

**Investigation into the circumstances surrounding the death
of a man at HMP Frankland in February 2006**

Report by the Prisons and Probation Ombudsman for England and Wales

November 2006

This is the report of an investigation surrounding the circumstances of the death of a man in February 2006 at HMP Frankland. He was 75 years old and the post mortem indicates that he died from natural causes.

My colleagues and I extend our sincere condolences to this man's family and friends for their loss.

One of my investigators conducted the investigation. I am also indebted to the doctor who carried out a clinical review on behalf of Durham and Chester-le-Street Primary Care Trust.

I would like to thank the Governor of Frankland and his staff for their co-operation and assistance during the course of the investigation. I am particularly grateful to the member of staff who ensured that all the necessary documentation was made readily available.

Judged overall, the man was very well cared for by staff at Frankland. However, no consideration was given to his possible release on licence when his condition became terminal, and record keeping on the night of his death was not carried out.

My report includes two recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

November 2006

CONTENTS

Summary	4
Investigation methodology	5
Background	6
<i>HMP Frankland</i>	6
Events leading up to the man's death	7
24 February 2006	8
Issues arising from the investigation	9
Conclusions	11
Recommendations	12

Summary

1. The man at the centre of this report died at the age of 75 at HMP Frankland on the morning of 24 February 2006. He was serving a 25 year sentence imposed in 1998. He died in his sleep, following a long illness.
2. The man had many medical problems, and was located in the prison's healthcare centre where he received 24 hour nursing care. He was located in a ward, rather than in a single cell, as he had a large electric bed with many attachments which would not fit into a single cell.
3. The nurse on duty overnight says that the man was physically observed every 15 minutes throughout the night in order to monitor his breathing and check that his condition had not deteriorated. However, the decision to carry out these observations was not recorded in the medical record.
4. At approximately 5.05am on 24 February, the nurse says she noticed that the man had stopped breathing and called for another member of staff to confirm that this was the case. The Night Orderly Officer was asked to attend the healthcare unit and the nurse then went into the ward and confirmed that the man had died.
5. The post mortem found that the man died from natural causes as a result of:
 - 1a Acute pyelonephritis, bronchopneumonia and septicaemia.
 - 1b Idiopathic transverse myelitis.
6. My report makes two recommendations.

Investigation Methodology

7. My investigator was given access to all the man's prison records including his medical records. No formal interviews were conducted during the course of this investigation, but copies of statements made by staff were considered.
8. Notices to staff and prisoners were sent to the Governor to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express. My investigator received one letter from a prisoner who said he had information about the man's death. However, when the investigator spoke with him by telephone, it transpired that his information in fact related to other matters.
9. Durham and Chester-le-Street Primary Care Trust (PCT) was invited to undertake a review of the clinical care the man received while in custody, and this was undertaken by a doctor.
10. One of my family liaison officers contacted the man's widow and her niece to enable them to be involved in the investigation process. They were asked if they had any questions or concerns that they would like the investigation to consider. Both wanted clarification as to the cause of the man's death. They also enquired about the return of the man's possessions, a matter which has now been resolved by the prison.

Background

HMP Frankland

11. HMP Frankland is a maximum-security establishment holding Category A and Category B adult male prisoners. It became part of the high security directorate of the Prison Service in April 1983. Two further wings were opened in 1998, bringing the establishment's certified normal accommodation (uncrowded capacity) to 653. Prisoners are held in single cell accommodation in six wings, four of which house vulnerable prisoners. Frankland is one of only six establishments assessed by the Prison Service as being a 'High Performance Prison'.
12. The most recent full inspection report by HM Chief Inspector of Prisons, dated March 2003, describes Frankland as offering a safe environment, based upon good relationships between staff and prisoners. The inspection found good staff understanding of individual prisoners and their needs.
13. Following a short unannounced follow up inspection on 25 October 2005, HM Chief Inspector records that healthcare services at Frankland had improved since the full inspection. Primary care still needed development but staffing shortages had hindered progress. However, mental health services were under pressure although the mental health team was well structured with clear policies and practices. Some prisoners were held in the healthcare centre for no medical reason. Of the 12 healthcare recommendations made during the full inspection, nine had been fully achieved, one partially achieved, and two had not been achieved.
14. The healthcare services at Frankland are commissioned by the Durham and Chester-le-Street Primary Care Trust. The prison's healthcare centre has 18 beds, eight in four bed wards and the rest in single cells, all of which are linked to the office with a call bell system. Adjacent to the centre is the Listeners suite which is a large and comfortable two bedded room. (Listeners are prisoners trained by the Samaritans.)

