Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr Ronald Harper, a prisoner at HMP Frankland, in April 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ronald Harper died of pneumonia and kidney disease in hospital in April 2015, while a prisoner at HMP Frankland. He was 77 years old. I offer my condolences to those who knew him.

The investigation found that Mr Harper received a high standard of care at Frankland, despite his refusal of treatment for kidney failure. Nurses were caring and compassionate, and provided good end of life care. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2015**

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Summary

Events

1. In 1974, Mr Ronald Harper received a life sentence for sexual offences and murder. He received an additional life sentence in 2000. He had been at HMP Frankland since 2002.

2. Mr Harper had a number of health problems and, in 2010, a prison GP diagnosed kidney atrophy (kidney shrinkage) and referred Mr Harper to a kidney specialist. Healthcare and hospital staff regularly reviewed and monitored Mr Harper's condition, which deteriorated over time. In May 2013, a prison GP diagnosed stage 5 chronic kidney disease, indicating his kidneys had lost almost all their function. In October 2013, he had a blood transfusion, which stabilised his condition for a while.

3. In January 2014, Mr Harper's condition deteriorated but he did not want any treatment or to be resuscitated if his heart or breathing stopped. He signed an order that effect, after he was assessed to have mental capacity.

4. Prison and hospital staff managed Mr Harper's condition with medication and regular blood tests. On 4 April 2015, Mr Harper was taken to hospital with low oxygen saturation, lethargy and shortness of breath. Doctors diagnosed deep vein thrombosis in his left leg, a collapsed lung and kidney failure. Mr Harper was treated with intravenous fluids and oxygen but refused treatment for kidney failure. His condition declined and he died in hospital.

Findings

5. We are satisfied that Mr Harper received a high standard of care at Frankland. Nurses were caring and compassionate throughout his illness. His end of life care was very good. The clinical reviewer concluded that the care he received was equivalent to that he could have expected to receive in the community.

6. Commendably, the prison implemented a thorough risk management plan, which took account of Mr Harper's health and mobility when it became evident that his health was deteriorating. This meant that Mr Harper was not restrained when he went to hospital.

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The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Harper's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Harper's clinical care at the prison.

10. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. Mr Harper had not named a next of kin and the prison and coroner were unable to find any family.

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

13. The prison received a copy of the draft report; they noted one factual inaccuracy regarding the open door policy, which has been corrected.

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Background Information

HMP FRANKLAND

14. 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. Until April 2015, Care UK was the healthcare provider. This is now G4S. 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. Until April 2015, Care UK was the healthcare provider. This is now G4S.

HM Inspectorate of Prisons

15. The most recent inspection of Frankland was in December 2012. Inspectors 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

16. 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 said the quality of healthcare services was good and Frankland had reduced the number of staff vacancies that had affected the delivery of services earlier in the year. The IMB was very positive about palliative care at the prison.

Previous deaths at HMP [prison]

17. Mr Harper was the seventh prisoner to die from natural causes in the last two years at Frankland. We have previously recognised the high standard of end of life care at Frankland.

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Findings

The diagnosis of Mr Harper's terminal illness and informing him of his condition

18. In 1974, Mr Ronald Harper was sentenced to life imprisonment for sexual offences and murder. He received a further life sentence in 2000. He had been at HMP Frankland since January 2002. He was a life-long smoker and did not want help to give up. He had a number of health problems, including a stroke in 2005 and a heart attack in 2009. He had been diagnosed with chronic congestive heart failure since 2010. He also had asthma, sciatica, and osteoarthritis.

19. On 3 August 2010, a prison GP examined Mr Harper, who had chest pain and sent him to hospital. In hospital, doctors diagnosed Mr Harper with kidney atrophy. Over the next three years prison healthcare and the hospital nephrology (kidney) clinic monitored Mr Harper's condition with regular reviews and blood tests. His condition deteriorated to stage 4 kidney disease (advanced kidney damage and seriously reduced function).

20. On 30 May 2013, a prison GP reviewed Mr Harper's blood test results and noted his kidney function had declined. He now had stage 5 chronic kidney disease, which meant he was in established renal failure. The GP made an urgent referral to the nephrology clinic. On 25 July, Mr Harper attended the nephrology clinic at hospital, where his diagnosis was confirmed. Healthcare staff explained his condition and treatment to Mr Harper.

21. We are satisfied that healthcare staff looked after Mr Harper well once his kidney disease was diagnosed. He had regular reviews and blood tests and prison healthcare and hospital staff worked together to ensure his condition was effectively monitored. He received a timely diagnosis of renal failure.

