Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wyn Davies, a prisoner at HMP Frankland, on 18 April 2021

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 Wyn Davies died from throat cancer on 18 April 2021 at HMP Frankland. He was 69 years old. I offer my condolences to Mr Davies' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Davies received at Frankland was equivalent to that he could have expected to receive in the community. She made one recommendation.

5. Mr Davies had several hospital appointments in the three months before he died. He was restrained with an escort chain each time. We are concerned that the decisions to restrain Mr Davies when he was taken to his hospital appointments were unsound given his age, illness, and poor mobility. We have raised this issue in our last six investigations into deaths at Frankland as well as in previous investigations into deaths in 2019. The prison told us in response that they would review their risk assessment processes by June 2021, and we will expect to see improvements in future.

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 Head of Healthcare, in line with the national MUST recommendations, should ensure that MUST scores are completed so that the risk of malnutrition can be identified if there is an identified weight loss.

- The Head of Healthcare should ensure that healthcare contributions to escort risk assessments are accurate, sufficiently detailed and reflect the prisoner's current clinical condition.

- The Governor should ensure that authorising mangers take account of the healthcare input to escort risk assessments and that all decisions to use restraints on prisoners taken to hospital are proportionate to their risk.

The Investigation Process

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

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

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Frankland

10. Mr Davies was the 15th prisoner to die at Frankland since April 2019. All the previous deaths were from natural causes. We have previously made recommendations to Frankland about the inappropriate use of restraints in relation to six deaths in 2019 and 2020. The prison told us in response that a review of risk assessment procedures would be completed by June 2021.

Key Events

11. In April 2015, Mr Wyn Davies was sentenced to four years in prison for sexual offences. In April 2016, he was convicted of further sexual offences and was sentenced to 15 years and five months in prison. He was moved to HMP Frankland on 24 May 2018.

12. Mr Davies had a history of peripheral vascular disease (a blood circulation disorder) and had had previous vascular surgery on his leg. He used a walking frame to get about.

13. On 29 November 2020, Mr Davies told a prison nurse he had had earache for the last two weeks. The pain in his ear radiated into his neck, shoulder, and crown of his head. The nurse gave him paracetamol for the pain. The next day another nurse examined Mr Davies' ear but found nothing of concern. The nurse booked a review with the GP and noted that the plan was for Mr Davies to have a blood test and take paracetamol for the pain.

14. On 3 December, a GP reviewed Mr Davies' records noting nothing of concern, and indicated it was likely to be muscular. The GP encouraged physical exercises for Mr Davies' neck and shoulder pains.

15. On 22 December, the GP reviewed Mr Davies following his blood test results, which noted slightly raised platelets (cells in the blood which form clots to help stop and prevent bleeding). The GP noted this was borderline and could indicate an infection.

2021

16. A nurse reviewed Mr Davies five times in early to mid-January 2021 due to his ear pain, which he said was radiating down his neck leaving him unable to sleep. Nurses gave him paracetamol. On 18 January, Mr Davies was still complaining

of ear pain. A nurse reviewed him and noted swelling behind his ear and arranged for a GP review.

17. On 21 January, a GP saw Mr Davies due to his ear and neck pain. He noted that Mr Davies had lost weight and had a hoarse voice, but no swallowing issues. The GP documented the diagnosis as possible head and neck cancer. The GP referred Mr Davies to hospital under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

18. On 1 February, Mr Davies told a prison nurse he had difficulty eating and swallowing due to pain. The nurse checked his observations and noted that his oxygen saturation levels had dropped, his heart rate and respiratory rates were high, and his blood pressure was low. The nurse arranged for an ambulance to take Mr Davies to hospital. Two officers escorted him, and he was restrained using 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).

19. While in hospital, Mr Davies was diagnosed with throat cancer.

20. On 17 February, Mr Davies returned to Frankland. A prison GP discussed the diagnosis with Mr Davies. The GP told him that the cancer was inoperable, that any treatment would be palliative and not curative, and that he had months, rather than years, to live.

21. On 10 March, Mr Davies said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

22. Mr Davies told staff that he did not want early release and wanted to die in Frankland.

23. On 14 April, a GP noted that he was gradually deteriorating, and that pain was the main concern. Healthcare staff contacted a Macmillan Nurse for advice on his oral pain control. The GP also decided to swap Mr Davies to a syringe driver to manage his pain (a small battery powered pump which delivers medication through a tube into the skin).

24. On 18 April, at 2.20pm, Mr Davies died in the healthcare unit at Frankland.

Cause of death

25. The Coroner accepted the cause of death provided by a prison doctor and no post-mortem examination was carried out. The doctor gave Mr Davies' cause of death as metastatic squamous cell carcinoma of the oropharynx (throat cancer).

Non-Clinical Findings

Restraints, security and escorts

26. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and 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. 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.

27. The investigator reviewed Mr Davies' escort risk assessments from February and March 2021, for five of his hospital appointments. On every occasion Mr Davies was restrained, despite being elderly and a wheelchair user, and having a visual impairment (blindness in left eye). In all the escort risk assessments Mr Davies' risk factors were rated as 'low' (including risk of escape), except for risk to the public which was assessed as 'medium'. Each time a manager authorised the use of an escort chain.

28. Mr Davies' risk assessment from 1 February noted that there was a medical objection to the use of restrains, and that his medical condition restricted his ability to escape. However, no further details were given. There was no mention of Mr Davies being a wheelchair user or that he was on oxygen to help him breathe.

29. Mr Davies' risk assessment from 24 February noted that there was no medical objection to the use of restraints, that his current medical condition did not restrict his ability to escape unaided and that he did not have impaired mobility. This was inaccurate.

30. Mr Davies' risk assessment for 5 March noted that Mr Davies had impaired mobility but gave no details, though the risk assessments for 11 and 18 March did mention that he used a wheelchair. The risk assessments also noted that Mr Davies had been diagnosed with cancer on 28 February. We note an entry in Mr Davies' medical record on 4 March which says, "Noted that he was a frail underweight man who has a reduced mobility due to recent illness". We consider that this was not properly reflected by healthcare staff in the escort risk assessment.

31. We recognise that Mr Davies was a Category B prisoner. However, we are not satisfied that the use of restraints on Mr Davies was proportionate to the risks he posed. We consider that in the earlier risk assessments there was insufficient, and sometimes inaccurate, information provided by healthcare staff, which meant that the authorising manager did not have a full picture of Mr Davies' current state of health and mobility. In the later risk assessments, even though more healthcare information was provided, we are not satisfied that the authorising manager took this into account when authorising restraints. Mr Davies was an

elderly prisoner with reduced mobility who had a very low risk of escape and who was accompanied by two prison officers. We do not consider that the use of restraints was justified.

32. We have repeatedly made recommendations to Frankland about the inappropriate use of restraints, and particularly about inadequate contributions from healthcare staff to the escort risk assessments. We make the following recommendations:

The Head of Healthcare should ensure that healthcare contributions to escort risk assessments are accurate, sufficiently detailed and reflect the prisoner's current clinical condition.

The Governor should ensure that authorising mangers take account of the healthcare input to escort risk assessments and that all decisions to use restraints on prisoners taken to hospital are proportionate to their risk.

Louise Richards
Assistant Ombudsman **October 2021**

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