Investigation into the circumstances surrounding the death of a prisoner at HMP Frankland in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of an investigation into the death of a man who died in April 2007. The man was a prisoner on the Dangerous and Severe Personality Disordered (Westgate) Unit at HMP Frankland. The post mortem report says that the man died of natural causes that occurred as a result of a coronary thrombosis. The man was 40 years of age and was an insulin dependent diabetic.

I would like to extend my condolences to the man's family for their loss.

One of my investigators conducted this investigation. I am grateful to the doctor who undertook the clinical review into the care and treatment afforded the man while in custody. That review is highly complimentary of the quality of medical care offered to the man. Regrettably, he was not a compliant patient and that almost certainly contributed to his premature death.

I would also like to thank the Governor of Frankland and the staff on the Westgate Unit for their help and co-operation during this investigation.

I make two recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

The man died in April 2007 on the Westgate Unit at HMP Frankland.

The man was an insulin dependent diabetic who, during his time in prison, was challenging and non-compliant in the management of his condition. Prior to his imprisonment he had led a chaotic, nomadic lifestyle that twice led to his admission to local hospitals because of deliberate insulin overdoses.

The man had been sentenced to an indeterminate sentence with a minimum of 700 days to be served before release on licence could be considered. He pleaded guilty to three charges at Crown Court in April 2006 and was sentenced in August 2006. He was transferred from HMP Durham to HMP Frankland in March 2007.

On the morning of 5 April, when the man had been at Frankland for approximately three weeks, he complained to a member of the discipline staff that he had chest pains. A Nurse went to his cell and examined him, but did not feel that there was undue cause for concern. The man wished to cancel an appointment with the podiatrist (sometimes referred to as a chiropodist) due later that day. At approximately 11.00am the Nurse confirmed the podiatrist appointment had been cancelled and that the man would be seen later that day by the visiting GP.

At 11.27am, two staff went to collect the man for his GP appointment and found him motionless and un-responsive. They called for help from colleagues via the radio and by shouting. Uniformed and nursing staff arrived very quickly and CPR was begun immediately. The doctor also arrived. Sadly, no signs of life were apparent after 15 minutes of trying to revive the man, and the doctor pronounced life extinct at 11.45am.

THE INVESTIGATION PROCESS

1. My investigator visited Frankland in March 2007. He was shown around the Westgate Unit where the man had been resident. He collected papers pertaining to the man and offered to meet members from the Prison Officers' Association and the Independent Monitoring Board should they wish to see him. He ensured Notices to Staff and Prisoners were displayed at the establishment, particularly on the Westgate Unit. He met with the Westgate Unit manager.

2. Due to the complex commissioning arrangements for the Westgate Unit, the Home Office's DSPD programme lead was asked to commission the clinical review into the circumstances surrounding the man's death. He appointed a doctor to review the clinical care the man had received during his time in custody, including the care he received immediately prior to his death.

3. One of my Family Liaison Officers made contact with two of the man's brothers to explain the purpose of my investigation and invite the family to raise any concerns they wished to be considered and addressed as part of the investigation. The man's family will receive a copy of this report. I hope it helps them better understand what happened to the man in the time leading up to his death.

4. I received a letter from a prisoner in response to my Notice to Prisoners. My investigator interviewed the prisoner who was quite concerned at the general provision of healthcare. (The prisoner was not someone who knew the man very well, owing to the short time they had been together on the Westgate Unit.) My investigator was able to reassure the prisoner that he would look into matters raised by him in so far as they applied to the man's death.

5. As part of the investigation, my investigator also jointly interviewed the Nurse mentioned in this report (who is a Registered Mental Nurse) with the clinical reviewer.

6. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem and toxicology reports. The Coroner will receive a copy of my report and appendices upon completion of this investigation to assist in his enquiries into the man's death.

HMP FRANKLAND

7. Frankland is part of the Prison Service's high security estate. Its main function is to keep some of the most dangerous prisoners in the system in custody. It was built in 1983 and had further accommodation added in 1998. It now holds approximately 740 prisoners at any one time, half of whom are likely to be serving life sentences.

8. Frankland has been recognised as amongst the highest performing prisons in the Prison Service. In a speech on 27 July 2005, the Director General of the Prison Service, Mr Phil Wheatley, said, "High performing status is about more than meeting targets. Staff in these establishments do the basics very well but the level of care and support that they provide for prisoners sets a benchmark for other prisons to aim for."

9. In the report of an inspection in 2003, Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, described Frankland as offering a safe environment. This was based upon good relationships between staff and prisoners, with appropriate levels of interaction and good staff understanding of individual prisoners and their needs. An unannounced short follow up visit in 2005 also considered that the prison was performing well.

10. All prisoners at Frankland are held in single cell accommodation. The Westgate Unit is a purpose built 80 bedded unit, opened in May 2004. It is a joint venture between the Prison Service, the Department of Health, and the Home Office. The Unit was designed to accommodate prisoners who meet the DSPD criteria either for assessment or treatment. The Unit works in close cooperation with others in the DSPD programme including Broadmoor hospital, Rampton hospital and HMP Whitemoor.

