Investigation into the circumstances surrounding the death of a male prisoner at HMP Frankland, at the University Hospital of North Durham in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the death of a man. The man suffered a heart attack at HMP Frankland, and died shortly after arriving at the University Hospital of North Durham.

I would like to offer my condolences to the man's family and friends for their loss. The family had many concerns about the care the man had received while at Frankland, and in particular about the conduct of prison staff during his stay in hospital six weeks before his death. I hope that my report addresses these matters fully.

The investigation was conducted by one of my Assistant Ombudsmen assisted by an investigator from my office. A clinical review was commissioned from Durham Primary Care Trust (PCT), who appointed a doctor from the PCT to conduct the review. The doctor attended some of the interviews with healthcare staff, and I am grateful to him for producing a timely report. I would also like to thank the Governor of Frankland and his staff for their assistance. In particular I thank the Liaison Officers. It has taken longer than expected to issue this report, and I must apologise for the delay.

The man arrived at Frankland from HMP Durham in November 2007. He had a long and complex medical history, having being involved in a road traffic accident while serving with the Territorial Army, and he subsequently received treatment for Post Traumatic Stress Disorder. He also had problems with his heart, and had had an operation in 2004 to have stents (tubes to ensure the flow of blood through blocked vessels) inserted. During his time in prison, despite being a quiet prisoner, the man was a demanding and uncooperative patient who often failed to take his medication. After a heart attack in August 2008, he had an emergency operation to fit more stents. Once again, he failed to take his medication. Six weeks afterwards, he suffered another heart attack. Sadly, on this occasion medical staff were unable to save him.

I make four recommendations in my report. One of these is taken from the clinical review, and relates to the procedure for dealing with medical emergencies involving chest pain. I have also made a recommendation about adjudications, one about the storing of drugs at Frankland, and one that a full debrief should be held after all sudden deaths in custody.

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Deputy Prisons and Probation Ombudsman
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SUMMARY

The man was sentenced to 16 years imprisonment in 2007 for various sexual offences. He was initially held at HMP Durham, where he had previously spent time on remand.

The man had a long medical history prior to arriving in prison. He had been involved in a road traffic accident while in the Territorial Army that had left him with back problems. He also received treatment for Post Traumatic Stress Disorder. In 2004, he had suffered a heart attack, and had stents inserted.

While at Durham, he refused to take his medication on many occasions, which at one point prompted his solicitors to write to the prison to express their concern. His refusal was, in fact, a pattern of behaviour that had begun in 1998. Staff at Durham and subsequently at Frankland made repeated efforts to persuade him to take his medication, but he often failed to comply.

In August 2008, the man suffered another heart attack. He was taken directly to James Cook Hospital, Middlesbrough, where he underwent an operation to insert stents. Immediately after the operation, there was a prolonged altercation between the man and members of the bedwatch team who had accompanied him to hospital. This led to him complaining that he had been tortured and beaten up.

On his return to Frankland, the man chose to return to the wing rather than stay in healthcare. Nursing staff told him that it was essential that he took his medication. Because he had a job as a cleaner, he was selected for a mandatory drug test on 25 August. He failed the test and the positive result was said to be due to the effects of the opiate based painkillers. As a result, he again started to refuse to take his medication.

During the night of 21 September 2008, the man pressed his cell bell and told staff that he thought he was having another heart attack. He was taken to healthcare where nursing staff followed the agreed protocol and sent an electro cardiogram (ECG) to an out of hours doctor. The doctor advised that an ambulance should be called, but at the same time he collapsed. By the time paramedics arrived, he had become unresponsive and, although he was taken to hospital, doctors were unable to revive him.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 22 September 2008 and appointed an Assistant Ombudsman to investigate. The Assistant Ombudsman spoke to HMP Frankland later that day, and arranged for the man's records to be sent to him.

2. Notices were sent to the prison informing prisoners and staff of the investigation, and inviting them to speak to the Assistant Ombudsman if they had any relevant information. No one responded to these notices.

3. I asked Durham PCT to appoint a clinical reviewer to undertake a review of the care the man received while in custody. A doctor from the local PCT was appointed and has produced a timely and thorough review for which I am grateful.

4. HM Coroner for Durham was notified that I would be investigating. He will receive a copy of this report.

5. One of my Family Liaison Officers (FLOs) contacted the man's family and arranged to meet them with the Assistant Ombudsman. At this meeting, the family raised a number of concerns about the man's care while he was at Frankland. I hope that this report helps to answer their questions. They were concerned that :

    - The man had been given medication called Champix to help him stop smoking, but that this should not have been prescribed to someone with a heart condition.
    - The man had had a heart attack four weeks earlier. He said that he had felt unwell during the night and had pressed his cell bell but it had not been answered. He collapsed the next day.
    - There had been a delay providing care after this heart attack.
    - He often spoke to the men in the cells next to him, and they might have more information.
    - The man had a cell bell and the family asked whether he had used it, especially on the night of his death, and whether the staff had responded appropriately.
    - There was a delay between him being taken to hospital after his heart attack on 4 August and the family being informed.
    - The prison said that a visiting order was required in order to visit the man in hospital.
    - The man had been given a "hard time" by officers while in hospital and that this caused undue stress.
    - He returned to the wing after returning from hospital, and the family asked whether this was correct or whether he should have stayed in healthcare.
    - An officer had visited him in his cell and threatened that he would be moved to the Isle of Wight if he caused any more trouble.

- The man failed a drug test shortly after his return from hospital because he had been put on different medication. He refused to take the medication because of the problems it was causing him.
- He was taken to University Hospital of North Durham on the night that he died, whereas previously he had been taken to James Cook Hospital in Middlesbrough. The family asked whether the distance travelled had had any effect on his health.
- The man suffered from Post Traumatic Stress Disorder (PTSD) and the family asked whether he was treated appropriately, and whether the prison sought records from external sources.
- The man found it difficult to do tasks others found easy because of the paranoia brought on by PTSD. The family wondered whether the prison had done everything it could to ensure he received proper care.
- On one occasion he was interviewed by a mental health nurse in the corridor, and the family asked whether this was appropriate.
- Whether the police had taken any letters or property from his cell?
- Whether the man had said anything before he died and whether there was anyone with him when he died?
- There had been minimal contact with the prison since the man's death, and it had taken a long time to inform the family of his death.

6. The Assistant Ombudsman and an investigator visited Frankland on three occasions and interviewed 13 staff. The Clinical Reviewer was also present at some of these interviews. The Assistant Ombudsman also spoke to a member of the nursing staff by telephone.

7. After the publication of the draft report, the Assistant Ombudsman visited the man's family at their request, with another of my FLOs. The family pointed out one item of factual inaccuracy, and the report has been amended as a result. The man's mother also said that an entry in his medical record was wrong and did not present a true record of events during his childhood. The Assistant Ombudsman agreed to speak to the nurse who made the entry to advise her of this, but was unable to do so as she no longer worked at Frankland.

8. The Prison Service was also invited to comment on the draft report. Although they have informed the Assistant Ombudsman that they have not identified any matters of factual inaccuracy, they have not yet responded to the recommendations.

HMP FRANKLAND

9. HMP Frankland was opened in 1980 to hold 432 prisoners. Subsequent expansion has meant that it can now hold 750 prisoners, all of whom are accommodated in single cells. The population is made up of category A and B adult men serving four years and over, prisoners on indeterminate sentences for public protection or life sentences, and high and standard risk category A remand prisoners. (The man was a category B prisoner).

