Investigation into the circumstances surrounding the death of a man at HMP Frankland in September 2009

Report by the Prisons and Probation Ombudsman for England and Wales

October 2010

This is the report of the investigation into the circumstances surrounding the death of a man. He was 53 years old when he died at HMP Frankland in September 2009. His death was a result of heart disease, aggravated by diabetes. His coronary artery bypass graft, the result of an operation in 2001, had become blocked.

The man entered custody in 2002 after committing some very serious offences. He had come to the UK from Poland in the 1990s. His heart problems continued and he suffered chest pains and significant ill health throughout his time in prison. He also refused treatment on numerous occasions. He died in his cell during the night and was found by staff during a routine check.

The man had no family in the UK, but had an elderly stepfather in Poland. I extend my condolences to him and also to any prisoners who may have been affected by his death. I apologise for the delay issuing my report and any additional distress this may have caused.

The investigation was completed by my colleague. He visited Frankland and interviewed staff who were working on the night the man died, as well as members of the healthcare team who oversaw his long term care. My Assistant Family Liaison Officer wrote to the man's stepfather to tell him about the investigation.

A clinical review of the treatment which the man received in prison was undertaken by a clinical reviewer appointed by the NHS. She assessed whether the care that he received in custody was comparable to that he would have been offered in the community. I am grateful to her for her assistance. A copy of her review is annexed to my report.

I would like to express my thanks to the Governor and the staff and prisoners at Frankland for their full cooperation whilst the investigation was completed. I would particularly like to thank those in the prison's business unit for liaising with the investigator and helping to organise interviews.

The investigation has highlighted a number of issues. The man repeatedly refused treatment that might have improved his health. Although he spoke some English, there were conflicting accounts about his level of understanding. I stress the need for the healthcare team to reassure themselves that a patient has refused treatment whilst in full possession of the facts about his illness, for example with an interpreter or translated documents. The clinical review also highlights concerns about the potentially harmful interaction between the different medications the man took. I endorse her recommendations.

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 **October 2010**

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SUMMARY

In 1996, the man arrived in the UK from Poland. He committed a serious offence in 1997. In 2001 he underwent heart bypass surgery. The following year he committed further serious offences and was arrested. He was taken to HMP Wormwood Scrubs and told healthcare staff about his history of heart disease. The next month he transferred to HMP Belmarsh in south London. He was the subject of repeated suicide and self harm monitoring from 2002 until 2004.

In May 2003 and March 2004 the man was sentenced for different serious offences. At the latter hearing he received a life sentence. In September 2005 he moved to HMP Wakefield, and then in November of that year to HMP Frankland.

The man had a limited understanding of English, and at various times healthcare staff questioned in his clinical record whether he understood them properly. Between 2005 and 2009, he experienced numerous episodes of breathlessness and chest pain at Frankland, but usually refused to be admitted to hospital, instead signing a disclaimer. If he was taken to outside hospital after a particularly serious collapse, he would refuse ongoing treatment and ask to be returned to the prison because he did not like being handcuffed to an escorting officer. Throughout his time in custody he was assessed by visiting consultants from local hospitals, but they all advised against surgical intervention to address his heart disease.

He often did not take his prescribed medication, which he was allowed to collect and keep in his cell. Because he was unwilling to stay for treatment in either outside hospital or the prison's healthcare centre, he became over-reliant on his angina spray to ease his chest pain.

The man was diagnosed with diabetes and his condition was checked at regular intervals by a visiting specialist nurse. He was prescribed several different medications to treat his diabetes. The nurse struggled to persuade him to comply with his diabetes treatment.

In October 2008, he made a cut to his arm. Because staff were concerned that he might try to harm himself again, Assessment, Care in Custody and Teamwork (ACCT) monitoring was started. ACCT procedures are put in place if a prisoner is thought to be at risk of harming themselves. The prisoner is interviewed and a plan for their care is drawn up. The process is ongoing and the document remains open whilst the risk remains.) His ACCT document was closed after a week.

In February 2009, the man was admitted to hospital after he collapsed with an irregular heart rhythm. He spent five days in hospital before returning to the prison with a significant amount of prescription medication.

Following his admission to hospital there was some confusion about the medication he should be given. A procedure called cardioversion was proposed to treat his irregular heart rhythm, for which he was supposed to be given a drug called warfarin in preparation. However, there were problems giving him the drug each day and in May he withdrew his consent to the proposed treatment. After he decided not to

proceed with cardioversion, healthcare staff received contradictory information from the hospital regarding his ongoing medication.

The man died overnight in his cell in September. He was found by an officer carrying out a routine check on category A (high risk) prisoners. Before he was locked in his cell that evening, he had apparently asked another prisoner to take his life. The prisoner refused. The post mortem report confirms that he died of his long standing coronary artery disease, something which may have been worsened by his diabetes.

My investigation addresses a number of issues, including the interaction of multiple medications with potentially harmful results for the patient. The man was prescribed a significant quantity of drugs to treat his heart disease and diabetes. I also express concern about his limited understanding of English and highlight the need to make quite sure that foreign national prisoners are fully and unambiguously informed of their treatment options.

THE INVESTIGATION PROCESS

1. The investigator was formally notified of the man's death on 23 September 2009. Notices were subsequently issued to both staff and prisoners at HMP Frankland, informing them of the investigation process and giving them the opportunity to contact my colleague with any relevant information.

2. He contacted staff at Frankland and they liaised with the investigator throughout the investigation. He was provided with all the documents relating to the man's time in custody.

3. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation. He obtained copies of the post mortem and toxicology reports. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.

4. He also contacted the NHS and asked that a clinical review be carried out with regard to the medical treatment which he received at Frankland. The purpose of the review is to establish whether the care that he was offered in prison was comparable with that he would have received in the community. The clinical reviewer completed the review, the most recent draft of which is annexed to my report.

5. Having examined the man's prison file and clinical record, the investigator visited Frankland to conduct interviews on 24 and 25 November 2009 and 2 March 2010. The clinical reviewer joined him for the final day of interviews with healthcare staff.

6. My Assistant Family Liaison Officer wrote to the man's stepfather in Poland (his only known relative). Her translated letter was delivered and explained to his stepfather by visiting police officers. The man's stepfather understood the purpose of the Ombudsman's investigation but told the officers that he did not wish to be involved. (As a consequence, he did not receive or comment on the draft report.) He did not raise any concerns for the investigator to address.

HMP FRANKLAND

7. HMP Frankland holds 750 adult male prisoners, all of whom are accommodated in single cells. It is one of only eight high security prisons in England and Wales. These prisons hold the most dangerous offenders in the prison system. There are many category A prisoners at Frankland. These are prisoners whose escape would be considered to be particularly dangerous to the public. Many are serving either indeterminate sentences for public protection or life sentences. (The man was a category A prisoner serving a life sentence.)

Healthcare

8. Healthcare is provided by the local NHS. There is a healthcare centre providing primary (physical) healthcare and inpatient facilities. There is also a mental health team in the prison. Medication can be issued to prisoners "in possession" subject to a risk assessment. (If a prisoner is given his medication in possession, he receives a supply that lasts for perhaps a fortnight or a month at a time. He keeps the drugs in his cell and it is his responsibility to take them. The risk assessment considers whether the prisoner can be trusted with medication and whether he might either use it in significant quantities to harm himself or supply it to other prisoners.)

HM Chief Inspector of Prisons' report

9. Her Majesty's Inspectorate of Prisons completed an announced inspection of Frankland in February 2008. HM Chief Inspector commented that healthcare provision was "in general good". She noted low staffing levels in the healthcare department (something which the investigator was told had since been successfully addressed when he spoke to staff about the man). She wrote that prisoners with chronic diseases (like the man) were managed well.

