Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Frankland, in February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2010

This is the report of an investigation into the circumstances of the death of a man in February 2009. He was 68 years old and a prisoner at HMP Frankland. He died at hospital from post operative complications following planned surgery to repair an aortic aneurysm.

Although the man had been unwell with suspected heart problems for some time, the aortic aneurysm was only diagnosed shortly before his death. He was a Jehovah's Witness. His refusal to have a blood transfusion because of his religious beliefs was a complicating factor, and his death was sudden and unexpected. I offer my sincere condolences to all who knew him and were affected by his death.

My colleague conducted the investigation on my behalf. An independent review of the man's medical care was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful to him for his very valuable contribution. I would also like to thank the Governor and staff at Frankland for their cooperation and assistance with the investigation. I am particularly indebted to the liaison officer who provided a high standard of liaison to my investigator. I must apologise for the delay in issuing this report.

A Root Cause Analysis of the man's clinical care while in hospital was also undertaken by the NHS Foundation Trust. I am very grateful to the Trust for disclosing their report to my office. The Patient Safety Manager gave consent on behalf of the Trust for the Root Cause Analysis to be annexed to this report.

The man gave his former wife as his next of kin. The prison tried to notify her of his passing but discovered, sadly, that she had herself died some time before him. He had also nominated a Jehovah's Witness minister who was unaware that he had done so. There were no other named next of kin who could be involved in the investigation.

I make four recommendations in my report. The first relates to the cancellation and re-arrangement of medical appointments: the reasons for any cancellation should be clearly marked in the prisoner's medical record with an audit trail to the clinician who agreed the decision. The second asks the Head of Healthcare to ensure that, if handwritten entries are made on a medical record, the corresponding information is also entered on the EMIS computer system. A third recommendation asks the Head of Healthcare to ensure the regular review of prisoners with long term medical conditions within nationally accepted guidelines. The fourth and final recommendation relates to the recording of all significant medical conditions in a prisoner's medical records so that they are easily accessible to the healthcare professionals providing care.

The National Offender Management Service has accepted my recommendations and their response is documented on page 21 of my report.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2010**

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SUMMARY

The man was sentenced to life imprisonment on 14 December 2001 at Crown Court. He served his sentence at Frankland until his death in February at hospital from a haemorrhage following planned surgery. He was 68 years old.

Throughout his sentence, the man attended prison healthcare for various medical complaints. He complained of a pounding heartbeat in November 2004 and underwent an electrocardiogram (ECG) the following year. (An ECG is a test to measure the electrical activity of the heart.) The prison doctor was concerned that the ECG showed he had a slow heart beat. The doctor referred him to a consultant cardiologist and in July 2006 he was diagnosed with a leaking heart valve and high blood pressure. A yearly review of the condition was advised.

In December 2006, the man complained of chest pain and was sent to hospital as an emergency but discharged the following day with a diagnosis of non-specific cardiac pain. A few months later, the hospital wrote to prison healthcare staff to give the result of a 48 hour ECG. In that letter, the hospital raised concerns regarding the cancellation of cardiac clinic appointments by the prison.

In July 2007, the man changed his religion from Roman Catholic to Jehovah's Witness. He signed an Advance Medical Directive form consenting to all necessary medical treatment but not blood transfusions or blood products. Records show that medical staff at the prison and the hospital discussed the implications of this with him. This is relevant to the circumstances surrounding his death as his religious beliefs affected his medical treatment when he needed a blood transfusion following surgery shortly before he died.

The man continued to attend healthcare and hospital appointments throughout 2007 and 2008. He was diagnosed with triple vessel disease in February 2008 and surgery was recommended. In May 2008, the cardiologist referred him to a cardiothoracic surgeon at hospital. The surgeon decided to take a joint approach with a vascular surgeon. This was because a scan had revealed that he had an aortic aneurysm as well as a leaking heart valve. The hospital consultants had to decide in which order to treat the leaking valve and the aneurysm as both were life threatening conditions. They decided that he would undergo heart surgery first followed by a repair to the aortic aneurysm.

Further concerns around the cancellation by the prison of an appointment for a medical procedure to deal with the man's heart problem were raised by the consultant cardiologist in September 2008. The medical procedure was successfully carried out in December.

In February 2009, the man underwent surgery to repair the aneurysm. While in the intensive care unit, complications arose and he was returned to the operating theatre. He deteriorated further and prison officers escorting him throughout have described a "magnificent effort" by hospital staff to save his life. Their efforts were sadly unsuccessful and he died shortly after.

