Investigation into the circumstances surrounding the death of a man in hospital while a prisoner at HMP Frankland in February 2012

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Frankland. He was sentenced to life imprisonment in 2002 and was 51 years old when he died. The post mortem report found that his death was caused by a brainstem haemorrhage (following a stroke), which was probably caused by hypertension and was further linked to chronic kidney disease. I extend my condolences to his family and others affected by his death.

The investigation was carried out by one of my investigators. The local Primary Care Trust (PCT) commissioned a clinical reviewer of the care the man received in prison. Frankland co-operated fully with the investigation.

The man arrived at Frankland in April 2008. He told staff that he had epilepsy. During the next two years, he was treated for high blood pressure and, in 2010, had a stroke for which he received treatment at hospital. In June 2011, he was sent for a scan to assess his kidney function. During the scan, doctors found that he had chronic pancreatitis. The clinical reviewer found that several clinical investigations were not followed up, which meant that the diagnosis of kidney disease was delayed.

The man was taken to hospital on 20 November 2011 with an accelerated heart beat. Before being discharged, the hospital increased the level of tramadol he received, to help him manage his pain. However, this was reduced by a doctor at Frankland shortly after he returned. Despite reporting increasing levels of pain, it was only at the end of December that the level of tramadol was increased again. In the meantime, he used an improvised hot water bottle on his stomach, which caused burns on his skin, to help ease the pain. On 12 February, he was found in pain in his cell. He fell unconscious and was taken to hospital. After a test on 18 February, his family were told that he would not recover and ventilation was removed.

While the clinical reviewer was satisfied that the care the man received at Frankland was similar to that he could have expected in the community, our investigation identified a number of areas for improvement. First, there is a need to ensure that clinical investigations are undertaken when requested. Second, the management of kidney disease at the prison needs to be brought in line with best practice. Third, it is of concern that the man appears to have resorted to using a plastic bottle filled with hot water to ease his pain. While understandable fears that strong pain relief medication might be misused led to restrictions on its use, too much emphasis appears to have been placed on security and not enough on effectively relieving his pain. The report also calls for better risk assessment to determine whether a low risk and unconscious prisoner such as he should have been restrained. Finally, we also repeat a recommendation made in another recent investigation at Frankland that next of kin lists should be periodically updated.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

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SUMMARY

1. The man was sentenced to life imprisonment in 2002 and arrived at HMP Frankland on 18 April 2008. During a reception health screen, a nurse recorded no concerns about his health.

2. A prison doctor saw the man on 20 January 2009, after he complained of left loin pain. A urine sample was taken which showed a presence of blood and protein. However, no further action was taken as there was no infection.

3. The man was in generally good health up until 14 July 2010, when he was taken by emergency ambulance to hospital after suffering a stroke. His blood pressure was dangerously high at 221/154 and, as a result of his stroke; he suffered left-sided paralysis.

4. The man saw a nurse on 27 October 2010, as he had lost four kilogrammes since the previous year. A sample of blood was taken and sent for analysis. On 10 November, he saw a doctor who advised that the results showed a raised potassium level. The doctor requested a repeat blood sample but this test was not repeated until May 2011, some seven months later.

5. A doctor reviewed the results of the test and noted that the man's kidney function was deteriorating. However, no action was taken until 7 June, when another doctor met him to review his blood pressure. She referred him for an ultrasound scan of his abdomen and kidneys, which took place on 26 July. The scan did not reveal any abnormalities in his kidneys but did show chronic pancreatitis (inflammation of the pancreas).

6. The man was admitted to hospital in November 2011 after suffering from an accelerated heart beat. He was released the next day with an increase in the level of his pain relief. However, a doctor reduced the level again and it was not increased for a month despite him complaining about his pain.

7. In January 2012, he was diagnosed with chronic kidney disease after being admitted to hospital for a kidney biopsy.

8. At 4.36am on 12 February, the man was found in his cell clutching his arm complaining of being in pain before losing consciousness. After a scan at hospital, prison staff were told that he would not regain consciousness. On 18 February, the mans consultant concluded that the most likely outcome he would be in a "permanent vegetative state". After discussions with his nominated next of kin and an independent advocate, it was decided that ventilation should be withdrawn. He died a few days later.

9. We make six recommendations in this report, including the need to ensure that requests for follow up medical investigations are completed and appointments are actioned, and that a protocol is established for the management of kidney disease. We also address issues surrounding the management of pain and the use of restraints, and repeat a recommendation about updating details of next of kin.

THE INVESTIGATION PROCESS

10. The investigator issued notices announcing the investigation to staff and prisoners. She asked anyone with information about the man's death to contact her.

