Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Frankland, at hospital in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

February 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Frankland. He died in February 2010 at hospital, having been admitted nearly two weeks earlier. He was 68 years old. His cause of death was found to be acute bronchopneumonia. He was escorted by three officers and had been restrained with an escort chain until ten minutes before he died.

I offer my sincere sympathy and condolences to the man's family and all who have been affected by his death. I am sorry that my report has been delayed and regret any additional distress this may have caused.

The investigation was carried out by my colleague. A review of the man's medical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to her for her assistance.

I would also like to thank the Governor and staff of Frankland for their full and ready co-operation during the course of the investigation. My particular thanks go to the member of staff in the Business Unit for her work in liaising with the investigator.

By the time the man arrived at Frankland in 2003 he had been diagnosed with a number of medical conditions. He suffered from painful leg ulcers during the majority of his time at the prison. Although he did not always comply with his treatment plan, the clinical reviewer concludes that he was treated appropriately. The report makes three recommendations for healthcare.

The man was convicted of serious offences. However, he was very poorly during his last stay in hospital and could not move about on his own. For the chain to have been removed at such a late stage is, in my mind, undignified and I recommend that the Governor give greater weight to a prisoner's mobility when deciding what restraints are required.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **February 2011**

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SUMMARY

The man arrived at HMP Frankland in July 2003. He had already served nearly 20 years in prison, considerably longer than his seven year tariff (the minimum time that a life sentence prisoner must serve before release can be considered). He had a number of medical conditions, including high blood pressure, asthma and diabetes. He had also developed an ulcer on his lower left leg. The clinical reviewer describes this as his "most significant and enduring health problem" for the remaining six and a half years of his life.

A year after his arrival, the man was selected for the dangerous or severe personality disorder (DSPD) programme at Frankland. He therefore moved to the Westgate Unit, a specialist unit in the prison for the assessment and treatment of prisoners deemed suitable for the programme. During his time on the Westgate Unit, staff continued to manage his leg ulcer, which eventually healed in late 2006.

The leg ulcer recurred in January 2008 and healed around six months later. In May 2009, he was removed from the DSPD programme, and moved from the Westgate Unit to a standard prison wing. In early June, his leg ulcer recurred for a third time. It had not healed before his death eight months later.

In the last week of January 2010, healthcare staff were called to the wing to see the man on three occasions. On the first of these occasions he had reportedly collapsed and on the other two occasions he was "feeling unwell" and "distressed". On 29 January, he moved to Frankland's healthcare unit after developing a suspected chest infection. The following day, his blood pressure and pulse fell significantly, and he was sent to outside hospital. That evening he had a heart attack and was unconscious for three days. Once he regained consciousness, he remained very unwell and bed bound. During this period, restraints (in the form of an escort chain, a long chain with a handcuff at each end) were applied in hospital as well as a three officer escort. Even though he was a prisoner in the highest security category, my view is that the presence of the officers would have been an adequate arrangement at this time. He did not recover and died at 9.50am in February. The restraints were removed shortly before his death.

The man was sometimes a difficult patient to manage and did not always comply with his treatment. Nevertheless, the clinical reviewer concludes that he received an "acceptable level of care" at Frankland. However, she highlights some areas that could have been improved. In particular, she notes that his leg ulcer and high blood pressure were not always managed in line with national guidelines. I make two recommendations in relation to this and a further recommendation about the use of care plans for prisoners with complex care needs.

THE INVESTIGATION PROCESS

1. The investigation was opened on 10 February 2010 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No one came forward as a result.

2. The investigator visited Frankland on 2 and 3 March as part of the investigation into a previous death in custody. During this visit he collected copies of the man's prison files, including the medical record. He returned to Frankland on 21 May and interviewed four members of staff.

3. An independent clinical review of the man's health care in prison was carried out by a clinical reviewer on behalf of the local PCT. She and her colleague joined the investigator for the interviews at Frankland on 21 May.

4. During one of his visits to Frankland, the investigator met the man's sister, his nominated next of kin, and a family friend who was also visiting the prison at the time. On behalf of the Ombudsman's family liaison officer the investigator explained the purpose of the investigation. The man's sister was also given the opportunity to raise any concerns she wished the investigation to address. At the meeting and via a subsequent email to the family liaison officer, she raised the following issues:

    - He had ulcers on his legs for a number of years. When she visited him she said that her brother's legs were "smelly" and he told her he was not receiving appropriate care.