The man did not have next of kin and had nominated the prison's Jehovah's Witness minister, who was unaware he had been so appointed.

The clinical reviewer has made a number of recommendations relating to record keeping and the management of patients with long term medical conditions that I endorse. He has also raised the issue of the cancellation of important hospital appointments. I have been unable to determine conclusively whether the prison or the hospital cancelled those appointments, although the available evidence suggests strongly that the prison was responsible on a number of occasions.

As the man was a prisoner at the time of his death, the hospital undertook a Root Cause Analysis to review his care. They concluded that he died from bleeding following surgery and raised concerns that prison escort staff witnessed the traumatic details of surgery.

My investigation found that the man received healthcare comparable to that which he would have received in the community.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in February 2009. Terms of Reference and notices were issued to staff and prisoners at Frankland telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of his core and clinical records, as well as other documents relevant to his time in custody and to his death.

2. My investigator also contacted the Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The report concludes that the man died of:

    1a: Haemorrhage, due to
    1b: Repair of atherosclerotic abdominal aortic aneurysm.

3. A clinical review of the man's medical care was commissioned from the local Primary Care Trust (PCT) and undertaken by a clinical reviewer. He focussed on the medical care he received at Frankland and while at hospital. He reviewed all necessary records and conducted interviews jointly with my investigator. His review appears as an annex to this report.

4. My investigator visited Frankland in May 2009 with the clinical reviewer. She toured A wing where he had been located and spoke with staff and prisoners who knew him. She also spoke with a member of the prison's Independent Monitoring Board (IMB).

5. The man did not have any next of kin who wished to be involved in the investigation. He had nominated the prison's Jehovah's Witness minister but he did not know about this.

HMP FRANKLAND

6. HMP Frankland is part of the Prison Service's High Security Estate. It holds prisoners convicted of serious offences including category A prisoners, as well as those serving life sentences and sentences of over four years. The maximum prison capacity is 732 men. Frankland has been assessed as one of the National Offender Management Service's high performing prisons.

7. The prison's inpatient healthcare centre has 18 beds. The healthcare department has adopted 'teleheal' technology. This is a diagnostic service with a direct camera link between the prison and a hospital Accident and Emergency Department. It means a doctor within the prison can have a second opinion on a medical problem from a consultant at the hospital. There are good links with the Primary Care Trust, with visiting consultants for orthopaedic clinics, a dental suite, digital x-ray facilities, and two full time doctors.

8. In her inspection report published in June 2008 HM Chief Inspector of Prisons acknowledged the difficulties Frankland faced with a challenging, albeit relatively static, population. She assessed that healthcare provision was good, with well-maintained accommodation

9. In their last available report dated 2006, the prison's Independent Monitoring Board (IMB) identified problems relating to difficulties in transferring prisoners to other prisons where they could access courses in order to progress through their sentence. A member of the IMB told my investigator that the IMB viewed the prison as professionally run by both governors and staff. He described prisoners as receiving "fair treatment" and considered that "processes were adhered to" despite frustrations in dealing with a cumbersome and bureaucratic culture.

10. I have raised concerns in previous death in custody investigation reports that important medical appointments in the community have been cancelled by Frankland because of a lack of escort staff. My investigator raised this issue with the prison during this investigation as both she and the clinical reviewer noted that it was a relevant factor in the care the man received.

KEY FINDINGS

11. The man was remanded into custody at HMP Forest Bank on 13 February 2001. He was convicted of serious sexual offences and sentenced to life imprisonment with a tariff of seven years and one month on 14 December 2001 at Crown Court. (A 'tariff' is the minimum time that must be served in prison before release can be considered by the Parole Board.) His tariff was due to expire in January 2009.

12. The man had served lengthy sentences for similar sexual offences in the past, and asked to be protected from other prisoners under prison rule 43 (now rule 45) and the prison agreed. (Rule 45 is a provision under which prisoners can be segregated from others for the good order of the prison or for their own protection.)

13. An entry in the man's records dated 27 December 2001 says that, while in the segregation unit, he was coping well with the news that he had been sentenced to life imprisonment.

14. In early 2002, the man regularly attended the healthcare centre in Forest Bank to have an abscess on his left knee dressed. He moved to HMP Frankland in March 2002 where he remained until his death. A reception interview identified that he should attend for an asthma assessment. His knee condition deteriorated and he was sent to hospital for treatment.