11. The investigator visited Frankland on 6 March 2012, and collected copies of the man's prison files and medical records. She visited the healthcare unit, viewed his cell and introduced herself to the staff on the wing.

12. She returned to Frankland on 22 May 2012, to interview a prison GP. A review of the clinical care the man received in prison was carried out by a clinical reviewer on behalf of the local PCT. The review was received by the investigator on 29 May 2012.

13. This report will be forwarded to the Coroner's office to assist with the Coroner's enquiries.

14. One of the Ombudsman's family liaison officers contacted the man's family (his brother and sister) and his ex partner, his nominated next of kin. She told them about the investigation and provided them with an opportunity to raise any concerns. The mans ex partner queried whether the prison was aware of his epilepsy and wondered whether this had anything to do with his death. She also asked whether the prison could have done more to inform them sooner that he was ill, as he was already in a coma when she found out. Family members were very positive about the contact and the support they had had from Frankland's family liaison officer.

15. After receipt of the draft report, the family liaison officer contacted the man's family to see if they had any comments to make. The man's sister-in-law commented that the family had been unaware that he had suffered from a stroke whilst in prison, and had found it upsetting to see that he should have had some tests in hospital which were not carried out. The family had no other comments to make on the draft report.

HMP FRANKLAND

16. Frankland is one of eight high security prisons in England and Wales, and can hold up to 859 men. Situated on the outskirts of Durham, the prison accommodates convicted male prisoners serving sentences of over four years.

17. Until April 2011, healthcare services at Frankland were provided by the local Primary Care Trust. A healthcare provider now provides healthcare services at Frankland and a number of prisons in the area. There is 24 hour inpatient care.

Independent Monitoring Board

18. All prisons have an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. Members of the Board are unpaid volunteers from the local community and have full access to the prison. They help to ensure that standards of care and decency are maintained. In their latest annual report covering the year from December 2010 to November 2011, the Board noted:

> "There has been a major change in Healthcare within this reporting year, with the switch to a new provider. A healthcare provider took over responsibility from Co. Durham and Darlington Community Health Services on a three-year contract. This has had significant effects in all areas of Healthcare within the prison as they redesigned the service to meet their own operational model. Some areas of performance are causing concern – specifically around waiting times and access. However recent nurse led triage has significantly reduced the GP waiting time to below 7 days, meeting the target."

Her Majesty's Inspectorate of Prisons (HMIP)

19. The most recent HMIP report detailed an unannounced full follow up inspection conducted in November 2010. At the time of the inspection, healthcare services at Frankland were provided by a Primary Care Trust. Another healthcare provider now provides healthcare services at Frankland.

20. The Inspectorate found that waiting times to see a prison doctor were unacceptably long. Inspectors also found that Frankland had lists of prisoners with life-long [or chronic] conditions, but had not monitored them for several months. Many services for this group of prisoners had also been suspended because of staff shortages. At the time of the inspection, new staff were in post and general health care services were noted to have improved.

Previous death in custody investigations at Frankland

21. This office has investigated 43 deaths at Frankland since 2004 (this figure includes two deaths that occurred after the man's). We have recently made a recommendation about updating next of kin records, which is repeated in this report.

KEY EVENTS

22. The man was charged with murder on 21 April 2002. He was convicted on 19 December 2002 and sentenced to life imprisonment.

23. After spending time at other prisons, he arrived at Frankland on 18 April 2008. A nurse completed a reception health screen and noted that the man suffered from epilepsy, his last fit being in January 2005. He had taken an overdose of his epilepsy medication at HMP Gartree in 2005. The nurse had no immediate concerns about his health.

24. On 12 August 2008, the man became unwell while working in the prison wood mill. He was examined by a nurse, who found his blood pressure to be raised at 164/106. He returned to the wing and was told that he would be referred to the prison doctor. There is no record that this appointment happened or that his raised blood pressure was followed up.

25. Doctor A saw him on 20 January 2009, after he complained of "left loin [side of the abdomen] pain". A urine sample was taken which showed traces of blood and protein. However, laboratory results showed no infection. No further action was taken and he was advised that the pain might be due to a muscle strain.

26. Early in 2010, a risk assessment was undertaken to consider whether he was suitable for having medication dispensed "in possession" (so he could keep it in his cell rather than needing to collect it from a nurse). A security information report noted that there was information that he might be involved in the trafficking of drugs. The completed assessment was reviewed by the doctor on 22 February 2010 and she concluded that, if "trafficable drugs" were to be prescribed, the doctor should consider whether they should be issued "in possession". A note was placed on the front of the electronic medical record to this effect.

