Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Murray, a prisoner at HMP Frankland, on 29 February 2020

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

3. Mr Lee Murray died of lung cancer on 29 February 2020 at HMP Frankland. He was 46 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Murray received at Frankland was equivalent to that which he could have expected to receive in the community.

5. Mr Murray had an order in place not to be resuscitated if his heart or breathing stopped. Despite this, three emergency ambulances were inappropriately sent to the prison. We are satisfied that Frankland has since reviewed and changed its emergency response procedures for prisoners with an order in place not to be resuscitated. However, we are concerned that healthcare staff considered it necessary for an ambulance paramedic to verify Mr Murray's death when it was clear that he had died. While we note that Frankland has since trained a number of nurses to confirm death, we would like some reassurance that enough staff have received training.

6. We did not identify any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that sufficient nursing staff are trained to confirm that a prisoner has died.

Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Murray's clinical care at HMP Frankland. The clinical review is attached to this report at Annex 1.

8. The PPO investigator has investigated the non-clinical issues in Mr Murray'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 Murray's next of kin to explain the investigation. She had no specific questions.

10. We shared the initial report with the prison service. There were no factual inaccuracies and their action plan has been appended to this report.

11. Mr Murray's next of kin received a copy of the initial report. She asked a number of questions that did not impact on the factual accuracy of this report and have been addressed through separate correspondence.

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

Previous deaths at Frankland

13. There were seven deaths from natural causes and one self-inflicted death at HMP Frankland in the two years before Mr Murray's death and two deaths from natural causes after Mr Murray's death. In one of the deaths after Mr Murray's death, the emergency control room officer did not know that the prisoner had signed an order not to be resuscitated and therefore inappropriately arranged for an emergency ambulance to be called.

Key Events

14. Mr Lee Murray was convicted of assault in 2001 and sentenced to life in prison the following year. On 6 July 2015, he was transferred to HMP Frankland.

15. On 2 October 2019, a prison GP reviewed Mr Murray because he had abnormal blood test results. He told the prison GP that he had lost his voice and had a sore throat for three weeks. He also said that he had been coughing up sputum for a few days. The prison GP noted that he had a slight wheeze on both sides of his chest and referred Mr Murray to the respiratory department under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

16. Mr Murray frequently harmed himself in prison, and on 3 October, he injured his left arm. He was taken to hospital, where he was then referred to the respiratory team. Mr Murray remained in hospital and on 5 October, a consultant respiratory physician, told the prison GP that a chest x-ray indicated a shadow on his chest. On 7 October, Mr Murray returned to Frankland.

17. On 15 October, a Macmillan nurse told Mr Murray that he had lung cancer.

18. On 22 November, Mr Murray went to hospital for an outpatient appointment. A consultant oncologist told Mr Murray that the cancer had spread and was incurable. He declined chemotherapy but agreed to have radiotherapy to help reduce his pain.

Events of 29 February 2020

19. At 9.10am on 29 February 2020, an officer went into Mr Murray's cell to check on him. The officer saw that Mr Murray was not breathing and radioed a code blue (which indicates that a prisoner is unconscious or having difficulty breathing). Healthcare and prison staff went to Mr Murray's cell. A nurse found Mr Murray cold to touch, unresponsive and with black froth at his mouth. Mr Murray had an order in place not to be resuscitated so healthcare staff did not try to resuscitate him.

20. At 9.18am, an Operational Support Grade (OSG) who worked in the emergency control room, telephoned the ambulance service and asked for an emergency ambulance. The ambulance service operator said that three ambulances were making their way to the prison. The OSG said that she had not been aware that Mr Murray had an order in place not to be resuscitated.

21. At 9.22am, an ambulance arrived at the prison and at 9.45am, an ambulance paramedic confirmed that Mr Murray had died.

Findings

22. The clinical reviewer concluded that the clinical care that Mr Murray received at Frankland was equivalent to that which he could have expected to receive in the community.

23. The Head of Operations and Drug Strategy, said that after Mr Murray's death and the death of another prisoner in April 2020, who had also had an order in place not be resuscitated, she had reviewed the medical emergency procedures. She said that the officer in the emergency control room now had to check if a prisoner had an order in place not to be resuscitated when a code blue was called and that there was now a file in the emergency control room which contained this information. The Governor implemented these changes on 20 May. We therefore make no recommendation about this issue.

24. At the time of Mr Murray's death, there were no nurses qualified and competent to confirm that he had died. Healthcare staff who treated Mr Murray therefore needed an ambulance paramedic to verify that he had died.

25. On 1 April 2020, the contract for healthcare at Frankland transferred from G4S Forensic and Medical Services to Spectrum Community Health. On 4 May, Spectrum Community Health published a policy on the verification of adult expected deaths by registered nurses. The policy states that the Head of Healthcare should identify all experienced nurses who wish to verify death and ensure that they complete relevant online training and assessment.

26. The Head of Healthcare said that six nurses have been trained to confirm death since Mr Murray's death. He said that prison GPs could also verify the death of a prisoner.

27. We welcome the action taken but would like assurance that that a sufficient number of healthcare staff are now trained to meet Frankland's potential needs. We make the following recommendation:

    The Head of Healthcare should ensure that sufficient nursing staff are trained to confirm that a prisoner has died.

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