Independent Monitoring Board (IMB) report

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

11. The IMB at Frankland last issued an annual report covering the period between 1 December 2007 to 30 November 2008. With regard to healthcare, the Board commented on some delays issuing medication to prisoners and also noted staff shortages in the department.

Previous deaths at Frankland

12. Since my office assumed responsibility for investigating all deaths in prison custody in 2004, I have investigated 24 other deaths at Frankland. When I investigated the death of a prisoner in January 2009, I made a recommendation regarding the need to check on a prisoner's 'in possession' medication to make sure that he is taking it properly. I return to the need for staff to manage the supply of 'in possession' medication in this report.

KEY FINDINGS

13. The man was remanded into custody on 25 September 2002. He was taken to HMP Wormwood Scrubs in West London and was asked about his health in the reception area. He spoke about a history of family heart problems and his recent heart bypass surgery. He mentioned his high blood pressure and said that he smoked 20 cigarettes each day.

14. Over the next couple of years, there was ongoing concern about the possibility of the man harming himself. At the time, Prison Service staff used a document entitled 'F2052SH' to monitor prisoners who were considered to be at risk of harming themselves. The first document was opened between September and October 2002 when the man's solicitor expressed concerns about his client. Six subsequent documents were opened in March 2003, October 2003, December 2003, March 2004, September 2004 and November 2004. The trigger in each case was either he was cutting himself, threatening to cut himself or expressing suicidal thoughts.

15. Just a week after his arrival in prison, on 3 October 2002, the man transferred to HMP Belmarsh in south east London. A few months later, in January 2003, a doctor referred him to the local hospital because he was having difficulty walking any distance. The doctor was worried that the man's arteries were beginning to narrow and harden, potentially becoming blocked and causing him to struggle to walk properly.

16. At the start of April 2003, the man was convicted at court of the serious offences he committed in September 2002. (He was sentenced the following month.) Later in April, he was assessed at hospital by a general surgeon, who thought that the narrowing of his arteries could be managed 'conservatively' (in other words, without an operation).

17. The man's arterial disease was reviewed by a registrar in the outpatient department of the hospital in July. The registrar assessed the blocking of the arteries as 'mild' and made arrangements for him to undergo an angiogram (a visual assessment of a patient's arteries and heart). At the end of July, the man was arrested in Belmarsh for a murder he had committed in 1997.

18. With the aid of an interpreter, he was assessed by a psychiatrist in December. Just before Christmas he reported gall bladder pain. He underwent an ultrasound examination of his gall bladder at hospital in February 2004. Later that month, Prison Doctor A at Belmarsh wrote a referral letter to the hospital. He highlighted the high level of fatty molecules in the man's bloodstream.

19. Prison Doctor A commented that the man's arterial disease would make any possible operation problematic. He wrote that the man's blood pressure was 'way too high' and noted that there had been a failure since the previous November to issue him with the correct medication. The doctor prescribed him ramipril (a drug used to treat high blood pressure and heart problems), amlodipine (another drug used to treat high blood pressure) and simvastatin (a drug used to reduce high blood pressure and cholesterol).

20. On 31 March 2004, the man received a life sentence for the murder he committed in 1997. A hospital appointment resulting from Prison Doctor A's referral was cancelled in April, and the man refused to attend a further outpatient appointment in May. In June, a consultant surgeon at the hospital wrote to the doctors at Belmarsh recommending that the man undergo a computerised tomography (CT) scan (a three dimensional image of the inside of a patient's body).

21. Later that year, in November 2004, the man spent two nights at hospital undergoing a CT scan. He was escorted by prison officers and handcuffed to them at all times because of the nature of his offences. Staff found a large stone at the neck of his gall bladder which was causing inflammation. This was treated with antibiotics and pain killers. He also had a kidney stone. He returned to the healthcare centre at Belmarsh, felt very unwell and tried to harm himself. Staff initially kept him under very close supervision. The consultant surgeon wrote to the doctors at Belmarsh with the results of the CT scan in December, noting that 'nothing urgent' needed to be done for the time being.

22. In September 2005, the man transferred to HMP Wakefield. Two months later, on 1 November, he transferred to HMP Frankland. His blood pressure was taken during the reception process. The next day, one of the general practitioners referred him to a consultant colorectal (bowel) surgeon at a hospital. He wrote about the man's 'multitude of problems' and ongoing surgical issues.

23. Two days later, on 4 November, the consultant colorectal surgeon held a clinic in the prison and assessed the man. He remarked upon the man's 'significant comorbidity' (the presence of other diseases in addition to the patient's main illness). Because of the man's limited English, the consultant found it difficult to either assess him or gain a full medical history. He noted that the man smoked heavily and found walking painful, probably because of poor blood circulation in his legs. The consultant decided to refer him to a consultant surgeon in vascular surgery.

24. Later that month, the man completed an ESOL (English for Speakers of Other Languages) assessment. His English was considered to be 'poor'.

25. The consultant colorectal surgeon assessed the man in the prison again on 30 May 2006. He was reluctant to proceed with surgery because of his multiple health problems. The consultant referred him to the consultant surgeon for a second time (there is no evidence that the original referral resulted in an appointment) because the pain he was experiencing down his legs was restricting his ability to walk.

26. In August 2006, a prison doctor told the man that he had developed a mild form of diabetes. A few weeks later, on 6 September, he attended an outpatient's appointment with the consultant surgeon at hospital. Although he had narrowed arteries running from his chest to his legs, the consultant did

not think that vascular problems were necessarily affecting his ability to walk. He considered that the man might have back problems. Because of his medical history, the surgeon was unwilling to operate on him.

27. The next year, on 4 May 2007, the man complained of chest pains after returning from work. He was taken to the prison's healthcare centre and staff thought he should be taken to outside hospital for assessment. However, he refused to travel to the cardiac treatment unit at hospital. The following day, he signed a disclaimer form confirming his refusal of treatment against medical advice.

28. Several months later, in November 2007, the man complained of chest pains. He was taken to the healthcare centre but returned to his cell an hour later. The doctor used an electrocardiography (ECG) monitor to check his heart rhythm and faxed the results to the cardiology department at hospital for comparison with readings taken in May 2007.

29. The following year, in March 2008, Nurse A encountered difficulties prescribing atorvastatin (a drug used to lower cholesterol) to the man. She noted that the prescription had been stopped and then restarted. She did not know why this had happened or who had made the decision. He told her that he was not receiving the drug. The pharmacy confirmed this information and the nurse resolved the problem.

30. Nurse A met the man on 17 March and explained his diagnosis of type 2 (adult-onset) diabetes. She stressed the importance of controlling his condition and reducing his sugar intake. She provided him with leaflets but was unsure how much he understood because of his poor English. She decided to provide him with little bits of information regularly to aid his understanding. He told her that he understood and would use a dictionary to translate the reading material she gave him.

31. On 20 March, the man was prescribed metformin (a common diabetes treatment) but four days later stopped taking the drug because he reacted badly to it and was experiencing stomach pains. His medication was changed to a gradually increasing dose of gliclazide (another diabetes treatment). At the end of March healthcare staff noted that he had not been receiving his atenolol (which lowers the heart rate and reduces blood pressure) since January. In early April, he spoke to the diabetes nurse and told her that he was not interested in learning more about diabetes.

32. During this period, on 8 April, the man experienced a headache and chest pain. He went to the healthcare centre and an ECG reading of his heart rhythm was faxed to the out of hours doctor, who told healthcare staff that the results were not unduly concerning. He was allowed to return to the wing as he had requested and told to contact the healthcare centre if the pain returned.