27. The man was otherwise in generally good health until 14 July, when he was taken by emergency ambulance to hospital after suffering a stroke. As a result of the stroke, he suffered left-sided paralysis. He was discharged from hospital on 20 July. He was prescribed amlodipine, dipyridamol, periondopril and simvastatin medication to help prevent future strokes and control high blood pressure.

28. On 22 July, he complained of a severe headache and said that he felt unsteady on his feet. He was added as an urgent extra to the GP surgery list and saw the doctor the following day. He explained that his headache had gone. However, his blood pressure was high at 175/110 and the doctor noted that no blood pressure reading had been recorded to see how he was the day before. He was advised to return to healthcare if he felt unwell again. A blood sample was sent for analysis on 26 July, but was unusable as it was received late. He was advised of the error and the test was repeated on 20 August. The results of the test, which were completed four days later, showed that his kidney function was reduced.

29. The man saw a nurse on 27 October, after he was concerned that he had lost weight. In March 2009, he weighed 63kg, but now weighed 59kg. Another sample of blood was taken and sent for analysis. On 10 November, he saw Doctor B to review his blood results. The doctor advised him that due to a

raised potassium level he should stop taking perindopril (a blood pressure medication) as this could have caused a false potassium reading. The level of amlodipine (another drug to control blood pressure) was increased to ensure that his blood pressure stayed within normal limits. The doctor requested that a repeat blood sample be taken four weeks afterwards. It does not appear that this was done.

2011

30. On the morning of 4 April 2011, the man saw a nurse after he had an epileptic fit. His blood pressure was again raised at 160/80. That afternoon he told the nurse that he had stopped taking his epilepsy medication. He was advised to restart his medication and to contact healthcare if he felt unwell.

31. The mans blood pressure was reviewed by a nurse on 12 May and was recorded as 192/120. Doctor A requested that it be reviewed again that evening and, when doing so, a nurse noticed that Doctor B's request in November 2010 for a repeat blood test, which should have happened in early December, had not been completed. After referral to Doctor A, an urgent blood sample was taken.

32. Doctor B reviewed results of the blood test the following day and noted that the man's kidney function was deteriorating. His blood pressure had reduced to 140/90, so the doctor asked for his blood pressure to be checked weekly and reviewed by a doctor the next month.

33. No action was taken about the man's worsening kidney function until 7 June, when Doctor A saw him to review his blood pressure. He complained of pain in the loin area. The doctor reviewed his medical file and noted that his high blood pressure was not being well controlled by medication. In light of his worsening kidney function, loin pain and high blood pressure she made a referral for him to be seen at hospital for an ultrasound scan of his abdomen and kidneys. She prescribed doxazosin, a blood pressure medication, to bring his blood pressure under control.

34. On 3 July, the man saw a nurse in healthcare as he was experiencing kidney pain on the left side. He explained that, on occasion, the pain was so bad that he had to go on his hands and knees to alleviate it. She commented that "he {the man} did not appear to be unduly uncomfortable" but, in light of his recent test results, she booked an urgent appointment with a doctor.

35. Doctor A reviewed the man's notes the following morning and felt that the cause of the pain could be a kidney stone. She requested another blood test and for him to be reviewed by a GP later that afternoon. He was seen by Doctor C, who prescribed codeine for the pain which, as it is susceptible to misuse in prisons, was prescribed to be collected as required from healthcare each day.

36. The man had an ultrasound scan on 26 July. Despite his worsening kidney function, the scan showed that his kidneys were of normal size and shape, with no apparent abnormalities. However, the results revealed "dilated pancreatic and common bile ducts with evidence of chronic pancreatitis" (inflammation of the pancreas causing severe pain and possible permanent damage).

37. Following the scan, a doctor saw him on 2 August. He complained of upper abdominal and back pain. At the time, he was prescribed codeine three times daily. He explained that he was able to manage the pain during the day on his current medication, but suffered from increased pain at night. The doctor increased the codeine to four times daily and referred him to be seen at hospital for his pancreatitis.

38. On 1 September, the man collapsed in the wood mill. His blood pressure was again raised at 191/122. He complained of worsening side pain but, when offered, refused to be admitted to healthcare. He was taken back to the wing and advised that someone would come and check on him later that afternoon. When checked later, his blood pressure was slightly reduced at 170/100.

39. He was seen by Doctor B the next day. He complained of increased pain and asked that his pain relief be increased. The doctor noted that he (the man) "was very keen on increasing his pain killers but objectively does not seem to be in pain. Might need to increase from next issue". He did not increase the mans codeine and decided to review his medication in three weeks.

