Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Matthews, a prisoner at HMP Frankland, on 13 October 2019

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 Brian Matthews died of a heart attack on 13 October 2019 while a prisoner at HMP Frankland. He was 72 years old. I offer my condolences to Mr Matthews' family and friends.

Mr Matthews had a number of long-term medical conditions. He repeatedly declined to attend healthcare reviews or assessments to manage his conditions and did not always take his medication. Healthcare staff encouraged him to attend his appointments and explained the risks of not doing so.

The clinical reviewer considered that his care was of a good standard. However, she was not satisfied that it was wholly equivalent to that which he could have expected to receive in the community because she considered that healthcare staff did not pursue Mr Matthews' reasons for not attending his long-term health appointments and there was no policy in place at Frankland to promote attendance at long-term condition clinic appointments.

I am concerned that the decision to use restraints on Mr Matthews during his admission to hospital on 12 October was unjustified and did not take account of his deteriorating health or level of risk.

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

Sue McAllister CB
Prisons and Probation Ombudsman **May 2020**

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Summary

Events

1. On 5 May 2006, Mr Brian Matthews was sentenced to life imprisonment for murder. On 18 May 2016, he was transferred to HMP Frankland.

2. Mr Matthews had type 2 diabetes and had previously had three strokes and a heart attack. He was prescribed appropriate medication but, despite the advice of healthcare staff, he consistently refused to attend healthcare reviews or assessments for the management of his long-term medical conditions.

3. On the afternoon of 12 October 2019, Mr Matthews collapsed outside his cell. An officer called a medical emergency code and healthcare staff attended. Control room staff called an emergency ambulance. Healthcare staff gave Mr Matthews oxygen and monitored him until the paramedics arrived.

4. Mr Matthews was taken to hospital by emergency ambulance. He was escorted by two officers and restrained using an escort chain.

5. At 2.25am on 13 November, it was confirmed that Mr Matthews had died.

6. A post-mortem examination gave Mr Matthews' cause of death as a heart attack.

Findings

7. The clinical reviewer considered that the care Mr Matthews was offered for his long-term conditions was of a good standard. However, she did not consider that his care was wholly equivalent to that which he could have expected to receive in the community because there is no evidence that staff pursued Mr Matthews' reasons for not attending his appointments, and there is no policy in place to promote prisoners' attendance at 'long-term condition' healthcare appointments.

8. The clinical reviewer concluded that the care and treatment Mr Matthews received during the emergency response was equivalent to that which he could have expected to receive in the community.

9. Control room staff called an emergency ambulance after Mr Matthews collapsed. The ambulance arrived at Frankland at 3.17pm but did not get to Mr Matthews' cell until 3.30pm, a delay of 13 minutes.

10. We are concerned, that following Mr Matthews' final admission to hospital on 12 October 2019, he was restrained using an escort chain. We do not consider it was appropriate or proportionate to use restraints, given Mr Matthews was 72 and had just had a heart attack and was seriously ill. We are concerned that healthcare staff did not provide full and accurate information about Mr Matthews' current state of health to enable prison managers to make a justifiable decision.

Recommendations

- The Head of Healthcare should ensure that there is a policy in place to promote prisoner's attendance at 'long-term conditions' clinic appointments.
- The Governor should ensure that there are plans in place to escort ambulance personnel to prisoners as quickly as possible in a medical emergency.
- The Governor and Head of Healthcare 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.
- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
    - healthcare staff must provide information on the prisoner's current state of health and mobility; and
    - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

The Investigation Process

11. 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.

12. The investigator obtained copies of relevant extracts from Mr Matthews' prison and medical records.

13. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at the prison.

14. We informed HM Coroner for County Durham and Darlington of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers wrote Mr Matthews' next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Matthews' next of kin did not respond to our letter.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies however they did not accept recommendation 2, relating to the use of NEWS during the emergency response. After consideration and consultation with the clinical reviewer, the recommendation and all references to it have been removed. The remaining recommendations were accepted and the Prison Service action plan is annexed to this report.

Background Information

HMP Frankland

17. HMP Frankland is one of eight high security prisons in England and Wales. It holds up to 844 men. There is 24-hour inpatient care. G4S Forensic & Medical Services provide general nursing services and substance misuse services. Spectrum Healthcare provides GP and pharmacy services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Frankland was in January 2020, although the report has not yet been published. The previous inspection was in March 2016. Inspectors reported then that while healthcare provision was reasonably good, staffing issues were impacting on care delivery. They noted that prisoners had access to a range of primary care services and visiting specialists and that appropriately trained staff regularly reviewed prisoners with long-term conditions.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2018, the IMB noted that healthcare staff had experienced a challenging year following the departure of the Head of Healthcare and the issue of a warning notice by the Care Quality Commission. A new Head of Healthcare had now been appointed.

