Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Wayne Mansfield, a prisoner at HMP Frankland, on 7 November 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*

# Summary


1. 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.

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

3. Mr Wayne Mansfield died of community-acquired pneumonia on 7 November 2019 while a prisoner at HMP Frankland. The removal of his pancreas after pancreatic cancer and frailty contributed to but did not cause his death. He was 44 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Mansfield received was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations, neither of which relate directly to Mr Mansfield's death, but which the Head of Healthcare will need to address.

5. We have made one non-clinical recommendation about restraints.

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


### Recommendations

- The Governor and Head of Healthcare should ensure that:

  - nursing staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and

  - prison managers regularly review the level of restraints used on prisoners in hospital.

# Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Mansfield's clinical care at HMP Frankland.

8. The PPO investigator investigated the non-clinical issues in Mr Mansfield's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Mansfield's next of kin, to explain the investigation. Mr Mansfield's next of kin asked a number of questions about his clinical care, the decline in his health and his refusal to have treatment which are addressed in this report and the clinical review. They also had concerns about the cancellation of prison visits and alleged verbal abuse by prison staff in the weeks before his death. While these concerns do not directly relate to the circumstances of Mr Mansfield's death, we have addressed them in separate correspondence.

10. Mr Mansfield's next of kin received a copy of the initial report. They pointed out two factual inaccuracies in the initial report which have been amended accordingly.

11. We shared the initial report with the Prison Service. There were no factual inaccuracies.

### Previous deaths at Frankland

12. Mr Mansfield was the ninth prisoner to die at Frankland since November 2017. Seven of those deaths were from natural causes. There have been four further deaths from natural causes at Frankland since Mr Mansfield's death. We made a recommendation in March 2020 about the use of restraints on a prisoner who died three weeks before Mr Mansfield.

# Key Events

13. On 10 October 2013, Mr Wayne Mansfield was sentenced to seventeen years in prison for sex and violence offences. In June 2014, he was transferred to HMP Frankland.

14. In 2017, Mr Mansfield had cancer of the pancreas, which was removed by surgery.

15. In June 2019, Mr Mansfield's health deteriorated. He was underweight, was frail had diabetes and poor mobility, but refused healthcare admission, treatment and medication, despite regular input from a specialist diabetes nurse

16. On 26 September, Mr Mansfield went to hospital because he had seriously abnormal blood test results and his health had deteriorated further. Before he went to hospital, prison staff completed an escort risk assessment. A nurse noted that Mr Mansfield did not have impaired mobility. Mr Mansfield was a Category B prisoner, and a Custodial Manager (CM) assessed him as posing a medium risk to the public, to hospital staff, of receiving outside assistance and of escape. The Deputy Governor authorised that he should be restrained by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). When he went to hospital, he was restrained and there is no record that the level of restraints was reviewed or removed while he was in hospital.

17. Hospital staff treated Mr Mansfield for malnutrition and on 4 October, he returned to Frankland. He went to the healthcare inpatient unit, where he continued to refuse treatment for his diabetes.

18. At 8.30am on 5 November, a Healthcare Assistant (HCA) found Mr Mansfield unresponsive. Healthcare staff treated Mr Mansfield for low blood sugar levels.

19. At 9.09am, paramedics arrived at Frankland and Mr Mansfield went to hospital, unrestrained. On 7 November, Mr Mansfield died in hospital. A hospital doctor established that Mr Mansfield died from community-acquired pneumonia and that the removal of his pancreas after pancreatic cancer and frailty contributed to but did not cause his death.

# Findings on non-clinical issues

### Use of restraints

20. When prisoners leave 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.

21. 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.

22. When Mr Mansfield went to hospital on 26 September, he was frail and had poor health. We are satisfied that the CM carried out a good assessment of Mr Mansfield's risk, but the nurse noted that he did not have impaired mobility which contradicts the evidence in the clinical review. We are satisfied that Mr Mansfield was restrained when he went to hospital, but we could not find any evidence that the use of restraints was reviewed while he remained in hospital and it appears that he was restrained throughout his hospital stay, a period of nine days. Officers who were with Mr Mansfield in hospital noted that he had poor health and mobility and his medical records show that the use of restraints caused significant swelling and bruising to his wrists.

23. In April 2020, Frankland agreed to implement a recommendation we made about the use of restraints on a prisoner who died three weeks before Mr Mansfield. While we welcome this, there were two areas that Frankland's action plan did not cover: the need for nursing staff to completing the medical section of the escort risk assessment accurately, particularly in relation to prisoners' health and mobility, and the need for prison managers to review regularly the level of restraints used on prisoners in hospital. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that:**

- **nursing staff accurately reflect the current health and mobility of a prisoner when they complete an escort risk assessment; and**

- **prison managers regularly review the level of restraints used on prisoners in hospital.**

**Caroline Mills** **April 2021**
**Assistant Ombudsman**