10. Healthcare is provided by County Durham PCT. There is a healthcare centre providing primary care and inpatient facilities, and a mental health team is also on site. Medication can be issued to prisoners "in possession" (meaning that they can keep it in their cells) subject to a risk assessment.

HM Chief Inspector of Prisons' report

11. In her foreword to the report of a full inspection of Frankland in February 2008, the Chief Inspector commented that although Frankland had been identified by the Prison Service as a high-performing prison, the inspection had "identified that the prison was drifting in some key areas, most worryingly in relation to safety". Relationships between staff and prisoners were described as "variable, with little active personnel work". However, health services were "generally good".

12. The Chief Inspector made several recommendations relating to healthcare and pharmacy procedures at Frankland. None is directly relevant to the circumstances of this investigation.

Independent Monitoring Board (IMB) report

13. The members of each IMB are unpaid members of the public. They monitor day-to-day life and ensure that proper standards of care and decency in the treatment of prisoners are maintained. Members have unrestricted access to the prison, and also play a role in dealing with problems within the establishment. Each IMB produces a report every other year which is sent to the Secretary of State for Justice.

14. The last available IMB report for Frankland was for 2006-07. The IMB judged that "all sections of healthcare appear to be working well", and that "headway has been made in the last year". The IMB did not raise any issues for either the Home Secretary (to whom they reported at the time) or the Prison Service that are relevant to this investigation.

Previous deaths at Frankland

15. Since my office was entrusted responsibility for investigating all deaths in prison custody in 2004, I have investigated 17 other deaths at Frankland. I have issued reports for 15 of these investigations. None of the circumstances of those deaths, or the recommendations I made as a result, is directly relevant to the circumstances of the man's death. Sadly, since the man died, there have been two further deaths at Frankland.

Assessment, Care in Custody and Teamwork (ACCT)

16. ACCT has been introduced at all prisons as a documented process to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk.

17. Each prisoner is assessed within 24 hours and then reviewed further at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care.

18. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner.

KEY EVENTS

The man's first period of custody

19. The man was arrested in July 2006 and, in August, charged with various sexual offences and one case of witness intimidation. He was initially bailed, and presented himself at hospital on 12 September after cutting his wrist. He reported that he had done so while feeling suicidal. He said that he had a significant history of harming himself. (Indeed, on two occasions in the previous month, he had gone to hospital. The first was after saying he had taking an overdose of codeine, and the second was for feeling unable to cope.) He was re-arrested as the police believed that he had made a threatening telephone call that morning. A psychiatric assessment undertaken while he was in hospital, and written for the police surgeon and custody sergeant, warned that he was at high risk of harming himself and that he required close monitoring.

20. The following day, the man was transferred from a local police station to HMP Durham. On arrival at reception, an ACCT document was opened and he was placed on constant watch. He was seen by a Registered Mental Nurse, who referred him urgently to a Community Psychiatric Nurse. It was noted that he was taking several different medications, including clopidogrel, a drug which prevents platelet aggregation often used when a patient has had stents inserted into their heart. The man had also been prescribed aspirin, nicarandyl and GTN spray, all of which are used to control heart disease and angina.

21. On 25 September, a GP working at Durham referred the man to a Consultant Psychiatrist. At this stage, he was still on constant watch and said that he felt that his mental state was deteriorating. The doctor's letter showed a clear understanding of the man's psychiatric history, and of his previous treatment. The man had refused to take his medication on 27 September as his evening dose of diazepam had been stopped. He told healthcare staff that he would "rather be dead than mad", but was eventually persuaded to take his medication.

22. The man refused to take his medication again on 30 September and 1 October, and on the first occasion was warned about the language he used to staff. He explained to a mental health nurse, that he continued to be upset about the withdrawal of diazepam. The Mental Health Nurse told him that the diazepam had not been withdrawn, but the man did not accept this and became "verbally confrontational". Eventually, the man calmed down and agreed to ask a nurse on night duty for his prescribed medication. He was prescribed diazepam on 3 October, but it was not issued to him as staff thought he appeared settled and was not anxious.

23. The man was given an appointment to see a consultant, on 3 October 2006, but unfortunately missed it as he was in court. It is unclear from

the records available to my investigator whether the appointment was rescheduled. He did attend an anxiety management group meeting in healthcare on 5 October, and participated well, but then failed to attend the following session on 11 October.

24. On 16 October, the man again refused to take his medication. A week later, on 23 October, the ACCT was closed after a review. At the review meeting, the man said that he was refusing his medication because of the withdrawal of the diazepam and because of the attitude of some of the nursing staff. He no longer voiced thoughts of harming himself. He also felt that he should be receiving further treatment for PTSD.

25. At a meeting on 24 October, the man explained that his refusal to accept medication was because he was "being denied his human rights", although he could not explain what he meant by this. A nurse recorded in his medical record that the man was "fully aware of the consequences of not taking his medications but still refuses to do so". Later that day, another nurse was asked to attend B wing as the man was suffering from chest pains. He was referred to the duty doctor that evening.

26. A letter was received by the Governor on 25 October from the man's solicitors, stating that a family member had contacted them. They were concerned that the man was experiencing chest pains, but had told them that he did not think that his concerns were given serious attention. The Prison Healthcare Manager replied on 30 October. In his letter, he said that the man had seen a nurse on 24 October and said that he had chest pain. He had also said that he was not taking his medication and so the pain was his own fault. The Prison Healthcare Manager wrote that the nurse ensured that he was seen by a doctor that night, and an appointment was made to see the doctor again on 26 October. He had not attended.

27. At a meeting on 3 November with a social worker from Sunderland with responsibility for his case, the man's wife expressed concern about his mental health. The social worker saw the man at HMP Durham on 9 November on the wing (he had refused to attend healthcare). The man said that he sometimes still felt suicidal, but was afraid to act upon these feelings in case he failed. He was not happy with the "lack of help" offered to him, although he was unable to say what he meant by that.

28. The man was seen by a psychiatrist (it is impossible to decipher the name) on 16 November 2006. The psychiatrist took a full history, but also noted that the man was "very irritated at times, stating I wasn't answering his questions". At one point, the psychiatrist suggested that it might be better to stop the interview.

29. The social worker, made two further attempts to see the man on 21 and 30 November. On both occasions, he refused to go to healthcare and, as the social worker was unable to be escorted to the wing, he did not manage to see him. On 1 December, the man was granted bail.

The man's return to prison

30. After ten months on bail, the man was convicted in September 2007 at a local Crown Court and returned to HMP Durham pending sentencing. Later in September, he was sentenced to 16 years imprisonment for various sexual offences.

31. On reception at Durham, another ACCT was opened because of the man's previous history of harming himself. The ACCT remained open until 10 October, when he confirmed at a review meeting that he had no thoughts of self harm.

32. Staff at Durham had noted that the man had been seen by his social worker during his previous period of custody. They asked the social worker to speak with him, which he did on 4 October. The man was in a better mood than he had expected, and talked about his future. However, he was again refusing to take his medication.

33. Over the next few weeks, the man twice refused his medication. He also failed to keep an appointment with a psychiatric nurse, and declined to attend two meetings with his social worker. In the meantime, the social worker met the man's wife and mother, both of whom expressed their concerns about his welfare and ability to cope with a long sentence.