    - She asked that the report include details of her brother's last few days, as she lives abroad and was unable to be with him. She asked particularly about the apparent rapid deterioration in health before her brother was admitted to hospital.

5. I hope that my report clarifies any issues that might remain unclear for the man's sister and helps her better understand what happened in the time leading to his death.

6. The post mortem report was not completed until October 2010, on account of additional tests that had to be carried out to establish the cause of death. This led to a delay in issuing the investigation report.

7. The man's sister received a copy of my draft report as part of the consultation process. Her response to the investigation findings can be found on page 22. I have also addressed some additional issues in separate correspondence.

HMP FRANKLAND

8. HMP Frankland is one of eight high security prisons in England and Wales. Frankland holds convicted category A and B adult male prisoners, and also holds high risk remand prisoners. E wing, where the man lived for around two months in 2009, is usually for category A remand prisoners. (Category A prisoners are those whose escape would be highly dangerous to the public or to national security.) B wing, where he lived from August 2009, is for vulnerable prisoners (those who request to be separated from other prisoners for their own safety). The operational capacity of the prison is 750.

9. Healthcare services at Frankland are provided by the local Primary Care Trust. The healthcare centre provides 24 hour inpatient care, consisting of two wards, holding a total of seven patients, and ten single cells. The man moved into one of these cells the day before his admission to hospital in January 2010.

10. The Westgate Unit is one of two prison sites in England and Wales providing specialist assessment and treatment for prisoners with dangerous or severe personality disorders (known as a DSPD unit). The unit works in tandem with Rampton Special Hospital. It is a self-contained facility within Frankland for 80 prisoners who live in four separate units. The unit has its own facilities, including a library, canteen, sports hall, classrooms and an outpatient healthcare facility. The man was one of the first prisoners to move to the Westgate Unit following its opening in 2004.

11. HM Chief Inspector of Prisons conducted a full announced inspection of Frankland in February 2008. The then Chief Inspector was broadly positive about health services provided at Frankland, and found the provision was equivalent to that which prisoners could expect to receive in the community. She found that relationships between staff and prisoners were reasonably good on B wing and very good on the Westgate Unit.

12. The Independent Monitoring Board (a body of local people who independently monitor and report on the prison) report for 2008-09 described the Westgate Unit as “outstanding” and praised the commitment of staff who worked on the unit. They noted that the healthcare rooms on individual wings were “working satisfactorily”.

13. This is the ninth death that the Ombudsman has investigated at Frankland since January 2009. There have subsequently been a further four deaths at the establishment. All but one of the other deaths were due to natural causes. An earlier investigation also highlighted the lack of nursing care plans for a prisoner with significant medical problems.

KEY EVENTS

14. At the time of his move to Frankland in July 2003, the man had been diagnosed with a number of medical conditions. They included hypertension (high blood pressure), asthma, type 2 diabetes (non-insulin dependent diabetes) and varicose veins. As a result of his diabetes and varicose veins, he had developed an ulcer on his lower left leg. It measured approximately 3cm x 4cm and had been present for many months. He was prescribed antibiotics to treat the ulcer, which was also redressed twice weekly. Shortly after his arrival at Frankland, he was referred to a consultant vascular surgeon at hospital. As well as the antibiotics, he was also prescribed atenolol (for high blood pressure) and amiodarone (to treat an abnormal heart rhythm).

15. The man had a chest x-ray in January 2004, the results of which showed that he had an enlarged heart. In a referral letter to a cardiologist (heart specialist) in April, it was noted that changes had been made to his medication. He was no longer taking amiodarone but was prescribed simvastatin (to lower cholesterol), bendrofluazide and cozaar (both used to treat high blood pressure). He also saw a consultant vascular surgeon in April, who recommended that the treatment for his ulcer should continue. Two months later it was noted that he often removed his dressings, despite being advised to leave them in place.

16. On 19 July, the man saw a cardiologist at hospital. For several years he had complained of breathlessness when walking or climbing stairs. The cardiologist did not think that the cause was related to his heart and requested no further investigations or follow up.

17. A week later, the man moved onto the newly opened Westgate Unit at Frankland. Following an assessment a month earlier, he had been found to meet the criteria for DSPD services (meaning that he had been diagnosed with a severe personality disorder which was considered potentially treatable). He was allowed to keep his medication 'in possession' on the Westgate Unit (meaning that he was given a week or several weeks supply at a time to keep in his cell and take as prescribed).

18. Nursing care plans were written in December 2004 and January 2005 following an assessment by a consultant vascular surgeon. The care plans provided detailed instructions about how to change the man's dressing, which was to take place every third day.