15. The clinical record reflects that the man did not attend the asthma clinic on a number of occasions, but no explanation is noted. On 28 January 2003, an entry in the clinical record shows that he received reassurance from the healthcare department about experiencing a heightened awareness of his heartbeat. He also attended healthcare throughout 2003 and 2004 with a foot wound requiring frequent treatment and dressing. Action plans were drawn up, implemented by healthcare staff, and reviewed by a prison doctor. An entry in the clinical record dated 18 June, with an illegible signature, said that a recurrence of tinea pedis[1] was suspected as the reason why his foot condition would not heal.

16. The man continued to attend healthcare during 2004 for asthma reviews and to have his foot dressed. In November 2004, he attended an asthma review in which he told the healthcare worker he was using the inhaler as directed and that he was experiencing a pounding heart rate. He was advised that this was normal but it was noted he was reluctant to accept this assessment. He was also advised to mention his pounding heartbeat to the doctor when he next saw him.

17. The following year, an entry in the clinical record dated 7 December 2005 says that the man had an Electrocardiogram (ECG). Healthcare staff were not concerned about the result and gave no supporting reason for further investigation as he was said to look and feel well at the time. However, a prison doctor wrote to a consultant cardiologist at hospital on 9 December 2005 asking

[1] Tinea Pedis is more commonly known as Athlete's Foot, a fungal infection.

him to comment on the ECG. Although the prison doctor acknowledged that the man did not have a family history of heart problems, he noted that his pulse was slow and wondered if the changes on the ECG were significant.

18. On 23 March, the hospital Cardiology and Respiratory Investigations Unit sent an appointment to the man for a further ECG on 31 March 2006. He attended the appointment and was diagnosed as suffering from moderate left ventricular hypertrophy[2] (LVH).

19. A few days later on 3 April 2006, the prison doctor wrote a further letter to the consultant cardiologist saying he was uncertain whether the man's problem was due to his blood pressure which had risen from 140/65 to 193/73 at the last reading. The cardiologist's response confirmed the previous diagnosis of LVH and suggested that the man had high blood pressure. He advised that the hospital should conduct a clinical assessment of the man's aortic valve disease and that he would arrange a routine clinic appointment on the prison's behalf. The appointment was made for 6 July.

20. The prison doctor wrote to the man on 8 May 2006. He explained that the consultant cardiologist was concerned that he might have mildly raised blood pressure and that his heart valve was slightly leaking. He advised him that he would need to begin taking medication to reduce his blood pressure. This included penicillin to cover the possibility of any future operations to the heart valve.

21. The man went to the hospital on 6 July. He was diagnosed with mild aortic stenosis[3], moderate aortic valve regurgitation[4] and high blood pressure. His prescription for ramipril[5] was increased to control his blood pressure and help with his LVH, while that of his inhalers for asthma remained unchanged. There was no indication that surgery was required at this stage, but it was acknowledged that he might need this at some point. A yearly review was advised.

22. The prison doctor told the man of the outcome of his hospital appointment. He placed responsibility upon him to keep in touch with healthcare regarding his heart condition.

23. On 17 December 2006, the man went to healthcare saying he had central chest pain that radiated down both arms and into his neck. He was sent to hospital as emergency. He was discharged the following day with a diagnosis of non-

[2] Left ventricular hypertrophy is enlargement (hypertrophy) of the muscle tissue that makes up the wall of the heart's main pumping chamber (left ventricle).

[3] Aortic stenosis is a narrowing which restricts red blood from moving from the left ventricle into the aorta.

[4] Aortic regurgitation (AR) is the leaking of the aortic valve of the heart.

[5] Rampiril is an ACE inhibitor (trade name Altace) used to treat high blood pressure or in some patients who have had a heart attack.

specific cardiac pain, an ECG having showed some ischaemic changes.[6] His medication on discharge was aspirin, ramipril[7], amlodipine[8], cetirizine[9], citalopram[10] and inhalers for asthma. The clinical reviewer has questioned the prescription of citalopram as there is no mention in the clinical notes of him suffering from depression.

24. An appointment was made for the man to have a computerised tomography (CT) scan on 29 January 2007. (A CT scan creates detailed images of the inside of the body, giving good pictures of the soft tissues of the body which do not show on ordinary x-rays.) The appointment was changed by a handwritten note on the letter to 7 February 2007. No reason is given in the clinical record.