40. The man attended healthcare on 3 September, and spoke to the clinical team manager. He complained that he was in pain and Doctor B would not increase his medication. She explained that the doctor felt that he did not require any further pain relief at this time and offered him the opportunity to be admitted to inpatient healthcare over the weekend to enable staff to assess his pain. The man agreed and was moved that afternoon.

41. During the weekend (3 and 4 September) he was observed by staff and it was noted that "he appeared comfortable with no obvious signs of pain". The man returned to his normal wing at the end of the weekend.

42. On 27 September, the man saw a nurse, complaining of continued left sided abdominal pain. He explained that codeine was no longer effective and requested an increase in dosage. She explained to him that he would need to be reviewed by the GP.

43. Also on 27 September, he was seen by a hospital doctor at the gastroenterology clinic at the hospital. The doctor examined him and requested that he be seen for a CT scan (a three dimensional X-ray) of his pancreas. A sample of blood was taken for testing.

44. On 20 October, the hospital doctor wrote to the healthcare department at Frankland:

> "This is to bring to your attention a worsening of his [the man's] renal function with his urea at 8.9 and a creatinine of 208. I do note that he has a chronic renal impairment with a creatinine sitting usually at around 140, however, this is quite a significant jump".

45. The doctor requested that the blood test be repeated and if they remained abnormally high they should consider referring him to a renal physician.

46. The man was examined by Doctor B on 11 November. He complained of continuing side pain, explaining that his current prescription of codeine was making him feel sick and he was unable to eat much. The man now weighed

54.4kg, a loss of a further 5kg since October 2010. The doctor stopped his codeine and prescribed tramadol (a pain killer) 50mg twice a day.

47. A nurse was called to the man's cell on the morning of 14 November. He was found in the foetal position close to tears in pain and was taken to healthcare in a wheelchair for assessment. Doctor A examined him but by this time his pain had subsided and he felt much better. The mans blood pressure was raised, and he admitted to her that he hadn't taken his blood pressure medication for a few days. The doctor requested that his CT scan appointment be chased up and he returned to the wing after being advised to restart taking his blood pressure medication.

48. At 9.00pm the following night, a nurse was called to the mans cell. He complained of a sharp stabbing pain under his rib. His blood pressure was recorded at 200/144, an extremely high reading. As it was late, the man was told he would need to wait until the doctor came in the morning to be prescribed suitable pain relief. (The nurse told him that she could only give him paracetamol in the meantime.) He was again reminded of the importance of taking his medication after he admitted that he had stopped taking his blood pressure medication.

49. Doctor B saw the man the following morning. He explained to the doctor that the current dosage of tramadol (50mg twice a day) was no longer effective and he was often unable to eat due to the pain. It was noted that he looked very thin, and now weighed 52.8kg. His tramadol was increased to 100mg twice a day and Ensure (build up drinks) were prescribed.

50. The man was reviewed by Doctor A on 17 November. She noted that his blood pressure was high but she could not check the previous day's result as Doctor B had not entered it in the record. It appears the letter sent by the hospital doctor to healthcare on 20 October was not received at the prison until 16 November (Frankland date-stamped the letter when it arrived). The doctor noted the request for a nephrology referral and asked the healthcare team to send the referral. She asked that his blood pressure be monitored daily and she decided that, due to his non-compliance with taking his blood pressure medication, it should be issued to him daily.

51. He was admitted to inpatient healthcare that evening as he could not sleep due to intense pain. The following afternoon, he discharged himself to the wing against the advice of healthcare staff. His blood pressure remained dangerously high until 20 November, when he was taken by emergency ambulance to hospital due to tachycardia (accelerated heart beat).

52. The man remained in hospital until 28 November. His hospital discharge paperwork noted that "CT scan were normal and ruled out anything sinister. The clinical impression was an inflamed pancreas… and no other cause could be found". His discharge paperwork showed that tramadol had been increased from 100mg twice a day to four times daily with a note to say "GP to review" next to it.

53. Doctor A reviewed the man on his return and noted that his blood pressure appeared to have returned to normal. She reviewed the medication listed on his hospital discharge papers and issued a prescription. After being discharged, he spent one night in inpatient healthcare before returning to the wing.

54. Two days later, on 30 November, Doctor B saw the man for a medication review. Only tramadol was named in the review, which was reduced from 100mg four times daily (as prescribed by the hospital) to 150mg twice a day.

55. On 1 December, the man was too unwell to collect his medication. A nurse visited him and he complained that his pain relief had been reduced. He said that to ease the pain he had been putting a plastic drinks bottle with boiling water on his stomach. The nurse spoke to healthcare about providing a heat pack but was told that they did not stock them.

