Investigation into the circumstances surrounding the death of A man on 28 April 2005 At HMP Frankland

Prisons and Probation Ombudsman for England and Wales

October 2005

The man was aged 40 when he died from a heart attack on 28 April 2005 in his cell at HMP Frankland. This is a report into the circumstances surrounding his death.

The loss of any family member is distressing, but especially so whilst they are in custody, and I offer my sincere condolences to his relatives and friends. One of my Family Liaison Officers contacted his parents and they raised questions which I hope the report has been able to answer for them.

The investigation was carried out by a member of my office. I would like to thank the Governor of Frankland for making the necessary facilities available to my investigator. I also pay particular thanks for the help and support of the Liaison Officer.

In the course of the investigation, I asked the Durham Primary Care Trust (PCT) for a clinical review of the care and treatment received by the man. The PCT report raises significant concern regarding the care received by him from the prison Healthcare Officer dealing with him when his symptoms first presented. I am grateful to the PCT for their report and support their recommendations.

My own report makes joint recommendations for the prison and PCT. It also identifies two examples of good practice.

Stephen Shaw CBE October 2005
Prisons and Probation Ombudsman

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Summary

1. At 2:45pm on 28 April 2005, the man attended the Healthcare Centre at HMP Frankland. He complained of chest pains, cramp across his shoulders and aches in both forearms. A prison Healthcare Officer carried out an electrocardiograph (ECG), blood pressure and temperature check and considered the readings to be within normal ranges. He advised him to return to his cell and rest. A referral was made by the officer for him to be seen by the doctor the following day.

2. At approximately 7:15pm that same day, a Prison Officer was informed by another prisoner that he could see the man through the cell observation glass. He was lying on the floor, and the other prisoner was unable to obtain a response from him. The officer unlocked the cell door and entered. He too was unable to gain a response from him. The officer summoned assistance from another officer who was on duty in the wing, and they immediately began to check for signs of life. Emergency assistance was requested via the local procedure *code black*, and the officers began CPR pending the arrival of healthcare staff.

3. The healthcare staff arrived at the cell and could not detect any signs of life. A defibrillator was attached to him and gave no indication that life was present. It did not instruct the medical staff to administer an electric shock to stimulate his heart.

4. At 7:38pm, paramedics arrived and took over his care. Following their own examination, they announced that he had died. The paramedics left the prison at 8:03pm and the cell was sealed pending the arrival of the police.

The man

5. He was born on 11 June 1964 in Oldham, Lancashire and was educated in the area. He gained four GCSE qualifications and an NVQ in Business Management. After he left school he joined the army, but was medically discharged after 18 months. He had periods of unemployment, labouring, and finally working as a disc jockey in public houses.

6. He had two children but was separated from his wife.

7. On 6 February 1997, he was found guilty at Manchester Crown Court of murder, rape and abduction. He was sentenced to life imprisonment with a recommendation from the sentencing judge that he serve a minimum of 25 years. During the time that he was on remand, he was categorised as a Category A prisoner, the highest security category available. This meant that at all times his movements in the prison were closely monitored by prison staff. Once he had been sentenced, the Category A status was reviewed by the Prison Service and downgraded to Category B.

8. Following his conviction, he was transferred first from HMP Manchester to HMP Leeds, and then to HMP Frankland which is part of the Prison Service's High Security Estate.

9. Prior to his current sentence, he had a total of 76 offences recorded against him with the earliest recorded date being June 1980.

HMP Frankland

10. HMP Frankland is a maximum-security establishment holding Category A and Category B adult male prisoners. It is part of the high security directorate of the Prison Service.

11. Frankland opened in October 1980 as a temporary prison, staffed by the army. After three months the establishment was closed for further modification. It reopened as a fully operational high security prison in April 1983. Two further wings were opened in 1998, bringing the establishment's certified normal accommodation (uncrowded capacity) to 653. Prisoners are held in single cell accommodation in six wings, four of which house vulnerable prisoners. The establishment's performance rating is "High Performance", which is the highest level achievable.

12. An inspection report by HM Chief Inspector of Prisons in March 2003 described Frankland as offering a safe environment, based upon good relationships between staff and prisoners, with appropriate levels of interaction and good staff understanding of individual prisoners and their needs.