33. In the middle of April, the man spoke to Prison Doctor B and asked to be referred to a vascular surgeon because of difficulty walking. On 22 May, the

diabetic nurse recorded that he was not cooperating with his diabetes treatment and was refusing to take the recommended dose of gliclazide. Two days later, on 24 May, Nurse B noted that he was continuing to refuse to take his medication or attend the healthcare centre when this was suggested.

34. On the evening of 25 May, the man was taken to hospital after he experienced chest pains that were spreading down his left arm. He had been complaining of feeling unwell all day. Once he arrived at the hospital, the doctor confirmed that he was having a heart attack. The doctor strongly advised him to stay in hospital for five days and explained the risks involved if he discharged himself. However, he refused, signed a disclaimer and returned to Frankland the next morning. He was prescribed aspirin and clopidogrel (a drug used to prevent blood clotting in patients with coronary artery disease). He also refused to stay in the healthcare centre and was advised to alert healthcare staff if he experienced any further chest pain.

35. On 29 May, Prison Doctor C became concerned about the man because his heart was not beating in a normal rhythm. The man refused to travel to hospital to be assessed because he did not want to be cuffed to an escorting officer. The doctor wrote to the hospital asking how to proceed. The man's leg and chest pain meant that he found it difficult to walk very far at all. His pulse was not detectable in the lower part of his legs. The man spoke to the diabetic nurse but again refused to heed her advice about managing his diabetes. He was not complying with his treatment and had not taken the gliclazide for four days.

36. Early the next month, on 3 June, the man's ECG reading was faxed to a cardiologist for advice because his heart rhythm had still not returned to normal. Just over a week later a consultant cardiologist at the hospital replied to Prison Doctor C's letter. The doctor received the letter on 18 June. The cardiologist provided advice regarding the man's medication although there is no evidence that the advice was then acted upon for several months.

37. Nurse A examined the man on 12 June. His heart rhythm was still irregular and he was given a glyceryl trinitrate (GTN) spray to relieve his angina pains. His blood sugar remained too high. She told him that he was risking his health by refusing to cooperate with treatment. He chose not to be assessed by the doctor. He also refused nicotine replacement therapy but had begun to cut down his smoking.

38. On 26 June, the diabetic nurse noted that the options for the man's diabetes treatment were limited. He was intolerant of one drug (metformin) and another (gliclazide) was considered inadvisable because it had the potential to affect his other health problems. She wanted him to begin injecting insulin instead, but he refused.

39. Prison Doctor D assessed the man on 30 June. He reported that his chest pain became worse when he ate or drank. The doctor considered the possibility that his diabetes medication might be aggravating his heart

problems. He decided that his heart medication and diabetes treatment should be reviewed.

40. On 10 July, the man failed to attend the diabetes clinic as planned. The next day, 11 July, a nurse was called to the workshop where he worked when he reported chest pains. His GTN spray did not seem to help and he had not taken his prescribed medication that morning. However, he refused to go to the healthcare centre so no further assessment was possible. The following day, 12 July, he complained that he had not received his medication for the week. Healthcare staff contacted the pharmacy and he was given his drugs.

41. A fortnight later, on 25 July, Nurse C gave the man a GTN spray from the out of hours cupboard because he had used up the one he had been provided with the previous week. She was concerned about his heavy reliance on the spray and thought that he should receive alternative treatment if his chest pains were causing him to use it so frequently.

42. By September, the man was only taking half his daily dose of gliclazide for his diabetes. He told the diabetic nurse that the drug caused him stomach pains. She contacted the hospital and organised for a blood glucose meter to be supplied so that he could test himself. She also consulted a diabetologist, who agreed that the best form of medication would be injectable insulin. His blood tests showed high sugar levels.

43. Later that month, Prison Doctor E (another of the doctors in the prison) decided to review the man's over reliance on his spray. Amongst other drugs, he was being prescribed clopidogrel and ramipril (to reduce his blood pressure).

44. On 1 October, Prison Doctor D echoed Prison Doctor E's concerns about the man's reliance on his GTN spray. He also thought the situation should be reviewed. When Prison Doctor E assessed him on 14 October, he reported suffering angina pain about five times each day. He told her that the spray relieved the pain. She strongly advised him to stop smoking. She prescribed atenolol and made reference in the clinical record to the advice the consultant cardiologist had given in his letter in June. He was examined by the diabetic nurse in the diabetes clinic on 16 October. He said that he did not want to inject himself and again refused to take insulin.

45. Shortly before midnight on 17 October, the man was placed under observation after he cut his left forearm. The cut was sterilised and dressed. Staff opened Assessment, Care in Custody and Teamwork (ACCT) procedures because he was thought to be at risk of harming himself. (The ACCT document replaced the F2052SH form. The process is continuous and the document remains open whilst a risk of self harm is thought to remain. Monitoring and support are provided and regular reviews are undertaken. Any staff who have contact with a prisoner can make entries in the ACCT document. Staff must check the prisoner at set intervals and write down all checks in the ongoing record.)

46. The man seemed to be worried about being punished and losing his job in the workshop because he had been keeping tailoring equipment in his cell. An adjudication hearing (when a governor decides what should happen to a prisoner who has misbehaved) took place the next day, on 18 October. His mood was low but he told staff monitoring his welfare that his actions were a cry for help and that he did not intend to take his own life. The ACCT document was closed a week later, on 24 October.

47. Early in the morning on 5 November, the man experienced chest pains. He used his GTN spray but the pain returned and he was taken to the healthcare centre. He was given oxygen and assessed by Prison Doctor E. She told him that he had experienced a 'potential heart event' and explained the danger of complications if he did not seek treatment. She noted that he understood her but refused to remain in the healthcare centre or go to hospital. He told her that he would rather die in prison. Having gone against medical advice, he signed a disclaimer and returned to his cell, where he was told to rest.

48. On 10 November, Prison Doctor E assessed the man. He said that he had stopped smoking and felt better, although he was still having some chest pains. Three days later, he complained of chest pains to Nurse D, who advised him to go to the healthcare centre. However, he refused.

49. The man experienced more chest pains at about 5.00am on 17 November. Prison Doctor E assessed him at about 9.00am that morning, but he told her that he felt better. He had resumed smoking and she again encouraged him to give up.

50. At the diabetic clinic on 27 November, the diabetic nurse noted that the man was still only taking one of his two doses of gliclazide each day because he thought this medication caused him stomach pains. She did not think that he understood the significance of his condition. He again refused to begin injecting insulin.

51. On the same day, Nurse A became worried about the man's over-reliance on his GTN spray to relieve his symptoms. She spoke to Prison Doctor E about his chest pains and his refusal to go to hospital to be checked by a specialist. They agreed to act on the advice the consultant cardiologist had provided in his letter originally received in June.

52. On 11 December, Prison Doctor D had a long and frank conversation with the man about his illness, the need for treatment and the potentially fatal outcome if he did not listen to the advice of healthcare staff. He agreed to use insulin and be assessed by a cardiologist at the hospital. The doctor noted that he tended to become very short of breath, could not walk far and was using his GTN spray all the time.

53. About a week later, on 17 December, Nurse E noted that the man was requesting repeat GTN sprays. Prison Doctor E thought that his reliance on the spray needed to be reviewed. The next day, the diabetic nurse showed

him how to inject insulin and how to recognise and treat hypoglycaemia (a condition when blood sugar drops too low).

54. A few days later, on 22 December, Nurse E spoke to the man about changing his diabetes medication from gliclazide to insulin. He stressed the importance of taking insulin regularly, but had to repeat the instructions because he did not seem to understand him.