56. The man collapsed while waiting for medication that evening. His blood pressure was raised at 230/150 and he was unresponsive for a few minutes. An ambulance was called and he complained of feeling dizzy and appeared to be slightly confused. He was taken to hospital.

57. At 11.20pm that evening, the man was discharged from hospital. A nurse called the hospital as no discharge information was sent with him. She was told that nothing abnormal had been detected and after being administered with pain relief he was discharged with a diagnosis of 'non specific abdominal pain'. When the man returned to Frankland he was asked to spend the night in prison healthcare for observation. He declined this offer and returned to his wing.

58. The following morning, 2 December, the man was reviewed by Doctor A. She noted that, "pt [patient] walked in very spritely - pupils noticeably small but is alert and talking normally". Based on his presentation, she asked if he had taken any illicit drugs. The man said that he "had been close to taking stuff off others on the wing". He was able to move about without difficulty and the doctor detailed in her notes that she was unable to find the cause of the pain. She suggested reducing his tramadol but, after he resisted the idea, she agreed to review his medication at his next appointment.

59. The doctor reviewed the man on 20 December, after he complained of increased pain and disturbed sleep. He requested that he be given tramadol at night to help with the pain. She noted that his pupils were again 'pin point' (small) and noted that "although he denies illicit use, I am concerned that [his] nocte [night time] dose will not be properly supervised". (Like codeine, tramadol is subject to misuse in prison and is therefore usually administered under supervision.) She explained to him that prescribing tramadol at night could be problematic as he would have been locked behind his door at this time and it would be difficult to supervise him taking his medication.

60. The man made a complaint to healthcare on 22 December. He mentioned the consultation he had with Doctor A two days earlier, explained that his stomach pain increased during the night and said that staff could see him taking his medication through the hatch in his door. He asked to see a manager and requested that he had no further contact with Doctor A. (The healthcare provider replied to his complaint on 30 December. The man was told that a note would be placed on his medical record advising that he did not wish to see Doctor A again. However, they also told him that this might cause a delay should he wish to see a doctor.)

61. On 28 December, the man was found rocking with pain on the floor of his cell. He was taken to healthcare. Despite requesting not to see Doctor A again, he saw her for a follow up examination the next day. (A note was made on his

medical record on 30 December that he did not want to see her.) The man explained that he had not been able to sleep for two days because of the pain. The doctor noted that he was very pale and his eyes were puffy. He now weighed 50.4kg. As it was clear that his level of pain had increased since she had last seen him, she prescribed a later dose of tramadol (the overall dosage remained the same, but was spread out through the day to allow for a dose to be given much later in the day). She discussed the mans case with a nephrologist (a kidney specialist) from the hospital. He felt that there was no need to admit him to hospital at that time but said that he would arrange for a kidney biopsy to be undertaken a later date.

62. The man was seen in healthcare by a nurse on 31 December as skin on his stomach had broken down where he had been using a plastic bottle (filled with boiling water) to ease the pain. He declined her offer to dress the wound as he would only remove it to apply heat to his stomach.

2012

63. The man was admitted to hospital for a kidney biopsy on 10 January 2012. He was discharged on 13 January, after being diagnosed with IgA nephropathy, a chronic kidney disorder that occurs when IgA, a protein that helps the body fight infections, settles in the kidneys.

64. At 4.36am on 12 February, the man was found in his cell clutching his arm complaining of being in pain before losing consciousness. When healthcare staff arrived he was unresponsive. A nurse checked his eyes and found his pupils to be pin point and un-reactive to light. His blood pressure was recorded as 170/100. Paramedics arrived at 5.00am and, at 5.45am, took him to hospital. He was restrained with an escort chain (a long chain with a handcuff at either end).

65. The man was seen at hospital by a consultant. He was sent for a CT scan. At 9.52am, he was moved to the intensive care unit where the consultant advised a prison officer that the CT scan showed that the man had a blood clot on the brain and he would not regain consciousness. The officer spoke to a governor, who authorised the removal of restraints.

66. The family liaison officer (FLO) at Frankland attempted to contact the man's ex-partner, who was his nominated next of kin. However, she had not visited him for a number of years and the address held on his prison file was incorrect. The man had a brother but the FLO could not find an address for him. The following morning, Monday 13 February, she contacted the man's offender manager (probation officer) to help locate his family. After obtaining contact details for his ex-partner, she arranged to meet her at the hospital so she could visit him.

