparable level of care to that he could have expected in the community.

15. The man's family asked why he had to die in Frankland rather than in a hospice or hospital. The report explains the release proposals and why, ultimately did not happen.

16. The man's family asked the investigator to speak to a prisoner who assisted him when he lived in the healthcare centre.

17. The man's relatives had a number of more specific concerns which they wished the investigation to consider:

- They were concerned that he did not always get food that he could easily consume
- They were worried about his access to physiotherapy
- They thought that he should have seen a Macmillan nurse sooner
- They were concerned that he was given the same antibiotics for a long time
- They were worried that his medication was sometimes not issued
- They were concerned that he was checked only through his cell observation panel at night

18. The man's family were unhappy that they had not been told about his admission to hospital when his health significantly deteriorated in October or how serious his condition was. They complained that they were not advised that he was very near death until the morning of his death, when he had declined rapidly during the night. His relatives felt that with more warning they could have spent more time with him before he died. They were distressed to be told that they would have to leave the prison at 9.30pm whether or not he had died by then.

19. The man's family were further upset that a letter of condolence from the Governor was signed on his behalf and that one of the family liaison team who was expected to attend his funeral was unable to be there.

20. The man's family were provided with a copy of our draft report. They responded to the draft and raised a number of matters with us, but none of these have resulted in amendments to this final version of the report. We have however written to the man's family separately to address their concerns.

HMP FRANKLAND

21. 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 commission Care UK to provide the healthcare. The man was the first prisoner with multiple sclerosis to be looked after in the inpatient unit.

22. The man spent most of his time on a shared ward in the inpatient unit. This is open during the day and staffed by prison officers and healthcare staff. Two qualified nurses are based in the healthcare centre overnight. One stays with the inpatients and the other is responsible for dispensing medication in the prison. At night the man was locked up, but he could call for a nurse. If necessary the nurse can ask the orderly officer, who carries keys, to come to the healthcare centre and unlock the cell door.

Her Majesty's Inspectorate of Prisons (HMIP)

23. HMIP's most recent inspection of Frankland took place in December 2012. At the time of writing, the full report of the inspection has not been published. However, the Care Quality Commission took part in the inspection and has published its findings. They 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. At the 2010 HMIP inspection, inspectors found that the regime for inpatients was poor but palliative care arrangements at the prison were excellent.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report, covering December 2011 to November 2012, the IMB wrote:

> 'Healthcare is available equally to all prisoners. …Outpatient care is generally provided in a reasonable time but staffing levels do give rise to some problems and there are delays with doctor's appointments. Priority cases are always dealt with promptly. Inpatient care is provided according to clinical need with treatment at outside hospitals where necessary and with appropriate security requirements.'

HMP WOODHILL

25. HMP Woodhill has the dual role of a local prison and a high security prison and holds up to 819 prisoners. It accepts adult male prisoners and young offenders from the Magistrates' and Crown courts in the Milton Keynes area and also holds category A prisoners (prisoners deemed to be of high risk to the public should they escape).

GLOSSARY

Multiple sclerosis

26. The clinical reviewer provides more information about the man's condition in his clinical review:

> 'Relapsing remitting Multiple Sclerosis is the most common type of MS, affecting around 80 per cent of everyone diagnosed with MS (NICE Guidelines (2003). This means that symptoms appear (a relapse), and then fade away, either partially or completely (remitting). The progress of MS can be unpredictable, making it difficult to access the right care (Multiple Sclerosis Society, (2013)).
>
> 'Caring for a patient with MS is challenging in the community environment. To care for someone in a secure environment such as prison presents additional challenges in terms of the complex multiple physical and emotional problems and the need for effective multidisciplinary team working.
>
> '…the problems which can arise with the disease progression of MS [include] deteriorating mobility, susceptibility to pressure damage, fatigue, pain, bladder and bowel problems, respiratory and emotional problems.'

27. National Institute for Clinical Excellence (NICE) guidelines state:

> 'Specialist neurological and neurological rehabilitation services should be available to every person with MS, when they need them. This is usually when they develop any new symptom, sign, limitation on activities, or other problem, or when their circumstances change.'

KEY EVENTS

2005

28. The man was diagnosed with multiple sclerosis (MS) in 2001. His MS was found to be relapsing and remitting. He was arrested in relation to sexual offences against children, remanded into custody and taken to HMP Woodhill on 26 August 2005. While he was held at Woodhill, the man lived in a cell on a standard residential wing for vulnerable prisoners (at risk from others because of the nature of their offence.)

29. The man was under the care of a consultant neurologist at outside hospital, and a nurse specialist from the hospital visited him at Woodhill. Initially, he was not confined to his wheelchair. His family were concerned about the care he was receiving at Woodhill and his ability to cope in a cell which was not equipped for his needs.

2006

30. The man corresponded with the Healthcare Commission in early 2006 about his care. They referred his concerns back to the healthcare department at Woodhill. The Head of Healthcare replied a week later. In July, the man wrote to the Parliamentary and Health Service Ombudsman, who referred him back to the Healthcare Commission. We have not seen any documentation to indicate the final outcome of his complaint.

31. On 28 July 2006, at a Crown court, the man received an indeterminate sentence for public protection. He had to serve a minimum of two years and 28 days before he could be considered for release. The sentencing judge was aware of the man's illness and said that this would not necessarily stop him offending again. Release would be dependent on the Parole Board being satisfied that it was no longer necessary in the interests of public protection for him to continue to be detained.

32. The man attended an outpatient appointment on 2 August. In September, his offender supervisor queried with colleagues whether Woodhill was a suitable environment for him. She began a period of Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring after he told her how useless he felt.

2007

33. In February, the man's community probation officer noted in a post-sentence report that Woodhill was not ideal because of the limited facilities for wheelchair users. He depended on other prisoners to collect his meals, help him wash and push his wheelchair. He was still living in a normal cell on a vulnerable prisoner wing. It was difficult to get his wheelchair through his cell door so he often had to get out and crawl across the floor to his bed. He told his offender supervisor that he often wet himself because he was unable to reach the toilet in time.