KEY FINDINGS

11. The man was received at HMP Durham in July 2005. His initial reception health screening showed him to be an insulin dependent diabetic who had been discharged from the care of a General Hospital six months earlier following a deliberate overdose of his insulin. The clinical review says that from the very early days of the man's stay in prison there were problems with self management of his diabetes. He eventually struck up a balanced relationship with a GP at Durham and, according to the clinical review, the man responded positively to requests under his care.

12. The man was sentenced in August 2006, to an Indeterminate Public Protection (IPP) sentence with a tariff of not less than 700 days. (An indeterminate sentence is given to dangerous offenders convicted of violent offences that carry a penalty of 10 years' imprisonment or more. Courts set a tariff for punishment and retribution, after which release would be at the Parole Board's discretion. As with life sentences, prisoners stay in custody until the Parole Board is satisfied that it is safe to release them. In the man's case this meant the Parole Board could not consider his case until he had served at least 700 days in custody. After release an offender may remain on licence indefinitely but, unlike life licensees, they can apply to have their licence reviewed 10 years after release.)

13. The clinical review concentrates on three main areas of concern; the man's diabetes, his behaviour and his mental health issues. The review says that careful control and monitoring of diabetes is the key to a safe and healthy life. The man persistently and deliberately interfered with the process of controlling his diabetes. This resulted in poor control of his illness and three admissions to hospital in order to stabilise his condition.

14. The man had 21 proven instances of aggressive and threatening behaviour toward staff (mainly female nurses) during his time at HMP Durham according to the clinical review. These included threats to kill. There are many other recorded incidents of abuse towards staff contained in both the clinical and prison records that did not result in adjudications (prison disciplinary hearings).

15. The man reported that he was low in mood on his admission to prison and as such was the subject of special observation because of the perceived risk of suicide. These special observations were repeated on occasions during his time at Durham, but he always refused to engage in any attempt to monitor his mental state or to take the anti-depressant medication prescribed him. The clinical record shows that he was assessed by at least four psychiatrists, none of whom felt he was psychotic or mentally ill but all judged he had a personality disorder of one description or another.

16. Throughout the man's time at HMP Durham (from July 2005 until June 2006), there were problems associated with the self management of his diabetes. He was frequently in conflict with the nursing staff and, due to the nature of his behaviour, he was placed occasionally in the segregation unit. The doctors at

Durham worked very hard to keep him safe and it is to their credit that he had so few diabetic crises during his time there.

17. The conflict between the man and healthcare staff continued until he was sent to HMP Holme House in June 2006. It seems he had similar difficulties at Holme House and he was therefore returned to Durham in July. The man gradually settled down after sentencing in August 2006, although his behaviour was not completely trouble free.

18. In November 2006, the man was referred to the Dangerous and Severe Personality Disorder (DSPD) Unit at Frankland (the Westgate Unit) as part of his Multi Agency Lifer Risk Assessment Panel (MALRAP) review. PSO 4700 says in respect of MALRAPs: *"The period following conviction and sentence is the first opportunity to carry out an* assessment *of the lifer's risk and likelihood of re-offending. It is also a time when the case is still fresh in the memory of investigating police officers and when information relating to the case has not been filed away or disposed of. It is vital that this information is appraised, collated and documented at this early stage. This is an opportunity for representatives of the various Criminal Justice agencies to share and exchange information about the lifer and his/her offence, and to identify areas of concern."* It was therefore seen as part of the man's sentence plan that issues such as dangerousness and anti-social personality disorder should be addressed. He was accepted and transferred to the Westgate Unit in March 2007. He was to undergo assessment for inclusion in the DSPD programme.

19. The DSPD programme is a unique programme, aimed at reducing the risk of some of the country's most dangerous offenders. Those on the programme are often described as psychopathic or having psychopathic traits. An article in Prison Service News (2004) reports that the *"programme is designed to be very closely linked to the whole environment where the offender is housed to ensure their progress is applied to every area of their life, not just the therapy room. Offenders have structured one-to-one and group therapy sessions with a multi-disciplinary team of facilitators including officers, psychologists and nurses. And these are complemented by activities which occur throughout the unit outside of the more formal treatment."* In other words, the whole time a person is on the Unit, they are being observed, scrutinised, assessed and worked with in a therapeutic manner.

20. With the exception of one minor incident in March, all seems to have gone quite well for the man following his arrival at the Westgate Unit. On the morning of 25 March, healthcare staff were called to see him. The man was acting very bizarrely, running around the Unit and throwing himself on the floor. The nurse attending felt this was due to the man not receiving, or taking, his mid morning snack and the problem was quickly rectified.

21. On 5 April, at approximately 10.00am, an Officer (a member of the Unit staff) asked for healthcare staff to visit the man who was complaining of chest pain. When the Nurse arrived, he took some simple observations (pulse, blood pressure and respirations), but felt that the man was not acutely unwell. The man seemed to have more of a problem about the nurse asking questions about

his diabetes and insulin doses, than in actually complaining about pain. The man also said that he did not want to see the podiatrist, with whom he had an appointment later that morning. The physical observations the Nurse took were within normal limits, and so he departed leaving instructions to Unit staff to keep an eye on the man.