19. In May 2005, the man was admitted to outside hospital overnight after experiencing chest pain spreading down his left arm. On his return to Frankland, he was given a cell on the inpatients wing for observation, but discharged himself against the advice of healthcare staff. He had a follow up x-ray in August, which showed no change to the previous x-ray of January 2004.

20. Later that month, the man was admitted to hospital for five nights after suffering pain in his groin. A scan revealed the presence of a deep vein thrombosis in his left leg (DVT, a blood clot). He was treated with a course of warfarin (to thin the blood), which continued following his discharge from hospital. The warfarin prescription was stopped in April 2006 as his symptoms had resolved. His ulcer was also reported to be much better at the time with the wound described as “very healthy”.

21. The man complained of chest pain on two occasions later in 2006. Both times he saw a nurse, who took clinical observations (clinical observations include measuring the heart rate, blood pressure and respirations). The pain subsided on the same day and he did not need to go to hospital on either occasion. In November, he said he had vomited and felt sick. He was advised to remain in the healthcare centre whilst blood tests were taken, but refused. He said he felt better later that day.

22. During 2007, the man complained on several occasions of feeling nauseous and dizzy. On each occasion the symptoms seemed to resolve after a short period of time. In November 2007, he attended an outpatient appointment with a consultant colorectal surgeon. This followed a referral made by a prison doctor after he said he had been bleeding from his rectum. The consultant found nothing significant but referred him for a flexible sigmoidoscopy (an examination with a micro camera of the rectum and colon). This took place the following month and identified haemorrhoids, which were considered to be the cause of the bleeding.

23. In December, the man told clinical nurse manager on the Westgate Unit that his leg ulcer was recurring. She examined his leg and could find no evidence of the ulcer, but noted that it should be monitored regularly. In January 2008, he began to experience swelling and dry skin on his lower left leg. This soon developed into an ulcer and he was prescribed a course of flucloxacillin (an antibiotic for skin and soft tissue infections). Nursing staff on the Westgate Unit dressed his wound as previously.

24. The man reported to staff on 16 February that he had not eaten for six days, although a prison nurse noted that he did not present like a person who had not eaten for this period of time. A food refusal log was opened but was closed two days later as he had been seen collecting meals from the servery.

25. On 21 February, it was noted that the man was reluctant to use the recommended type of dressing, known as a compression dressing. The results of a swab taken of his wound showed that he had put faeces into the wound. The clinical nurse manager said at interview with the investigator that the results suggested that the faeces came from his budgerigar, which he kept in his cell. She added that he denied this when questioned. He was told that he should not remove the dressing.

26. In March, the man contacted the Prison Reform Trust and complained that none of the proposals to treat his ulcer had come to fruition, including the

availability of compressed support stockings. The clinical nurse manager replied later that month. In her letter, she wrote that he had had compression stockings for some time and his dressings were changed three times a week. She added that she had explained to him that treating an ulcer like his can be a lengthy process which was not helped by him mistreating the wound as he had done in February.

27. The man was visited on 27 March by a tissue viability nurse. As his leg was not infected, she recommended that a particular compression dressing be used. On 20 April, he told a nurse that he had blood stains on the dressing. On checking the wound, the nurse could find no indication of bleeding on the inside of the dressing. Her conclusion was that he had put blood on the outside of the dressing. She considered that he might have done this as a recent adjudication (a prison disciplinary hearing) had reduced his association time (when he was allowed out of his cell) for a period of seven days.

28. Through May and June, the man's ulcer was reported to be healing well and, on 3 July, it had healed and no further treatment was required. In August, he began to complain of pain in his left heel and was prescribed a pain killer. An x-ray of his left foot and ankle in September showed nothing abnormal. In October, he confirmed that his heel pain had improved.

29. In December, the man told a nurse that his chest had felt tight for two to three weeks and this tightness was followed by a "pin prick" sensation down his left arm when he rested. An electro-cardiogram (ECG, a test of the electrical activity of the heart) was taken, which showed nothing abnormal. He was advised by staff not to rush around, as he often did, and to take his time over activities.

30. The man saw the clinical nurse manager on 10 February 2009 and told her he had experienced shortness of breath on exertion for several weeks. She took his clinical observations, which were normal other than an irregular pulse and slightly low blood pressure at 110/50. An ECG was performed, which showed possible atrial fibrillation (irregular heart beat).