25. On 8 January 2007, the man attended the clinic of a consultant ear, nose and throat surgeon. The man had longstanding nasal difficulties following an injury in earlier life. An urgent scan was advised and an appointment given by the hospital for 26 March 2007 at 4.00pm. He did not attend. The appointment letter is crossed through and a note "cancelled – staff and time" is written on the lower right hand side. The hospital wrote to the prison on 26 March to advise that he had not attended his appointment. This suggests that the prison might not have told the hospital to cancel the appointment. A note at the bottom of the letter says that the appointment was cancelled by the prison due to the time it was scheduled and the prison was awaiting a further appointment. An entry in the clinical record dated 27 March confirms that he should have attended the ENT clinic the day before but this was cancelled by the prison. This was not the first occasion that his appointments with the hospital were cancelled and I address the matter later in this report.

26. The clinical record shows that, on 14 May 2007, the man went to the healthcare centre complaining of chest pain. The prison doctor referred him to a cardiac consultant at hospital, giving a brief history and asking for her advice on the nature of the chest pain. The consultant responded by letter on 21 May that the chest pain could be due to a number of causes, and she would assess the man shortly on his annual review. However, at that review clinic, he denied having chest pain or tightness on exertion in the previous December.

27. On 4 June, the cardiac consultant invited the man to have a 48 hour ECG at the hospital. (A portable tape recorder would be fitted to record the rhythm of his heart.) The result of the investigation was detailed in a letter from the consultant to the prison doctor on 23 July. In that letter, she said that the man's original review was due in July but the prison had changed it to 16 October 2007 and had also cancelled the September appointment. She was concerned about this and said that she would contact the prison again after his review in October.

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[6] Ischaemia means a reduction in the blood supply, usually as a result of a blocked artery, causing less oxygen to be transported to tissue.
[7] Ramipril is a drug used to treat high blood pressure.
[8] Amlodipine is a long-acting calcium channel blocker used for treating high blood pressure and in the treatment of angina.
[9] Cetirizine is a non-sedating antihistamine used in the treatment of allergic rhinitis.
[10] Citalopram is an anti-depressant drug used to treat major depression associated with mood disorders.

28. Meanwhile, healthcare staff continued to monitor and treat the man for hypertension (high blood pressure). The handwritten clinical record shows that he had an ECG at the prison around 18 July and the results were sent to the cardiac consultant.

29. The man's core record contains a signed Notification of Change to Religious Registration indicating that he changed his religion from Roman Catholic to Jehovah's Witness in July 2007. This is significant as he was unable to have a blood transfusion when his condition deteriorated after surgery shortly before he died.

30. My investigator and the clinical reviewer spoke with a prisoner who knew the man well. Regarding his conversion to Jehovah's Witness, the prisoner thought that he "believed in it deeply" and was aware he might need blood during any future surgery but would refuse. The prisoner was not confident that the man fully understood the consequences of refusing a transfusion. However, he had also told him that he was not bothered about it as he was not going to be released from prison as he had "nothing to go back to".

31. Healthcare staff were called to the wing on 21 August 2007 when the man experienced palpitations and shortness of breath after lifting boxes. He was advised to go to healthcare if he felt any further episodes, but declined to attend the doctor that evening.

32. Neither the electronic nor the handwritten clinical records show that the man attended the cardiac consultant's clinic on 16 October 2007. However, she wrote to the prison doctor following the man's attendance thereby evidencing that he did go to the clinic. She found him "somewhat vague and variable" when he gave her his medical history, but she was pleased to hear that he had given up smoking in January 2007. She confirmed he had been placed on the waiting list for a coronary angiography to explore whether he had coronary artery disease, and she hoped to perform this within the next two months.

33. On 13 February 2008, the man attended the healthcare cardiovascular disease (CVD) clinic. He said he had stopped smoking a year before and felt better for it. He had managed his high blood pressure by using his religious beliefs to reduce the stress in his life. He was given the opportunity to ask questions about his health but declined saying that he was fine at the time.

34. The man saw the cardiac consultant at hospital on 20 February 2008. He underwent a cardiac catheterisation[11] procedure and was diagnosed with triple vessel disease. An entry in the clinical record notes his religion as a Jehovah's Witness and that surgery was recommended. It was also implied that there were issues to be discussed about further surgery and his religious beliefs.

[11] A coronary catheterisation is a minimally invasive procedure to access the coronary circulation and blood filled chambers of the heart using a catheter. It is performed for both diagnostic and treatment purposes.