34. In March, the man's offender supervisor pursued a transfer for him. He wanted to move to HMP Ryehill. The manager responsible for indeterminate sentenced prisoners at Woodhill said he was waiting for a copy of the sentencing judge's comments before submitting a transfer application.

35. The man's brother wrote to his local MP and the Governor about the care his brother was receiving. He complained that his brother:

- had not been given access to the drugs needed to keep his MS in check
- did not have access to physiotherapy
- could not attend education classes because the department was inaccessible to him
- had struggled to gain enhanced prisoner status because his disability prevented him from working
- was not found any kind of employment for a long time
- was forced to leave his wheelchair at the entrance to his cell and drag himself across the floor to his bed
- was the victim of bullying, as other prisoners stole his wheelchair
- was not given a properly equipped and safe cell
- could not reach the cell bell to call for help
- was wetting himself because he was not being properly assisted to use the toilet and the toilet was not equipped with hand rails
- had not been moved to a prison with appropriate facilities

36. In May, prison managers responded saying that:

- The man's medication had been stopped by his consultant neurologist at the hospital
- He had been assessed as medically unfit to use the gym
- He had been reviewed by a physiotherapist from the PE department, who was unable to offer him any support
- His wheelchair was not being abused by other prisoners
- He had been given a personal alarm because he could not reach his cell bell

37. At the end of May, the man's offender supervisor was still seeking the documents which would allow an application for transfer to begin. His probation officer in the community referred the question of his transfer to the Governor. At the end of August, she was told that a transfer was problematic because the extent of the man's disability meant that only certain prisons could accommodate his needs.

38. The man attended hospital appointments on 17 May, 7 and 26 June, 13 September and 4 October that year. During the first appointment, a doctor told an escort officer that he thought the man was exaggerating the symptoms of his illness and might prove to be an escape risk.

39. A consultant neurologist from outside hospital visited the man on 11 June and completed a report for his solicitors. He wrote:

> '… it was quite inappropriate for him to be held in an establishment of this kind without the provision of appropriate expertise for management of his difficult neurological problems.'

40. In July, his treating consultant neurologist from outside hospital wrote to the man's solicitors. He stated that MS naturally worsens, that no medication could make it better and that it was impossible to say if the lack of physiotherapy at Woodhill had adversely affected him.

2008

41. The man attended a hospital appointment on 7 February. On 9 April, the healthcare operational manager wrote to the man's solicitors about his ongoing care after they had lodged a complaint. He had been the subject of two case conferences. The healthcare operational manager acknowledged that it had taken longer than expected to make necessary adjustments.

42. The healthcare operational manager accepted that there had been problems with the man's wheelchair and offered his apologies. The chair did not fit easily through the cell door so the hand grips had been removed. The man's houseblock was provided with a ramp to help him get on and off the unit. It was not possible to install a hinged medical bed as his cell was too small.

43. The man turned down a move to a larger fully equipped cell for prisoners with disabilities because it was located on the first night centre and he did not want to lose the support of his friends on his existing wing. Because of his vulnerable prisoner status, and the transient nature of prisoners on the first night centre, he was worried that he would not be able to make friends. He was also worried that he would be an easy target for bullying from newly arrived prisoners.

44. The healthcare operational manager urged the man to reconsider, because there was a group of long- term prisoners working on the first night centre who he could mix with. He indicated that he might have to move the man to this cell in any case because his deteriorating health and the demands this was placing on staff meant that the existing arrangement was becoming untenable.

45. The man's cell had been fitted with bars and rails, remote controlled lighting, remote controlled cell bell activation. He had been given a special knife to help him eat and a remote control for his television. A fan had been ordered for the cell and a toilet with an automatic flush. Adjustments had been made to help him attend a course. He was still awaiting a referral for physiotherapy.

Frankland

46. On 5 June 2008, the man transferred to HMP Frankland, another high security prison. There were two reasons for this. Firstly, he needed to complete the sex offender treatment programme (SOTP) to help reduce his risk and improve his chances of release. Frankland specialises in delivering this programme. Secondly, Frankland offered an inpatient healthcare unit able to provide the necessary care for him.

47. A senior nurse at Frankland had visited the man at Woodhill to assess him before he transferred. At Woodhill another prisoner was acting as a 'buddy' to move him between his chair, toilet and bed during the day, but at night, he had to crawl from his bed over a mattress to the toilet.

48. Special transport was arranged to take the man to Frankland. Once he arrived, he had 24 hour nursing care as an inpatient in the healthcare centre. A risk assessment determined that two staff should use a hoist to move him between his bed, his wheelchair, the toilet and the shower. He lived in a shared ward with two other prisoners.

49. A physiotherapist and an occupational therapist saw the man in July. They recommended that staff always used the hoist to move him and that he should have an electronic hoist with a head support and an electronic wheelchair. They thought that a doctor should possibly increase his medication to reduce his spasms and asked that he should be referred to a local MS specialist.

50. On several occasions, the man scalded himself with boiling water from the kettle, or fell off the toilet or out of bed. Staff told him to wait for them to move him with the hoist and gave him a user-friendly kettle.

51. In September, the man asked about moving to HMP Peterborough but was told that, although they held disabled prisoners, there was no dedicated unit there he could live in. In October, he visited an outside hospital to see a consultant neurologist specialising in MS.

2009

52. In February 2009, the man had a scan at outside hospital. In April, he was given a better wheelchair. In May, he asked for physiotherapy. A prison GP referred him to the Frankland physiotherapist but thought that he might need more specialist physiotherapy. As his eyesight was deteriorating, he also saw an optician regularly.

53. In June, the man learnt that his first application for parole had been refused. Healthcare staff finalised his MS care plan. At the end of the month, he saw the Frankland physiotherapist, who thought that he should be referred to a physiotherapist who specialised in neurological problems. There is nothing in his clinical record to show that a referral was made.

54. A conference was held in June to assess the man's needs before he began the sex offender treatment programme in July. The SOTP was adapted to accommodate his disability and staff devised a new care plan to help him get through the sessions. A ramp was positioned at the entrance to the programmes unit, the group was held on the ground floor and he was allocated a prisoner helper to assist him with writing and drawing. However, he had to return to the healthcare centre if he needed the toilet.