20. Recruitment of nursing staff continued to cause concern although the employment of full-time agency staff had helped. Waiting times for appointments for 'outpatient' services had improved but the actual time that prisoners had to wait when attending appointments was unacceptable. Two new officer posts had been approved to assist the movement of prisoners between the wings and healthcare.

21. Prisoners entering Frankland with existing or undiagnosed mental health issues, those using psychoactive substances and the elderly prisoner population continued to place increased demand on both prison and healthcare staff.

Previous deaths at HMP Frankland

22. Mr Matthews was the seventh prisoner to die at Frankland in the last two years. Six of those deaths were from natural causes. There have been two further deaths from natural causes since Mr Matthews' death.

Key Events

23. On 5 May 2006, Mr Brian Matthews was sentenced to life imprisonment for murder, with a 30-year tariff. He was sent to HMP Forest Bank. On 18 May 2016, Mr Matthews was transferred to HMP Frankland.

24. Mr Matthews had a number of pre-existing medical conditions including type 2 diabetes, diagnosed in February 2001, three strokes in 2000 and a heart attack in 2001, for which he took appropriate medication. Mr Matthews consistently refused to attend healthcare reviews and assessments relating to the management of his long-term medical conditions.

25. In 2009, Mr Matthews stopped attending both eye and foot assessments which formed part of the assessments for managing his diabetes. He continued to attend diabetic reviews twice a year until 2014, after which he declined to attend all appointments offered to him. Despite the efforts of healthcare staff to engage with Mr Matthews and make him aware of the risks posed to his long-term health, he declined to attend all long-term condition clinics, including assessments for chronic heart disease. Healthcare staff continued to offer Mr Matthews annual reviews, both in person and by letter (most recently on 5 April 2019).

26. On 21 November 2018, a prison GP saw Mr Matthews to review his medication. Mr Matthews wanted codeine (an opiate) for pain management. The prison GP told him that this was not appropriate but Mr Matthews refused to try any other medication. Mr Matthews told the prison GP that he had recently noticed blood in his urine and agreed to take a blood and urine test. The prison GP highlighted the possibility of prostate issues and of the need to exclude prostate cancer but Mr Matthews refused a urology referral. He told the prison GP that he took his medication as prescribed and agreed to take the blood test.

27. On 28 November, a nurse reviewed Mr Matthews' medication compliance and noted that he did not take his medication for his diabetes as prescribed. She recommended a review of his chronic diseases but Mr Matthews refused.

28. On 18 December, a nurse reviewed Mr Matthews' diabetes in line with his care plan. He noted Mr Matthews' continued refusal to attend diabetic reviews, assessments, tests or screenings.

29. On 2 January 2019, Mr Matthews was offered help to stop smoking but he declined the offer. On 25 January, he refused to attend for a planned blood test.

30. On 2 February, Mr Matthews attended the medication hatch and asked a nurse to take his blood pressure, the results of which were normal.

31. On 5 April, a prison GP reviewed and authorised Mr Matthews' medications but noted his continued refusal to take a blood test. Mr Matthews had no further significant contact with healthcare staff.

32. In March and April, Mr Matthews told his key worker that he was not interested in participating in rehabilitation programmes as he would be in his 90s before he was eligible for parole and "would be dead by then". He was on the enhanced

regime and was visited every day by his next of kin, and said he was happy doing hobbies and a bit of cooking.

33. At around 2.42pm on 12 October, Mr Matthews collapsed outside his cell. A prisoner helped him into his cell and onto his bed. The prisoner alerted staff and told an officer that Mr Matthews had fallen.

34. Th officer went to the cell and described Mr Matthews as breathing, conscious, distressed, disorientated and looking unwell. He radioed an emergency code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and was joined immediately by other officers. They monitored and reassured Mr Matthews. The control room requested an emergency ambulance.

35. Prison healthcare staff arrived at 2.44pm and examined Mr Matthews. He was breathing but unresponsive, cold and clammy with a grey pallor. A slight pulse was detected. Healthcare staff gave Mr Matthews oxygen. His blood pressure was low so they sat him up and raised his legs.

36. Healthcare staff continued to monitor Mr Matthews' vital signs. They did an electrocardiogram (ECG - a test used to check the heart's rhythm and electrical activity), which indicated that Mr Matthews had had a heart attack. Mr Matthews became more alert and started to talk. He said that he had a pain in his chest and was given aspirin under his tongue. His blood pressure remained low.

37. Mr Matthews' son, also a prisoner at Frankland, was brought from the gym to be with his father.

38. At approximately 3.13pm, the North-East Ambulance Service contacted the prison requesting that the emergency ambulance response be downgraded because Mr Matthews was now alert and breathing. A nurse said that Mr Matthews remained very ill and insisted the ambulance continue as an emergency.

39. The ambulance arrived at Frankland at 3.17pm. The ambulance crew arrived at the wing at 3.30pm, and took over Mr Matthews' care and treatment.

40. At 4.12pm, Mr Matthews was taken to hospital by emergency ambulance. He was escorted by two officers and restrained using 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.)