35. On 21 April, the man signed an Advance Medical Directive form, witnessed by the Jehovah's Witness minister. The form confirmed that he consented to all necessary medical treatment excluding the transfusion of blood or blood products.

36. The cardiac consultant referred the man to a consultant cardiothoracic surgeon at another hospital. In her referral letter of 27 May, she gave a detailed background of his medical history including information regarding the cardiac catheterisation performed in February. A computerised tomography (CT) scan revealed that he also had an aortic aneurysm[12] measuring 7.5cm in diameter. She said that he wished to be considered for cardiac surgery, and that she had referred him to a vascular surgeon for an opinion on management of the aneurysm. She suggested to the cardiothoracic surgeon that he might wish to consider a joint approach with the vascular surgeon. She copied her letter to the prison doctor at the prison and asked him to discuss the situation with the man.

37. In addition to the man's heart complaint and aortic aneurysm, he also had a long term chest complaint and arthritic pains. On a routine appointment in June a healthcare worker thought he appeared a little anxious about his forthcoming operation. He recorded that he would review the man again shortly.

38. The consultant vascular surgeon wrote to the cardiac consultant in early June to advise that he had arranged for an urgent CT scan to see if the man was suitable for surgery for the aneurysm. On 8 July, he wrote to the prison doctor saying that he and the vascular surgeon had concluded that the best course would be for the man's heart to be treated first and then the vascular surgeon would arrange to repair the aortic aneurysm. The vascular surgeon commented that the cardiothoracic surgeon had planned to see the man on 7 July but the prison had cancelled the appointment "due to lack of prison warders". He said that the cardiothoracic surgeon would be able to see him in two weeks with surgery planned for August. The vascular surgeon asked the prison doctor if there was any added weight that the hospital could give to the man's case regarding "the prison officer staffing side of things". Again, I refer to the matter of the cancellation of appointments later.

39. The man told healthcare staff on 15 July that he was using the GTN[13] (glyceryl trinitrate spray) much more often, even for the smallest physical exertion. He was advised not to exert himself too much as it appeared that he was making himself do some form of exercise regardless of whether he felt like it. He was asked to tell discipline staff if he was finding it too hard to keep his cell clean and make his bed. If so, healthcare staff would be able to help him manage his daily living.

40. The cardiothoracic surgeon wrote to the cardiac consultant confirming he had spoken to the vascular surgeon about the man's conditions. The cardiothoracic

[12] Dangeous ballooning of the aorta (the main artery leaving the heart) caused by disease to the artery's wall.
[13] Glyceryl trinitrate (GTN) is an alternative name for the chemical nitroglycerine, which has been used to treat angina and heart failure.

surgeon said that the vascular surgeon was quite worried about the possibility of the aneurysm rupturing. From the content of the letter it is clear that the cardiothoracic surgeon knew that the man was a Jehovah's Witness. An angioplasty was considered to be a suitable method of dealing with the heart problem, with the added benefit that he would quickly be able to have "life saving aneurysm surgery" if this route was adopted.

41. In her letter dated 2 September, the cardiac consultant says she saw the man at the hospital on that day. She said that the percutaneous coronary intervention (PCI)[14] (otherwise known as an angioplasty) planned in August to deal with his heart problem had been cancelled by the prison due to shortage of staff. There is no entry in his medical record referring to either the appointment or the cancellation. She discussed his planned surgery with him. She told him that he did not need aortic valve surgery at present and that, following his PCI, the vascular surgeon would carry out surgery to repair the aortic aneurysm. She would review him in six months when she expected both operations to have been carried out.

42. The external appointments clerk at Frankland made an entry in the man's clinical record on 11 November 2008. She said that the appointment for the angioplasty operation had been cancelled by the hospital as the doctor was unavailable. In contrast, the doctor recalls that the prison cancelled the appointment due to the unavailability of prison staff. Meanwhile, the prison continued to monitor the man's other health conditions such as his eye care, chronic rhinitis, bladder problems and asthma.

43. The doctor carried out the PCI on 17 December. He wrote to the prison doctor at the prison on 13 January, commenting that he hoped the surgery would relieve the man's angina. He suggested medication should be continued (aspirin and clopidogrel[15]) for four weeks, and at that point a repair to the aortic aneurysm could be considered if necessary. The man returned to his cell at his own request (rather than staying in healthcare), and staff saw that he looked well with no further problems.