55. In July, a nurse noted her concern that the man should be treated by a male nurse. She believed that he was capable of more physical movement than he suggested and that he might be inappropriate with female staff. At his annual sentence planning meeting in August, he complained that he should have started the SOTP sooner, before his illness had deteriorated.

56. In September, he complained that he had not seen the consultant neurologist specialising in MS for a long time, that he was still waiting to see a specialist physiotherapist and that he wanted to see an optician because his eyesight was getting worse. He saw the consultant neurologist specialising in MS at outside hospital at the end of the month. The doctor recommended that he start weekly intra-muscular injections of interferon beta-1a (also known as Avonex, which is used to treat the symptoms of MS).

57. The man saw the optician during the autumn. On 12 November, healthcare staff received an initial supply of pre-filled disposable syringes of interferon-beta 1a, to be given once a week. However, injections did not begin until 21 December, when a senior nurse confirmed the arrangement with a colleague of the consultant neurologist specialising in MS at outside hospital. The subsequent records do not clearly demonstrate that he was then given his injection every week.

2010

58. The man visited outside hospital on 13 January, 10 February, 17 February and 3 March 2010, but it is not clear from his clinical record what treatment he received. He completed the sex offender treatment programme in February. Afterwards, the programmes team thought that he required additional one-to-one work to further reduce his risk to others. His deteriorating health meant that he was unsuitable for any further groupwork.

59. The man had regular spasms during the spring, lost strength in his arms and his movement was uncoordinated. The prison GP recorded that the man had recently suffered a relapse but that his MS was nonetheless stable according to recent hospital tests and his symptoms were starting to improve again.

60. The man was sometimes tearful and frustrated with his condition. Healthcare staff encouraged him to do exercises. He asked for steroids but these were not prescribed as the consultant neurologist specialising in MS had advised healthcare staff that there was no evidence that his MS was currently deteriorating further. His exacerbated symptoms were caused by damage resulting from the progression the disease had already made.

61. The man saw the consultant neurologist specialising in MS on 27 April. In May, staff sought advice because they were having problems hoisting him when he had spasms. A manual handling coordinator visited to ensure that the hoist was being used properly. In June, he was confined to bed for a week when his wheelchair broke.

62. From 28 June to 1 July, the man was admitted to outside hospital for a trial of intrathecal baclofen (a drug to reduce his spasms). The trial was successful, so the consultant neurologist specialising in MS agreed to arrange for an operation to fit him with a baclofen pump.

63. The man asked for steroids again in August and the prison GP wrote to the consultant neurologist specialising in MS for advice. The consultant neurologist thought that these were unlikely to help unless there was a very clear deterioration in his condition and might lead to an infection. The man claimed to be having an acute relapse, but the prison GP considered that he was exaggerating. The GP also noticed in mid-September that the man had not had an injection of interferon beta 1a for three weeks and took steps to address this.

64. In November, the Frankland physiotherapist suggested that the man be referred to the neurological rehabilitation team outside of the prison. There is no evidence in the clinical record that this referral was taken any further. He attended outside hospital on 29 December.

2011

65. The man had a persistent sore on his heel for most of 2011, but this was ultimately successfully treated. He moved to HMP Durham on 24 January while the healthcare centre at Frankland was being renovated. The inpatient centre at Durham had 21 beds. The investigator has confirmed with Durham that the man's hoist came with him and that healthcare staff at Durham used this every day to move him between his bed, chair and toilet.

66. The man returned to Frankland on 16 May. He told a nurse that he had experienced a number of relapses at Durham and was not feeling as well as when he left. He also said that he had been coughing up green sputum for months. His sputum was sent for testing.

67. The man's case was considered by the Parole Board again in April 2011. The programmes team, his offender supervisor and his offender manager did not recommend his release. Psychology staff thought that he had still not fully addressed his offending behaviour.

68. The consultant neurologist specialising in MS provided the Parole Board with information about the man's condition. The doctor confirmed that he had to be moved using a hoist, was confined to his wheelchair and was doubly incontinent. His movement was uncoordinated and he suffered from double vision. He required help with washing, dressing and feeding himself. The

doctor commented that the man's MS had become aggressive and progressive since he had been in prison and that his disability was marked. His deterioration was ongoing and prognosis poor. He would not regain any physical function. He informed the Board that the man was too ill to commit any kind of physical or sexual assault. Because the man still had some use of his upper limbs, the doctor conceded that he could still theoretically operate a computer whereby he might be able to create indecent images of children. However, the doctor added that the man's movement was so limited that an appropriate release address in the community could be used to restrict his access to a computer.

69. The Parole Board decided that the man should not be released on licence and the Board did not recommend a move to an open prison. They acknowledged his deteriorating health and that he was confined to a wheelchair. However, they found that his loss of mobility did not equate automatically to a reduction in his risk. They agreed with the sentencing judge that his condition would not prevent him from further offending if he was minded to do so. He was asked to do further one- to-one work to address his risk. His solicitors challenged the decision to keep him in a high security prison but he remained at Frankland.

70. In July, the man started to spend some days in bed because he felt weak and had spasms, incontinence, weakness and immobility. In August and September, he completed the remaining one-to-one work to address his risk of offending.

71. In late September, healthcare staff stopped the man's interferon injections for a month on the advice of staff at outside hospital following abnormal blood test results. Further tests in mid-October also provided abnormal results so the injections remained suspended. Another blood test was done in mid-November but it is not clear from his clinical record when exactly the interferon injections were restarted.

2012

72. The man had a chest infection in January and was prescribed an antibiotic. He felt weak in March and often stayed in bed. A letter from the consultant neurologist specialising in MS dated 19 March indicated that he was still on the waiting list for a baclofen pump to reduce his muscle spasms. The consultant noted that the man's MS was at the stage when he could expect advancing problems.

73. A senior nurse at Frankland reviewed the man in early April and noted that he had not been seen by the consultant neurologist specialising in MS for a long time and was still awaiting an operation to fit his intrathecal baclofen pump, originally suggested in 2010. He was weak, lethargic and dizzy. As he was losing weight, staff gave him nutritional supplements. They discussed his case at the daily morning meetings and contacted outside hospital for advice.