Events leading up to the man's death

15. After being sentenced, the man was held first at HMP Exeter, transferring in March 1999 to HMP Wakefield. He was transferred again to HMP Frankland on 25 October 2000, remaining there until his death.
16. In 2001, the man developed a neurological condition which was thought to be transverse myelitis. It left him partially paralysed and requiring considerable nursing attention, in addition to repeated hospital admissions. In this man's case, the condition also resulted in loss of function below the waist with altered or absent sensation. His bowels and bladder were affected and he required an indwelling urinary catheter, because of the retention of urine.
17. The man was located in the healthcare centre in a shared ward with two other prisoners. He made regular visits to outside hospital for treatment and monitoring of his condition. His nursing care involved frequent turning to try to avoid pressure sores, monitoring of fluid balance and management of his urinary catheter. A specialist electrical bed was provided to help prevent pressure sores. The clinical review records the extent of the man's illness.
18. On 23 February 2006, the man's health appeared to be deteriorating as his breathing became laboured and he was very chesty. He appeared confused and was slurring his words. He asked to see his wife.
19. An entry that day in the man's medical record, timed at 8.15pm, by a Healthcare Officer says, "to monitor situation overnight and contact the duty M/O (medical officer) if required".
20. A nurse was on duty overnight and she reports that throughout the night the man was physically observed by the nursing staff every 15 minutes. This was to check his breathing and any deterioration in his condition. For security reasons, the observations were carried out from outside the ward and the man's bedside lamp was left switched on. The observations were not part of the nursing care plan nor were they recorded in the man's medical record.
21. The nurse says that the ward was unlocked three times during the night so that the man could be physically examined. My investigator has reviewed the control room logs where each unlock should be recorded. No entries have been made.
22. The only confirmation of the 15 minute observations and the three physical examinations is in the statements made by three members of prison staff after the man's death. (Following a death in custody, the staff involved are required to prepare a statement for the Governor, detailing what has occurred.) Two officers, as well as the nurse, have prepared statements which state that they either carried out the checks themselves or were aware of them being done by the nursing staff.

24 February 2006

23. According to the statements, the man was checked at 4:50am and seen to be breathing. At 5:05am, the nurse checked again and it appeared to her that his breathing had stopped. She asked an officer to look at the man with her to confirm that he was not breathing. Once they confirmed that this was the case, they called the Night Orderly Officer, a Principal Officer in the prison. The PO attended the healthcare centre at 5:10am and unlocked the ward, allowing the nurse to enter along with the officer.
24. The nurse checked the man's pulse. Judging that he had died, she asked for the doctor to be contacted. The doctor arrived at the healthcare centre at 6:00am and confirmed the death.
25. At 6:05am, the PO set in motion the requirements following a death in custody as required by Prison Service Order 2710. The two prisoners in the ward were woken up and taken out so that the room could be sealed. They were advised that the Listeners were available should they be needed. (As noted, Listeners are prisoners trained by the Samaritans to offer support to other prisoners at times of distress). The support of the chaplaincy team was also offered. Neither of the prisoners concerned has asked to speak to my investigator on the telephone or when he visited the prison. (Although I make no formal recommendation on this point, the Governor and Healthcare Manager will wish to consider if there are lessons here in terms of whether terminally ill patients could be accommodated in single cells or if fellow patients in a ward can be reallocated.)
26. A governor arrived at the prison and attended the control room to ensure that the contingency plans following a death in custody had been activated. The police were contacted at 5.25am; they arrived at the prison at 5.40am, leaving shortly thereafter. Scenes of Crime Officers arrived at the prison at 9.20am to take photographs and collect any evidence. Once this had been completed, the ward was relocked and sealed.
27. The man's wife was also a serving prisoner. The governor arranged for the Governor of her prison to inform her of her husband's death. At 6:40am, she then held a staff de-brief and advised that the care and welfare team was available should they be required. She also contacted the chaplaincy team as additional support for staff.
28. The undertakers arrived at the prison and removed the man's body at 10:40am.
29. The post mortem report concluded that the man had died of:-
- 1a Acute pyelonephritis, bronchopneumonia and septicaemia.
 - 1b Idiopathic transverse myelitis.