44. On 3 February 2009, a Risk Assessment for Hospital Escort/Bed watch form was completed. Restraints were to be applied on leaving the prison and removed once the man was under anaesthetic. They were to be reapplied in the recovery room before he regained consciousness. He was said to be an enhanced status[16] prisoner with no adjudications against him and was not at risk of self-harm.

45. On 8 February, the man was admitted to ward 13 at hospital for the operation to repair the aortic aneurysm. At 11.00pm that day, the escorting officers recorded

[14] Percutaneous coronary intervention is a procedure used to open blocked blood vessels that cause heart attacks.
[15] Clopidogrel is an oral antiplatelet agent used to inhibit blood clots in coronary artery disease.
[16] There are three levels under the Incentives and Earned Privileges scheme: basic, standard and enhanced. Enhanced status is the highest level for those prisoners who comply with the prison rules and address their offending behaviour. It confers privileges such as additional visits.

in the bed watch log[17] that he had been polite and cooperative while travelling to the hospital.[18] It was also recorded in the log that he did not have next of kin but, in the event of a difficulty, he wished his former wife and the prison chaplain to be told. The hospital had the contact details. It was noted in the log that he had signed "forms from the surgeon" to confirm that he did not wish to have a blood transfusion.

Events in February

50. Events on the day of the operation were recorded in the bedwatch log. The man was prepared for his operation early in the morning. Medical staff explained to him in depth what would happen during the operation and the risks involved. The log indicated that he was happy and underwent the operation at around 9.30am. The officers were able to watch the operation through a window with loosely slatted blinds.

52. The operation ended at 2.30 pm, and the man was placed in the intensive care unit where he was assessed constantly by staff. The Root Cause Analysis (RCA) document[19] completed after his death said he had lost 900ml of blood during surgery and received four litres of Hartmans[20] plus 450 mls of saved blood. The operation was described as "uneventful" and a plan of how to manage him post-operatively was put in place.

53. Around 15 minutes later, the man began to deteriorate and medical staff were concerned. The RCA said that he was noted to be pale and clammy with a distended stomach. The consultant was not overly concerned at this point and went to operate on another patient. The size of his stomach gradually increased and medical staff told the consultant surgeon.

54. By 3.30pm, there was little sign of improvement in the man's condition. An hour later, medical staff began cardio pulmonary resuscitation (CPR) because he did not have any blood pressure.

55. Two officers[21] were the escort officers on duty at the hospital and were present during the medical team's efforts to save the man when he returned from the operating theatre on the first occasion. Officer A said that once the man began to deteriorate, the medical team made a "magnificent effort" to save him.

56. The on-call surgeon reviewed the man while the consultant surgeon was performing another operation. He was taken back to the theatre at around 4.30pm. Both officers watched the operation in the preparation room outside the

[17] A Bedwatch Log is the written history of time and events taking place while the prisoner is out of the prison in hospital. Escort officers are responsible for recording the details.
[18] A Bedwatch officer is a prison officer who escorts the prisoner to the hospital and remains with him/her at all times. This is to maintain the safety and security of the public and to ensure that the prisoner does not escape.
[19] A Root Cause Analysis is a formal review of clinical care of a patient that is undertaken by the hospital when a patient dies.
[20] Hartmans is a substitute solution for blood products that is acceptable to Jehovah's Witnesses during operations.
[21] Officer B was not interviewed for this investigation as he was on sick leave.

operating theatre. The escorting officers were told by hospital staff that the first operation had to be repeated. However, their efforts to save the man were unsuccessful as they could not stop the bleeding.

57. While the man was in the operating theatre, a surgeon asked one of the officers to try and contact the Jehovah's Witness minister as the man had nominated him as his next of kin. The minister arrived at 6.27pm. He spoke with medical staff and spent a few minutes at the man's bedside. A few minutes later the prison officers were told that he had died.

Events after the man's death

57. Officer A recorded that another officer on duty, Officer C, had contacted the prison at 7.10pm to give prison staff essential information regarding the time of the man's death. Officer C also gave the name of the member of the medical staff (consultant anaesthetist) who pronounced the man death. In respect of the man's next of kin, Officer C explained to the Duty Governor that the Jehovah's Witness minister was unaware he had been nominated as next of kin and did not wish to be involved.

58. The police were called in accordance with procedures following a death. A police constable and Officer C identified the man at 8.10pm. The prison officers left the hospital to return to the prison at 8.45pm.