55. The man started his insulin treatment on 23 December (a day late because he had inadvertently taken gliclazide the day before). Staff checked his blood sugar regularly and sent the results to the diabetic nurse, who visited the prison at intervals to hold diabetic clinics. After Christmas, he felt unwell, was short of breath and had a very bad cough. Nurse C assessed him on 29 December and gave him cough syrup. The next day, Prison Doctor E diagnosed a chest infection. A nurse showed him how to use an inhaler.

56. On 31 December, Nurse E wanted to contact the diabetic helpline to discuss the man's blood sugar readings, but it was closed until 6 January 2009. At about 6.00pm that evening, he became light headed and dizzy and collapsed in the kitchen. His collapse was attributed to his weak state resulting from his chest infection. He recovered in his cell.

57. A few days later, on 5 January, Nurse E remained concerned about him. The man had written him a letter the day before expressing his anxieties. He had been prescribed two different antibiotics and was using an inhaler, but remained short of breath. He was still reluctant to take insulin, but the nurse tried to encourage him to do so for his own good. He did not seem to understand and said that he was frightened to use insulin in case it gave him breathing difficulties. Nurse E consulted the diabetic nurse for advice.

58. On 9 January, Prison Doctor D assessed the man. Nurse A contacted the diabetic nurse because his blood sugar reading was too high. His insulin dose was changed accordingly. At the end of the month, the diabetic nurse examined him and noted that he had not experienced any recent episodes of hypoglycaemia and felt better.

59. At the beginning of the following month, Prison Doctor D assessed the man. He still had a chest infection and was prescribed more antibiotics and cough syrup. He was feeling hot and cold and experiencing chest pain. On 5 February, Nurse C went to the workshop after he reported chest pains. He was taken to the healthcare centre and assessed. He was told to take the next day off work and to contact healthcare staff if he felt unwell again.

60. On 6 February, the man returned to the healthcare centre because he continued to experience chest pains and shortness of breath. He was prescribed further medication for an 'acute upper respiratory tract infection'. On 10 February, Prison Doctor E offered to refer him to hospital but he declined. Later that day he complained of chest pains on his way back from the workshop. He had to sit down outside. Nurse E suggested he either go to

the healthcare centre or to outside hospital, but he refused. He did agree to the nurse's suggestion to be taken back to his cell in a wheelchair.

61. The following day, 11 February, the man collapsed on the floor of the wing on his way to work. When healthcare staff arrived he did not respond. His skin looked blue and he was not breathing properly. His heart rhythm was irregular. He was given oxygen and began to regain consciousness. He became more responsive after about ten minutes and agreed to be taken to outside hospital. An emergency ambulance was called.

62. The man stayed in hospital until 16 February. Hospital staff stopped his clopidogrel prescription and prescribed digoxin (a drug used to treat heart failure and shortness of breath), before switching to amiodarone (a drug used to correct irregular heart rhythms) and warfarin. Warfarin is used to stop the blood clotting and prevent strokes, but its use has to be carefully monitored because it can interact with other commonly used drugs. He was discharged with a significant amount of prescribed medication. The prison healthcare staff mistakenly gave both amiodarone and digoxin. Doctors at the hospital planned for him to undergo cardioversion (a procedure which gives the heart a brief electric shock to turn an irregular rhythm back to a normal one).

63. On 17 February, the man was asked to go to the healthcare centre or sign a disclaimer if he did not wish to do so. The next day Nurse F spoke to him about his medication and insulin use. She did not think that he fully understood her because of his poor English. On 20 February, Nurse E reminded him of the importance of taking his insulin and the consequences of not doing so. The next day, the clinical record indicates that he began taking his medication again.

64. About a week later, on 27 February, the healthcare team received a letter from the hospital. They were told that the man would be able to undergo cardioversion to correct his irregular heart rhythm as long as he continued to take warfarin and stable readings were recorded over a three week period. The next day Nurse D spoke to Prison Doctor F about the use of warfarin.

65. A few days later, on 3 March, the man felt unwell. He used his GTN spray, took his insulin and checked his blood sugar in front of Nurse G. He was told to contact healthcare staff if he had any further problems. The nurse noted a problem with the man's warfarin dosage. His blood had been tested the day before but he had not been given warfarin since. Prison Doctor B was unable to prescribe a further dose.

66. A week later, on 10 March, Prison Doctor E recorded another failure to give the man the correct dose of warfarin. His prescription had been interrupted and the drug had last been administered on 6 March. Nurse D consulted Prison Doctor G about the man's warfarin therapy on 13 March.

67. On 16 March, Prison Doctor E noticed that the man's prescription for amiodarone had been discontinued. He was supposed to have been receiving this drug since his discharge from hospital so she restarted the

prescription. The next day she was told by pharmacy staff that liver function tests showed that amiodarone was causing liver toxicity in him. During interview, the doctor told my investigator that the man had received his first dose of the drug in February after he returned from hospital, but that the subsequent regular, repeat prescription had not yet begun.

68. During the evening of 24 March, the man was brought to the healthcare centre with chest pains. He was escorted to outside hospital but did not want to remain handcuffed and soon returned to the prison. He refused to stay in the healthcare centre, signed a disclaimer and returned to his cell. His condition improved once he used the GTN spray. Healthcare staff contacted an out of hours doctor for advice regarding an abnormal ECG reading.

69. A few days later, on 27 March, Prison Doctor E wrote in the man's clinical record that he missed a dose of warfarin on 24 March. However, he had taken the drug each night since and the dosage had been increased by 20 percent. At the end of the month, he told her that he was worried about side effects from the warfarin therapy, such as stomach pain. However, she encouraged him to keep taking the medication and told him that the pain he was having was not connected to the warfarin.

70. Early the following month, on 3 April, the man declined his dose of warfarin when Nurse F treated him. The next day he did not collect his dose and said that he associated the therapy with stomach pain. The nursing staff tried to convince him to take the drug but, for the second day running, he refused. On 6 April, Prison Doctor E noted in the clinical record that he was feeling somewhat better after he had been prescribed omeprazole (used to treat stomach pain). She asked him (who was still not complying) to start taking warfarin again or the cardioversion would be further delayed. There was some suspicion in the medical notes that he might also have stomach cancer.

71. Three days later, on 9 April, Prison Doctor D noted that the man was still missing doses of warfarin. (During this period healthcare staff had to regularly consult out of hours doctors regarding the correct dosage of warfarin to give to him.) The diabetic nurse checked his diabetes on the same day and noted that he was still failing to take his insulin as instructed because he associated it with stomach pain.

72. On 14 April, the man had what was described in the clinical record as a 'difficult discussion' with Prison Doctor H. On 27 April, Prison Doctor E decided that a further ECG reading needed to be taken from him before he could be sent to hospital for cardioversion. The next day, an ECG reading was sent to the cardiology department at hospital.

73. At the end of the month, on 30 April, the man missed his appointment at the diabetes clinic. A week later, on 5 May, Prison Doctor E reviewed and continued his warfarin prescription. On 8 May, Nurse H consulted the out of hours doctor about the correct dosage of warfarin, who advised that it remain constant over the weekend. The doctor subsequently reduced the dosage by

20 percent. On 14 May, the diabetic nurse checked his diabetes. Five days later, on 19 May, the doctor increased his warfarin dosage by 25 percent.

74. The following day, the man experienced a further irregular heart rhythm. Prison Doctor E told him that he needed to undergo cardioversion or he would have to continue taking a variety of medication indefinitely. However, he strongly objected to being taken to outside hospital in handcuffs and signed a disclaimer refusing the proposed cardioversion. (Because of the nature of his offences and because he was a category A prisoner, he was always handcuffed when he travelled to hospital.) The doctor noted that he understood the implications of his refusal of further treatment at outside hospital.