Issues arising from the investigation

The man's location

30. The man was located on a ward with two other prisoners, rather than in a single cell. This raised a concern as to whether this was the most appropriate location for him, and why he had not been provided with more privacy. However, I understand that the man needed a large electric bed with many attachments and this was too big for a single cell. Moreover, the single cells had insufficient power outlets for this type of equipment.
31. The prison did not consider releasing the man on temporary licence, or transferring him to a hospice. My investigator was told this was because he had only served eight years of a 25 year sentence and because of the serious nature of his offences. However, in line with PSO 6330, Release on Temporary Licence, consideration should have been given to releasing the man on compassionate grounds to a hospice. (It may well be that the necessary risk assessment would have found that the man could not be released, but the procedures should have been correctly followed.)

The Governor should ensure that all terminally ill prisoners are considered for compassionate release or temporary licence to an appropriate hospice. The necessary documentation should be completed and the decision made once all aspects of the application have been considered.

Quality of clinical care

32. The clinical reviewer judges that the man would have presented formidable problems for the nursing team. However, the care he received was as good as could have been achieved in the community. The reviewer comments that providing such levels of nursing care is not easy when dealing with a patient in a secure environment. He makes no recommendations, and considers that the nursing team should be commended for their efforts in caring for the man.
33. My investigator visited the prison to assess whether the night time observations could be carried out effectively. The visual checks took place through the door window and a light was left switched on. The investigator was satisfied that the observations could be carried out clearly and to an acceptable standard, with minimal disruption to the man or the other prisoners sleeping on the ward.

Record keeping

34. No record was made of the decision that the man should be visually checked every 15 minutes, and no records were made when the checks took place. Furthermore, no record was made of the decision that the man should be

physically checked three times during the night, and no records were made by discipline or healthcare staff that the ward was unlocked and the checks carried out. The absence of any records renders it impossible to confirm that the checks were actually carried out. The only record is in the statements made for the prison after the man died.

I recommend that the Governor and Primary Care Trust ensure that staff are reminded to record their decisions about the level of nursing care, their observations and when a cell is opened to enable the checks to be made.

Contact with the man's next of kin

35. The man asked to see his wife the evening before he died, but unfortunately there was not enough time to arrange a visit. There were also difficulties because his wife was not listed as his next of kin. The man's son was identified as the next of kin but his location was unknown at the time of the death. (I understand that his son is in fact also serving a prison sentence.)

Conclusions

36. My investigator and I concur with the clinical reviewer that the man was cared for very well over many years by the nursing staff at Frankland. His location in a ward with two other prisoners was not ideal, but was understandable in the circumstances.
37. The absence of any records of the care provided for the man on the night of his death is not satisfactory.
38. I am also concerned about the reasons given for not considering release on temporary licence or compassionate release.

Recommendations

- I recommend that the Governor and Primary Care Trust ensure that staff are reminded to record their decisions about the level of nursing care, their observations and when a cell is opened to enable the checks to be made.
- The Governor should ensure that all terminally ill prisoners are considered for compassionate release or temporary licence to an appropriate hospice. The necessary documentation should be completed and the decision made once all aspects of the application have been considered.