67. On 18 February, it was noted that the man had "made no neurological progress in the last six days". His consultant was of the view that the most likely outcome would be a "permanent vegetative state … and he should not be resuscitated". Hospital staff noted in the mans record that he "has no obvious advocate. His ex-partner is the closest … to a next of kin but prior to admission she had not seen [him] for several years".

68. The hospital, after consultation with Frankland, sought advice from the Independent Mental Capacity Advocate (IMCA). (The IMCA are an

organisation which helps vulnerable people who lack the capacity to make important decisions about serious medical treatment, and who have no family or friends that it would be appropriate to consult about those decisions.) After speaking to the man's next of kin and other members of staff, the Advocate wrote in his hospital notes on 21 February that:

> "From the information received it would appear that the man's perceived wish would not to be in a persistent vegetative state. It would not be in his interests to continue to be ventilated or to have any further interventions that would result in him being in a persistent vegetative state. All professionals agree that withdrawal of ventilation is the most appropriate option. In view of the above it would appear that a DNAR [do not resuscitate] notice would be appropriate".

69. The prison chaplain visited the man, prayed and gave him the Last Rites. His breathing tube was removed and he continued to breathe unaided until he died a few days later. The officer supervising him at the hospital contacted the prison to pass on the news. The duty governor arrived at the hospital at 7.40pm to debrief and offer support to the officer.

70. The officer and duty governor returned to Frankland and met the Night Orderly Officer to have a hot debrief, to enable staff to discuss what had occurred while the events were fresh in their minds. The services of the care team were offered to all staff involved, but none asked for any assistance. The FLO had met the man's former partner previously and discussed how the news should be broken when he died. The former partner was aware that he was very seriously ill and had agreed that when he died she could be notified by telephone.

71. The FLO was informed of the man's death late on the day of his death. Because it was so late, she decided to contact his former partner the following morning. Despite trying the next day, she was not able to contact her until two days later.

72. On 28 February, the man's sister contacted the FLO asking why no one had got in touch when her brother died. The FLO explained that she had not been listed as his next of kin and the prison had no contact details for her. The man's brother called the prison the following day. The FLO subsequently liaised and corresponded with all family members.

73. Notices were put up around the prison informing staff and prisoners of the man's death and offering support to those who required it. Support was offered to his friends by staff on the wing and all prisoners who were subject to self-harm monitoring procedures were checked. His funeral was held on 23 March 2012 and, in line with national guidance, the prison contributed to the cost.

ISSUES

The man’s clinical care

74. The man was admitted to hospital on 14 July 2010, after he had a stroke which caused left-sided paralysis. His blood pressure had been dangerously high at 221/154. The clinical reviewer commented that the man “was discharged on appropriate medication for [the] prevention of further strokes and hypertension management”.

75. The clinical reviewer commented that the high levels of potassium in the blood and raised blood pressure should have led to more urgent and detailed follow up in October 2010. He noted that, at this time, Doctor B correctly stopped the prescription of perindopril, as it could have been giving a false potassium reading. However, the blood test was not repeated until May 2011. The clinical reviewer also felt that the diagnosis of chronic pancreatitis following the ultrasound scan in July 2011 meant that the original purpose of the scan – to check on the man’s kidney function – was overlooked.

76. Frankland does not have a system in place to ensure that requests for follow up investigations and appointments are actioned. Doctor A confirmed to the investigator that diary entries are not used at Frankland to monitor follow up investigations and appointments, and agreed that they should be.

77. It is obviously important that investigations such as blood tests are completed if a doctor believes they are necessary to diagnose an illness. Doctors at Frankland are aware that this is an area for improvement. We make the following recommendation:

    The Head of Healthcare should ensure that a robust system is introduced to ensure that all requested health investigations and tests are followed up to check that they have been actioned appropriately.

78. After reviewing the man’s records, the clinical reviewer commented that “the fatal stroke might have been averted with earlier diagnosis and treatment of his IgA nephropathy allowing better blood pressure control”.

79. Two blood tests were taken at Frankland between May and July 2011, both of which showed further deterioration of the man’s kidney function. A urine test also showed high levels of protein. The clinical reviewer commented that high blood pressure and tests showing blood and protein in the urine, and worsening renal function, should have alerted medical staff to consider referrals for further specialist kidney tests. The reviewer notes that, had NICE (National Institute for Clinical Excellence) guidelines been followed, this would have been done. At interview, Doctor A explained to the investigator that there was no formal protocol for managing kidney disease at Frankland, and agreed that there was a need for one.

80. The man’s renal referral was sent on 16 November 2011, following advice from the gastroenterology registrar. Two GPs had considered nephrology referral several months earlier, but the clinical reviewer noted that “there appears to have been some reluctance to refer”.