13. The Standards and Security Audit carried out by the Prison Service during February and March 2003 gave an overall "good" rating for both categories. Good is defined as an establishment that performs to a high level and there is evidence which gives assurance that risks are being effectively managed.

14. The minimum healthcare provision in all prisons is such as to ensure an opportunity for prisoners to be seen by a doctor at surgery on any week day. To access the service, prisoners make an application to see the doctor. This normally happens when they are first unlocked in the morning. The names of the prisoners asking for a doctor's appointment are passed to the Healthcare Centre for processing. The prisoners are then called to the Healthcare Centre for an appointment with the doctor.

15. Once the morning application period has ended, prisoners can request to go "special sick". This is the term used by staff and prisoners referring to a request for medical care outside the normal appointment times. Prisoners who report as "special sick" would normally be first assessed by a nurse, rather than seen immediately by a doctor. All prisons have an on-call doctor, who is available 24 hours a day, seven days per week, and who is able to respond to any medical situation. This allows the nursing staff to seek medical advice from a doctor. The doctor can give advice to the nurse on the telephone, including advice on whether an ambulance should be called.

16. Prisons employ a range of clinical staff, including Prison Officers who are nurse qualified or have received some health related training. They are known as Healthcare Officers.

Conduct of the Investigation

17. On 10 May, my investigator opened the investigation and met with the Governor who briefed him on the circumstances of the man's death. He was also shown the cell where he had died. A number of documents were made available for the investigator to consider. The same day, my investigator met again with the Governor and fed back his initial findings.

18. The Prison Healthcare Manager and my investigator met on 11 May with the Medical Director Durham Cluster of Prisons and the Cluster Development Manager of Durham and Chester-Le-Street PCT. Also present was the Deputy Director of Community Service.

19. The Medical Director said that he would be issuing new guidelines regarding the use of ECG machines and interpretation of the readings. He would also be recommending to the Governor that the Healthcare Officer should be removed from clinical duties, pending the outcome of their investigation. My investigator raised the concerns of the PCT with my Deputy Ombudsman. She wrote to the Governor to recommend a local investigation – in partnership with the PCT– into the level of care afforded to the man by this Healthcare Officer.

20. On 18 July, my investigator received the clinical review from the PCT. He wrote to the Governor and supplied him with a copy of the report as it contained recommendations of sufficient importance to warrant immediate notification.

21. One of my Family Liaison Officers contacted the man's parents and they raised questions which I hope the report has been able to answer.

Key Findings

22. On the morning of 28 April 2005, the man made a telephone call to his parents. During the telephone call, he said to his mother *this morning right, I got this pain in my chest right through to my back, down right between my shoulder blades.* His mother advised him to see a doctor. He also said *it's right across my shoulder blades down my arms.* His mother advised him again to see a doctor, but she was interrupted when he said *it's eased off now. I felt so bad this morning I was going to ask them to send me to the hospital.* He went on to say that he would go to the hospital if the pains returned.

23. At approximately 2:30pm that day, another prisoner who was in C wing informed an officer that the man felt unwell. The officer discussed the symptoms with the man. As it was too late to make an the application to see a doctor, the officer telephoned the Healthcare Centre and made immediate arrangements for him to be seen "special sick". He initially said that he did not wish to go to the Healthcare Centre, but the officer insisted. The officer offered wheelchair assistance, but he declined as he preferred to walk.

24. At 2:45pm, a Healthcare Officer (HO), a qualified Second Level Registered Nurse, interviewed him in the Healthcare Centre. He made a note in his Inmate Medical Record (IMR): *s/sick c/o central chest pains, stabbing like causing a cramp like pain across shoulders and causing an ache like pain in forearms.* He also added *B/P160/84, P 84 and T 36.7C*. Additionally, he carried out an ECG and recorded in the IMR, *ECG done, nil significant, advised to rest, for M/O morn*. (I may paraphrase the entry as follows: The man had pains in his chest, across his shoulders and in his forearms. The (Healthcare Officer) HO took his blood pressure, pulse and temperature. He also undertook an electro cardio graph (ECG) reading but found nothing significant. He advised him to rest and see the doctor in the morning.)