31. Two days later, concerns were raised that the man might be being bullied by another prisoner. He apparently put £40 into a kitty with another prisoner to buy food for meals. (An arrangement made by some prisoners to supplement meals provided by the prison.) However the other prisoner was reportedly not putting in his share and the man had been seen doing chores for him. He insisted that he was not being bullied and that he and the other prisoner were friends.

32. On 12 March, the man saw Prison Doctor A in relation to the suggested diagnosis of atrial fibrillation. He told the doctor that he had suffered "palpitations" for three to four weeks and became breathless after walking 100 paces or on climbing stairs. He also said that exertion brought on chest pain, which was relieved if he lay down. The doctor examined him

and referred him to a cardiologist (heart specialist) at a local hospital. In the meantime, he advised him not to do any "hectic" work and to inform staff if the chest pains returned. Ten days later, he was prescribed a course of aspirin (to prevent blood clots from forming and reducing the flow of blood to the heart). He was also given a glyceryl trinitrate spray (GTN, a spray used as required to ease angina pains).

33. Following a review of his position on the Westgate Unit, the man was removed from the DSPD programme on 12 May. The corresponding report noted that he "did not demonstrate a sufficient level of progress to conclude that the treatment in the Westgate Unit was of meaningful benefit to him". As a result, he left the Westgate Unit on 25 May and moved into a cell on E wing.

34. In early June, the man's leg ulcer recurred. He was given a compression dressing as previously and the wound was cleaned and changed regularly by nursing staff. Over the course of the following two months the ulcer went through fluctuating periods of improvement and deterioration. He started a course of flucloxacillin on 2 July.

35. On 9 July, the man went to an outpatient appointment at the cardiology clinic at hospital, following his referral in March. The cardiologist found nothing abnormal and concluded that the chest pains were "clearly non-cardiac" and might be due to an "element of anxiety". However, the cardiologist made an appointment for an additional scan to check for underlying heart disease.

36. From mid to late July, the man's ulcer began to deteriorate and he reported significant pain in his leg. On 31 July, it was noted that his mobility was poor. Although not explicit, it seems that the deterioration in his mobility was related to his ulcer.

37. The man moved to a ground floor cell on B wing on 1 August. He was slightly breathless on arrival and had very high blood pressure, at 196/102. He was advised to rest for a while. That evening a nurse returned to check on him and noted that he seemed better. The nurse also noted that his blood pressure would be checked again the following day, although this does not appear to have happened. The next recorded blood pressure reading was four days later on 5 August, when it had fallen to 157/76.

38. At a review with Prison Doctor A the following day, the man was prescribed co-codamol for the pain from his ulcer (prior to this he had been taking ibuprofen). As the ulcer showed no sign of healing, the doctor referred him to a tissue viability nurse. In addition, the man said he was urinating much more frequently in the last month and so the doctor also referred him to a consultant urologist.

39. When he next saw Prison Doctor A, on 14 August, his ulcer wound was improving and nurses were to continue dressing it at the same frequency.

The doctor also agreed that he could take oromorph (a stronger painkiller) before his dressing was changed to counteract the additional pain he experienced whilst it was treated.

40. Over the following week, the man's ulcer continued to improve. However, he was reported to be unhappy with his treatment and disputed that it was improving. He was subsequently reviewed by Prison Doctor A on 19 August, who noted the view of the nursing staff that the wound was improving. The doctor also noted that the man had seen the tissue viability nurse in the previous week, although it is not clear when this happened or who the nurse involved was.

41. On 25 August, he saw a consultant urologist via a telemedicine link at the prison (whereby the patient sees a doctor or consultant via video conferencing facilities). Given the symptoms he described, the consultant thought he might have a urinary tract infection and recommended a two week course of antibiotics. However, on 1 September, it was noted that he had not collected his antibiotics since they were prescribed.

42. The man visited the hospital on 28 August for the first part of the scan recommended on 9 July. He returned to complete the scan a week later. After examining the results, the cardiologist concluded that he was unlikely to have heart disease and that no further action was necessary.

43. In early September, the man's ulcer wound was noted to be slowly improving. He saw Prison Doctor A on 9 September for a review of his urination problems. Although he said his symptoms had improved, a test confirmed that he had a urinary tract infection. The doctor prescribed another course of antibiotics. However, a week later, it was noted that he had not taken the antibiotic and had returned his supply to healthcare. During the course of this week he also declined an appointment with Prison Doctor B, to discuss the results of a further urine test. He apparently told a member of staff that he "didn't need the doctor".