22. As an additional precaution, the Nurse decided to have the man reviewed by the doctor later that day. The Nurse returned to the man's cell at approximately 11.00am and told him he had cancelled the podiatrist appointment as requested and had booked him to see the GP later. Again, the Nurse reports that the man was not in undue discomfort, nor did he appear to be in much distress.

23. At approximately 11.30am, Unit staff went to the man's cell to take him to the GP surgery. They found him collapsed on his bed. Initially, they did not realise this. It was only when they entered his cell to try and rouse him from what they thought was sleep that they realised the extent of the man's collapse. They immediately summoned assistance and healthcare staff attended promptly. A doctor also attended but, despite efforts to revive the man, he was pronounced dead at 11.45am.

24. Paramedics arrived five minutes later and were let into the cell. In view of the fact the doctor had already pronounced life extinct, the paramedics left the cell which was then re-sealed.

ISSUES

25. The main issues for my investigation have centred around whether the man received appropriate treatment whilst in custody, and whether there is anything in the care given to the man that might have led to a different outcome. The clinical review undertaken by the doctor is quite clear that the care the man received in respect of his diabetes was extremely professional. The reviewer says that he has no criticism of the man's healthcare: "many attempts were made to improve his care and he rejected them all". He considers the local Primary Care Trust (PCT) should compliment the clinical team involved in the man's care for sticking to their task "in the most difficult circumstances".

26. The reviewer says that the man was somebody who abused his medical condition prior to entering custody and also throughout his time in prison. He did not pay heed to advice given to him by medical and nursing staff either in prison or outside. The man went one stage further in January 2005 and March/April 2005, when he deliberately overdosed on insulin requiring admission to hospital.

27. Although the man was not suicidal or setting out to deliberately harm himself, the long-term effect of his 'careless' behaviour was that his body suffered detriment in terms of his vital organs such as his heart. The post mortem reveals that the man died as a result of a coronary thrombosis. (A major vessel in the heart is closed off because of a blood clot which leads to the heart muscle being starved of oxygen and then stopping working; that is, the heart stops pumping.) According to the clinical review, this is directly attributable to a complication that careful management of diabetes is designed to control. The man was not careful in the management of his diabetes.

28. In his examination, the pathologist checked in minute detail for evidence of repeated fresh injection sites. He found no evidence of this, nor did he find any evidence of excessive insulin administration. This, together with the toxicology report, is a good indicator that the man did not deliberately overdose on insulin.

29. My investigation also required that I examine the emergency care provided under the circumstances of the man's collapse. He had complained to the wing officer of mild chest pain less than two hours prior to his death. The nurse who visited him initially made some clinical observations and concluded that the man did not require any urgent intervention. The clinical review shows that the Nurse's conclusion was completely reasonable under the circumstances. The man's physiological observations were within normal limits. The man's presentation to the Nurse, as described at interview, was not that of someone who was in acute pain or discomfort. This presentation gave the Nurse no undue cause for concern. However, the Nurse still referred the man to the doctor as a precautionary measure. The onset of the man's coronary heart condition was sudden and fatal.

30. As part of my investigation, I also examined recommendations made following previous investigations into deaths at HMP Frankland that had similar circumstances. I reviewed a death of a prisoner who died from a myocardial infarction (a heart attack) in 2005. In that case the clinical review made a

number of recommendations regarding the management of acute chest pain and heart conditions. I checked to see if Frankland had acted on those recommendations and was pleased to see that they had addressed all of them. As the Westgate Unit is part of Frankland (although it is a separate unit within the prison), I checked to ensure the Westgate Unit was affected by the same PCT actions as the rest of the prison in this respect. Again, I was pleased to find they had a protocol for the management of chest pain.

31. I note from the clinical review that both my investigator and clinical reviewer were concerned about the level of training that the Nurse had received in respect of severe chest pain presentation. (I also note that this nurse is a Registered Mental Health Nurse and is one of a number of similarly qualified nursing staff on the Westgate Unit). Although the reviewer is quite clear in his report that lack of training has not contributed to the circumstances surrounding the man's death, I believe that two formal recommendations are justified in respect of this matter.

    The commissioning and provider authorities should ensure that staff on the Westgate Unit receive up to date training in recognising the signs and symptoms of severe chest pain and its management.

    The chest pain guideline should be reviewed to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.

32. In conclusion, I am confident that the man received entirely appropriate, indeed high quality, medical treatment while in custody. However, he was not a compliant patient and it seems likely that his own non-compliance contributed to his death at a relatively young age.

RECOMMENDATIONS

1. **The commissioning and provider authorities should ensure that staff on the Westgate Unit receive up to date training in recognising the signs and symptoms of severe chest pain and its management.**

   Annual first aid training is already provided to all Westgate staff and all new staff will receive this training. Further ECG training will be organised for all Westgate nursing staff.

2. **The chest pain guideline should be reviewed to ensure it provides appropriate guidance for staff who are assessing patients presenting with severe chest pain symptoms.**