25. Following assessment at the Healthcare Centre, he returned to C wing and explained to the officer that he had had an ECG and said that he felt fine. He also said he had been given an appointment to see the doctor the following day, but was not going to bother to attend.

26. At 4:50pm, the man, who was employed as a food servery worker, helped to serve the evening meal and then cleaned the food area. He did not refer again to the pains that he had experienced earlier. He left the servery area at 5:25pm. The officer did not see him again.

27. At approximately 5:30pm, another prisoner on the same wing as the man saw him lying on his bed. He asked if he was feeling well, and he said that he had pains in his chest and arms and had been in this condition since approximately 8:30am. The prisoner decided to use one of the telephones on the wing to call a friend and seek advice about his condition. The person he telephoned suggested that he was suffering from angina, and the prisoner decided to pass the information to him when he next saw him, as he thought it would put his mind at rest. He did not raise any concerns with prison staff about the man's condition.

28. At 6:30pm, an officer unlocked the man's cell to allow him to wash his clothes in the laundry. At 7:00pm, he returned to his cell and locked himself away. This was not unusual, and was something that he was in the habit of doing on a regular basis.

29. At approximately 7:15pm, another prisoner returned to the wing after a period of exercise in the gymnasium. He went directly to the man's cell to pass on the information from his friend. He noticed that his cell door was locked. When he looked through the observation flap in the door, he could see him lying on the floor with a blanket around him. He could see that his left hand was clenched tight, and his skin colour was blue. As the prisoner was unable to obtain a response, he called for the assistance of the officer who was on the landing. The officer came to the cell and could see him on the floor, but he too was unable to obtain a response.

30. The officer called for additional assistance from a colleague who was on duty in the wing. When they entered the cell, one of the officers checked him for signs of life but could not detect any. The other officer raised a code black alarm. Code black is the local procedure for alerting medical staff that a patient is experiencing breathing difficulties, and it informs them which type of emergency equipment is required. This is good practice.

    The use of a code system to summon medical assistance is good practice, as it informs the clinical staff of the type of equipment they need to take to the scene to ensure appropriate clinical interventions.

31. A further officer arrived, and both he and his colleague commenced CPR, which continued until the arrival of healthcare staff who then took care of the man. The officer continued to check for any signs of life. My investigator has established that the officers were quick to react to the emergency and made every effort to resuscitate him.

    The officers should be commended for their prompt attempts to resuscitate the man.

32. At 7:20pm, a Staff Nurse heard a code black message on his prison radio which asked him to go to C wing, cell C2-07. He responded along with a Support Worker. At approximately 7:22pm, they arrived at the cell and saw the officers carrying out CPR. The Staff Nurse checked for signs of life but found none. He also noted that the man's was cyanosed, which is a medical term used to describe the blue colour of the skin caused by lack of oxygen. The Staff Nurse and Support Worker took over and continued with CPR at a rate of two breaths to 15 compressions.

33. The Staff Nurse asked for a defibrillator, and was informed that it formed part of the emergency equipment that had already been taken to the cell. Whilst this was quickly dealt with, it is worrying that the medical staff were unaware of the emergency equipment available to them when attending an incident. My investigator fed his finding back to the Governor during a briefing session at the end of the day.

34. A defibrillator was attached to the man, which instructed the medical staff to continue with CPR and not to administer an electric shock. The CPR continued until the arrival of paramedics.

35. Another officer became aware that something was wrong when he saw staff pushing the emergency trolley through the wing. As he was a trained defibrillator operator, he went to the man's cell to assist with its operation. He said that he encountered some difficulties with the Staff Nurse establishing who was responsible for the equipment. The officer said that the nurse attempted to adjust the controls, whilst other staff were in contact with the man's body. He said that this was a dangerous practice, as an accidental shock could take place and only one person should be in overall control of the equipment. In the event, there is no suggestion that an accidental shock did occur, or that equipment was incorrectly connected. However, there was clearly some confusion, and this finding was also fed back to the Governor for clarification with the PCT of the correct protocol for control of the defibrillator.

