

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Naylor, a prisoner at HMP Frankland, on 17 December 2021

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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

OGI

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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 George Naylor died on 17 December 2021 of intracranial haemorrhage (bleed on the brain) while a prisoner at HMP Frankland. He was 77 years old. We offer our condolences to Mr Naylor's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Naylor received at Frankland was equivalent to that he could have expected to receive in the community. She found that the nursing team tried to engage with Mr Naylor on every aspect of his care, but he refused to cooperate on most occasions. She made four recommendations.
5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that staff put appropriate care plans in place and that where necessary, care plans are continued when a prisoner is moved from the inpatient unit to a standard wing.
- The Head of Healthcare should ensure that advice is sought from other services where a prisoner requires specialist care and that referrals are followed up.
- The Head of Healthcare should ensure staff use validated assessment tools to monitor prisoners at risk of malnutrition.
- The Head of Healthcare should ensure that prison healthcare staff verify death where appropriate to minimise the use of emergency services.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Naylor's clinical care at Frankland.
7. The PPO investigator has investigated non-clinical issues, including Mr Naylor's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO investigator and clinical reviewer jointly interviewed two healthcare staff.
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 Naylor was the 17th prisoner to die at Frankland since December 2019. All the previous deaths were from natural causes. We have previously made recommendations to Frankland about training sufficient nursing staff to verify death and monitoring prisoners at risk of malnutrition.

Key Events

11. In February 1999, Mr George Naylor was sentenced to life imprisonment for murder with a minimum tariff of 16 years and six months. He was moved to HMP Frankland on 25 April 2001.
12. Mr Naylor had complex health needs. He had Parkinson's Disease, progressive supranuclear palsy (a rare neurological condition caused by increasing numbers of brain cells becoming damaged over time that can cause problems with balance, movement, speech, vision and swallowing), chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases), atrial fibrillation (irregular heartbeat) and hypertension (high blood pressure).
13. Mr Naylor was diagnosed with probable progressive supranuclear palsy in February 2019 after he had recurrent falls. He refused to take the medication prescribed to him and refused to go for a scan until September 2020, when the diagnosis was confirmed. He was told that the main symptom was falls and there was no cure. Staff tried to encourage him to move to the prison's inpatient unit so they could monitor him more closely but often he refused to go and if he did, he would discharge himself back to a standard wing. By October 2021, nursing staff were checking on Mr Naylor four times a day as he was struggling to care for himself on the wing.
14. On 28 November, Mr Naylor asked to see a nurse. The nurse who attended noted that Mr Naylor was feeling dizzy, appeared disorientated, tired, and stiff. Mr Naylor agreed to go to the healthcare unit for observation but later decided to go back to the wing.
15. On 2 December, a nurse attended Mr Naylor's cell. Mr Naylor reported having pain to his ribs, which the nurse suspected was the result of a series of recent falls. Mr Naylor declined to move to the inpatient unit.
16. At 12.45pm on 9 December, Mr Naylor spoke to a prison nurse through his cell door and said he had fallen. Officers opened the door and allowed the nurse access to assess Mr Naylor, who then became aggressive towards her and declined care.
17. At 1.39pm, Mr Naylor consented to a healthcare assistant recording his physical observations, including his oxygen saturation (a measure of how much oxygen the blood is carrying) and heart rate. They were within normal range.
18. The prison GP recommended that healthcare staff continue to monitor Mr Naylor, encourage him to drink fluids, and get urine and blood samples. Healthcare staff assisted Mr Naylor into bed and attended to his personal needs. Mr Naylor continued to be aggressive to the healthcare staff.
19. At 5.14pm, after a deterioration in Mr Naylor's condition, healthcare staff requested an ambulance. The ambulance arrived at 6.00pm, by which time Mr Naylor was no longer able to communicate, and had a droop to his face suggesting a stroke. The ambulance took Mr Naylor to hospital.

20. The hospital called the healthcare department at Frankland and told them that Mr Naylor had suffered a brain aneurysm, had been transferred to the stroke unit, and was no longer conscious.
21. On 10 December, the hospital discharged Mr Naylor to the Palliative Care Suite at Frankland for end-of-life care.
22. Mr Naylor remained unconscious until his death on 17 December.

Cause of death

23. The Coroner accepted the cause of death provided by a prison GP and no post-mortem examination was carried out. The doctor gave Mr Naylor's cause of death as intracranial haemorrhage.

Louise Richards
Assistant Ombudsman

January 2023

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