75. The man's cardioversion appointment was scheduled for 26 May but he did not attend. No further appointments were offered and his heart rhythm remained irregular.

76. He had been prescribed digoxin (to control his heart rate) and amiodarone since his release from hospital in February. The final prescriptions of both drugs were dispensed on 2 June and collected and signed for on 3 June. The discharge summary provided to healthcare staff by the hospital in February provided contradictory information about whether he should be given both drugs. It is not advised that the drugs are taken together as the combination can cause toxicity and careful monitoring is required. The prison pharmacist spoke to Prison Doctor D about the potentially harmful combination of drugs and the doctor stopped prescribing digoxin on 4 June. However, the nursing staff were not told to carry out any additional monitoring.

77. On 5 June, Prison Doctor D wrote to the consultant cardiologist, asking what medication the man should now be given (following his refusal of cardioversion) and how his care should be managed.

78. The hospital's cardiology nurse wrote to the healthcare department at Frankland on 8 June. Following the man's refusal of treatment, she indicated that he had now been removed from the cardioversion waiting list. She recommended changing his medication from warfarin to aspirin because cardioversion was no longer planned. This change was implemented on 12 June when the letter was received.

79. On 12 June, Prison Doctor D spoke to the man once again about the possibility of cardioversion. Again, he refused the treatment. The doctor thought that he understood the implications of his refusal.

80. About a fortnight later, on 24 June, Prison Doctor D referred the man to a consultant vascular surgeon because he was still struggling to walk properly. On the same day he felt dizzy and experienced chest pains after smoking. He used his GTN spray and felt better. He was advised by Nurse C to come to the healthcare centre so that an ECG could be performed, but he refused. The next day his diabetes was reviewed at an annual check up. His difficulty walking was noted.

81. On 7 July, a second consultant cardiologist at the hospital wrote to Prison Doctor D. He advised taking a further ECG reading to monitor the man's irregular heart rhythm (which he indicated was likely to continue). He wrote that the healthcare team should stop prescribing amiodarone, as this was supposed to prepare the man for the cardioversion treatment which was no longer scheduled. The cardiologist advised that he should be given warfarin in the long term, that digoxin should possibly be restarted and that his prescription for atenolol should be increased. The consultant's advice about warfarin was the opposite of the cardiology nurse's from 8 June, but the healthcare staff did not record any concerns about the contradictory advice they were receiving. It is unclear from the clinical record whether a prescription for warfarin was restarted.

82. A couple of days later, on 9 July, the diabetic nurse assessed the man's diabetes. Two weeks later, on 24 July, he experienced dizziness and chest pains and was taken to the healthcare centre. An ECG reading indicated that his heart rhythm had not changed. Prison Doctor D thought that he should be taken to hospital if his chest pains continued, but he did not want to go.

83. During the next couple of days, staff noted that the man was taking it upon himself to alter his dose of insulin. Nurse E tried to contact the diabetic nurse for advice. Nurse F advised him not to alter the amount of insulin until staff could speak to the diabetic nurse. His blood sugar levels were varying and the nursing staff sought Prison Doctor E's advice on the correct dose.

84. Late in the morning on 28 July, the man felt dizzy and sick in the workshop. He was experiencing chest pains which repeated use of his GTN spray helped to relieve. He was taken to the healthcare centre and an ECG was performed, showing an abnormal reading. He was examined by Prison Doctor E and his symptoms were attributed to an episode of angina. He was told to rest in his cell.

85. On 29 July, Prison Doct E made a note in the clinical record to indicate that she had read the letter from the second consultant cardiologist dated 7 July. It instructed the healthcare team to stop prescribing amiodarone as the man had refused cardioversion. She noted that this medication should no longer be given and digoxin should be restarted.

86. The man experienced more chest pains at 8.00am on 1 August. He said that he had been having dizzy spells and was trying to give up smoking. He did not use his GTN spray at first and fell asleep. He used the spray when he woke up but the pain did not recede. Nurse D visited him at 11.15am. He asked him to come with him to the healthcare centre to be monitored and undergo an ECG. However, he refused and decided to sleep in his cell.

87. Two days later, the man was checked by Prison Doctor D, who prescribed prochlorperazine maleate to treat nausea. The clinical reviewer writes in her clinical review that this drug should be used cautiously when a patient has conditions such as diabetes and heart disease and is being prescribed a

variety of other medications. It can result in low blood pressure. After he began taking the drug, his blood pressure did drop, but no action was taken to investigate the change.

88. Following Prison Doctor D's referral, the consultant vascular surgeon assessed the man at a clinic held in the prison on 6 August. The surgeon thought that the arteries in the man's legs were partially blocked, causing difficulty walking. The consultant planned to assess him again in six months time. On 17 August, Prison Doctor E assessed the man's heart disease and scheduled a follow-up appointment in six months time. Two days later, on 19 August, he failed to collect a prescription for paracetamol, instead collecting it the following week.

89. A few days later, on 24 August, the man was not well enough to be taken to see the dentist. He returned to his cell, feeling light headed and sick. He was checked by a member of healthcare staff. His eyesight was assessed on 3 September. (This was his last recorded interaction with a member of the healthcare team before he died.)

22 and 23 September

90. On the evening of 22 September, the prisoners on C wing collected their evening meals between 5.00pm and 5.30pm. Between 7.00pm and 7.15pm, a prisoner was talking to another prisoner. He subsequently explained to my investigator how the man had suddenly come into the cell. He had his hands together as if he was praying and he was red in the face. He pleaded with the prisoner to end his life, saying, 'Please kill me.'

91. The prisoner told my investigator that the man did not explain himself. He did not remember him telling the staff about his request. He was very shocked because the request was completely unexpected. He had never said anything like that before. The prisoner could not remember the man saying anything similar to any of the other prisoners.

92. During interview, the prisoner said that he refused the man's request and that he had left the cell after a couple of minutes, saying, 'No problem'. He did not see him again because they were locked up for the night soon afterwards.

93. Officer A locked the man in his single cell at 7.32pm. (He did not share a cell because of the risk he presented to other prisoners.) When he spoke to my investigator, the officer said that he was well acquainted with him and could not remember anything unusual about that evening. He did not recall him complaining about his health.

94. Overnight, Officer B and an OSG worked on C wing. At 9.32pm the OSG checked the man because he was a category A prisoner. (These prisoners are deemed to present the highest risk to the public and, for security reasons, staff are required to look in their cells at least every three hours during the night.) The OSG told my investigator that the man was sitting in his chair, facing the door and watching the television when he opened the observation

flap. He recalled that they made eye contact and he acknowledged him, although he did not speak or get up.

95. The man did not activate his cell bell during the night. After the OSG pressed it to register his check at 9.30pm, the bell was activated by other staff at 10.00pm and midnight. These activations were part of a scheduled sequence to demonstrate that staff were regularly monitoring all the landings. However, these prearranged activations of the cell bell do not require the member of staff to open the observation flap or physically check the prisoner.

96. At 12.29am Officer B carried out the next routine category A check. This was the second time the man had been observed by staff since being locked in his cell at 7.32pm. He told my investigator that he looked in the cell and assumed the man had fallen asleep in his chair in front of the television. He told my investigators that he often used to do this. The man was slumped forward and did not move.

97. Officer B carried on his checks on another landing. He returned to the man's cell a few minutes later because the television was still on and he was worried that the loud noise might wake other prisoners. The officer kicked the cell door but did not get a response from him. He thought that he had fallen into a deep sleep and later told my investigator that he had not realised anything was really wrong.