    The PCT and Healthcare Manager should ensure that all healthcare professionals are fully aware of the available emergency medical equipment and its correct and safe use.

36. At 7:40pm, paramedic staff arrived and carried out their own tests which gave no indication of life. At 7:46pm, they pronounced the man dead.

37. At 7:55pm, the on-call doctor was contacted by a member of the prison healthcare staff and asked to attend the prison. At 8:00pm, he arrived at the cell and after examining him confirmed that he had died.

38. At 9:45pm, the police arrived and carried out their own enquiries. They left the prison at 10:28pm.

39. My investigator interviewed the Healthcare Officer and asked why, when the man was presenting the symptoms described, he had not sought the advice of a doctor. He said that he had 30 years experience as a nurse, and was not concerned at the symptoms that the man was describing. He confirmed that he had neither sought a second opinion, nor discussed it with the on-call doctor, nor considered calling an emergency ambulance.

40. My investigator discussed the ECG trace with the Healthcare Officer and asked if he was qualified to assess the information. He said that he had seen numerous ECG traces and was able to tell if someone was experiencing a heart attack. He added that he had been on a training course to instruct him how to use ECG equipment, but later confirmed that the course did not qualify him to assess the information. He said that he had based his decision not to call an ambulance on the ECG printout which said that the reading was normal.

41. In all cases of a death in custody, I ask for a clinical review to be carried out. The review examines the level of care and treatment received by the deceased person, and makes any necessary recommendations.

42. On 11 May, the Prison's Healthcare Manager and my investigator met with the Medical Director Durham Cluster of Prisons and the Cluster Development Manager of Durham and Chester-Le-Street PCT. As noted earlier, also present were the Deputy Director of Community Service, who had been asked to undertake the clinical review, along with another doctor. The Deputy Governor of Community Service examined the decision made by the Healthcare Officer, and the doctor examined the man's care and treatment when he was in custody.

43. The Medical Director said that, even as a doctor, he was not qualified to interpret ECG readings and he would not rely on a printout as it was a specialist role. He said that the decision not to call a doctor or ambulance was wrong. He added that he would be issuing new guidelines regarding the use of ECG machines and interpretation of the readings. He would recommend to the Governor that the Healthcare Officer be removed from clinical duties, pending the outcome of the PCT review.

44. My investigator raised the concerns of the PCT with the Deputy Ombudsman, herself a certified clinician. On 12 May, she wrote to the Governor and recommended an urgent investigation, in partnership with the PCT, into the level of care afforded to the man by the Healthcare Officer.

45. The Clinical Review makes six recommendations which I endorse. Additionally, the report raises the question of whether its recommendations have wider implications for the Prison Service.

    The PCT in partnership with HMP Frankland should review what systems should be in place to implement the learning opportunities identified in the clinical review.

    Prison Health should review the management of chronic diseases across the wider prison estate to ensure it is in accordance with the best practice in the National Service Frameworks.

46. The clinical review adds:

- The significance of the man's symptoms was not recognised. The description in the medical record is that of a classical myocardial infarction. Based on history alone, a paramedic ambulance should have been summoned immediately.

- Too much reliance was placed on a normal ECG and the absence of any other signs or symptoms.

- Advice on management was available from nursing staff present or a GP by telephone.

- There was no subsequent discussion of the patient's management with anyone.

- The Healthcare Officer had not had recent training to update his skills and knowledge of the modern management of myocardial infarction.

47. Because the commentary and recommendations in the clinical review were of such importance, my investigator has already provided a copy to the Governor.

Recommendations

1. The PCT and Healthcare Manager should ensure that all healthcare professionals are fully aware of the available emergency medical equipment and its correct and safe use.

2. The PCT in partnership with HMP Frankland should review what systems should be in place to implement the learning opportunities identified in the clinical review.

3. Prison Health should review the management of chronic diseases across the wider prison estate to ensure it is in accordance with the best practice in the National Service Frameworks.

Good Practice

1. The use of a code system to summon medical assistance is good practice, as it informs the clinical staff of the type of equipment they need to take to the scene to ensure appropriate clinical interventions.

2. Two officers should be commended for their prompt attempts to resuscitate the man.