81. The nephrologist saw the man at hospital and arranged for a kidney biopsy on 10 January 2012. The biopsy revealed that he had been suffering from IgA

nephropathy, which had caused his high blood pressure.

82. Several opportunities were missed to address the man's kidney disease. This played a contributory role to the high blood pressure that eventually led to the stroke that killed him, although the clinical reviewer has pointed out that there is not a direct causal link between the kidney disease and the stroke. We believe that it is important for staff at Frankland to deal with kidney disease more effectively, and we make the following recommendation:

The Head of Healthcare should establish a protocol for the management of kidney disease to ensure that it is dealt with in accordance with NICE guidelines.

83. In his clinical review, the reviewer referenced a recent study of the diagnosis and treatment of chronic kidney disease in a primary care setting (which healthcare at Frankland is) in the UK. This study found that only a minority of patients met the NICE criteria for referral to secondary care. He has concluded that, although the treatment provided for the man's chronic kidney disease was "not optimal", it was of a similar quality to that which he could have expected in the community.

Pain management

84. The clinical reviewer did not comment specifically about the management of the man's pain. However, it is clear from the man's complaint against Doctor A, and the evidence of two fellow prisoners, that this was of great concern to him towards the end of his time at Frankland.

85. The man made a healthcare complaint on 22 December, detailing the consultation he had with Doctor A two days earlier. This is discussed in the key events section. He requested that he not be seen by her again. (In the event, he saw her on 28 December, and a note was put on his record two days later that he did not want to see her. He did not see her after this note was made.) The doctor was unaware of this complaint.

86. Two of the man's friends at Frankland contacted the investigator, who met them on 6 March 2012. They said that they were concerned about the care he received while at Frankland.

87. They told the investigator that, because of the pain from his pancreatitis, the man had been unable to sleep and had lost a considerable amount of weight. Before his diagnosis, his pain was not well controlled, but after the diagnosis the hospital increased the level of tramadol from 200mg to 400mg per day. However, they alleged that Doctor A reduced the man's pain medication back to 200mg when he returned to Frankland. One explained that the man was very anti-drugs and was on the voluntary drug testing scheme, always providing a clean result.

88. The man's discharge paperwork from the hospital confirms that he was on 400mg of tramadol per day with a note next to it saying "GP to review". He returned to Frankland on 28 November 2011 and saw by Doctor A the same day for a medication review. There is no record of tramadol being discussed, or his prescription being changed, at this review. He next saw Doctor B on 30 November. During this review, he was prescribed 300mg (150mg of tramadol twice a day), a reduction from the level prescribed by the hospital.

89. During December, the man returned to see Doctor A and asked if he could receive some of his tramadol at night, because of the pain he was experiencing. She initially rejected his request – which prompted his complaint – but, after seeing him in increased pain on 29 December, she agreed to amend the timings of the doses to ensure that he received his last dose much later in the day.

90. The investigator spoke to Doctor A about the man's pain management. The doctor explained that she had raised concerns with him about illicit drug use and whether he was dependent either on the drugs he was prescribed or drugs he obtained from other sources.

91. During this period, however, it is clear that the man was suffering from increased pain. A nurse had found him, on 1 December, using a plastic bottle filled with hot water to try and ease the pain in his abdomen and, on 31 December, he said that he did not want the wound on his stomach to be dressed as he wanted to continue to apply heat to ease the pain. He had also told his fellow prisoners of his continued pain.

92. In his clinical review, the reviewer states that he believes that Doctor A acted reasonably when not amending the level of tramadol for the man. He further says that, as tramadol is known to be abused because of its side effects, it should be administered under supervision in line with the provisions of PSI (Prison Service Instruction) 45/2010

93. However, we are concerned that, if the man was in so much pain that he used an improvised hot water bottle to the extent that it burnt the skin on his stomach, he did not receive appropriate pain relief when he needed it. We note that the level of tramadol was reduced following Doctor B's review on 30 November, and was not adjusted for almost a month. This decision seems to have been based on a review of in-possession medication conducted almost two years earlier, which in turn was based on information that was never proven. We believe that, in the circumstances, greater weight should have been given to the man's presentation and less to an old assessment. We make the following recommendation:

    The Head of Healthcare should ensure that appropriate pain relief medication is prescribed and issued to those prisoners who require it.

94. We also note that the man had to use the plastic bottle to apply heat to his stomach, with the result that he suffered a burn to his skin. This is clearly inappropriate. We make the following recommendation:

    The Head of Healthcare should ensure that medical heat packs are available for prisoners to assist with pain relief.