59. Officer A told the investigator that, upon their return, the Duty Governor, orderly officer and care team met with them. A hot debrief was carried out and they were given very good support, with members of the care team enquiring after their wellbeing some weeks after the man's death.

ISSUES

Cancellation of appointments and record keeping

62. This investigation has revealed that several of the man's hospital outpatient appointments were cancelled. The clinical reviewer was greatly concerned that they had been cancelled because of a shortage of prison escort staff. He explained that the man had two potentially life threatening conditions. In his opinion, the prison healthcare department did not appreciate the seriousness of the conditions and had left it to administrative staff to alter and cancel appointments.

63. My investigator and the clinical reviewer interviewed the external appointments clerk during the investigation. She told the clinical reviewer and my investigator that the reasons for the cancellations had not been recorded. She said that she was permitted two escorts to hospital per day, one in the morning and the afternoon, and had to prioritise prisoners. Around two hospital appointments per month were cancelled because of a lack of escort staff and, at the time my investigator visited in May 2009, she said seven had been cancelled since January. While someone unclear regarding what happens if an escort is not available for an appointment, she said that she would ask the Head of Healthcare or another medically qualified member of staff for advice before she cancelled it.

64. The clinical reviewer sought further clarification on the matter and wrote to the cardiac consultant, consultant cardiologist and cardiothoracic surgeon. All were clear that the cancellation of appointments was at the behest of the prison, and I annex copies of each of their letters to this report. However, the medical record entry made by the external appointments clerk on 3 November 2008 says that the appointment for the man's angioplasty was cancelled by the hospital as the consultant cardiologist was on leave. She made a similar entry around a week later saying that the provisional appointment made for that day had been cancelled as the surgeon was unavailable. In his letter to the clinical reviewer, the cardiothoracic surgeon's recollection appears to contradict this. He recalls that the consultant cardiologist had a "number of frustrations in getting the patient transferred over" and the PCI was not carried out until December.

65. I am critical of some of the record keeping at Frankland. The prison uses a dual system of handwritten notes alongside a computerised system. The computerised system was in place in August 2006, but healthcare staff used handwritten notes in parallel without updating the IT system with the potential for important clinical information to be lost. For example, the reference in the handwritten record to a healthcare discussion regarding the man's forthcoming operation and his religious faith dated 21 February 2008 does not appear in the computerised medical record. Neither record mentions the hospital appointment scheduled for 7 July or its cancellation.

66. Due to this poor record keeping, it is difficult for Frankland to evidence that the cancellations were initiated by the hospital. Moreover, the written recollection of the consultants places responsibility on the prison. Moreover, there is contemporary evidence to consider. In his letter of 8 July 2008 to the prison

doctor, the vascular surgeon is very clear that the prison had cancelled the man's appointment with the cardiothoracic surgeon on 7 July. The clinical reviewer says:

> "The consultant cardiologist had planned to carry out percutaneous coronary intervention in the third week of August 2008. However when this date was given to the Prison Service, the hospital was notified that this date was not suitable because of a shortage of staff available to escort the man to hospital. He had an appointment to see the cardiac consultant in July 2007 and this appointment was changed on several occasions by the prison authorities. The cardiac consultant states that no appointments were cancelled by the hospital."

66. The issue of whether the prison or the hospital cancelled appointments for the man remains unresolved, albeit the available evidence points strongly in the direction that on a number of occasions the prison was responsible. Whatever the case, it was evidently very unfortunate that hospital appointments to investigate and manage his serious medical conditions were not met. The clinical reviewer has noted that the man had two potentially life threatening conditions. In his opinion, the prison's healthcare department did not appreciate the seriousness of the conditions and left it to administration staff to alter and cancel appointments. I endorse the clinical reviewer's recommendations in respect of this issue.

The Governor and the Head of Healthcare should review the policy relating to cancelling and re-arranging appointments. The reasons for cancellations should be clearly marked in the medical records with an audit trail to the clinician who agrees the decision.

The Head of Healthcare should ensure that if handwritten entries are made on a medical record, the corresponding information is also entered on the EMIS computer system.

Prisoners with long term conditions

67. The clinical reviewer has noted that the man was diagnosed with hypertension in July 2006, but could not find evidence of regular monitoring of his blood pressure, cardiac condition or a review of his aneurysm by healthcare.

The Head of Healthcare should ensure that prisoners with long term conditions such as hypertension and ischaemic heart disease should be regularly reviewed in accordance with nationally accepted guidelines.