74. The man's next parole application began in May. The process was due to last for about six months while reports were prepared. There was no further offending behaviour work planned to reduce his risk. A member of staff from the psychology team suggested a move to an open prison, but this was considered unlikely because of the lack of inpatient healthcare facilities.

75. The man's offender manager thought that he could be released if the appropriate care provision was funded, but advised that this would not happen immediately as the relevant local authority would need time to assess his needs and prepare for his arrival. His offender supervisor also supported his release and proposed that he could be supervised in the community with a robust risk management plan. Her proviso was that an appropriate care home be found.

76. Staff obtained a pressure relieving mattress for the man in June. He stayed at outside hospital between 17 and 19 July when his intrathecal baclofen pump was successfully fitted. Since arriving at Frankland, he had used a Conveen sheath to manage his urinary incontinence, but a catheter was inserted during the operation.

77. A principal officer (PO) chaired the man's annual sentence planning meeting on 2 August, when it was decided that he was appropriately located for the time being but that a further meeting would be held after the outcome of his next parole hearing in early 2013. During the summer, his offender supervisor attended a Multi-Agency Public Protection Arrangements (MAPPA) meeting which addressed the man's possible release and involved the social services team who would be responsible for finding him an appropriate care home if he was granted parole.

78. The same day, a senior nurse updated the man's care plan, which directed:

- Hot drinks prepared for him throughout the day
- He may sometimes require assistance with feeding
- He requires assistance with washing and dressing
- He requires nutrient drink supplements
- He uses a wheelchair at all times
- He should always be transferred using a hoist by two members of staff
- His catheter should be changed every 12 weeks

79. The man became pale, cold and confused on 16 August. The prison GP diagnosed a probable urinary tract infection and prescribed antibiotics. A couple of days later, he felt better. On 22 August, he went to outside hospital to have his baclofen pump checked.

80. On 31 August, healthcare staff arranged for the man to be seen by a continence specialist following his recent urinary tract infection. They were concerned that his recently fitted catheter might have made him more prone to infection. The specialist thought that the previously used sheath was preferable to a catheter because of the associated risk of infection, but the man wanted to keep the catheter.

81. On 18 September, the man told a prison GP that he was struggling to swallow and felt like he was choking when he lay down. The doctor diagnosed oral thrush and prescribed antifungal drops. He saw the man again on 25 September. He was very weak so the doctor ordered tests. Two days later, the doctor asked the consultant neurologist specialising in MS at outside hospital to review the man because his condition was deteriorating.

82. On 30 September, the man's oral hearing in front of the Parole Board was scheduled for 7 January 2013. It was noted that he had complex health problems. Various professionals supported his release, but a detailed care and resettlement plan was required.

83. The man went to see the consultant neurologist specialising in MS and an MS specialist nurse at outside hospital on 1 October. His baclofen pump was topped up and a new catheter inserted. The consultant told the man that he had relapsed and now had extensive MS. However, healthcare staff at Frankland were not told of the updated diagnosis.

84. The next day, the man had a temperature and stayed in bed. On 3 October, he was taken to outside hospital in an emergency ambulance. He was breathing slowly when staff checked him. He was pale, cold, clammy, unresponsive and semi-conscious. A prison GP suspected sepsis (blood poisoning). The escort record mistakenly recorded that he had suffered a major heart attack. He was not restrained when he left Frankland.

85. A senior nurse at Frankland told the investigator that the man looked dreadful when he was rushed to hospital that day, and she thought he might not survive. He was in a critical condition when he arrived at the hospital. However, his family were not informed of his condition. He was taken directly to the resuscitation room in the accident and emergency department. Later that day, staff at the outside hospital put in place a 'Do not attempt to resuscitate' (DNAR) instruction for the man with his consent. He was given antibiotics for a chest infection and a urinary tract infection.

86. On 7 October, a manager from Frankland went to the outside hospital to conduct a management check on the man's escort arrangements. They asked the nurses if they had any concerns and they advised that he should be handcuffed because they thought he had much more use of his limbs than he claimed. Two of the nurses believed that he had moved his hands towards their groin areas while they were treating him. The duty governor ordered that the risk assessment be changed because he had some movement in his hands and arms. Staff applied an escort chain for the remainder of his time in hospital. (This is a length of chain with a handcuff at either end, one attached to the prisoner and the other to an officer.)

87. On 10 October, hospital staff contacted Frankland to discuss the man's discharge. They indicated that he would need a supply of oxygen, which Frankland could not offer. However, at 3.30pm, he was discharged to the prison with no warning or consultation as he no longer required an oxygen

supply. Staff were surprised by the 'Do not attempt to resuscitate' instruction because the hospital had not informed them or supplied any paperwork to explain the decision.

88. A prison GP saw the man the next day and prescribed one more week of antibiotics. He needed to be moved onto his side in order to cough up sputum.

89. On 12 October, a senior nurse at Frankland spoke to the man about his deteriorating condition and the progression of his MS. He told her that his family were unaware of his recent hospital admission and he gave his consent for the family liaison team to contact them. Two members of staff from the prison acted as family liaison. They contacted the man's relatives the same day and let him know that they would be visiting him soon.

90. As the nurse was unsure if the 'Do not attempt to resuscitate' instruction was permanent, she contacted outside hospital and confirmed that it was. She also spoke to the MS specialist nurse at outside hospital, who confirmed that the consultant neurologist's team had already diagnosed the man as end stage MS after his most recent review. The MS specialist nurse agreed to attend a multidisciplinary team (MDT) meeting at Frankland to advise staff.

91. On 18 October, healthcare staff discussed the man at the morning meeting. A senior nurse and a GP from the prison wanted greater clarity regarding his 'Do not attempt to resuscitate' instruction. He was struggling to breathe. The GP suggested that staff should consider planning the man's release from prison and recommended that a clinical nurse specialist for palliative care should be contacted. (This nurse is a Macmillan nurse who offers support and advice to healthcare staff looking after terminally ill prisoners.) The same day, the man moved to a single cell in the healthcare centre. He was still locked in his cell overnight.