44. At his next review with Prison Doctor A, on 17 September, the man's leg ulcer was noted to be much improved. The doctor discussed it over the telephone with the tissue viability nurse and agreed to continue with the current treatment plan. Eleven days later, the same nurse saw him via the telemedicine link. She made some suggested changes to his treatment, including reducing the changing of dressings to twice weekly, and later faxed an updated treatment plan to the prison.

45. On 30 September, a request for the man to be assessed for a wheelchair was faxed to the County Durham Wheelchair Service. The referral gave the following reasons for assessment:

> "The man is under the care of tissue viability nurse specialist. He has a leg ulcer on his right leg. He is able to walk independently (although can get out of breath) whilst on the wing. He has problems with walking when long distances are involved. I was wondering if you could assess for this. He currently uses the emergency wheelchair that is kept on the wing."

46. The man reportedly became aggressive towards nursing staff on 18 October after demanding that his dressing be changed. He was told by Nurse A that his dressing was clean and dry and did not require changing at the time. However, his ulcer did appear to deteriorate around this time. On 19 October, Prison Doctor A wrote a referral letter to a consultant vascular surgeon at the hospital. The following day, Nurse B dressed his leg and noted that it was "much deteriorated". He was visited by a physiotherapist on 28 October, to assess his mobility. The physiotherapist noted that his mobility improved when he used two walking sticks and recommended that he should continue to do so.

47. The consultant vascular surgeon visited the man at Frankland on 4 November. In his follow up letter, he said he initially planned for him to be admitted to the prison's inpatient unit for strict bed rest. However, the man did not agree and so the consultant instead recommended that he should be admitted to hospital for a scan and surgical removal of the dead tissue. An appointment was subsequently made for 10 November. However, on the day of the appointment he declined to attend. He apparently told staff that he was concerned about his budgerigar and whether someone would take care of it while he was in hospital.

48. The external appointments manager at Frankland telephoned the consultant vascular surgeon's secretary on 9 December to see whether an alternative appointment had been made. She was told that admission was not possible at present but that the man might be seen in the New Year.

49. At a review with Prison Doctor B on 22 December, the man said that he thought his wound was more like cellulitis than an ulcer. (Cellulitis is an infection of the deep layers of the skin and underlying tissue which is usually caused by particular bacteria.) She examined the wound but considered that there was no sign of cellulitis. However the wound had deteriorated over the previous two weeks, during which a different type of dressing had been used. She suggested they resume using the previous type of dressing. She also discussed the upcoming hospital admission with him and he agreed that he would go this time.

50. The man's wound improved through the remainder of the year and into the first days of 2010. On 6 January, he told a Healthcare Officer (HCO) that

he felt short of breath and could not use his inhaler properly (He had an inhaler for his asthma). The HCO noted that he did not appear to be breathless and advised him how to use his inhaler correctly.

51. The consultant vascular surgeon visited Frankland on 7 January and saw the man at one of his regular clinics. In his follow up letter, the consultant noted that the ulcer had "cleaned up considerably" with less evidence of infection and swelling. Although it is not specifically mentioned in his letter, it appears that the consultant no longer considered hospital admission for surgery to be necessary. He recommended a four layer compression bandage as "what [the man] really needs to treat his leg ulcer". The consultant suggested that the tissue viability nurse should be contacted to arrange this. Notes in his medical record through the remainder of the month indicated that the dressings were changed "as per care plan" but he was "awaiting compression therapy". (Compression therapy is the use of a particular type of dressing to treat the ulcer wound, known as a compression dressing.)

52. On 23 January, the man fainted whilst walking on his wing. A 'code black' was called by wing staff (code black is a radio call for emergency medical response) and Nurse C responded. When she arrived on B wing, he had regained consciousness. She took his clinical observations and noted that his pulse and blood pressure were low. She returned to see him later that afternoon, by which time his blood pressure and pulse had improved. He said that he felt much better.

53. Two days later, an officer on B wing telephoned healthcare regarding the man's health. The officer said the man was feeling unwell and had said that he was "going down hill". Nurse D visited him in his cell. She noted he had been incontinent of urine, which he explained was because he had slept in the wrong position and struggled to get out of bed. He said he felt fine and was reassured by her. The following day, she returned to see him after another code black call when he was reportedly "distressed". She took his clinical observations, which were described as "satisfactory".

54. Nurse C changed the man's dressing on 28 January. She noted that the wound was "foul smelling", which was attributed to him removing the dressing to shower. She warned him that removing the dressing could damage his wound, and advised him to cover it with a plastic bag whilst in the shower. He also said he felt unwell, got short of breath easily and was tired. On account of this, and his recent collapse, she made an appointment for him to see a prison doctor.