Mr Harper's clinical treatment

22. On 20 September 2013, a consultant nephrologist reviewed Mr Harper's medication and symptoms and said he would benefit from a blood transfusion. He agreed that it would be appropriate to involve the palliative care team because of his multiple conditions and renal failure. Nurses informed Mr Harper that they had referred him to a Macmillan specialist nurse. He had the blood transfusion on 11 October, which enabled him to remain relatively stable for some time. Healthcare staff continued to monitor him regularly.

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23. On 9 January 2014, a prison GP noted Mr Harper was deteriorating; he was confused and had not been eating or drinking. The GP spoke to a consultant nephrologist at the hospital, who said he would discuss the possibility of dialysis with the renal team. Mr Harper was considered to be in end stage renal failure and said he did not want any further treatment. A nurse assessed Mr Harper's mental health and was satisfied he had capacity to make his own decisions about his treatment.

24. On 15 January, Mr Harper told a Macmillan specialist in palliative care that he did not want any treatment for his condition or to be resuscitated if his heart or breathing stopped. On 31 January, he signed a do not resuscitate order. In February, Mr Harper was dehydrated and treated in hospital with intravenous fluids and had a catheter fitted.

25. Between February and November, Mr Harper's condition continued to deteriorate and he became unable to care for himself. He had regular blood tests to monitor his condition, but continued to refuse medication or treatment for kidney failure. On 8 December, blood tests indicated that Mr Harper needed a blood transfusion, but he refused. Later that month he agreed to a transfusion, which he had in hospital on 30 December.

26. On 29 January 2015, at a multidisciplinary meeting, Mr Harper reiterated that he did not want to be resuscitated. He declined to attend hospital for any treatment, including dialysis, kidney transplant or blood transfusion. Nurses told him that he could have blood transfusions at Frankland, but he refused to consider this. He said he wanted to receive end of life care at the prison.

27. On 2 March, a prison GP examined Mr Harper and diagnosed fluid on the lungs (pulmonary oedema). He discussed the possibility of dialysis again with Mr Harper and said it would improve his breathing. Mr Harper agreed to treatment, but not dialysis. The doctor consulted a nephrologist, who advised increased medication and close monitoring of fluid intake and output.

28. On 4 March, at a multidisciplinary meeting, Mr Harper said he wanted treatment to make him comfortable, such as for his swollen legs and breathlessness, but did not want to be admitted to hospital. Healthcare staff documented an advance directive to refuse treatment in his care plan. However, on 4 April, Mr Harper agreed to go hospital when his oxygen saturations were low and he was short of breath.

29. In hospital, Mr Harper was treated for a deep vein thrombosis in his left leg and pneumothorax (collapsed lung). He refused any treatment for kidney failure and received intravenous fluids and constant oxygen. His condition continued to decline and he was never well enough to return to the prison. He died in hospital.

30. The coroner gave the cause of death as pneumonia, severe acute chronic kidney disease, left ventricular failure and previous heart attack.

31. We agree with the clinical reviewer, that Mr Harper received good care at Frankland. The nursing and medical care throughout his illness, but particularly during the palliative stage was of a high standard.

Mr Harper's location

32. Mr Harper wanted to stay on his wing for as long as possible and officers and healthcare staff did their best to support him. When his health deteriorated on 7 January 2014, he agreed to move to the prison's inpatient unit. In February 2015, he told a Macmillan specialist that wanted to die at Frankland. On 28 February, he moved to a palliative care cell in the healthcare unit, which had a walk-in shower, hospital bed, and easy chair. Arrangements were made for Mr Harper's door to be left open at all times if needed and was in place for his anticipated return from hospital in April.

33. After his admission to hospital on 4 April 2015, his health deteriorated quickly and he was too ill to return to Frankland. We are satisfied that Mr Harper was located appropriately, throughout his illness and that the prison staff took account of his preferences and did their best to meet them.

Restraints, security and escorts

34. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

35. On 28 February 2014, the Head of Security completed a risk management plan detailing Mr Harper's risk of harm, risk of escape and current health. The management plan stated that restraints should not be used for any future escorts

because of Mr Harper's poor health and mobility. Prison managers regularly reviewed the plan.

36. We are satisfied that there was a comprehensive and considered risk management plan, which clearly took into account how Mr Harper's condition affected his risk of escape. We commend Frankland's proportionate approach, which was consistent with legal guidance for the use of restraints for seriously ill prisoners. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility.

Liaison with Mr Harper's family

37. Mr Harper did not name a next of kin and had no contact with any friends in the community. He said that there was no one he wanted to be informed of his illness or death. After Mr Harper died, the prison and coroner were unable to trace any family. The prison arranged his funeral.

Compassionate release

38. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. Mr Harper made it clear that he did not want to be considered for compassionate release.