34. On 31 October, the man's social worker spoke with him on the wing, as he had refused to attend healthcare because of problems with other prisoners. He had started taking his medication again, although he was suspicious of prison food, believing it had been tampered with. He was also concerned as to how other prisoners, and some staff, viewed him, and expressed concern for his own health and safety. He continued to maintain his innocence.

35. Two weeks later, on 13 November 2007, the man again failed to attend an appointment with the psychiatric nurse. The next day, he failed to attend an appointment with his social worker, although he then agreed to meet him in healthcare as long as he would not be exposed to other prisoners. Once again, the man had stopped eating and taking his medication because of a "lack of hope". The man's social worker noted that his physical appearance had deteriorated since he had last seen him.

36. He did not attend a sentence planning meeting with his offender manager and Social Worker on 20 November. The following day, he transferred from Durham to HMP Frankland.

The man's period of custody at Frankland

37. Staff at Frankland noted the man's history of mental health issues on his arrival there. An assessment was carried out by a doctor (it is impossible to see exactly who from the signature), in which the man was described as being "anxious" and was said to have been experiencing chest pain several times a week while at Durham. He said that staff there had ignored him.

38. A week later, on 28 November, the man was assessed by a Registered Mental Nurse (RMN). She found that he had no ideas of suicide or of harming himself. By the following day, staff on the wing had become concerned about his well-being and asked the RMN to attend. She found the man to be low in mood, anxious, tearful, with poor personal hygiene, no motivation and poor levels of concentration.

39. The RMN opened an ACCT document, with hourly observations, and removed the man's in-possession medication (which meant his medication would now be dispensed by staff). The RMN saw him the following day for a further assessment. He was still anxious and tearful at times, but he improved as the interview progressed and denied any thought of self harm. The RMN decided to monitor him through a weekly meeting in addition to the regular ACCT reviews.

40. The same day, the man attended an adjudication hearing after failing a drugs test. It is not clear why he had been selected for a test, nor when the test took place. He had, however, been prescribed an opiate based pain killer (codeine phosphate). The hearing took place in front of a Governor, and the man pleaded not guilty. The charge was dismissed.

41. At their next meeting on 4 December, the RMN noted that the man presented in a similar way to the previous meeting. At an ACCT review on 7 December, he asked for the ACCT to be closed and to be allowed to hold his own medication. His request was refused as he was still believed to be at risk of harming himself. The ACCT remained open, with hourly observations, and at least one quality conversation per day. The RMN told him what means of support he could be offered, and also saw him that day for a psychiatric appointment. The man discussed his childhood and having had feelings of emptiness and loneliness since the age of nine. He became "belligerent" when discussing certain aspects of his court case.

42. The RMN saw him again on 12 December. He presented more favourably, having contacted his family and made applications to attend education. However, he remained anxious. The man also reported having visual disturbances, including having his vision disturbed by butterflies and rainbows. He again asked to be allowed to hold his medication himself, and the RMN agreed to carry out a risk assessment, although it is not clear whether this was done.

43. On 14 December, the man was assessed by a Consultant Psychiatrist. They discussed the man's history, and the Consultant Psychiatrist found that he had "passive aggressive tendencies" and was emotionally unstable. Given the visual hallucinations that he said he was suffering from, the Consultant Psychiatrist advised that an investigation be undertaken to rule out temporal lobe epilepsy. (The temporal lobes are the parts of the brain responsible for speech, memory and hearing). The prison doctor sent a letter to the University Hospital of North Durham (UHND) on 2 January 2008, requesting an electroencephalogram (an EEG, a test that records brainwave patterns from the electrical activity in the brain).

44. A further mental health review was conducted by the RMN on 19 December. The man asked her for information about his physical and mental health and whether they would prevent him taking employment. The RMN replied that his current mental health state would not prevent him working, but that he would need to see a doctor about his physical condition. The man finished the session abruptly, arguing that "no one was prepared to help him", and that his PTSD should be addressed.

45. The man attended a chronic heart disease clinic with a nurse on 27 December 2007. He was still refusing to take his medication as he wanted to have it in his own possession. The nurse discussed the importance of taking the medication and explained what each drug was for. She asked him to consider taking his medication, but recorded in her notes that he "did not seem to want to take any interest whatsoever in current consultation". The man remained on an open ACCT.

46. After reading the Nurse's notes, the prison doctor wrote to both the man and the D wing treatment nurse on 2 January 2008, suggesting that they meet to see whether any of the medication could be given to the man to hold himself. The prison doctor said that he was concerned about the man's blood pressure and other aspects of his health, and that he appreciated that the man was concerned about going to healthcare. The prison doctor suggested that the man discuss these issues with the treatment nurse.

47. The treatment nurse, tried to speak to the man on 3 January. He refused to go to the treatment room, saying that he would not take his medication until he received counselling for PTSD. The treatment nurse arranged a doctor's appointment for the following week.

48. The RMN reviewed the man the next day. While noting that the man reported feeling less anxious and that his mood had improved, the RMN also recorded that he was now questioning the diagnosis of PTSD and denied asking for counselling. She felt that he was trying to split the healthcare team, as he now said that he would accept not having his own medication as long as he did not have to collect it in the morning. The RMN suggested that staff take a multi-disciplinary

approach to the man's care, and she completed an in possession risk assessment form.

49. On 8 January, the man declined to see the doctor. The next day, an appointment was arranged for him to see a visiting Consultant Psychologist, but he again declined, saying he would not leave the wing for appointments.

50. A further ACCT review was conducted on 14 January, and the man asked for it to be closed as he felt well. The RMN suggested that he have a doctor's appointment to discuss whether he could keep his own medication. The man replied that he had no intention of speaking to anyone in the medical profession as they were responsible for the difficulties in his life. He then said that he would not take his medication, whether in possession or otherwise, as he wanted to have a heart attack and die. The RMN noted that the man went from being calm to being tearful and agitated, expressing themes of hopelessness and suicidal ideas. He remained on an open ACCT, although with no recorded observations other than one documented contact each day.

51. The RMN conducted another mental health review on 28 January. The man repeated that he wanted to have a heart attack and die. He reported feeling low in mood and sleeping poorly, although the entries in the ACCT document suggested that he was sleeping well. He became aggressive when discussing his offence, and said that he had had episodes of breathlessness and flutters in his chest. He agreed to have a health screening, and the RMN made an appointment for 31 January. There is no record of the screening taking place, although there is an entry on 30 January recording that the man failed to see the treatment nurse.

52. The man was examined by a General Practitioner, on 5 February. The doctor noted that the man was not taking his medication for his heart condition, although he also reported using his GTN spray three or four times a day. The doctor conducted an electrocardiogram (an ECG, a test to measure electrical activity in the heart) which showed some irregularities including a left anterior fascicular block, a symptom which is seen in four per cent of acute myocardial infarctions (heart attacks), but which is also associated with hypertensive heart disease and other types of heart disease.

53. The doctor also took the man's blood pressure, which was 211/123. Both of these figures are above the levels normally regarded as being high. The doctor asked the man to take some medication (bisoprolol), wait for 20 minutes and then have his blood pressure taken again. The man refused both the medication and the second test and chose to return to the wing. Later the same day, the man spoke with a healthcare worker, who advised him to take his medication. The man said that he did not trust anyone. He agreed to have his blood

pressure taken, which on this occasion was recorded as 193/123, lower than before.

