Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Johnson, a prisoner at HMP Frankland, on 13 January 2024

A report by the Prisons and Probation Ombudsman

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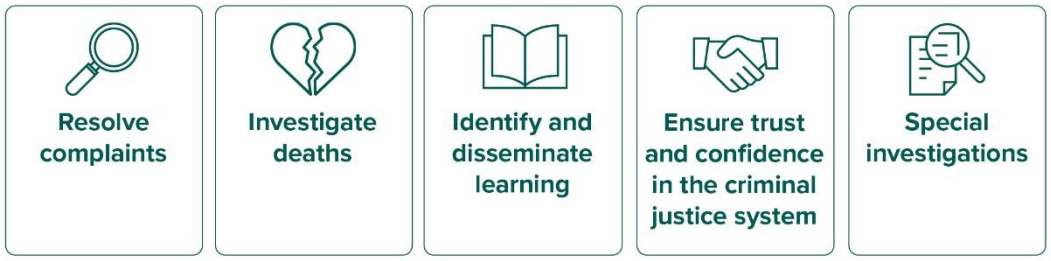
OUR VISION

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

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.

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.

Mr Lawrence Johnson died of a ruptured atherosclerotic abdominal aortic aneurysm (AAA) on 13 January 2024 at HMP Frankland. He was 82 years old. I offer my condolences to Mr Johnson's family and friends.

The clinical reviewer concluded that the clinical care that Mr Johnson received at Frankland was equivalent to what he could have expected to receive in the community.

My investigation found that when healthcare staff asked an officer to open Mr Johnson's cell door to allow them to conduct observations on him, the officer did not. The officer was unaware that all staff have the authority to open cell doors in patrol state, in line with local protocol.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

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Summary

Events

1. On 21 January 2000, Mr Lawrence Johnson was sentenced to life imprisonment, with a minimum tariff of eight years and three months for sexual offences. He was sent to HMP Swansea. In January 2001, he was transferred to HMP Frankland.

2. In January 2017, Mr Johnson was diagnosed with mild Chronic Obstructive Pulmonary Disease (COPD). He was urgently referred to a Consultant Respiratory Physician, and for a computed tomography scan (CT scan).

3. On 11 April, a CT scan of the thorax (chest) was completed. The results confirmed that there was a blood clot in the lower part of the lung that was blocking and stopping blood flow to an artery in the lung. Mr Johnson was prescribed Apixaban, however his medical records suggest that he only occasionally took his medication as prescribed.

4. On 15 April 2019, the GP at the prison saw Mr Johnson. He presented with several concerns, including chronic constipation and difficulty passing urine. The GP referred him for an ultrasound of his abdomen. On 4 June, Mr Johnson was diagnosed with an abdominal aortic aneurysm (AAA).

5. On 4 September, Mr Johnson attended an appointment with a Consultant Vascular Surgeon, and declined any further monitoring or follow-up screening for his AAA.

6. At 5.53pm on 13 January 2024, Mr Johnson pressed his cell bell. When an officer responded, Mr Johnson said he was not feeling well. She asked him what was wrong and if he required assistance from healthcare, but he continued to say he was not well.

7. At 5.58pm, the officer radioed healthcare for assistance and at 6.02pm, the officer went to collect healthcare staff from the wing gate and brought them back to Mr Johnson's cell.

8. The nurse observed Mr Johnson through the observation panel and asked him what was wrong, and again he responded that he was not well. She told the officer that she needed to get into Mr Johnson's cell to conduct observations. The officer did not open the cell, and instead radioed for the Custodial Manager (CM) to attend so he could open the cell door.

9. At 6:07pm, the CM attended the wing and opened Mr Johnson's cell door. Healthcare staff entered the cell and carried out observation checks. Mr Johnson appeared to be struggling to breathe and his speech was laboured.

10. At 6.10pm, the CM called a medical emergency code due to Mr Johnson's deteriorating presentation. Control room staff called an ambulance immediately. Mr Johnson became unresponsive and suffered a cardiac arrest. The nurse attached the defibrillator and staff began cardiopulmonary resuscitation (CPR). The defibrillator could not find a shockable pulse.

11. At 6.35pm, paramedics arrived and took over Mr Johnson's care. At 6.55pm, they decided to stop treatment as Mr Johnson was not responding to CPR attempts and confirmed that Mr Johnson had died. The post-mortem confirmed that Mr Johnson died from a ruptured AAA.

Findings

12. The officer who responded to Mr Johnson's cell bell radioed for healthcare assistance, however when healthcare attended and requested she open Mr Johnson's cell door she did not and instead radioed for a Custodial Manager (CM) to attend the wing to open the door, which is not in line with local guidance.

13. The clinical reviewer concluded that the care Mr Johnson received at Frankland was of a good standard and was equivalent to what he could have expected to receive in the community. She had some concerns about recording keeping and medication reviews.