98. Officer B did not get a response from the man but still thought that his television needed to be turned down. He therefore telephoned the control room, asking for a call to be put out over the radio to the night orderly officer (Oscar 1, in charge of the prison), a Principal Officer (PO). (Staff working on the wing overnight only carry a sealed pouch containing keys for use in an emergency. If they need to enter a cell, Oscar 1 must be present.)

99. The PO was contacted over the radio network and went to C wing with a dog handler (a dog handler always accompanies Oscar 1 around the prison during the night). He asked the OSG where Officer B was, and the OSG initially misdirected the PO because he thought his colleague had gone to check a different landing.

100. The PO and the dog handler met Officer B at the mans' cell on the first landing of C wing. The PO could not obtain a response from him either and became concerned. He contacted the control room by radio to tell them that he was unlocking the cell.

101. The PO unlocked the cell door and approached the man, who was slumped in his chair. The PO touched his neck to find a pulse but his skin was cold and thought he was probably dead. The officers did not move him. At about 12.40am the PO used his radio to send an urgent message to the control room. He asked for a Senior Officer (SO) (Oscar 2, the assistant night orderly officer) and a nurse to come immediately to C wing.

102. The SO collected Nurse I from the healthcare centre. (Just like officers on the wings, nurses do not carry keys overnight.) She briefly checked the man's medical history with the other nurse on duty before she set off. Once they arrived on C wing, she asked the SO to collect the emergency medical bag from the treatment room. She checked the man's neck and wrist but could not detect a pulse. He was not breathing and his skin was cold and grey. His pupils were fixed and dilated. His GTN spray was lying on the floor by his feet.

103. The PO went to an adjacent office to telephone the control room and request an ambulance. Once the SO brought the defibrillator, Nurse I attached it to the man. (A defibrillator is a portable machine that is attached to a patient and advises whether an irregular heart beat can be found and if the user should deliver an electric shock to reset it.) The machine found no sign of a heart beat and advised that an electric shock should not be given. She noticed the first signs of rigor mortis setting in and thought that he had probably been dead for up to an hour and a half. Her professional opinion was that it would have been both futile and undignified to attempt to resuscitate him. She confirmed his death at 12.47am.

104. Control room staff telephoned the duty governor to let him know what had happened. The PO asked the OSG to bring Officer B a cup of tea because he was upset. At 12.55am the ambulance arrived and the paramedics were escorted to C wing. They examined the man using an ECG monitor. There was no evidence of a heart beat and the paramedics declared his death at 1.11am.

105. At about 3.30am the PO organised for Officer B and the OSG to finish their shifts early and be taken home in taxis. He was conscious that both men had been affected by the man's death and knew that this was the first time the OSG had worked a night shift.

ISSUES

106. The man suffered with significant ill health from the time he arrived in prison. He was described as a difficult patient and often failed to take his medication as instructed. I am satisfied that staff made very creditable efforts to work with him and help him to understand his different health problems. The clinical reviewer's clinical review highlights a number of areas of concern for the Head of Healthcare to address. However, the recommendations I endorse should not detract unduly from the efforts of those who helped the man.

Cause of death

107. The prisoner told my investigator that the man asked him to help end his life shortly before the prisoners were locked in their cells on the night he died. He said that he refused and the man returned to his cell to be locked up. He was seen alive in his cell by the OSG over two hours later at 9.30pm. When Nurse I examined him after the PO called her to C wing, she observed nothing unusual and saw no evidence of any external injuries. She thought that he had been dead for up to an hour and a half.

108. The post mortem report confirmed the cause of death as heart failure. The pathologist wrote that there was no evidence of any external injuries to the man's body. He had normal levels of the prescribed drugs he was taking in his bloodstream. The prisoner acted appropriately in telling staff about their conversation after the man died. A security incident report was completed. The police investigation did not identify any suspicious circumstances. I am satisfied that he died of natural causes and that nobody else had any involvement.

Refusal of treatment

109. Throughout the last few years of his life in prison the man was often reluctant to take medication and frequently refused to accept treatment. He was particularly reluctant to engage with the plan to treat his diabetes. On numerous occasions he refused to consent to either being moved to outside hospital, remaining in outside hospital or even to staying in the prison's healthcare centre. His refusal to engage with the other treatment opportunities available led to an over-reliance on his angina spray to treat the pain he was experiencing as a result of his heart disease.

110. Patients are not supposed to use their angina spray as their main source of pain relief to the extent that the man did. However, in the circumstances, I am satisfied that the doctors were unable to offer him much in the way of alternative treatment because he would not consent to proper assessment in hospital. When they spoke to my investigator, Prison Doctors D and E agreed that the spray was one of the only forms of treatment that the man accepted, and therefore the healthcare staff were inclined to allow his dependence to continue. Prison Doctor E told my investigator that the man often said that he wanted to die in prison and not in hospital. She said that he strongly disliked

being handcuffed to escorting officers during visits to outside hospital because he found this procedure humiliating.

Delay in treatment

111. In November 2005, the consultant surgeon assessed the man in Frankland and planned to refer him to another consultant surgeon at hospital. The first consultant surgeon's assessment took place remarkably rapidly, within days of the man's arrival at Frankland. However, no subsequent referral to the second surgeon seems to have taken place. The first surgeon examined him again in prison the following May and this time successfully made a referral. The second surgeon assessed him in September 2006, ten months after the first surgeon originally examined him. It is not within my remit to comment on the service offered by visiting staff from the local hospital. I do not make a recommendation because the Head of Healthcare at Frankland was not responsible for the delay to the referral process. However, she may wish to work with visiting hospital staff to ensure that delays to the referral process are minimised in future.

Language difficulties and refusal of treatment

112. The man did not speak English as a first language. There is evidence in his records to suggest resulting difficulties in communication. When he was interviewed by a probation officer for the completion of a pre-sentence report, an interpreter was present. An interpreter also attended his psychiatric assessment in December 2003. In November 2005, a consultant surgeon found that his lack of English made it difficult to complete an examination or to gain a comprehensive medical history from him. An ESOL assessment in the same month revealed his English language skills to be 'poor'.

113. In March 2008, Nurse A doubted whether she had been able to communicate effectively with the man about his diabetes because of his language difficulties. Later, in December 2008, Nurse F did not think that he had understood him when he spoke to him about the importance of taking his insulin. The following month, in January 2009, he again did not seem to understand Nurse F's advice about taking insulin. The next month, Nurse F noted in the clinical record that the man did not seem to understand her.

114. In her clinical review, the clinical reviewer praises the efforts of those staff who tried to clarify the man's understanding of his illness by asking him to repeat back and explain to them what he knew about his condition and how to treat it. However, on several occasions he was asked to sign disclaimers written in English confirming his refusal of treatment either in the healthcare centre or outside hospital. She comments:

> 'In the Local Policies for Managing Foreign National Prisoners document issued by the Ministry of Justice and National Offender Management Service it states that 'staff should not assume that prisoners with some command of the English language fully understand what is being said, or the implications.''

115. My investigator asked healthcare staff who worked closely with the man whether they thought he fully understood the nature of the documents he was signing. They all thought that he had a reasonable or adequate understanding of English and probably took in more than he might have admitted. Prison Doctor D said that he had sufficient confidence in the man's understanding not to make use of a telephone translation service.

116. However, the man could be a difficult patient and regularly failed to cooperate with staff. It is not always clear from the clinical record whether his lack of cooperation was a result of his general attitude or if he simply did not understand the consequences of not treating his disease. Whilst staff clearly felt that he had understood them, they did not support this belief with any documented evidence.

