

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Farrow, a prisoner at HMP Frankland, on 21 August 2023

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Stephen Farrow died of oesophageal cancer on 21 August 2023, while a prisoner at HMP Frankland. He was 58 years old. We offer our condolences to Mr Farrow's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Farrow received at Frankland was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.
5. However, when Mr Farrow attended hospital, restrained, on 18 April 2023, the medical information section of the escort risk assessment was not completed and the authorisation section for restraining him had not been signed and dated. There was no evidence to establish whether Mr Farrow's medical condition had been taken into consideration when deciding to restrain him.
6. Frankland did not explain why staff deviated from the escort risk assessment and why Mr Farrow's restraints were changed from 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) to a double cuff (when the prisoner's hands are handcuffed in front of them and one wrist is attached to a prison officer by an additional set of handcuffs). In the absence of evidence, we were unable to determine whether this decision was necessary or appropriate.

The Investigation Process

7. HMPPS notified us of Mr Farrow's death on 22 August 2023.
8. NHS England commissioned an independent clinical reviewer to review Mr Farrow's clinical care at HMP Frankland.
9. The PPO investigator investigated the non-clinical issues relating to Mr Farrow's care.
10. The PPO family liaison officer wrote to Mr Farrow's niece, his next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Frankland

12. Mr Farrow was the sixteenth prisoner to die at HMP Frankland since 21 August 2020. Of the previous deaths, 14 were from natural causes and one was self-inflicted. We have previously made a recommendation to ensure that healthcare staff complete the medical information section of the escort risk assessment. We have also previously recommended that security information on the escort risk assessment is fully completed.
13. Frankland agreed to implement both these recommendations. They told us that the Head of Operations had briefed nursing staff in May 2021 and had given them a copy of the Graham judgment which sets out that security risk must be balanced by considerations of care and decency when deciding whether to restrain a prisoner. Nursing staff also received training about recording medical information in the escort risk assessment. We were told that the training would be rolled out to new staff. Frankland said that they gave staff training in defensible documentation, and that this was monitored. In addition, Frankland told us that security and operational managers were aware of the need to ensure risk assessments were fully completed.

Key Events

14. On 2 November 2012, Mr Stephen Farrow received a whole life sentence for murder and burglary. He was transferred to HMP Frankland on 19 June 2017 and lived on the Westgate Unit which treats those with a severe personality disorder.
15. On 6 September 2022, a nurse saw Mr Farrow because he had difficulty keeping food down, he had lost weight and was unable to eat solid food.
16. On 8 September, a GP operating at Frankland urgently referred Mr Farrow for a blood test, chest X-ray and ultrasound scan. He also arranged for Mr Farrow's weight to be taken weekly for a month. He discussed the two-week wait referral (when cancer is suspected) with Mr Farrow. However, Mr Farrow refused the referral.
17. On 15 September, Mr Farrow refused to attend his healthcare appointment to discuss his blood test results.
18. On 21 October, a nurse reviewed Mr Farrow, and they discussed that his September blood test results were abnormal. They also discussed Mr Farrow's ongoing weight loss, loss of appetite, nausea and vomiting. She told Mr Farrow that he had been given a two-week wait referral for a hospital appointment. He agreed to the referral this time.
19. On 6 November, Mr Farrow felt very unwell and was admitted to hospital.
20. On 9 November, Mr Farrow was diagnosed with oesophageal cancer while in hospital. The hospital told healthcare staff that Mr Farrow needed a further scan and a stent (a small tube inserted surgically) to be inserted.
21. Frankland had started a family liaison log for Mr Farrow at the time of his cancer diagnosis in November, Mr Farrow said that did not have a next of kin and did not want anyone to be contacted.
22. On 20 December, hospital staff inserted Mr Farrow's oesophageal stent and arranged for him to have palliative chemotherapy to slow the progression of the cancer.
23. Between 11 January and 14 March 2023, Mr Farrow refused multiple offers to move to the healthcare unit.
24. On 7 February, a Macmillan nurse told Mr Farrow that the oncology team would not offer further treatment as he had declined to attend appointments. It was noted that Mr Farrow had mental capacity to make these decisions. She explained to Mr Farrow that he would receive palliative and supportive care, and his symptoms would be managed when they arose. Mr Farrow was initially shocked by this but then told her that he did not want to be or to die in pain.
25. On 28 February, Mr Farrow told his keyworker that he did not want to attend another hospital appointment to discuss his treatment options, and it should be cancelled. She advised Mr Farrow that it was unlikely that he would get another

appointment. Despite this, Mr Farrow still asked for the appointment to be cancelled.