92. A prison GP spoke to the man on 19 October. He confirmed that he had agreed at the hospital that he did not want to be resuscitated in the event of a cardiac or respiratory arrest and indicated that he had not changed his mind. He promised to discuss the matter with his family, who had a visit booked the next day. When they arrived they met family liaison staff who had facilitated the visit on the inpatient unit. The man's relatives asked about extra visits, the possibility of his release on compassionate grounds and how often he was being checked at night.

93. The next day, staff recorded that the man's diet needed to be adapted. Overnight on 23 October, he pressed his alarm because his bed needed adjusting, which was done. On 23 October, he was placed on the Frankland palliative care register as he was now regarded as terminally ill.

94. The clinical nurse specialist for palliative care saw the man on 24 October and was satisfied that he was receiving nursing care equivalent to that available in the community. He was comfortable and his symptoms - spasms, pressure sores and fatigue – were being managed. She did not think there was any

need for a palliative care consultant to visit. The man told her that he did not wish to be resuscitated. Two nurses were assigned as the man's named nurses and key workers. Another prisoner was acting as his buddy.

95. The next day, one of the nurses assigned as his named nurse and keyworker reviewed the man's care plan. The prison GP and the clinical nurse specialist for palliative care spoke about the man's wish not to be resuscitated and agreed that it was appropriate. He missed an appointment with the doctor that day because the surgery ran out of time.

96. On 26 October, a multidisciplinary meeting was held to discuss the man's care needs. The man's offender supervisor, a principal officer from the prison, the clinical nurse specialist for palliative care and the family liaison officers were among those present. It was thought that the man had only months to live. His solicitor was trying to arrange a care home for a possible release.

97. His offender supervisor told the meeting that she expected the man's parole hearing in January to lead to a recommendation for release. She was hoping to find a nursing home near his family predominantly staffed by men with no access to either the internet or visiting children. Were he successful, she did not expect him to be released on parole until March 2013 because arrangements needed to be put in place to care for him and manage his risk. She had also looked at transferring him to a prison nearer his family but none offered 24 hour care. She was considering escalating the matter to Prison Service headquarters. The principal officer told the meeting that securing the man's early release on compassionate grounds could take up to three months. Staff planned to give him different release options and ask him to decide which avenue to pursue and to ask the consultant neurologist specialising in MS for a letter supporting the man's release at his next appointment.

98. During the meeting, the principal officer, one of the nurses assigned as the man's named nurse and keyworker and the clinical nurse specialist for palliative care advocated that the man's cell door should be kept open overnight. Other staff pointed out that he had tried to touch a female nurse at outside hospital and that he had more mobility in his arms than he admitted. The meeting agreed that further discussion was needed before permission was granted.

99. At the end of the meeting, the man's offender supervisor agreed to look at both the possibility of a transfer and early release on compassionate grounds (ERCG). She scheduled a meeting to discuss these options for 7 November. The clinical nurse specialist for palliative care agreed to provide evidence to support keeping the man's cell unlocked throughout the night. Another prisoner was assigned as the man's buddy. Staff obtained a disposable camera so that his family could take pictures with him. The family liaison team asked for a hands free telephone in the man's cell because he could not currently make calls.

100. The same day, one of the nurses assigned as the man's named nurse and keyworker asked kitchen staff to liquidise his food as he was starting to choke on any lumps. She also spoke to the MS specialist nurse on the telephone, who advised that, subject to an assessment that he was fit to travel, he would be admitted for a week at outside hospital.

101. The man's family visited again on 27 October and met the clinical nurse specialist for palliative care and the two prison FLOs. They asked whether he could move to a prison near their home in Essex. The man told the clinical nurse specialist for palliative care that he needed help coughing up phlegm from his chest. She thought that he needed a physiotherapist.

102. During the night of 28 October, a nurse had to be let into the man's cell in order to perform physiotherapy, because he had no cough reflex. The next day he saw a prison GP, who referred him for physiotherapy and sent his sputum for analysis. On 30 October, a doctor ordered blood and urine tests and the man was seen by the prison's regular physiotherapist as the palliative care physiotherapist was on leave. The same day, one of the named nurses assigned to the man updated his care plan in his clinical record.

103. On 31 October, the physiotherapy service discharged the man. Nurses were now turning him on his side with his head off the bed every day in order to clear sputum from his chest. They were also feeding him, although he was able to lift a cup. During the night of 1 November, the orderly officer unlocked his cell to allow the nurse to help him with breathing difficulties.

104. The man's relatives visited again on 2 November. Staff held another multi-disciplinary team meeting the same day. His next hospital appointment had been brought forward to 12 November. HMP Belmarsh and HMP Whitemoor had been identified as prisons with 24 hour healthcare nearer to the man's family. An inter-departmental risk assessment meeting was still scheduled for 7 November to discuss release and transfer plans. The security manager turned down the clinical nurse specialist for palliative care's request for the man's door to be kept open at night as his condition was regarded as stable and he required minimal assistance during the night. An officer was available to come to the healthcare centre to unlock the man if the need arose.

105. During this period, the man was prescribed:

- baclofen (to reduce spasms)
- gabapentin (pain relief)
- pizotifen (to treat migraines)
- aspirin
- cinnarizine (to treat nausea and vomiting)
- paracetamol

106. A senior nurse at Frankland told the investigator that the man seemed bright and lively the day before he died. However, later that evening, staff gave him physiotherapy and used suction to clear his airway. He was hot and sweaty

and anxious. Two nurses monitored him as his condition deteriorated in the early hours of the following morning.

107. During the night, a nurse informed the Night Orderly Officer that, if the man had been in hospital, she would want his family to be told about his deterioration. The Night Orderly Officer told her that the matter would be discussed at the handover meeting when the day staff arrived in the morning.

108. At 7.30am that morning, the senior nurse came on duty and immediately instructed that staff stay with the man at all times. He was unresponsive and his breathing was laboured. Family liaison staff telephoned his family at about 8.30am and advised them that he was dying and that they should travel immediately if they wanted to see him.

109. The man's cell door remained open all day. A prison GP reviewed him at 9.00am as soon as he arrived for his surgery. The man did not complain of any pain. He was placed on the prison integrated end of life care pathway that morning. During the day, healthcare staff sat with him and he was visited by the chaplain, who said prayers. The senior nurse asked the Macmillan nurse to come to the prison. The Macmillan nurse stayed in the healthcare centre for the rest of the day to provide support. End of life pain relief was prescribed in advance by the doctors but was not given because the man did not request it.