54. A mental health review was conducted by the RMN on 8 February. The man spoke about his childhood, and also about PTSD, saying that he found it difficult to cope with but that he did not suffer from it. He continued to refuse to take his medication, and told the RMN what the consequences would be. He again said that he wanted to have a heart attack. The RMN believed that the man was suffering from a personality disorder and referred him to a consultant psychiatrist. She also handed over his care to a Community Psychiatric Nurse (CPN).

55. An ACCT review was held on 11 February, when the man was reported to be agitated. It was decided that the ACCT should remain open and the same level of observations continued.

56. On 14 February 2008, the man accepted his medication. He also advised a nurse that he would like to talk to the mental health team.

57. A psychiatrist, saw the man the next day. After noting his history, the psychiatrist said that the man was very fixed on discussing issues relating to his trial and how he had been let down by mental health services (including when he was in the army). The man also said that he did not think that he suffered from PTSD. The psychiatrist did not think that the man was suffering from a depressive or psychotic disorder, although he would probably meet the criteria for borderline and anti-social personality disorders. The psychiatrist recommended that the man undertake a sex offender treatment programme, but he "adamantly refused to do so". The psychiatrist did not think that the man was suitable for medication to address any psychiatric issues, nor that he would benefit further from mental health intervention. He did not arrange to see the man again.

58. The nurse that saw the man previously at the chronic heart disease clinic had a consultation with the man on 20 February about his history of heart disease. He complained that he had been bleeding from his nose and his rectum. Once again, he was refusing to take his medication, on this occasion because he had been told that he had a personality disorder. The nurse explained the importance of taking the medication, and she also suggested that the doctor review his medication (in particular, clopidogrel) to see if he still needed it. The nurse wrote in her notes that, "the man does not wish to have any further appointments with anyone in healthcare … I am at a loss on how to manage this gentleman." She suggested that the Mental Health Team (MHT) at Frankland become involved. The prison doctor agreed and also advised that they stop prescribing clopidogrel.

59. The CPN met the man on 29 February. He described him as being quite anxious and agitated, and found it difficult to get him to focus on the present rather than the past. The CPN challenged the man to take

his medication to see if it helped, and agreed to provide some information about personality disorders.

60. A further ACCT review was held on 4 March, attended by a multi-disciplinary team including the CPN. It was decided that the CPN would examine ways of delivering the man's medication to his satisfaction. The CPN agreed to ensure that the man was given his medication in possession, delivered by night staff so he would not have to see the nurse every morning. This proved not to be possible, as night staff could not fit the medication under the cell door. On 5 March, the CPN negotiated a compromise where the man would collect his medication from the nurse at tea time, when there were fewer people around. The arrangement would be reviewed a couple of weeks later. The CPN spoke with the man the following day, and he said that he was already feeling better for taking the medication.

61. The ACCT document was finally closed on 25 March, and the man was issued with his medication in possession every week. He said that he was feeling better and had no more suicidal thoughts.

62. On 15 April, the man was taken to see a neurologist, at UHND, after the earlier referral by the prison doctor. After examining the man, the Neurologist felt that the most likely cause of his problems was psychiatric not medical. He suggested that a magnetic resonance imaging (MRI) scan might be more appropriate than an EEG, but also said that he would expect to find that it would be normal. There is no evidence from the medical record that the scan was undertaken.

63. The CPN attempted to speak to the man on 17 April to discuss his discharge from the care of the MHT. According to the CPN's note in the medical record, they were unable to use an interview room. The man asked what the meeting was about and, when told, became angry and abusive and eventually walked away. The CPN wrote to the man, and noted that his attitude was "threatening" and that "this attitude is not tolerated by the NHS".

64. The man experienced an episode of chest pain on 22 April. The General Practitioner that had previously seen the man administered GTN spray, after which the pain subsided. The man said that during the consultation that he was very stressed and unhappy with the withdrawal of the MHT. The doctor conducted an ECG, which was in line with previous ECGs, and checked the man's blood pressure, which was 147/92. This was much lower than it had been on 5 February.

65. The man refused to take his medication at tea time on 2 May. It is not clear what medication this was, or why he had to collect it, given that he was supposed to have his medication in his own possession. After failing to attend chronic disease management clinics on 7 May and 17 June, the man seems to have complied with his treatment programme.

He was treated for an unrelated condition during this period, for which he was referred to a Consultant Urologist.

66. On 9 July, two officers, searched the man's cell. This was a routine search, conducted as he had a responsible job as a cleaner. Records show that nothing was found. This was the only time that his cell was searched while he was at Frankland.

The events of 4 August

67. On 4 August, the man was taken ill in a workshop. He complained of chest pain at 9.45am. A Nurse attended, and found him to be cold, clammy and with poor colour. The man was taken to healthcare in a wheelchair, given oxygen, and clinical observations were taken, including blood pressure and an ECG. They showed some abnormal activity suggesting that the man had suffered an acute myocardial infarction (heart attack). The nurse gave the man buccal, aspirin and diamorphine under the instruction of the prison doctor, and paramedics were called. They decided that the man needed to go to James Cook Hospital on Teesside rather than to UHND, because of the severity of his condition.

68. In line with standard procedure, three officers were detailed to escort the man to hospital. They were the two officers that had previously searched his cell and one other officer. My investigators interviewed two of the officers, and saw the bedwatch log (the record of events at the hospital which the officers made at the time).

69. The ambulance left Frankland at 10.30am. The journey was made under "blue light" conditions, and one of the paramedics attempted to obtain further information from the man. He asked him to describe the level of pain he was suffering on a scale of one to ten. The man refused to do so, and was abusive to the paramedic. One of the officers tried to intervene, but the man also refused to tell him.

70. On arrival at James Cook Hospital, the man was seen immediately by a specialist and taken for an operation to insert more stents into his heart. Following the operation, at 12.45pm he was taken to a side room on the coronary care unit next to the nursing station. Nursing staff attended to the man for approximately 45 minutes.

71. As they had left the prison at very short notice, the officers had not had the opportunity to collect any food. The officer that previously tried to intervene in the ambulance went to collect some food for the officers, and returned to the side room.

72. As the officers started eating, the man said that he wanted to use the toilet. The same officer alerted nursing staff, but when they attended the man said that he did not want to use the toilet but was trying to annoy the officers. According to an entry in the bedwatch log made by

one of the officers at 2.32pm, the man became aggressive and abusive. He alleged that the officers were torturing him and beating him up. The officer that wrote the previous record in the log recorded the man as saying, "I want out of here, I wish to discharge myself." At 2.40pm, a nurse entered the room and said that the man's daughter was on the phone. The man said to "tell her that these three are going to beat me up. When you leave the room nurse these are going to beat me up." The officers ensured that a member of the medical staff was present whenever they spoke to the man or had to deal with him afterwards.

73. During the afternoon and evening, the man continued to make allegations about the officers, including one of torture and another of making excessive noise. At 6.32pm, he refused painkillers and accused officers of stopping him telephoning his family and receiving visits from them. At 7.20pm, the officer that previously made record in the man's log telephoned Frankland and spoke to a senior officer (SO) in the security department. He was told that the man's family had contacted the prison to complain that the escorting officers had been torturing him and threatening to beat him up. At 7.50pm that evening, there was a change of escorting officers.