The computer record

68. The clinical reviewer has noted that the Active Problems section of the EMIS computerised record system does not give an easily accessible summary of his significant medical conditions. I endorse his recommendation in that regard.

The Head of Healthcare should ensure that healthcare staff review and record all significant medical conditions in the medical records so that they can be easily accessible to the healthcare professional providing care. Significant medical conditions should be highlighted in the Active Problems section of the computer records.

Root Cause Analysis

69. As the man was a prisoner at the time he died, a Root Cause Analysis (RCA) was undertaken by the NHS Foundation Trust. This focussed on his clinical care while in hospital. The root cause of his death was stated as "bleeding following surgery for abdominal aneurysm repair". A notable finding was the hospital's concerns that prison staff remained with the prisoner throughout the surgery and following recovery and saw "all the traumatic details of a massive bleed with chest and abdomen open".

70. The investigator raised this issue with Officer A and with the Security Policy Section at National Offender Management Service. Officer A said that he and Officer B attended the man while in the preparation room outside the operating theatre. This was because he was still handcuffed by an escort chain to Officer A. (This is a long chain with a handcuff at both ends. An officer is handcuffed to the prisoner via the chain. It is used when a prisoner is on bedwatch or being examined if there is deemed to be a risk of escape.) Both officers had to wait for the man to be sedated for his operation before the handcuffs could be safely removed. This was in accordance with policy and best practice. Before entering the preparation room, both officers had to remove their clothing and wear the same sterile gowns and masks as the surgical staff.

71. The actions of the hospital are not within my remit as Ombudsman. However, the Governor may wish to raise the issue with the hospital trust and ask that, where possible and appropriate, surgical staff close the blinds on windows in operating theatres to protect prison staff from unreasonable exposure to surgical procedures on prisoners.

The man's religious beliefs

72. The man made formal declarations that for religious reasons he would not be prepared to have a blood transfusion. Both the prison and the hospital explained to him the potential consequences. He also discussed it with a fellow prisoner who considered that, as well as being constrained by the doctrines of his faith he was unconcerned about the possible impact as he thought he would never leave prison. The post mortem report says that, although the outcome might have been the same, his "chances of survival would have been greater if transfusions had been available".

Conclusion

73. The man was already in late middle age, with a number of pre-existing medical conditions, when he entered prison in 2001. Two life threatening conditions were diagnosed during his sentence, namely a leaking aortic valve and an aortic

aneurysm. This investigation has found that important appointments to treat these two conditions were cancelled. It is not entirely clear whether these were cancelled by the prison or the hospital as each party cites the other as responsible. The available evidence suggests strongly that the prison was responsible on at least some occasions.

74. In July 2007, the man changed his religious belief to that of a Jehovah's Witness. As a result, he was unable to benefit from a necessary blood transfusion following complications after surgery. This had a considerable impact on his chances of survival.

RECOMMENDATIONS

1. **The Governor and the Head of Healthcare should review the policy relating to cancelling and re-arranging appointments. The reasons for cancellations should be clearly marked in the medical records with an audit trail to the clinician who agrees the decision.**

   Accepted. This new process has been implemented since beginning of February 2010.

2. **The Head of Healthcare should ensure that if handwritten entries are made on a medical record, the corresponding information is also entered on the EMIS computer system.**

   Partially accepted. Full electronic records have been used since mid 2007. Old IMR are no longer used as current working documents. Go Live date for transfer to TPP is July 2010.

3. **The Head of Healthcare should ensure that prisoners with long term conditions such as hypertension and ischaemic heart disease should be regularly reviewed in accordance with nationally accepted guidelines.**

   Accepted. Within the man's records his Blood Pressure recordings were identified as such and not coded as "Hypertension". He had a number of blood pressure checks in the year prior to his death – in excess of the nationally accepted guidelines. Coding issues will be addressed in line with the Go live date for transfer to TPP.

4. **The Head of Healthcare should ensure that healthcare staff review and record all significant medical conditions in the medical records so that they can be easily accessible to the healthcare professional providing care. Significant medical conditions should be highlighted in the Active Problems section of the computer records.**

   Accepted. This coding issue has been identified due to the poor training schedule for the original rollout of EMIS. This action will also be addressed in the Go-Live in July for TPP. Significant work is being undertaken regarding coding and clinic templates prior to July and a standardised approach across the cluster is to be implemented.