110. The man's family arrived at Frankland at 3.30pm. By this stage, he was unconscious. They were taken to see him, then attended a multidisciplinary meeting with the staff to discuss preparations for his death away from his hearing. They were told that they would have to leave the prison at 9.30pm even if he had not died, as they would not be able to stay in the prison during night state. They then returned to sit with him at his bedside.

111. The man died at about 5.10pm in his cell, with his mother, step-father and brother by his side. The two prison FLOs, the Macmillan nurse, one of the man's named nurses and keyworkers, a principal officer and two officers were present on the inpatient unit at the time. The man's relatives stayed with him until about 7.00pm. A hot debrief meeting was held for staff in the healthcare centre before they went home. Staff telephoned the out of hours' doctor and asked him to attend the prison to certify death, but he refused, as he said it was not part of his duties. In the event, a police doctor certified death at 8.50pm.

112. The post-mortem report found that the man died from pneumonia resulting from his existing multiple sclerosis.

113. The man's funeral was held on Monday 19 November. The prison paid reasonable funeral costs. One of the FLOs had planned to attend the man's funeral but at the last minute she was not able to so. His relatives were upset about this. Another member of staff who had worked with the man offered to attend instead.

ISSUES

Woodhill

114. The man, his solicitors and family members all complained about the facilities available to him at Woodhill between 2005 and 2008. Prison managers acknowledged failings and made changes to his environment while he was there. Ultimately he had to transfer to Frankland for access to appropriate facilities and to undertake offending behaviour work. When he arrived at Frankland he was immediately assessed as requiring 24 hour healthcare in the inpatient unit. Staff used a hoist to move him. It is regrettable that he did not transfer sooner, because Woodhill was clearly unsuitable for his needs.

115. The investigator contacted the current Head of Safer Prisons and Equality at Woodhill to request an update on the facilities now offered to disabled prisoners. Significant improvements appear to have been made. He said that Woodhill now has three fully adapted disabled cells. Each of these cells has full wheelchair access and a toilet area and wet-room. The showers are operated via a sensor and the cell bells and lighting are remote controlled.

116. The chapel, education department, visits area and workshops all offer wheelchair access and stairlifts where necessary. The vulnerable prisoner wing has permanent wheelchair access to the exercise yard. If a prisoner is located on another wing then there are portable ramps available for use around the prison. Auto-flushing toilets, hinged medical beds and extra power sockets can be installed. Wheelchairs are provided and maintained by the NHS.

117. Woodhill holds monthly forums for disabled prisoners. There is a dedicated Disability and Older Prisoner Lead Officer. Their role is to liaise with other departments to address the particular needs of disabled prisoners. Programmes are individually adapted to allow a disabled prisoner to participate. A physiotherapist attends the prison on a regular basis to treat prisoners referred by the GP. Should a disabled prisoner need to go out of the prison, then suitable transport is arranged that can accommodate a wheelchair. Where possible a prisoner with a disability is placed into suitable accommodation as soon as possible. If no accommodation is available, then his cell is adapted to suit his needs.

Frankland

118. The clinical reviewer completed a review of the man's clinical care at Frankland. He comments:

> 'I have seen good evidence… in the records, staff interviews and supplementary documents provided to me by the healthcare team at HMP Frankland to suggest [the man] received comprehensive holistic care.

'He was allocated two key workers with whom he appeared to develop a good rapport. His individual needs appear to have been assessed and reviewed.

'There is good evidence that [the man's] physical needs were assessed and action taken to address those needs… Although, as is often the case when caring for someone with complex needs, lessons can be learned, I feel the care [he] [was] given was comparable to that which could have been expected outside of prison.'

Seeking specialist advice for the man's care

119. There are several entries in the clinical record indicating that the man should be referred for physiotherapy to alleviate the symptoms of his MS. He was seen shortly after his arrival at Frankland, so this issue was given some priority. However, the clinical reviewer notes that a physiotherapist tended only to be involved reactively and it would have been better if one had monitored him on an ongoing basis.

120. The clinical reviewer also found no evidence that the man was referred to a dietician, speech therapist, psychologist (for emotional support) or tissue viability specialist (for his pressure sores). He would have expected to find evidence in the clinical record that these issues were at least considered. We endorse his findings and make the following recommendation:

The Head of Healthcare should ensure that patients with complex needs are referred to appropriate specialists relevant to their condition.

Access to secondary care

121. The man's baclofen pump (designed to relieve the spasms of MS patients) was trialled in July 2010, but it was not fitted for another two years. The clinical reviewer comments that this was a surprisingly long time, and thinks that prison healthcare staff should have actively anticipated and managed any obstacles preventing the operation. He believes that the man should have been allocated a lead GP with oversight of his care needs. He saw a number of different GPs during his four years at Frankland, none of whom had special responsibility for him.

122. It is not clear from the clinical record who was chasing the delayed operation with the hospital. (The Head of Healthcare told the investigator that she later pursued the matter with the outside hospital.) Specialist advice was occasionally sought from the man's neurologist. However, there were gaps of over a year between assessments by the doctor. The clinical reviewer has not found a clear explanation from either the hospital or the prison clinical record for the delay to the operation, but is clear that it should not have happened.

123. In response to our initial feedback, the Head of Healthcare at Frankland said she considered it was entirely the responsibility of the outside hospital staff

and the man to pursue his secondary care options. She pointed out that the man wrote to the consultant neurologist himself. However, the primary healthcare provider has a basic level of responsibility to a patient to help him access treatment and we consider this responsibility is greater in the prison setting as prisoners have very restricted opportunities to pursue their own care arrangements.

124. When the man was discharged from the local hospital on 10 October, Frankland staff were told that he was now terminally ill. They were then surprised to learn that the hospital where the man was receiving care from the consultant neurologist specialising in MS had already reached this diagnosis when they reviewed him ten days earlier. The clinical reviewer thinks that communication with the hospital could have been better and more proactive on Frankland's part. We endorse his findings and make the following recommendation:

The Head of Healthcare should ensure that patients with complex needs are allocated a lead GP with oversight of their long term care.