55. The following day, Friday 29 January, staff on B wing contacted healthcare again and said that the man was "walking badly", had slurred speech and sounded vague and confused. Later that morning, he saw Prison Doctor B for a review. He told her that he was "chesty" and more short of breath than usual. He also said that it hurt when he coughed or breathed deeply. She examined him and noted crackling noises from his chest and that he was coughing regularly. She considered that the

symptoms should be treated as a chest infection and prescribed a course of amoxicillin (an antibiotic). She also asked that blood and urine tests be carried out. It was later agreed that he should remain in healthcare over the weekend for observation.

56. At around 11.00am the following morning, the man's pulse was checked by Nurse E. It was low, at 45 beats per minute, although his blood pressure was normal, at 141/81. She also noted that he was "chesty" and was coughing, but not producing phlegm. Around an hour later, Nurse F checked his clinical observations and found that his pulse and blood pressure had both fallen: to 34 beats per minute and 107/57 respectively. She made a call for an emergency ambulance and he was admitted to hospital in the early afternoon. He was reportedly reluctant to go to hospital initially, but was persuaded to do so by her.

57. Before taking the man to hospital a standard risk assessment was carried out. It was judged that he should be accompanied by three officers, including one senior officer. His hands were cuffed together and one of his wrists was cuffed to that of an officer by means of an escort chain, a long chain with a handcuff at each end. (Similar arrangements had been made on the previous occasions that he went to hospital.)

58. At 9.20pm that evening, the man had a heart attack. The escort staff removed the restraints and hospital staff successfully resuscitated him. Shortly afterwards, he was moved to the hospital's intensive therapy unit. He was unconscious and the restraints were not reapplied at this time. He regained consciousness on the afternoon of 2 February. He was given an oxygen mask to assist with his breathing. After consulting with the duty governor at Frankland, the escort staff reapplied an escort chain.

59. The following day, a member of healthcare staff contacted the hospital to ask for an update on the man's condition. She was told that there was no diagnosis at present and staff "remain puzzled" about his symptoms. He underwent various tests in the first week of February.

60. On 4 February, the man moved from the intensive therapy unit to a ward. He was thought to have a chest infection. It was noted the following morning that his low body temperature was giving hospital staff cause for concern. Some entries in the bedwatch records (the record of events made by the escort staff) over the following days noted that he was confused and disoriented, although one entry indicated that it might not be genuine as he was also coherent for periods. The risk assessment was reviewed on 6 February, with no changes recommended to the staffing levels or the use of restraints. On 7 February, it was confirmed that he was diagnosed with bilateral consolidation (a disease of the lung whereby it becomes a firm, solid mass).

61. Two days later, doctors at the hospital were concerned about the man's fluctuating temperature and were considering whether to conduct tests on his brain. It was considered likely that he would remain in hospital for at

least another week. That afternoon, he was able to get out of bed, with the help of a hoist, and spend some time sitting in his bedside chair. He was unable to move about independently.

62. The following morning, at around 9.40am, the escorting officers noticed that the man was foaming at the mouth. They alerted nursing staff, who began to resuscitate him. At the same time, the escort chain was removed. The resuscitation attempts were unsuccessful and he was pronounced dead at 9.50am.

63. The man's next of kin was his sister. As she lives abroad, the news of her brother's death was broken to her over the telephone. She subsequently visited Frankland on 2 March, shortly before her brother's funeral. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

64. A post mortem examination was carried out on 12 February and was supplemented by a neuropathological examination (examination of the brain) on 16 June. In the post mortem report, completed in October 2010, the pathologist made the following comments:

> "The man's last illness, which in essence involved treatment for a chest infection, was unexpectedly complicated by hypothermia and there was, I think, a clinical suspicion that this might indicate some other underlying disease process potentially involving the brain. Whilst the brain was by no means normal the abnormalities present appear either to predate his final illness or to be consequences of his final illness, and do not [therefore] explain [the final illness].
>
> "…Thus we are brought back to his original problem when he was admitted to hospital, which was thought to be a chest infection for which he was treated. Post mortem certainly confirmed that at the time of his death he did have a chest infection (acute bronchopneuomina) … Infection can itself cause hypothermia and can also cause septicaemia and relatively sudden death. In the absence of any other explanation in my opinion his death has probably been the result of acute bronchopneumonia."