Recommendations

- The Head of Healthcare should ensure clinic letters are obtained and are available to view within the patient's SystmOne medical records. This will ensure continuity of care and support the ongoing management of diagnosed health conditions.

- The Head of Healthcare should ensure that a medication review is undertaken when a patient does not request a repeat prescription of critical medications. This will ensure that the patients reasoning for non-concordance can be discussed and documented.

- The Governor should assure himself that senior managers are completing the monthly audits checks of staff's understanding of night procedures as stated in the HMPPS action plan dated March 2023.

The Investigation Process

14. HMPPS notified us of Mr Johnson's death on 13 January 2024.

15. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

16. The investigator obtained copies of relevant extracts from Mr Johnson's prison and medical records, CCTV and body worn video camera (BWVC) footage, and recordings of radio transmissions.

17. NHS England commissioned a clinical reviewer to review Mr Johnson's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with four members of staff from Frankland in March 2023.

18. We informed HM Coroner for Durham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The Ombudsman's office contacted Mr Johnson's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

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

Background Information

HMP Frankland

21. HMP Frankland is a high security prison. It holds male prisoners, aged 21 and over.

22. Spectrum provide healthcare services. Tees, Esk and Wear Valleys Mental Health NHS Foundation Trust provides mental health services. The establishment has an inpatients unit, with primary healthcare cover 24 hours a day.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Frankland was in January 2020. Inspectors reported that in a survey of prisoners, 38% described GP services as good and 41% described the overall quality of healthcare as good. Inspectors found that skilled nurses cared for prisoners with complex long-term health conditions and that healthcare staff provided an impressive range of primary and secondary health clinics.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to November 2022, the IMB reported that staffing in healthcare was an ongoing challenge and that waiting times for clinics were a concern.

Previous deaths at HMP Frankland

25. Mr Johnson was the seventh prisoner to die at Frankland since January 2022. Of the previous deaths, five were natural causes and one was self-inflicted.

26. We have previously made a recommendation to the Governor about staff being aware of and understanding their responsibilities during medical emergencies. The Governor agreed to publish a Governor's Notice to all staff to explain their responsibilities during a medical emergency.

Key Events

27. On 21 January 2000, Mr Lawrence Johnson was sentenced to life imprisonment, with a minimum tariff of eight years and three months, for sexual offences. He was sent to HMP Swansea. He transferred to HMP Frankland on 18 January 2001.

28. Between 2001 and 2017, Mr Johnson had little contact with healthcare staff. In 2014, he was invited to attend a routine abdominal aortic aneurysm (AAA) screening but he declined, in 2016, he had cataract surgery and in 2017, he was diagnosed with mild Chronic Obstructive Pulmonary Disease (COPD).

29. On 27 March, healthcare staff urgently referred Mr Johnson to the Consultant Respiratory Physician after he reported that he was experiencing shortness of breath and had observed flecks of blood in his sputum (mucus that is coughed up).

30. On 6 April, Mr Johnson attended an outpatients appointment with the Consultant Respiratory Physician. During this appointment he was referred for a computed tomography scan (CT scan).

31. On 11 April, the CT scan results showed that there was a blood clot in the lower part of Mr Johnson's lung that was blocking and stopping blood flow to an artery in the lung. Mr Johnson was prescribed Apixaban, however his medical records suggest that he only occasionally took his medication as prescribed. There is no evidence that healthcare staff followed up to establish why he was not taking his medication.

32. On 15 April 2019, a GP at the prison saw Mr Johnson after he complained of chronic constipation and difficulty passing urine. The GP referred him for an ultrasound of his abdomen.

33. On 4 June, the ultrasound showed a 4.7cm abdominal aortic aneurysm (AAA).

34. On 5 August, the GP met with Mr Johnson to explain the findings of the ultrasound. Mr Johnson agreed to be referred to the Vascular Service to discuss his diagnosis further with a vascular surgeon.

35. On 4 September, Mr Johnson attended an appointment with the consultant vascular surgeon, and declined any further monitoring or follow-up screening for his AAA.

Events of 13 January 2024

36. At 5.45pm on 13 January 2024, two prison officers started their routine checks.

37. At 5.53pm, Mr Johnson pressed his cell bell. An officer responded and Mr Johnson said that he was not feeling well.

38. Mr Johnson's cell door was locked as the prison was in patrol state. The officer spoke to Mr Johnson and observed him through the observation panel. She asked him what was wrong and if he required assistance from healthcare, but he continued to say he was not well. The officer said that Mr Johnson was swearing, throwing himself around on his bed and grunting.

39. At 5.58pm, the officer radioed healthcare for assistance. While waiting for them to attend, the officer said that Mr Johnson got up off his bed and went to the window and then returned to lie down on his bed again.

40. At 6.02pm, the officer left Mr Johnson's cell to go and collect healthcare staff from the wing gate. At 6.05pm, CCTV shows the two officers, a senior nurse, and a healthcare support worker (HCSW) returning to Mr Johnson's cell door.