Restraints and security

125. When the man was taken to outside hospital in an emergency ambulance on 3 October, he was not handcuffed because of his very poor health. However, on 7 October, nurses at the hospital expressed concern that he had tried to touch them inappropriately. They thought that he had more mobility in his arms than he would admit. The escort risk assessment was reviewed and the escort chain was subsequently applied until he returned to Frankland on 10 October. He did not go to hospital again before he died.

126. The Prison Service has a duty to protect the public when escorting prisoners at hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The British Medical Association (BMA) guidance is that 'prisoners are entitled to the same standards of health care as the rest of society…Outside prisons, there should be a presumption that prisoners are examined and treated without restraints, and without prison officers present, unless there is a high risk of escape or the prisoner represents a threat to him or herself, the health team or others.' We agree it was not appropriate to restrain the man when he first went to hospital because he was virtually immobile.

127. The man was not a risk of escape, which is the primary purpose of the use of restraints, but the prison needed to act on the information that the nurses were concerned that he posed a risk of harm to them. While it would have been preferable to have seen some discussion about alternative methods of managing this risk, there was some previous intelligence to suggest that he remained a risk in spite of his very limited mobility so this was not an isolated incident. In the circumstances we consider the decision to apply restraints was defensible because of the identified pattern of risk of harm to female staff.

Preparations for release

128. The man had been refused parole in 2009 and 2011. When his health deteriorated in October 2012, he was approaching his third parole hearing in January 2013. His release was being recommended by the different professionals involved. However, the requirement for an appropriate care home able to cope with his risk issues and level of disability would have meant that it was unlikely that he would have been released until the early spring of 2013, even if the Parole Board had approved his release.

129. This remained the situation until a multi-disciplinary team meeting was held on 26 October. By then, the man was terminally ill and it looked as if he might have only months to live. His offender supervisor arranged a meeting for 7 November to review three options:

- The man's ongoing parole application
- His possible transfer to a prison nearer his parents
- His early release on compassionate grounds (ERCG).

130. Prison Service Order (PSO 6000) sets out the procedures for the permanent early release on licence of prisoners on compassionate grounds. Early release may be considered where a prisoner is suffering from a terminal illness and death is likely to occur soon (usually expected to be within three months). The PSO emphasises that it is essential to obtain a clear medical opinion on the likely life expectancy of the prisoner. The Secretary of State also needs to be satisfied that the risk of re-offending has reduced and that there are adequate arrangements for the prisoner's care and treatment outside prison.

131. The man's offender supervisor told the investigator that early release on compassionate grounds was her priority rather than a transfer because he was so unwell. We accept that transferring him would have been very problematic, given his rapidly deteriorating health and the logistics of securing a suitable free healthcare bed in a prison near Essex. A transfer might also have been counterproductive because he was at least familiar with Frankland and the staff were coping with his needs.

132. His offender supervisor thought that an application for early release had a strong chance of success because the man's various parole reports had already recommended his release. His offender manager was invited to the meeting on 7 November because it was her responsibility to find an appropriate care home in the man's home area. It was decided at that meeting that this ideally needed to be staffed predominantly by men and have no access to visiting children or the internet. This was a very restrictive requirement.

133. The man's sudden decline and death within a few days of this meeting was unexpected and overtook any plans staff had to try to arrange a transfer or progress arrangements for an application for potential release on compassionate grounds. Sadly, he was too unwell to be moved and there was no practical alternative to him dying at Frankland. However, we are

satisfied that at the time appropriate consideration and plans were being made to help arrange his possible early release. These plans were hampered by the extent of his disability and his level of risk which required suitable care arrangements in the community to be settled before an application for release could be submitted.

Palliative care

134. The man was regarded as terminally ill on 23 October and placed on the local palliative care register. At that stage he was referred to the specialist palliative care nurse. The clinical reviewer comments that it is hard to assess the timeliness of this referral because the man's eventual decline was so much quicker than expected. Nevertheless, he concludes that the man received appropriate palliative care once the need for it had been identified and he was made comfortable in his last days.

The man's care at night

135. The man's cell door continued to be locked at night until he died. He told the staff that he sometimes struggled for breath and felt like he was suffocating. If he pressed his cell bell, an orderly officer had to attend the healthcare centre and unlock the cell door to allow a nurse to attend to him and treat him. This process takes some minutes. Nurses carry cell keys in a sealed pouch but they are only supposed to be used in an emergency, life-threatening situation.

136. At a meeting on 26 October, three days after the man had been placed on the palliative care register, healthcare staff, with the support of a manager on the unit, considered that his cell door should be left open at night to allow them ready access to care for him. This request was turned down by a security manager. The palliative care nurse told the investigator that the matter was discussed at length by staff. To keep a cell door open in the healthcare centre overnight requires an extra prison officer. The security manager told the investigator that this option is reserved for patients who require a nurse to sit with them round the clock. He explained that the man was not in this condition on 2 November when he made the decision. He considered the man's risk to nursing staff and his refusal was also influenced by the recent incident at outside hospital.

137. Clearly there is a need to take security factors into account, but the man was bed-ridden, immobile and recognised to be dying. We are concerned that greater weight was not attached to the opinion of healthcare staff and the principal officer in the healthcare unit. We think that the man's quality of life in his final days was adversely affected by the decision, as he sometimes struggled for breath on his own in a locked cell, which must have been distressing for him. In such circumstances, where there is a difference of opinion between staff in the healthcare department and staff in the security department we consider that the matter should have been referred to a senior manager. We make the following recommendation:

The Governor should ensure that security decisions affecting the welfare of prisoners on the palliative care register are referred to a senior manager.

A prisoner working as a hospital orderly

138. The man's family asked the investigator to interview a prisoner who worked as a hospital orderly on the inpatient unit at Frankland. The prisoner said that he believed that the man received excellent care within the constraints of the prison system. However, because the nursing staff were so busy, he said he did a lot of little tasks to help the man with his day to day life on the unit. The man became very attached to him and they became friends. The man had come to believe that his fellow prisoner was the only one who cared about him in the inpatient unit and told his parents this. The hospital orderly explained that the man did not get on with the nursing staff. He said that the man became very bitter during his last week on the unit and had unfortunately given his parents an unfair perception of his overall care.

