Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Matthison, a prisoner at HMP Frankland, on 3 November 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 Matthison died of bronchopneumonia and heart failure on 3 November 2020, while a prisoner at HMP Frankland. A stroke contributed to but was not the cause of Mr Matthison's death. He was 56 years old. We offer our condolences to those who knew him.

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

5. The clinical review found that Mr Matthison's long-term health needs and risks were assessed and reviewed in a timely manner and in line with National Institute for Health and Care Excellence (NICE) guidelines. The clinical reviewer also found that there was good communication between prison and healthcare staff.

6. The clinical reviewer has made one recommendation although not directly related to Mr Matthison's death, that the Head of Healthcare will need to address.

7. We have made a non-clinical recommendation about restraints.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertake 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.

Investigation Process

8. NHS England commissioned a clinical reviewer to review Mr Matthison's clinical care at HMP Frankland.

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

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

11. 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 HMP Frankland

12. Mr Matthison was the 20th prisoner to die at Frankland since February 2019. All the previous deaths have been from natural causes, five of which were related to COVID-19. We made two recommendations in March and October 2020 about the use of restraints.

Key Events

13. On 29 September 2017, Mr Steven Matthison was sentenced to 21 years in prison for sex offences and was sent to HMP Durham. On 30 August 2018, he was transferred to HMP Frankland.

14. Mr Matthison had complex medical needs. He had heart disease, constrictive pericarditis (inflamed heart tissue), atrial fibrillation (an abnormal and often fast heart rate), cirrhosis of the liver and a history of strokes.

15. On 1 May 2020, Mr Matthison signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped. On 4 July, Mr Matthison went to hospital because he had difficulty breathing. He was discharged back to Frankland on 7 July and hospital staff recorded that he had worsening symptoms of heart failure.

16. Mr Matthison went back to hospital briefly on 9 August and 28 August for investigation because of his deteriorating health. On 19 August, the prison convened the first multidisciplinary meeting to discuss Mr Matthison's palliative care.

17. The escort risk assessment (a prison assessment for using restraints for outside appointments) for Mr Matthison's hospital stay on 9 August, considered Mr Matthison's medical needs and risks. The prison could not find the risk assessment for his hospital visit on 28 August, so we do not know if or how he was restrained on that occasion.

18. On 15 October, healthcare staff moved Mr Matthison to a palliative care cell in the inpatient unit. On 20 October, a member of staff told Mr Matthison that end-of-life care had started as his condition was getting worse.

19. On 3 November, Mr Matthison died of bronchopneumonia and heart failure. A healthcare assistant was with him when he died.

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 considers 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 Matthison went to hospital on 28 August, he was in poor health and had impaired mobility. Frankland could not provide us with evidence of an assessment for the use of restraints. A safer custody officer, told the investigator it was possible that the risk assessment used by prison staff to escort Mr Matthison to hospital on 9 August, was also used for the hospital visit on 28 August. A risk assessment should be completed for each occasion that a prisoner leaves the prison and should include up-to-date information about the health of the prisoner.

23. In April 2020, Frankland agreed to implement a recommendation about the use of restraints following our investigation into a previous death in custody. In October 2020, we made a further recommendation about restraints. Frankland have not yet responded to this recommendation.

24. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertake 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.

Karen Johnson
Assistant Ombudsman **June 2021**