74. The following day, the SO visited the hospital and spoke to one of the nurses who had been on duty. She said that she had not witnessed any threats or abuse from the escorting officers, and said that the man's aggression might have been because of the effects of the heart attack and lack of sleep.

75. The SO also spoke to the man about the allegations. At first, he tried to deny them but then changed his mind and mentioned that the officers had deliberately tried to upset him by making a lot of noise. He became annoyed again while speaking to the SO, telling him to ignore him, and pulled a cannula (a small tube which can be inserted into the body) from his elbow. A nurse attended to treat him, and the man told her that he wanted to return to the prison as he could not take another day of "this".

76. The man appeared to calm down afterwards. He was visited by several doctors and a nurse who explained what had happened, what medication he would need to take, and suggested that he stopped smoking. The man's wife and mother called the hospital to find out how he was. The man was told about the contact his family had had with hospital staff.

77. The man remained calm for the remainder of his time in hospital. Medical staff attended on several occasions to explain again what had happened and give further information about what he should do in the future. He was released from hospital on 6 August 2008.

Return to HMP Frankland

78. The man was seen by a nurse on his return. He had been given sufficient medication for the rest of that day, and arrangements were made for the prison doctor to prescribe further medication the next day. The man asked to return to the wing rather than remain in healthcare. The nurse confirmed that he had received a manual containing information about how to look after his heart, and she recommended that he see a smoking cessation advisor.

79. The man saw a smoking cessation advisor, on 11 August, but there is no record of their conversation. In the next two days, he missed two appointments for a blood test and to collect his weekly medication.

80. On 20 August, the man saw the nurse he had previously seen at the chronic heart disease clinic for a review. He said that he was not following the heart manual and did not want to use the gym. The nurse asked him to do some gentle exercise in his cell to help his recovery. The man said that he continued to get some chest pain, but would not take his GTN spray. The nurse reminded him that it was vital that he should comply with his prescribed medication. She booked a follow up appointment with a prison doctor, and confirmed that he had some nicotine patches. He attended a further smoking cessation clinic on 21 August.

81. Despite his ill health, the man was employed as a cleaner on his wing. An officer explained at interview that the man was quiet on the wing and only associated with a couple of other prisoners. As he was reluctant to come out of his cell, the officers gave him a job cleaning although he often had to take breaks.

82. Because of his job, the man was required to undergo a mandatory drug test on 25 August. He returned a positive test as a result of the opiate-based medication he had been prescribed. The result was returned on 5 September. At the time of his death, the adjudication for the failed test had not been held.

83. The man kept his appointment with a doctor. He said that he was feeling low after his heart attack, with a loss of appetite and lack of sleep. He said that stress had caused his previous heart attacks, and that PTSD was the cause of all his symptoms. He was signed off work for four weeks and a follow up appointment with a cardiologist arranged.

84. The doctor saw the man again on 2 September after he reported further chest pain. On this occasion he had used his GTN spray, but this had not helped. He said that it felt different to his previous chest pain. The doctor gave him some buccal suscard (a medicine used to treat angina and heart attacks), and told him to tell staff that he needed to go to hospital if the pain got worse. The man was reviewed later in

the day by another doctor and confirmed that the pain had eased. He was returned to the wing.

85. On 8 September, while a blood sample was being taken, the man told a nurse that he had stopped taking his medication. He said that this was because of problems with a member of staff on the wing. The nurse said that he would discuss this with wing staff. Later the same day, the man was seen by a member of the mental health team, who arranged with the charity MIND for him to attend a six week anxiety management course. Three days later, the man again refused to take his medication, this time saying it was because of the failed drugs test.

Events of 22 September

86. At 3.42am on 22 September 2008, the man pressed his cell buzzer. A Operational Support Grade (OSG) spoke briefly with the man and then alerted the officer that was interview about the man's role as wing cleaner. This officer had known the man since he had arrived at Frankland and was aware of his health problems. He immediately went to the cell where the man said he was sure that he was having a heart attack. The officer told him to take any medication that he had, and went to call the duty nurse.

87. The duty nurse attended D wing with a wheelchair, and took the man back to the healthcare unit. In line with the procedure for dealing with chest pain emergencies at night, the duty nurse checked the man's pulse and blood pressure and then took an ECG. She faxed this to an out of hours doctor who immediately advised her to call an ambulance and to give the man 2.5mg of diamorphine (a pain killer) and 50mg of cyclizine (a drug to counteract the nausea often associated with diamorphine).

88. The duty nurse went to the out of hours drugs cabinet to get the drugs, but could not find them. She decided to call the doctor again to ask what alternatives could be given, but at that point the man became unconscious. The duty nurse immediately commenced cardio pulmonary resuscitation (CPR) and was joined by ambulance staff who had arrived in healthcare. The ambulance crew used a defibrillator (a machine which uses electrical impulses to restart or stabilise the heart) and intubated him (the insertion of a tube into the throat to ensure a viable airway).

89. While this was taking place, a Principal Officer (PO) who was the Night Orderly Officer in charge of the prison that night, asked a Senior Officer to organise an escort for the man to hospital. The SO ensured that the correct documentation was prepared and all restraints available. Meanwhile, the officer who was first on the scene and a second officer, were asked to go to healthcare so that they could accompany the man to hospital.

90. At 5.21am, the ambulance left Frankland for UHND. No restraints were used while ambulance staff continued to work on the man. On arrival at UHND, the man was taken straight to A&E. Sadly, 20 minutes after he arrived, hospital staff told the officers who had accompanied him that the man had died.

Events after the man's death

91. All the staff who had been involved with the man's death were seen by a Governor, and statements were taken from them. They were also offered the services of the prison's Care Team. Notices were sent from the Governor to staff and prisoners to inform them of the man's death.

92. One of the prison's Family Liaison Officers, was asked by the Deputy Governor to visit the man's family to inform them of his death. Another Governor accompanied her, and they left Frankland shortly after 9.00am. They arrived at the man's wife's address but could not get a response. The Family Liaison Officer telephoned the man's wife and said that they needed to see her, and they arranged to meet her at home at lunchtime. The Family Liaison Officer explained what had happened, and also explained what investigations would take place. The prison offered to help pay for the mans' funeral. The Governor returned a few days later to give the man's property to the family.

93. A notice was issued for prisoners and staff to explain what had happened.

94. Although staff were seen by a Governor on the morning of the man's death, no members of staff recall whether a critical debrief was held.

ISSUES

Whether the man was treated appropriately for his mental health problems?

95. The man had a long history of mental health issues, originating from the road traffic accident in 1986. He had been treated by several psychiatric professionals.

96. On his arrival at HMP Durham on 13 September 2006, the man was seen by a reception nurse. A referral notice was sent to the Mental Health team that day, and an assessment carried out the following day. It recommended that an urgent referral be made to the Community Psychiatric Nurse, and on 25 September, the prison doctor at Durham made an urgent referral for the man to see a psychiatrist. After missing an appointment through being at court, he saw a psychiatrist on 16 November 2006.

97. After being released on bail, and before he was sentenced, the man was seen by a Consultant Psychiatrist, who provided a lengthy report to the local Crown Court. A copy of this report was attached to the man's prison records, and it would appear that staff at Durham were aware of his psychiatric history. However, during this period, the man missed several appointments with psychiatric staff.