41. Prison healthcare staff remained in contact with hospital staff and obtained updates about Mr Matthews' condition and treatment. At 7.00pm, escort officers removed the escort chain and restraints were not reapplied.

42. At 2.25am on 13 October, it was confirmed that Mr Matthews had died.

Contact with Mr Matthews' family

43. At approximately 6.10pm on 12 October, the prison appointed a Custodial Manager (CM) as the prison's family liaison officer (FLO). At 7.08pm, the FLO telephoned Mr Matthews' wife and told her that Mr Matthews had collapsed in

prison and was in hospital. Mr Matthews' wife said that she already knew because her son, also a prisoner at Frankland, had telephoned her. The FLO telephoned Mr Matthews' next of kin and arranged for the family to visit Mr Matthews in hospital. The family arrived at the hospital shortly after midnight and were present when Mr Matthews died.

44. The FLO spoke to Mr Matthews 'next of kin later that morning and again the next day. She told him that the prison chaplain had told Mr Matthews' son about his father's death and that she had also been to see him. Mr Matthews' next of kin asked if Mr Matthews' son could be released to attend the funeral. She kept in contact with Mr Matthews' wife and next of kin and arranged the return of his property.

45. Mr Matthews' funeral was held on 7 November. Mr Matthews' son was released on temporary licence to attend the funeral and the FLO remained in contact with him at the prison to offer support. The prison contributed towards the funeral costs in line with Prison Service instructions.

Support for prisoners and staff

46. After Mr Matthews' death, a prison manager debriefed the staff involved in the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support.

47. The prison posted notices informing other prisoners of Mr Matthews' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Matthews' death.

Post-mortem report

48. A post-mortem examination gave Mr Matthews' cause of death as acute myocardial infarction (a heart attack).

Findings

Clinical care

49. Mr Matthews had a number of health conditions for which he had declined treatment. Healthcare staff respected Mr Matthews' decision not to attend health assessments, screenings and reviews and made him aware of the long-term risks to his health of not doing so.

50. However, the clinical reviewer concluded that although the care Mr Matthews was offered in relation to his long-term conditions was of a good standard, she was not satisfied that his reasons for not attending long-term health assessments were adequately pursued by healthcare staff. She also found that Frankland does not have a policy in place for prisoners who continually decline treatment. She therefore concluded these aspects of Mr Matthews' care were not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

    The Head of Healthcare should ensure that there is a policy in place to promote prisoners' attendance at 'long-term conditions' clinic appointments.

Emergency response

51. A code blue medical emergency was called at 2.42pm and control room staff called an emergency ambulance. Despite confirmation from healthcare staff that they needed an emergency ambulance, it did not arrive at the prison until 3.17pm.

52. Although this initial delay cannot be attributed to staff at the prison, the ambulance did not get to Mr Matthews' cell until 3.30pm, a delay of a further 13 minutes.

53. Frankland is a high security prison. There are two electronically controlled security gates at the entrance. An officer accompanied the ambulance from the second security gate, through three manually controlled vehicle gates, to the healthcare compound, arriving at 3.21pm. The ambulance crew unloaded their equipment onto a stretcher and made their way on foot to Mr Matthews' cell, through three locked internal doors.

54. The clinical reviewer could not confirm how or if the delay impacted on Mr Matthews' death but she was satisfied that the care he received during the emergency response was of a good standard. We make the following recommendation:

    The Governor should ensure that there are plans in place to escort ambulance personnel to prisoners as quickly as possible in a medical emergency.

Use of restraints

55. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public when escorting prisoners outside prison,

but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary in the circumstances and decisions should be based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

56. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

57. The risk assessment for Mr Matthews' admission to hospital on 12 October was signed by a senior manager at Frankland. Mr Matthews, who was a Category B prisoner, was assessed as being a medium risk to the public, and a low risk of escape. There were no objections from medical staff to the use of restraints and they did not consider that Mr Matthews' condition restricted his ability to escape unaided. Two officers accompanied Mr Matthews to hospital and he was restrained using an escort chain.

58. We are surprised that healthcare staff considered that a man of 72, who had just had a heart attack and was still very ill, had the ability to escape unaided from two escort officers. Despite that advice, the senior manager assessed that Mr Matthews posed a low risk of escape. In these circumstances we are concerned that he decided that Mr Matthews should be restrained.

59. We also accept that the decision on whether or not to use restraints rests with prison staff and not with healthcare staff. However, we are concerned that the member of healthcare who completed the healthcare section of the risk assessment form did not understand the legal position and their responsibility to provide accurate information about Mr Matthews' current state of health to enable prison staff to make a justifiable decision.

60. We are satisfied that at 7.00pm, after Mr Matthews' admission to hospital, a prison manager appropriately authorised the escort chain to be removed. As a result, Mr Matthews was not restrained when he died.

61. We make the following recommendation:

The Governor and Head of Healthcare 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.

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**

- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

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