ISSUES

Management of the man's leg ulcer

65. The clinical reviewer describes the man's leg ulcer as his "most significant and enduring health problem". His sister also referred to her brother's leg ulcers and said that he had told her that he did not think he was getting the "right care".

66. The ulcer was already present when the man arrived at Frankland in July 2003. It eventually healed in late 2006 but recurred in January 2008 and, on this occasion, healed around six months later. A year later, the ulcer developed for a third time.

67. The clinical reviewer's comments that "chronic leg ulcers are extremely difficult to resolve". She notes that the man did not always cooperate with his treatment and so managing his care was more difficult than it might otherwise have been. Despite this, she considers that he "appears to have had an acceptable level of care" and notes some areas that were managed well, such as the referral to the tissue viability nurse and consultant vascular surgeon.

68. However, the clinical reviewer identifies some areas of poor record keeping by prison healthcare staff:

> "There is no evidence that an initial assessment took place when the man's leg ulcer developed in June 2009, or that subsequent routine management was provided in accordance with national guidelines such as SIGN – The Care of Patients with Chronic Leg Ulcers, and The Royal Marsden Hospital Manual and Clinical Nursing Procedures.
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> "National guidance also states that ABPI [ankle brachial pressure index, a simple measure of the blood pressure of the arteries supplying the legs] readings should be undertaken on initial assessment and then every 12 weeks until the ulcer is healed. In diabetic patients they should be undertaken every six months when the ulcer is healed. There is no evidence of any Doppler assessments [a means of calculating ABPI] having been undertaken."

69. A nursing care plan for the management of the man's ulcer was created in early 2005. However, the clinical reviewer has found no evidence that subsequent care plans were initiated and implemented when the ulcer redeveloped in 2008 and 2009. She comments that nursing care plans "are essential to the provision of safe and effective care". Moreover, such documents formally set out the interventions which healthcare staff will deliver and what the patient could be expected to do for himself.

    The healthcare manager should review staff training regarding the management of leg ulcers and ensure that national guidelines are followed.

The healthcare manager should audit the leg ulcer care plans and ensure that all prisoners with such care needs have a care plan.

Monitoring the man's blood pressure

70. The clinical reviewer notes that the man's blood pressure was raised during July and August 2009. On 1 August, his blood pressure was recorded as 196/102, which is a very high reading. Although it was noted that it should be checked the following day, the next reading was actually four days later on 5 August. No further blood pressure readings are recorded until 4 November, when it was again high, at 190/100. The next recording was on 24 December, when a reading of 136/60 is noted, which is within the normal range.

71. Although she considers that he was "maintained on the appropriate [blood pressure] medication", she notes:

> "All blood pressure observations were taken as a result of an acute episode and not as routine clinical observation of hypertension, as would be expected … NICE [National Institute for Health and Clinical Excellence] Guidelines for the Management of Hypertension (2006) suggest, for an initial diagnosis, readings should be made at monthly intervals for three months before a diagnosis is made and treatment commences, followed by annual reviews."

The healthcare manager should review the protocols for managing hypertension and audit clinical staff awareness of the national protocols and guidance.

Overall standard of care

72. The clinical reviewer summarises the man's time at Frankland as follows:

> "He appears to have been a sometimes difficult patient to manage, demanding attention and occasionally non-compliant with his medical care and treatment … He was not always happy with the care he received. It is also apparent that he was not always compliant with the advice given to him by healthcare staff."

73. She concludes as follows:

> "He received an adequate standard of care whilst a prisoner at Frankland. He was referred appropriately for specialist advice and his limited mobility was taken into consideration when determining his location within the main prison.
>
> "Whilst the documentation regarding the management of his leg ulcer is poor, it seems from the information available that his care was appropriate."

Use of restraints

74. The Prison Service has a duty to protect the public and hence restraints and escort staff are routinely used when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner's health and mobility.

75. A risk assessment was conducted when the man was taken to hospital on 30 January 2010. His mobility was poor and he used walking sticks to help him move around the prison. He was described in the assessment as a high risk to public and hospital staff and a "dangerous man who will carry out threats".

76. The assessment concluded that the man should be accompanied by three officers, including one senior officer. The risk assessment also concluded that his hands should be cuffed together and one of his wrists should be cuffed to that of an officer by an escort chain. Given his history of offending, even though he was not fully mobile, I think that this level of caution on the part of the prison was understandable and I do not criticise the level of restraints.