98. On transfer to Frankland, the man's history of mental health problems was noted during his reception screening. He was referred to the Registered Mental Nurse, who saw him frequently during the next few weeks. He was also seen by a consultant, who referred him for investigations to rule out possible temporal lobe epilepsy problem. He believed the man presented with dysfunctional personality traits.

99. On 15 February 2008, after further consultations with psychiatric staff at Frankland, the man was seen by a Specialist Psychiatric Registrar. The Psychiatric Registrar believed that the man exhibited no signs of mental illness, and would not benefit from further mental health intervention or medication. He also believed that the man was more likely to have "both a borderline and anti-social personality disorders".

100. The man was seen by the CPN on several occasions in the following months. On 17 April, however, the CPN told the man that he proposed to discharge him from the Mental Health team's caseload, at which point the man became "angry and quite abusive". He had no more psychiatric intervention following this meeting.

101. During his time at both Durham and Frankland, the man received extensive care from various health professionals. Two specialists concluded that he did not display any signs of mental illness and would not benefit from further intervention. I believe that both prisons had good access to records about the man's prior history, and that he was

provided access to relevant healthcare professionals whenever it was appropriate.

Whether the prison helped the man cope with his paranoia?

102. The man's family asked my investigator to establish whether staff at Frankland made allowance for the paranoia he suffered as a result of PTSD. Specifically, they were concerned that the man would not attend the treatment hatch to collect his medication and, as a result, frequently failed to take his medication.

103. Although the man refused on many occasions to collect his medication, it is clear from his medical records that staff made many attempts to find a way to ensure that he could obtain it. On arrival at Frankland, he was still on an ACCT and it was not possible to give him his medication "in possession" because of the risk that he might harm himself. Once it became clear that the man would present less of a risk if given his medication "in possession", staff made every effort to accommodate him. Although it was not possible to give him his medication at night, they did agree to give it to him in the afternoon when there were fewer people around. While medication continued to be an issue, it is clear to me that staff at Frankland responded to the man's needs.

Whether the man was seen by a mental health nurse in a corridor?

104. The man had told his family that a mental health nurse had interviewed him in a corridor, in the hearing of other prisoners, and that he had found this stressful.

105. This incident is probably the meeting on 17 April 2008 with the CPN . The CPN recorded that he was unable to see the man in an interview room and, given that he was unwilling to attend healthcare, it is likely that this would have been on the wing. The CPN has recorded the event as follows:

> "Unable to see the man to discuss discharge. We were unable to use an interview room and he asked why I was seeing him today. When I mentioned discharge he became angry and quite abusive. He strongly argues that he has had many years of therapy and refused to listen to my point at all. The man eventually walked away, but was still agitated and angry."

106. Given the man's unwillingness to attend healthcare, it is clear that any interviews would need to take place on the wing. However, any such interviews should be confidential and not conducted in a public environment. The CPN had evidently tried to use an interview room, and thus it would be inappropriate to make a formal recommendation. However, I draw the matter to the attention to the Head of Healthcare and suggest that staff are reminded of the need to ensure privacy before discussing confidential medical issues on the wing.

The man's heart attack on 4 August

107. The man complained in one of the workshops on 4 August that he had central chest pain. He was taken to healthcare and clinical observations were taken. They strongly suggested that the man was suffering from a myocardial infarction, and, under the supervision of a doctor, medication was given and an ambulance was called.

108. The man's family believed that he had pressed his cell bell during the night but that it had either not been answered, or there had been a lengthy delay before it was answered. They also said that he had told officers that he thought he was having a heart attack but the officers had said he was having a panic attack. He also mentioned this to a prisoner in a neighbouring cell. The family gave my investigator the names of two prisoners who might have been able to provide further details.

109. My investigator attempted to speak to one of these prisoners during a visit to Frankland, but he refused to be interviewed. The only other record of events was made by the nurse that saw him when he was taken ill at the workshop. Although there is an electronic record of when cell bells are pressed, my investigator was unable to establish whether the man pressed his bell that night, or if he spoke to officers.

110. When the paramedics arrived at Frankland, staff believed that he would be taken to UHND (indeed the prisoner escort form records the destination as being UHND). The paramedics decided, however, that they should proceed directly to James Cook Hospital, which is better equipped to deal with this type of emergency. An angioplasty was performed almost immediately upon the man's arrival there.

111. The man's family have asked whether there was undue delay in him receiving the care he needed before and after this heart attack. Given that the first reported notification to healthcare was at 9.45am, and that he departed for hospital at 10.30am, it would seem that the response of prison and healthcare staff, and of the paramedics, gave the man the best chance of survival. He arrived at James Cook Hospital at 11.15am and was immediately seen by staff.

Family visits

112. My investigator was also told by the family that they had had difficulty visiting the man while he was in hospital. They had been told that they required a visiting order to see him, and wanted to know if this was necessary.

113. Frankland has a local instruction for bedwatch staff informing them of visiting arrangements for prisoners in hospital. Two paragraphs are of special relevance. Paragraph 2 states, "Visits to prisoners will be

booked in the usual way by phoning the prison on the visits booking number." , and Paragraph 4 says, "Visitors will be in possession of a valid visiting order."

114. My investigator asked staff at Frankland to explain this process. The manager of the Operational Support Unit, said that, ideally, visitors would have a visiting order, although she accepted that this would not always be possible in the circumstances. Anyone wanting to visit a prisoner in hospital would, however, need to book a visit with the visits desk. This was primarily to ensure the safety of staff and the prisoner. In an emergency, the Governor could allow the family to visit without following the process. The manager of the Operational Support Unit said that the guidance was currently under review.

115. It is important that prisons risk assess visits to hospital to ensure the security of the prisoner, staff and the public. However, it is also very important that the needs of the families are taken into account at what is obviously a stressful time. Having reviewed the current guidance, I do not think that it is clear what families need to do to visit prisoners in hospital. While welcoming the prison's internal review, I make the following recommendation:

The Governor should ensure there is clear guidance in place so that families understand what they need to do in order to visit prisoners in hospital.

Conduct of escort staff

116. The family expressed concern that, while the man was recovering from his operation, he was threatened and bullied by the escorting staff. They were concerned that the man's health was further affected by the stress caused by this episode.

117. My investigator interviewed two of the escort team separately. He also examined the bedwatch logs, which are a contemporaneous account of events completed whenever a prisoner is taken to hospital.

118. From this evidence, it is clear to see that several incidents took place during the man's transfer to James Cook Hospital. Both officers recalled that the man would not comply with the paramedic who was trying to treat him on the way to hospital, and was abusive towards him. After his operation, the man was also abusive towards the escorts and hospital staff, saying that the escorts were torturing him and beating him up. Later, he complained that the officers were "making excessive noise, banging and slamming doors and windows".

119. When interviewed, both officers described the layout of the room that the man was in, and its positioning relative to the nurses station. As the nurses were working immediately outside the room, it would have been very difficult for the officers to have made any noise without it

being noticed by nursing staff. One of the officers reported these events to an SO, a security officer at Frankland. The Senior Officer visited the hospital on 5 August and spoke to nursing staff and to the man. A nurse confirmed that she had been caring for the man the day before and had not witnessed any threats or abuse from the escort staff. When the SO spoke to the man, he initially denied making any allegations, but then repeated his claim that the escorts were making too much noise.