139. The fellow prisoner explained that the nurses had always acted purely professionally with the man. He said that there were a whole team of healthcare professionals looking after him. He said that the man's time on the unit had been a learning experience for everyone and that palliative care is developing all of the time. He acknowledged that there is very little activity available on the inpatient unit (which was a criticism at the 2010 inspection) and he felt that the man's negative perception of Frankland came about because he never saw the rest of the prison and the opportunities available to other prisoners. The fellow prisoner said he became depressed for a while after the man's death because they had been so close, but he said that healthcare staff supported him well and he now felt better.

Family liaison

140. The man's family complained that they were not informed when he was rushed to outside hospital on 3 October. The nurses were very worried about him and feared he might not recover. Prison Rule 22(1) states:

> 'Notification of illness or death
>
> '22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

141. Although the man rallied in hospital, he was sufficiently ill when he was admitted by emergency ambulance to warrant contact with his family.

142. During a night in November, a nurse told the Night Orderly Officer that she thought that the man was so unwell that his family should be notified. She was told that this would be discussed with the day staff in the morning. The

family liaison officer was informed when she arrived for work in the morning and then immediately called the man's relatives. However, by the time the family arrived after a long journey, he was very near death and they only got to spend a short time with him. We consider that his family should have been contacted, in line with Prison Rule 22, as soon as the nurse advised that he was nearing the end of his life. It should not have been necessary to wait until the family liaison officer attended the next day. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

143. The man's family were unhappy that they were taken into a meeting shortly after they arrived at the prison, when they wanted to spend time with their relative. From our discussions with the staff involved, we consider that this meeting was held with the best of intentions to include the family in the decision making process and to make plans and help prepare them for his imminent death. The timing of his death so soon after the meeting could not have been predicted. Although the timing was unfortunate, we believe it was reasonable to include his relatives in the meeting.

144. The man's relatives were upset that prison staff informed them that they would have to leave the prison by 9.30pm, even if he had not died by that time. In the event, he died at 5.15pm so this did not become a problem. However, we understand it was difficult for his family to face the prospect of having to leave him to die without them overnight.

145. It is possible that another family might be placed in a similar position in the future. The investigator spoke to the Head of Security at Frankland. He said that, although it has never happened before and would be very unusual in a high security prison, he believed it was reasonable for managers to consider how to accommodate the family of a man in similar circumstances to this man. Any stay overnight would be subject to a full risk assessment of family members, advice from healthcare staff about the man's condition and the availability of an appropriate level of extra staffing. We make the following recommendation:

The Governor should introduce a local policy to allow a dying prisoner's family to remain with him in the healthcare centre overnight.

146. The man's family were also upset that a letter of condolence from the Governor was signed on his behalf. The letter was signed by the deputy governor. The deputy governor told the investigator that he had done so because the Governor was not on duty at the time. He did not want the letter to be late. He considered that it was inappropriate for a letter of condolence to be written by anybody other than the Governor. Although we think that the deputy governor acted with the best of intentions, we can understand why the man's family were unhappy with the resulting letter. The signature was not legibly that of the deputy governor. We think that it would be appropriate in future for a senior manager running the prison in the absence of the Governor

to express their own condolences in writing. We make the following recommendation:

The Governor should ensure that letters to bereaved families are personally signed.

147. The man's family were unhappy that the prison's family liaison officer (FLO) who had originally agreed to attend his funeral, was unable to attend. We understand that she was instead obliged to attend a meeting at the prison. The other FLO did not attend as it was her first day back from a week's leave so no arrangements had been made for her to attend. We understand from the FLO who was due to attend the funeral that a manager on the unit was asked to attend in her place. The manager worked on the inpatient unit at the time of the man's death and had had significant input into both his care and family liaison. While we agree that it is preferable to have prison representation at a funeral which the family has agreed, we are satisfied that in the circumstances it was reasonable to ask the manager to represent the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with complex needs are referred to appropriate specialists relevant to their condition.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'All patients will be referred (if consenting) to a specialist relevant to their medical needs. This may need commissioning if specialists are not already commissioned.'

2. The Head of Healthcare should ensure that patients with complex needs are allocated a lead GP with oversight of their long term care.

   The Head of Healthcare accepted the recommendation and provided the following response:

   'All patients will be identified with a lead GP to oversee long term care. This will also require a degree of consistency from The Gables Medical practice in terms of GP rota.'

3. The Governor should ensure that security decisions affecting the welfare of prisoners on the palliative care register are referred to a senior manager.

   The Governor accepted the recommendation and provided the following response:

   'The decision taken in [this man's] specific circumstances was made by an experienced security manager. Future decisions on security related matters for prisoners on an end of life pathway/palliative care register will be made or sanctioned by an operational manager.'

4. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

   The Governor accepted the recommendation and provided the following response:

   'It should be noted that the [man's] family had spent a significant amount on time with [him] on a number of previous weekends leading up to his death. They had been informed of his deteriorating condition following advice by HC to the FLO to contact the family. Visits had been facilitated and the prison accommodated the family outside of visits protocol to make things easier for them. All three of the prison's FLOs attended the prison at different times on a weekend meeting the family, liaising between staff and the family and ensuring any concerns they had were addressed. Regular contact was also maintained between visits (logged on FLO log). There are systems in place to ensure prisoner's families are informed as soon as possible when a prisoner becomes seriously ill.'

5. The Governor should introduce a local policy to allow a dying prisoner's family to remain with him in the healthcare centre overnight.

   The Governor accepted the recommendation and provided the following response:

   'Each particular case should be risk assessed in order to make an informed decision on individual cases. Security considerations should be given to the prisoner, visitors, resources etc without having a unilateral refusal.'

6. The Governor should ensure that letters to bereaved families are personally signed.

   The Governor accepted the recommendation and provided the following response:

   'The Head of Safer Prisons ensures a letter is drafted which is appropriately worded and personal in tone, which the Governor will read and personally sign. In the case of a long term absence of the Governor from the establishment, the Deputy Governor will sign.'