77. I am satisfied that the restraints were rightly removed on the evening of 30 January when he had a heart attack and had to be resuscitated by hospital staff. They remained off whilst he was unconscious. He regained consciousness on 2 February, and the escort chain was re-applied. Despite regaining consciousness, I believe that his condition was not good throughout the last week of his life. He used an oxygen mask to help his breathing and could not get out of bed until a hoist was used on 9 February to lift him into a chair. Nevertheless, the escort chain was only removed when he had to be resuscitated on the morning of 10 February.

78. The man was a category A prisoner, which is the highest security category, meaning that his escape would be "highly dangerous to the public". It is understandable that prison staff would want to take the greatest precautions when he was outside the prison. However, even after regaining consciousness on 2 February, he remained bed bound and very unwell.

79. In these circumstances I think it would have been reasonable to escort him in hospital on this occasion without the use of restraints. Given his condition, I judge that the presence of the three officers would have been an adequate security arrangement. Were his mobility to have improved, the risk assessment could have been revised and use of restraints reconsidered.

80. I appreciate that the man's death was not expected. He had been well enough the day before to be lifted out of bed to sit in an armchair. The

doctors expected that he would stay in hospital for a week before returning to Frankland. Nevertheless, in my view, it is not dignified for a prisoner – even one convicted of serious offences – to be restrained in these circumstances.

The Governor should review the use of risk assessments and encourage senior managers to give greater weight to a prisoner's mobility when they assess risk and consider the use of restraints on a bedwatch.

Family response to the draft report

84. In response to the draft findings of my report, the man's sister expressed concern that he was bullied at Frankland and that prison staff were aware of this. I would like to assure her that I take such an allegation very seriously. His prison records indicate one occasion on which it was highlighted that he might be the victim of bullying. This followed an incident observed by staff in February 2009 (and described in paragraph 34 of this report). Staff spoke to him, who insisted he was not being bullied. He did not report any incidents of bullying to staff throughout his time at Frankland.

85. The man's sister also said she was concerned that her brother was the victim of prejudice on account of his ethnic origin. There is no indication from the records that this might be the case and he did not make any complaints, either formally or informally, about such actions. Nevertheless I would, of course, expect staff to conduct themselves in a professional and appropriate manner at all times.

86. In her feedback, the man's sister also said she did not feel her brother received appropriate treatment for his leg ulcer, and referred specifically to a visit in 2009 when his leg was infected and discoloured. As I have noted, his leg ulcer was his most significant and enduring health problem. The clinical reviewer concludes that he received an appropriate standard of care at Frankland and that some areas were managed well. However, she does identify some areas that could be improved and made relevant recommendations. These recommendations were accepted (see page 23).

CONCLUSION

87. The man spent the majority of his adult life in prisons or special hospitals. By the time he arrived at Frankland in 2003 he had been diagnosed with a number of medical conditions. The most significant and long term of these was a recurring leg ulcer, which affected him for most of the rest of his life. Although he did not always comply with his treatment plan, the clinical reviewer concludes that he was managed "to an adequate standard". However, there were some areas that could have been improved, notably in relation to the application of national clinical guidelines at Frankland.

88. Following a deterioration in his health in the last week of January 2010, the man was admitted to hospital for investigation. The report considers the question of the appropriate use of restraints on category A prisoners. It is my view that a bed bound and very unwell prisoner, even one who is category A, should not be restrained except in extreme circumstances. I encourage the Governor to give greater weight to a prisoner's mobility and, as such, their real and current threat, when considering the use of restraints.

RECOMMENDATIONS

1. The healthcare manager should review staff training regarding the management of leg ulcers and ensure that national guidelines are followed.

   Accepted – clinical management of leg ulcers is provided by the PCT and the head of healthcare will ensure that all clinical staff attend this training.

2. The healthcare manager should audit the leg ulcer care plans and ensure that all prisoners with such care needs have a care plan.

   Accepted – head of healthcare to commission an audit from the PCT tissue viability nurse.

3. The healthcare manager should review the protocols for managing hypertension and audit clinical staff awareness of the national protocols and guidance.

   Accepted – current review of NICE guidelines is underway and any recommendations will be implemented.

4. The Governor should review the use of risk assessments and encourage senior managers to give greater weight to a prisoner's mobility when they assess risk and consider the use of restraints on a bedwatch.

   Accepted – this issue has already been addressed. Discussion with regards to prisoners on a bedwatch, their condition and restraints now takes place systematically at the Governor's 9.00am meeting, which is attended by all senior managers. We currently have a prisoner located at an outside hospital. His condition is reviewed daily which has resulted in his security status being reduced to no restraints being applied and supervised by two prison officers.