120. In the circumstances, I find it highly unlikely that the man suffered any abuse during his stay in hospital. His allegations were recorded at the time by prison staff, and a nurse who was working at the time confirmed their version of events. The SO made sure that he spoke to the man to clarify what happened the day before and was satisfied that nothing untoward had occurred. My investigator, in reviewing the evidence, also believes that the officers did not behave in the way the man alleged.

121. Indeed, my investigator found other occasions when the man had been abusive towards medical staff, including the conversation with the CPN mentioned above. The Consultant Psychiatrist, in his report to the local Crown Court, also mentioned an episode on 22 February 2007 when the man had taken an overdose of tablets while drunk. He had been taken to hospital but "was very aggressive during the time in casualty and on the ward and the police had to be called".

The man's return to Frankland

122. When the man returned to Frankland, he was assessed in healthcare. He was seen by a nurse who ensured that he had the right medication and had been given information about his heart attack. When interviewed, she said that all patients returning from hospital are given the option of staying in healthcare or returning to the wing, and that the man chose to return to the wing. The nurse believed that this might have been because the man would not have been able to smoke in healthcare.

123. One of the family's concerns was that the man had been visited in his cell by an officer who had said that he had made a complaint against prison staff and that, if he caused any more trouble, he would be sent to the Isle of Wight. My investigator has found no evidence of a formal complaint being made by the man and, for this reason, it has not proved possible to take this matter further or determine whether the alleged incident actually took place.

Drug tests and the man's refusal to take his medication

124. The family were further concerned that the man had stopped taking his medication after failing a mandatory drugs test. They told my investigator that he had been taken before the Governor for adjudication. The man had explained that the failed test was caused by a prescription drug, and the Governor allegedly told him that he must choose whether to continue to take the drug. The man said that his cell was searched three times in a week in between his return from hospital and his death. The family were concerned that the man's refusal to take his medication had directly contributed to his death.

125. The man did fail a drugs test (which he was required to take because of his job as a cleaner). However, at the time of his death, an adjudication had not taken place. This makes it unlikely that he had the conversation as he had described with the Governor. My investigator examined the cell search logs. Other than a search conducted on 9 July 2008, in which nothing was found, there was no record of any other cell searches conducted in 2008. (In addition, like all prisoners, the man would have been subject to checks on the fabric of the cell.)

126. It is clear, however, that the man did refuse to take his medication. As the Clinical Reviewer says in his clinical review, "it is impossible to say to what extent this behaviour led to his death, but it certainly did not help". The man had a long history of refusing to take medication. My investigator found a letter written by a doctor in 1998 that said the man" was very reluctant to take his medication. He has not been taking his Stelazine regularly." During his time at Durham, it was regularly reported that the man was refusing to take his medication, and on one occasion his solicitors asked the prison to ensure that he was being properly monitored.

127. After he arrived at Frankland, the man continued frequently to refuse his medication. On two occasions, he said that he would rather have a heart attack and die than take his medicine. The prison doctor, wrote to the man asking him to consider taking his medication again. On his return from James Cook Hospital, he was seen by a nurse who went through what had happened and the medication he had been prescribed. At interview, she said that the man would have been fully aware of the importance of continuing his medication. On his medical record, there is a copy of a letter sent from the hospital to prison medical staff which discusses the role of clopidogrel. This says, "it is vitally important that [it] is not stopped early".

128. It seems highly unlikely that the man was unaware of the importance of continuing his medication, or of the consequences if he failed to do so. He had a long history of not complying with medication regimes. It is not clear why this was, although staff tried on many occasions to

encourage him to comply. It would appear that this final refusal was another episode in the general pattern, rather than a specific response to an incident. Although the man may have been upset by the drug test, he had not been adjudicated upon or seen the Governor (although he reported to another nurse on 11 September that he had).

129. The Clinical Reviewer comments in his clinical review that:

> "In particular, stopping the drug clopidogrel was most unwise as this was given to prevent clotting in the newly inserted stent. It is entirely possible that stopping this drug resulted in the further heart attack."

The man had been given much information about the dangers of stopping his medication and seems to have made an informed decision to have done so.

130. Although there is a disparity between the man's account of the failed drugs test and that recorded in prison records, it is clear that he failed a mandatory drugs test because of a prescribed drug that he was taking. He was charged under prison rule 51 (9), which refers to administering a controlled drug. Prison records suggest that the hearing had not taken place at the time of his death. Since the result of the test had been received on 5 September, this seems a long wait for a resolution that could well have proved stressful for the man.

131. I understand the purpose of a drugs test even when a prisoner is known to be taking a medication that would produce a positive result. The test may, after all, show that he was taking another substance that has not been prescribed. I am less sure, in circumstances when the result is only positive for the known drug, why it should take so long for the matter to be resolved. I make the following recommendation:

The Governor should review procedures for managing adjudications to ensure that charges resulting from the use of properly prescribed medication are dismissed more quickly.

The man's anti-smoking medication

132. The man's family also asked whether the medication he had been given to help him stop smoking was suitable for someone with heart problems. When they met my investigator and FLO, they provided a medical leaflet for Champix, an anti-smoking medication. From his pharmaceutical records, however, there is no trace of the drug being prescribed for the man at Frankland. When interviewed, the pharmacist at Frankland said that he had been prescribed nicotine patches which are different to Champix.

133. My investigator asked the Clinical Reviewer to examine this issue. He writes in his clinical review:

> "I was asked to look specifically at Nicotine Replacement Therapy and whether it was contra-indicated in patients with recent Myocardial Infarction such as the man.
>
> "The British National Formulary [which gives doctors guidance on prescribing drugs] recommends caution when given to a patient with recent Myocardial Infarction and further recommends that, if given, replacement is commenced under clinical supervision.
>
> "It does not say that Nicotine Replacement is contra-indicated in such cases.
>
> "The Smoking Cessation form completed on 05.08.08 clearly indicates that the treatment was started after a risk / benefit analysis and the man signed the form to indicate that any risk had been discussed with him.
>
> "It was clearly felt that the benefits to his health of discontinuing smoking outweighed any risks involved.
>
> "The treatment was commenced 24 hours before his discharge from hospital under clinical supervision."

134. The Clinical Reviewer is clear that the anti-smoking medication prescribed for the man was appropriate. It was dispensed while he was still at James Cook Hospital and this was also appropriate. The benefits to the man of stopping smoking were greater than the risk of him taking the medication. It would seem, therefore that the correct course was followed by clinicians.

Events of the night of 22 September

135. Another concern for the family was whether the man had access to a cell bell, and whether he used it on the night of his death. My investigator has seen a copy of the print out for the cell bells on D wing that night, and asked the officer second on the scene at interview to explain the timings on the print out.

136. The cell bell was pressed at 3.42am and 23 seconds. The Operation Support Grade that responded and reached the cell at 3.43am and 19 seconds. He reset the bell two seconds later, and an officer arrived another 15 seconds after that. These timings seem to be appropriate and, from speaking to the officer at interview, my investigator is satisfied that staff acted quickly and effectively once alerted by the man.