41. The nurse observed Mr Johnson through the observation panel and asked him what was wrong. Mr Johnson said that he was not well. The nurse told an officer that she needed to get into Mr Johnson's cell to conduct observations.

42. The officer radioed the custodial manager (CM) to attend so he could open the cell door.

43. During this time, Mr Johnson's presentation started to deteriorate so the HCSW went to collect the emergency response bag and defibrillator.

44. At 6.07pm, the CM attended the wing and opened Mr Johnson's cell door.

45. The nurse and the HCSW entered the cell to tend to Mr Johnson and assess him. The nurse noted that Mr Johnson was grey in colour and was "moaning and groaning" but he did not say what was wrong. Mr Johnson appeared to be struggling to breathe and his speech was laboured. The nurse said that when attempting to obtain his clinical observations, Mr Johnson was clammy and had a weak pulse.

46. At 6.10pm, the CM called a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Control room staff called an ambulance.

47. Mr Johnson then vomited and became unresponsive. Staff moved him from his cell onto the wing landing to allow more room to deliver interventions. At this point, Mr Johnson suffered a cardiac arrest. The nurse attached the defibrillator and staff began CPR. The defibrillator could not find a shockable pulse.

48. At 6.35pm, paramedics arrived and took over Mr Johnson's care. They continued to deliver CPR. At 6.55pm, they stopped treatment and confirmed that Mr Johnson had died.

Contact with Mr Johnson's next of kin

49. Shortly after Mr Johnson's death, the prison allocated a supervising officer (SO) as the family liaison officer (FLO). As Mr Johnson's next of kin was a prisoner who lived in a different prison, the FLO contacted the prison but was told there was no on-call FLO available there. He contacted the next of kin's wing manager who told Mr Johnson's next of kin of his death.

50. The Coroner contacted a member of Mr Johnson's family however they declined any further involvement.

51. The prison paid for Mr Johnson's funeral in line with national guidance.

Support for prisoners and staff

52. After Mr Johnson's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues, and to offer support. The staff care team also offered support.

53. The prison posted notices informing other prisoners of Mr Johnson's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Johnson's death.

Post-mortem report

54. The coroner gave Mr Johnson's cause of death as ruptured atherosclerotic abdominal aortic aneurysm (AAA).

Findings

Clinical care

55. The clinical reviewer concluded that the care Mr Johnson received at Frankland was of the required standard and equivalent to what he could have expected to receive in the community.

56. She, did, however identify some concerns about recording keeping and medication reviews. She found that the clinic letter following Mr Johnson's consultation appointment on 4 September 2019 about the management of his AAA was not in his medical record as it should have been. The letter reflected that he was informed of the potential consequence of his AAA diagnosis and that he could change his mind and participate in the monitoring programme at any time.

57. There is no evidence that healthcare staff discussed Mr Johnson's non-compliance with his prescribed medication with him in order to understand why he was no longer requesting and taking his medication.

58. The clinical reviewer made the following recommendations:

The Head of Healthcare at HMP Frankland should ensure clinic letters are obtained and are available to view within the patient's SystmOne medical records. This will ensure continuity of care and support the ongoing management of diagnosed health conditions.

The Head of Healthcare at HMP Frankland should ensure that a medication review is undertaken when a patient does not request a repeat prescription of critical medications. This will ensure that the patients reasoning for non-concordance can be discussed and documented.

Emergency response

59. The local Medical Emergency Response protocol at Frankland states that the first member of staff on the scene should make a dynamic risk assessment of the situation and if they decide to enter the cell, the control room must be informed of that decision.

60. When Mr Johnson pressed his cell bell for assistance, the prison was in patrol state. The officer had just completed the routine check when she responded to Mr Johnson's cell bell. When the nurse asked the officer to open the cell door to enable healthcare staff to conduct observations, she did not and instead radioed for a custodial manager to attend the wing to open the cell.

61. The officer told us that at the time she was unaware that she could open a cell door during patrol state. She said that even if she had been aware she would not have opened the cell door as Mr Johnson had been swearing, which she assessed as being aggressive.

62. Following Mr Johnson's death, senior managers held a cold debrief on 26 January 2024 where they identified learning. They discussed staff authority to open cell

doors in a medical emergency during patrol state and agreed to issue a notice to all staff to reflect this.

63. Staff are expected to make dynamic risk assessments in complex and fast-moving situations, and we accept that the officer might have decided not to unlock Mr Johnson's cell until senior staff were present. However, the fact that she did not know that she had the authority to open the cell, and that we have previously noted a similar issue at Frankland, suggests that the earlier Notice to staff issued by the Governor, and the implementation of senior manager monthly audit checks in response our recommendation in March 2023 has not been sufficient to change staff practice. We therefore make the following recommendation:

The Governor should assure himself that senior managers are completing the monthly audits checks of staff's understanding of night procedures as stated in the HMPPS action plan dated March 2023.

Inquest

At the inquest held on 10 January 2025, the Coroner concluded that Mr Johnson died of natural causes.

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