117. The clinical reviewer notes that, when Prison Doctor D had a very blunt conversation with the man in December 2008 (essentially telling him that he would probably die if he did not cooperate) he agreed to treatment. This might indicate that he had not previously understood what staff told him and was, in the clinical reviewer's words, 'potentially responsive' when given the facts of his condition in a stark manner. She remarks:

> 'It is not apparent in the clinical notes if the reasons for the man's ambivalence about treatment were explored with him at any time.'

118. The Department of Health has issued guidance to healthcare staff requiring them to offer prisoners sufficient information on which to base their treatment decisions. The clinical reviewer suggests that the disclaimer (a very short document) could have been translated into Polish to assist his understanding. She also suggests that an interpreter could have been used very occasionally to impart important information to him about his treatment options. Both measures would have ensured understanding, removed ambiguity and demonstrated that the healthcare staff had done everything possible to tell him about his condition. I endorse her recommendation.

The Head of Healthcare should ensure that patients with a chronic disease whose first language is not English are given access to an interpreter and written information in their first language when they are asked to decide on potentially life saving treatment options.

Lack of a care plan

119. The clinical reviewer makes the following comment about the man's treatment:

> 'The man's health needs were multiple and complex. He was being seen by a variety of professionals in both primary and secondary care and was prescribed a variety of interventions and medications. It is unclear from the clinical record how his care was organised and who took responsibility for co ordination, communication and maintaining an

overview. There were no care or management plans which were identified as such in the notes and no evidence of a key working system or process for multi disciplinary review being utilised. At times there appeared to be confusion regarding prescribing as he was being seen by several doctors and there were delays in implementing the advice of specialists from secondary care.'

120. A cardiologist from the hospital provided the healthcare staff with advice about the man's treatment in June 2008. Clinical records indicate that this advice was not put into practice for several months. The clinical reviewer thinks that properly documented multi-disciplinary care management (allowing a full overview of the man's case by all of those involved) might have prevented errors like this occurring.

121. Similarly, I note that there is no record of him being assessed by a member of healthcare staff for nearly three weeks before he died, which is notable given how frequently he had previously interacted with them. (Although the diabetes nurse indicated that, when he died, he had made progress in treating his own diabetes and had mastered the delivery of his insulin.) The clinical reviewer notes that only traces of amiodarone and paracetamol were found in the toxicology tests after he died. She expresses concern that there were up to five other prescribed drugs which he does not seem to have taken in the hours or days before he died. Again, a more formally coordinated approach may have served to keep a check on his compliance with his medication. I endorse her recommendation:

The Head of Healthcare should put in place a care management and review system for prisoners with enduring and complex health needs to ensure effective communication, co ordination and ongoing review of all care activity. Prison pharmacists should have a clear and important role in this process.

Whether the man took his medication

122. In her clinical review, the clinical reviewer comments:

'The man's heart disease and diabetes were very poorly controlled. There is little doubt that this was largely due to his non compliance with prescribed treatment and lifestyle advice and also errors in prescribing and supply of medication which meant that he did not always have access to the appropriate medications, in the right dosages, at the right time. Also, it is unclear how much of his medication he actually took. It is important to note that there is no reason to believe that these issues contributed directly to his death in September 2009, but may have impacted on the longer term progression of his condition.'

123. During his time at Frankland, the man was given his medication in possession, meaning that he was given a supply that would last (for example) a fortnight or a month at a time. He kept these drugs in his cell and it was his responsibility to take them. As the clinical reviewer writes, he frequently did

not cooperate and did not take his medication as he was supposed to do. There is no evidence that the decision to allow him medication in possession was ever reviewed, or that healthcare staff considered making him take his medication regularly under the supervision of a nurse.

124. The clinical reviewer considers that supervised delivery of his medication might have improved the man's compliance, or at the very least may have made staff aware of what drugs he was and was not taking. When my investigator and the clinical reviewer spoke to the Head of Healthcare, she indicated that the supervised delivery of medication to prisoners was usually considered when there was thought to be a risk of them overdosing on it, rather than taking too little of it. I endorse the clinical reviewer's recommendation:

The Head of Healthcare should ensure that patients with serious health concerns who exhibit ongoing compliance issues undergo regular risk assessment with regard to the appropriateness of them having their medication 'in possession'. The decision should be reviewed on a regular basis and consideration given to nurse supervision if the patient's non-compliance presents a serious health risk.

Medication errors

125. In February 2009, doctors at the hospital agreed that, following admission to hospital, the man should undergo a procedure known as cardioversion to reset his irregular heart rhythm. In order for this to happen, he had to be given warfarin regularly and blood tests had to demonstrate stable readings over a three week period. He began warfarin therapy in February. She notes that healthcare staff were not properly advised by the hospital that he was supposed to be prescribed warfarin upon his return. She finds this concerning because warfarin therapy requires careful monitoring.

126. On 3 March, the man missed a dose of warfarin when the doctor on duty wrote that she was unable to prescribe the drug. A week later, on 10 March, Prison Doctor E realised that his warfarin therapy had been interrupted for a second time. He had not been given the drug for four days. She told my investigators that warfarin is only dispensed in regular, small amounts for short periods, and she thought, in hindsight, that staff had neglected to rewrite and continue the prescription on this occasion. He also missed a dose of warfarin on 24 March, possibly because he was taken to the healthcare centre with chest pains.

127. Prison Doctor E explained in interview that the man believed warfarin to be poison and required some convincing by staff in order to take the medication. It is not always clear from the clinical record whether his failure to take warfarin on a consistent daily basis throughout March was a result of his reluctance or an oversight by healthcare staff. Warfarin was supposed to be given directly to him by a nurse each day. Any refusal should therefore have been noted in the clinical record.

128. In the middle of March 2009, Prison Doctor E noticed that the man was not being prescribed amiodarone. He was supposed to have received this drug since his discharge from hospital in February. She restarted the prescription and told my investigators that she thought, with hindsight, that an initial 'acute' dose of amiodarone had been given to him following his discharge, but that a subsequent, 'repeat' prescription had not then been organised.

129. In June 2009, Prison Doctor D correctly identified that the man had been wrongly prescribed both digoxin and amiodarone since his stay in hospital in February. (The hospital staff had switched from prescribing digoxin to amiodarone whilst he was still with them in February.) The doctor contacted the hospital, who confirmed that the man should only have been taking amiodarone and should not have been prescribed digoxin. (The clinical reviewer comments that the hospital discharge summary contained contradictory advice about whether to give him digoxin.) The digoxin prescription was stopped. The prison pharmacist did not question the prescription prior to the doctor's enquiries. The clinical reviewer notes that the combination of amiodarone and digoxin is inadvisable because it can cause toxicity.

130. The man eventually elected to abandon his proposed cardioversion treatment in May 2009. In June, the cardiology nurse at the hospital wrote to the healthcare department to advise that they stop giving warfarin to him. However, on 7 July the second consultant cardiologist wrote with the contradictory advice that warfarin be given in the long term. He also instructed the healthcare team to stop prescribing the man amiodarone. However, this advice does not seem to have been noted until Prison Doctor E wrote in the clinical record on 29 July. I endorse the clinical reviewer's recommendation:

The Primary Care Trust should ensure that details of the conflicting prescribing advice being given by the cardiology service at the hospital is shared with the local provider trust and that action is taken to prevent reoccurrence.