Use of restraints

95. When the man was taken to hospital on 12 February, he man was restrained using an escort chain. At the time he was taken from the prison to the hospital he was unconscious, and a nurse had noted that his pupils were unresponsive to light. However, the cause of his condition was not known so a cautious approach to his risk was taken.

96. Before he left the prison a risk assessment was completed. The first part of the assessment is completed by a member of healthcare, in this case a Healthcare Officer (HCO). The HCO confirmed that there were no medical objections to the use of restraints, and that the man's condition did not restrict his ability to escape unaided (although he was unconscious at the time). In the security assessment, the man was considered as a low risk to the public and hospital staff.

97. It is not clear how the assessment of low risk necessitated the use of an escort chain. Restraints were removed promptly once the true extent of the man's condition became clear a few hours later, which we are pleased to note. However, we question whether the original decision to use an escort chain was commensurate with both his condition and the security risk assessment. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents.

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Contacting the man's next of kin

98. The man had listed his former partner as his next of kin. However, when the FLO tried to contact her, she found that the details held on file were incorrect. Contact was eventually made through his probation manager.

99. After his death, the man's sister contacted Frankland to ask why she had not been informed of his illness. The FLO explained that they did not have any details for her.

100. While it was clearly up to the man to decide who to list as next of kin, the prison should also ensure that prisoners are asked periodically, whether they wish to update the details. This ensures that, if necessary, the correct next of kin can be contacted quickly. We have recently made a recommendation about this issue in another report of an investigation into a death in custody at Frankland, and we repeat that recommendation here.

The Governor should ensure that there are processes in place to maintain up to date records of prisoners' next of kin contact details.

CONCLUSION

101. The man was received in to Frankland in April 2008 and remained there until his death in hospital. During this period, he developed high blood pressure, abdominal pain, pancreatitis and worsening kidney disease.

102. Several opportunities were missed to identify his kidney problems. In particular, the diagnosis of chronic pancreatitis following an ultrasound scan in July 2010 seems to have diverted attention away from his possible kidney disease. Other tests further contributed to the delay. This, in turn, contributed to the high blood pressure which was a factor in his fatal stroke.

103. We have also found that the man's pain was not managed as well as it could have been. In particular, the level of tramadol was reduced following his return from hospital in November 2011 and only increased again a month later, despite him complaining that he was in pain at night. In order to help control the pain, he used an improvised hot water bottle which left him with burns to the skin on his stomach.

104. We make six recommendations as a result of this investigation. Four of these relate to healthcare and include recommendations concerning the follow up of clinical investigations, the establishment of a protocol for dealing with chronic kidney disease and pain management. We also make recommendations about the risk assessment of restraints and about the updating of next of kin details is repeated from an earlier investigation at Frankland

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a robust system is introduced to ensure that all requested health investigations and tests are followed up to check that they have been actioned appropriately.

   The National Offender Management Service responded with,

   Accepted - GP Integrated Systems will be introduced in September 2012; which will amongst other things, will focus on pathology management and follow-up of results.

2. The Head of Healthcare should establish a protocol for the management of kidney disease to ensure that it is dealt with in accordance with NICE guidelines.

   The National Offender Management Service responded with,

   Accepted - A protocol will be developed for the management of kidney disease in line with NICE Guidance.

3. The Head of Healthcare should ensure that appropriate pain relief medication is prescribed and issued to those prisoners who require it.

   The National Offender Management Service responded with,

   Accepted - Whilst the Head of Healthcare and other senior nurses can challenge prescribing practices, it is ultimately the decision making process of the GP reviewing the patient to decide on the most effective and appropriate medication to give to an individual. However, current decision making processes are not considered to be making best use of national guidance and assessment tools, therefore a protocol will be written to support these.

4. The Head of Healthcare should ensure that medical heat packs are available for prisoners to assist with pain relief.

   The National Offender Management Service responded with,

   Partially Accepted - Hot and cold packs were removed from issue due to the chemicals within the packs, which were deemed to be a security risk. A review to determine what products can be used, and whether this will impact on security procedures and risk assessments, will take place so that staff will be able to order appropriate medication to assist with pain relief.

5. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents

   The National Offender Management Service responded with,

   Accepted - Security managers are aware of the necessity to risk assess prisoners taken to hospital, taking into account the actual risk that the prisoner possesses.

6. The Governor should ensure that there are processes in place to maintain up to date records of prisoners' next of kin contact details.

   The National Offender Management Service responded with,

   Accepted - Next of kin details are now systematically reviewed every six months. This process will be driven by the Safer Custody Governor.