26. On 15 March, Mr Farrow attended hospital after he reported that he had coughed up his stent. He vomited blood and could not tolerate fluids as a result. During this hospital admission, a do not attempt cardiopulmonary resuscitation (DNACPR) instruction was put in place for Mr Farrow.
27. On 18 March, Mr Farrow was moved to the prison's healthcare unit for palliative care.
28. On 23 March, Mr Farrow asked to return to the Westgate Unit to see his peers, and told staff that he wanted to spend his remaining time with friends. He was told that he could return to the healthcare unit at any point.
29. On 28 March, Mr Farrow told the Macmillan nurse that he wanted the family liaison officer to contact his family. (The family liaison officer recorded that she was told Mr Farrow would like contact with his niece in May and contacted her by phone and letter and arranged a visit.)
30. On 7 April, a nurse offered to send Mr Farrow to hospital because of his continuous vomiting and inability to keep food and fluids down. However, he refused. Healthcare staff initiated a syringe driver (a device which administers a continuous supply of medication).
31. On 18 April, Mr Farrow was admitted to hospital to reverse dehydration so an endoscopy could be considered after his significant vomiting over the previous 24 hours.
32. On 21 April, Mr Farrow returned from hospital, restrained with double handcuffs, and he was admitted to the healthcare unit. He told a nurse that his oesophageal cancer had spread to other parts of the body, and he wanted life-prolonging treatment.
33. On 2 May, Mr Farrow removed his syringe driver because he was stressed about non-healthcare related matters. At 3.32pm, he asked a nurse to reinsert the driver.
34. On 4 May, Mr Farrow moved back to the Westgate Unit.
35. On 20 June, Mr Farrow refused to attend a healthcare appointment to plan his computerised tomography (CT) scan.
36. On 22 June, Mr Farrow told the Macmillan nurse that he did not want to go ahead with radiotherapy, stating that he should 'let the cancer do what it has to do'.
37. On 20 July, there was a notable deterioration in Mr Farrow's condition. However, he declined a move to the healthcare unit. The Macmillan nurse created an end-of-life care plan for him.
38. On 21 July, Mr Farrow initially declined inpatient admission. However, he was then moved to the healthcare unit at 11:55am and given medication.

39. On 26 July 2023, staff on the Westgate Unit advised that they could no longer meet Mr Farrow's needs and he could not return there. Mr Farrow told a nurse that he did not want to have the DNACPR instruction in place and wanted full and active treatment. The palliative care team continued to provide support and the syringe driver remained in place.
40. On 27 July 2023, a GP operating at Frankland reviewed the DNACPR instruction but decided in Mr Farrow's best interests not to revoke it as any attempt at resuscitation would be futile.
41. On 17 August 2023, the family liaison officer facilitated a visit between Mr Farrow and his niece as she had been told of his deterioration.
42. On 21 August 2023, it was confirmed at 7.05pm that Mr Farrow had passed away.

Post-mortem report

43. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Farrow's cause of death as oesophageal cancer.
44. At an inquest held on 10 April 2024, the Coroner concluded that Mr Farrow died of natural causes.

Governor and Head of Healthcare to note

Restraints, security and escorts

45. We identified deficiencies in the completion of the escort risk assessment a number of months before Mr Farrow's death. Mr Farrow attended hospital on 18 April 2023, and when he was escorted back to Frankland on 21 April, he was restrained with a double cuff, even though the risk assessment said an escort chain should be applied (and upgraded to a single cuff if his behaviour deteriorated), the medical section was not completed, and the authorisation section was not signed and dated.
46. In the absence of completed documentation, we could not establish whether or not restraints were appropriately used.
47. We recognise that Mr Farrow was a high risk Category A prisoner, with a history of inappropriate behaviour at hospital, and he was not restrained again in the months before his death. We do not therefore make a recommendation about this on this occasion. However, we draw it to the attention of the Governor and Head of Healthcare, particularly in the context of the previous recommendations we have made and the action Frankland agreed to implement to address these same concerns.

Good practice

48. Frankland paid for Mr Farrow's niece to visit him in prison, including meeting the cost of her travel and an overnight hotel stay.
49. The minutes of Frankland's debrief after Mr Farrow's death were detailed and appropriately identified learning points.

Adrian Usher
Prisons and Probation Ombudsman

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