131. The clinical reviewer notes that, whilst the clinical record seems to indicate that amiodarone was dispensed to the man in July 2009, the Head of Healthcare has actually confirmed that the last time this medication was issued was at the start of June. The clinical reviewer questions the accuracy of the recording of which drugs were issued to the man at different times. She also writes:

> 'Some of the other combinations of the drugs that the man was prescribed were also contraindicated with each other, potentially causing a variety of different side effects including nausea, dizziness and shortness of breath, all of which were experienced by him. It is acknowledged that these are also symptoms of heart disease and could have been taken to be standard manifestations of his disorders but they may have indicated some medication related toxicity which was never explored.'

Prescribing medication

132. In August 2009, the man described symptoms such as dizziness and shortness of breath to Prison Doctor E. She prescribed prochlorperazine maleate to reduce his nausea. The clinical reviewer writes that this drug is not supposed to be taken with some of the other medication he was prescribed. It can cause patients with heart disease to experience an irregular heart rhythm and low blood pressure. His blood pressure was found to be unusually low in early August (potentially indicating these side effects) but no action was taken. I endorse the clinical reviewer's recommendations:

The Head of Healthcare should ensure that staff report unusual test results such as decreased or raised blood pressure to a doctor at the earliest opportunity.

The Head of Healthcare should ensure that prescriptions are reviewed on a regular basis by a qualified pharmacist to monitor the possibility of harmful drug interaction or inappropriate prescribing.

The Head of Healthcare should ask staff to document that medication has been removed from a patient's possession, when an 'in possession' prescription that has already been dispensed is stopped.

Diabetes treatment

133. The man was prescribed metformin, gliclazide and insulin to treat his diabetes. As with his heart disease, he often refused to cooperate with his treatment. The diabetes nurse recalled in interview that he would laugh and tell her that diabetes 'was not a problem'. She showed admirable persistence in repeatedly trying to persuade him to comply with his diabetes treatment and consulting a diabetologist.

134. The man was intolerant of metformin. An alternative treatment, gliclazide, was not compatible with his medication for his heart problems. He was reluctant to begin taking insulin. He complained that the drug gave him stomach pains, although staff do not appear to have looked into this possibility or referred him for tests, if only to put his mind at rest. (He repeatedly mentioned stomach pains throughout his time in Frankland, but no action was taken.) The clinical reviewer considers that, had staff done so, then he may have demonstrated increased compliance.

135. The clinical reviewer considers the possibility of psychological support for the man following his diagnosis of diabetes. She notes that the diabetes nurse did some one-to-one work with him to assist his understanding of his condition. However, she finds that the nurse does not have the allocated time or resources to offer formal psychological support or group sessions to prisoners with diabetes. These kinds of options are supposed to be offered to diabetic patients in the community.

136. The clinical reviewer highlights the acknowledged link between diabetes and depression. The man was supposed to be screened for associated depression but was not. She also suggests that he should have been referred to a podiatrist to have his feet checked sooner than was the case. Patients who smoke and have diabetes and heart disease quite often develop problems with their feet. I endorse the following recommendations made by her in her review:

The Head of Healthcare should set up a programme of interventions that promotes health for those who have recently developed (or are at risk of developing) chronic diseases. The programme should be offered to patients as part of a care management plan. It should include weight management, foot care, access to advice from a dietician, psychological support and nicotine replacement therapy for those who smoke.

The Head of Healthcare should ensure that patients who are newly diagnosed with diabetes are screened for depression.

CONCLUSION

137. The man was in poor health when he arrived in prison in 2002. Many of the staff who worked with him over the following years tried to help him to understand his heart disease and diabetes. His lack of cooperation is documented, and there is little doubt that staff made determined efforts to treat him despite his lack of cooperation. However, I hope that some lessons can be learned from his care. In particular, the need to clearly manage a number of different medications that may interact with one another is a theme that emerges strongly from the clinical reviewer's review, as is the need to consider how foreign national prisoners with poor English are told about their condition and treatment options. Furthermore, the Head of Healthcare needs to ensure that staff maintain patients on a course of medication without interruption.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that patients with a chronic disease whose first language is not English are given access to an interpreter and written information in their first language when they are asked to decide on potentially life saving treatment options.

   The prison did not accept the recommendation and gave the following response:

   'Clinicians already have immediate access to translation services through the Big Word UK Government Interpreting Service. This service is successfully used in HMP Frankland where appropriate. The amount of written information provided in First Language must be a judgement made by the clinician.'

2. The Head of Healthcare should put in place a care management and review system for prisoners with enduring and complex health needs to ensure effective communication, co ordination and ongoing review of all care activity. Prison pharmacists should have a clear and important role in this process.

   The prison accepted the recommendation and gave the following response:

   'This work is already in progress; however it is reliant on getting the required staffing levels and developing the use of [the electronic clinical record system] ie. read codes and chronic disease registers. There will also be further development of case management workloads as the chronic disease service develops further.

   'Management and medication reviews are carried out on a systematic basis within the constraints of the resources available.

   'The role of the pharmacy is acknowledged and with increasing resources there will be increased delivery.'

3. The Head of Healthcare should ensure that patients with serious health concerns who exhibit ongoing compliance issues undergo regular risk assessment with regard to the appropriateness of them having their medication 'in possession'. The decision should be reviewed on a regular basis and consideration given to nurse supervision if the patient's non-compliance presents a serious health risk.

   The prison accepted the recommendation and gave the following response:

   'Where lack of compliance is related to physical or mental capacity, medication is regularly transferred to "not in possession". When non-compliance is the choice of a competent individual, transferring to not-in possession is likely to be seen as an affront to dignity and has regularly in the past been noted to result in even poorer compliance. However, compliance monitoring should improve with the further development of the Chronic Disease Service.'

4. The Primary Care Trust should ensure that details of the conflicting prescribing advice being given by the cardiology service at the hospital is shared with the local provider trust and that action is taken to prevent reoccurrence.

   The prison accepted the recommendation and gave the following response:

   'This is done as a matter of routine and good practice and was done in the case in hand.'

5. The Head of Healthcare should ensure that staff report unusual test results such as decreased or raised blood pressure to a doctor at the earliest opportunity.

   The prison accepted the recommendation and gave the following response:

   'It is accepted that abnormal results or findings should be communicated to an appropriately responsible clinician.'

6. The Head of Healthcare should ensure that prescriptions are reviewed on a regular basis by a qualified pharmacist to monitor the possibility of harmful drug interaction or inappropriate prescribing.

   The prison accepted the recommendation and gave the following response:

   'All staff involved in the generation, dispensing and issuing of prescriptions are aware of these hazards and continue to strive to limit them. Reviews by clinicians and pharmacists are conducted within the constraints of resource.'

7. The Head of Healthcare should ask staff to document that medication has been removed from a patient's possession, when an 'in possession' prescription that has already been dispensed is stopped.

   The prison partially accepted the recommendation and gave the following response:

   'This recommendation is not equivalence of care with the community. It is appropriate to record that medication no longer in possession is requested to be returned. Unless medication retained is deemed to be a security or deliberate self harm hazard, it is not appropriate to physically remove it from the prisoner.'

8. The Head of Healthcare should set up a programme of interventions that promotes health for those who have recently developed (or are at risk of developing) chronic diseases. The programme should be offered to patients as part of a care management plan. It should include weight management, foot care, access to advice from a dietician, psychological support and nicotine replacement therapy for those who smoke.

The prison partially accepted the recommendation and gave the following response:

‘This recommendation overlaps with the second recommendation and will be implemented in conjunction with it.’

9. The Head of Healthcare should ensure that patients who are newly diagnosed with diabetes are screened for depression.

   The prison accepted the recommendation and gave the following response:

   ‘The Head of Healthcare will review the provision of service from diabetes specialist nurse to ensure that depression screening is included as standard for this service.’