137. The man was taken to healthcare by a nurse. She followed the procedure for dealing with a medical emergency involving chest pain. The man was taken to healthcare in a wheelchair as a heart attack could not be ruled out, and his clinical observations were taken. An ECG was also taken and sent to the out of hours doctor who advised that an ambulance should be called immediately and diamorphine and cyclizine given.

138. The Clinical Reviewer has considered the procedure followed by the nurse. He believes that it is satisfactory, but he notes that the procedure does not mention when an ambulance should be summoned or in what circumstances. In his clinical review, he writes:

> "Valuable time would have been saved if the ambulance had been summoned immediately he presented with chest pain. (The National Framework for Coronary Heart disease points to this as best practice where there is a suspicion of myocardial infarction (and with his history, there must be a very high likelihood) and indicates that this should be done before other investigation is undertaken.)
>
> "It is not possible to say whether, had the ambulance been summoned earlier, the outcome would have been different. It is important to note that the nursing staff present followed the local protocol to the letter and no criticism of them is implied."

139. I agree with this conclusion. It seems strange that, for a man who had had a previous heart attack seven weeks earlier, an ambulance was not called almost immediately. The Clinical Reviewer has made the following recommendation in his clinical review, which I endorse:

The PCT should review its guidance on the management of suspected acute myocardial infarction (as opposed to atypical chest pain) to ensure that emergency ambulances are summoned without delay.

140. My investigator was also concerned as to whether Frankland's status as a high security prison was a factor in the ambulance not being called immediately. He spoke to the Safer Prisons Advisor for the high security estate. He explained that the medical procedures (for example, those the nurse had followed) would be drawn up by the local Primary Care Trust, and would probably be the same for each of the prisons in their area. He added that, because Frankland is a high security establishment, it might take slightly longer to send a prisoner out to hospital because of the procedures for breaking the night state. I am afraid I think this is inevitable in a high security jail.

141. I am satisfied that the delay calling the ambulance was due to the procedures being followed, and not because of any reluctance on the part of staff to open the prison while it was in night state. As such, I

believe that Clinical Reviewer's recommendation will help ensure that this is not an issue should similar events happen in the future. The Governor may wish to ensure that staff are aware that the wellbeing of prisoners should always be their first consideration.

142. When the nurse called the out of hours doctor, he advised her to give the man two drugs – diamorphine and cyclizine. The nurse looked in the out of hours cupboard, but was unable to locate the drugs. She was trying to call the doctor for advice when the man collapsed. My investigator spoke to the pharmacist about the lack of available drugs for night staff. In this instance, the drugs were in fact available, and documentation confirming this was provided by the pharmacist,. Alternative drugs were also available had the nurse spoken again to the out of hours doctor. Following her conversation with my investigator, the pharmacist said that she would reissue the list of drugs held at Frankland to all medical staff. I welcome this, and am pleased that staff at Frankland have been proactive in addressing this issue.

143. The man's family asked whether he said anything before he died, and whether anyone was with him. My investigator spoke with several of staff who were with him that night. The officer, who knew the man well from D wing, spoke to him when he pressed his cell bell, and asked him if he was alright. The man replied "I am having a heart attack,". He was then taken to healthcare, where the nurses treated him. One of the nurses recalled that he was agitated and said that he thought he was dying. She comforted him and tried to assure him that he was not, stroking his arm as she did so. Sadly, shortly afterwards the man suffered a heart attack and became unresponsive. Staff were with him at this point.

144. The officer who arrived second on the scene was also part of the escorting team who accompanied the man to UHND. When interviewed, he said that he had travelled in the ambulance with him and, because of the nature of the situation, no restraints were applied. Upon arrival at UHND, the man was taken to a side room, and two officers remained outside until they were informed of his death.

Contact with the family

145. My investigator was asked by the family to find out whether the police had taken any letters or other documents from the man's cell. I am happy to confirm that they did not.

146. The man's family were also concerned about the length of time it took for them to be informed of his death. My investigator spoke to a Governor who explained that he had left Frankland with the Family Liaison Officer as soon as they had the relevant details. They were, however, unable to get a response when they visited the man's wife's address. Having eventually made contact, they waited for the man's

wife to return home, and also visited his mother to break the news. The Family Liaison Log, which my investigator has seen, confirms the Governor's account.

147. Further contact was made by the Family Liaison Officer the next day, when she arranged for the family to visit the mortuary to see the man. The Governor visited again on 26 September to return the man's property, and the Family Liaison Officer spoke with the man's wife on 2 October to answer a query. It would appear from this that staff at Frankland were available to assist the family when they were needed. There is a difficult balance to strike between being available for the family and interfering more than the family wants. I am aware that, in this instance, the perception of the family is that they had very little contact. Without implying any criticism of the contact in this case, the Governor may wish to look at the FLO role and assure himself that, in all instances, the needs of the bereaved family are fully considered.

Support for staff

148. Following the man's death, staff were seen by a Governor. This gave them an opportunity to write statements about their involvement and discuss any issues they had. They were also given the chance to speak to a member of the staff care team, and several people involved confirmed that the care team followed up this initial contact.

149. There was, however, no critical incident debrief. Debriefs can be important for people to reflect on an incident some time after the event and see what lessons can be learnt. Prison Service Order (PSO) 8150 lists several categories of event when a critical incident debrief is mandatory. They include "violent death in custody", but not a death from natural causes. The PSO (section 2.2) does, however, give the Governor discretion to hold a critical incident debrief if he considers that the staff may have been exposed to trauma.

150. In a closed institution, a death can be traumatic for staff involved regardless of its cause. A critical incident debrief could help as staff would be able to speak more widely about the issues involved. As important, however, is the opportunity for learning and improvement. Unlike the hot debrief, which occurs immediately after the event, a critical incident debrief allows for reflection. In this case, it seems that holding a critical incident debrief was not considered, and the opportunity was lost. I recommend that the Governor considers implementing critical incident debriefs more widely:

The Governor should consider holding a critical incident debrief after all sudden deaths in custody.

151. During the investigation, the Governor provided my investigator with some documents prepared by the Directorate of High Security. These included a strategy to enhance the psychological well-being of staff in parts of the high security estate. While not directly relevant to this case, I have been pleased to learn that this work is underway.

CONCLUSION

152. The man had a history of serious heart disease. He had also suffered from Post Traumatic Stress Disorder following a road traffic accident in 1986.

153. The man frequently refused to comply with his medication regimes, although he was warned of the consequences of not doing so. Doctors and other medical staff at the two prisons where he served his sentence repeatedly tried to engage him in a consistent regime, but with little effect.

154. After a heart attack in August 2008, the man was again told that he needed to comply with his medication. Once again, he chose not to take the medication. Not taking clopidogrel was especially risky as this medicine was designed to ensure that the stents in his heart were not blocked with platelets. Sadly, the man had a further heart attack six weeks later and on this occasion staff were unable to save him.

RECOMMENDATIONS

1. **The Governor should ensure there is clear guidance in place so that families understand what they need to do in order to visit prisoners in hospital.**

2. **The Governor should review procedures for managing adjudications to ensure that charges resulting from the use of properly prescribed medication are dismissed more quickly.**

3. **The PCT should review its guidance on the management of suspected acute myocardial infarction (as opposed to atypical chest pain) to ensure that emergency ambulances are summoned without delay.**

4. **The Governor should consider holding a critical incident debrief after all sudden deaths in custody.**