PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of Mr Paul Culshaw, on 6 February 2013, at University Hospital of North Durham, while a prisoner at HMP Frankland.

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the investigation report into the death of a man in February 2013, at University Hospital of North Durham, while a prisoner at HMP Frankland. The man was 45 years old and died heart disease. I offer my condolences to the man's family and friends.

An investigator was appointed and a clinical reviewer reviewed the man's clinical care in prison. HMP Frankland cooperated fully with this investigation.

The man had been in custody since July 2004. He had very little contact with healthcare services during his time in prison. The last occasion was in 2009 when the dentist extracted two teeth. The man was offered a number of well-being checks throughout 2011 and 2012 but he declined.

On the evening of 5 February 2013, the man experienced breathing difficulties. A nurse came to his wing to assess him and requested an emergency ambulance. By the time paramedics arrived, the man was unconscious and was taken to hospital, accompanied by two prison officers and restrained by an escort chain. The man was taken to the hospital's intensive care unit at 11.00pm. Hospital doctors twice asked for the restraints to be removed and on each occasion the request was refused. The man died at 3.40am, still chained to a prison officer.

The clinical review has concluded that the man was offered a good standard of care while he was at Frankland, even though he chose to exercise his right not to accept health checks. I am satisfied that the emergency response was appropriate and that the man's care was passed to hospital specialists in a timely manner.

However, I am very concerned about the use of restraints on the man. He was unconscious before he was taken to hospital and, although his risk of escape was assessed as low, restraints were used and medical opinion was not considered. The man died handcuffed by a chain to an officer, despite requests from doctors that restraints be removed. This was inhumane.

This is the fourth time since 2012 that I have identified the need for staff at Frankland to take a prisoner's current medical condition fully into account when assessing risk, as they are required to do by law. Accordingly, I am formally drawing the matter to the attention of the Deputy Director for High Security Prisons for action.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2014**

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SUMMARY

1. The man was serving a mandatory life sentence for murder and had been in custody since July 2004. He had very little contact with prison healthcare staff throughout his time in custody. The most recent was in 2009 when a dentist extracted two teeth. He declined a number of invitations to attend health checks in 2011 and 2012.

2. During the evening of 5 February, the man was found having difficulty breathing. A nurse was called and requested an emergency ambulance. Paramedics arrived and took over the man's care, but by this time he was unconscious. He was taken to hospital, accompanied by two officers and restrained using an escort chain. He was assessed in the emergency department and then transferred to intensive care. Throughout his time in hospital the man remained unconscious, yet was still restrained. Hospital doctors twice asked for the restraints to be removed but each request was refused. The man died at 3.40am on 6 February, still chained to an officer.

3. We are satisfied that the man had appropriate clinical care at Frankland and that the emergency response was also appropriate. However, the decision to use restraints was not justified by a fully considered risk assessment and the decision to refuse to remove restraints at the request of doctors when the man was unconscious in hospital was unacceptable. We make one recommendation about this matter.

THE INVESTIGATION PROCESS

4. The investigator, visited Frankland on 13 February 2013 and obtained copies of all documentation relating to The man. He met the Governor. Notices were issued to staff and prisoners inviting anyone with information to contact the investigator. No one came forward as a result.

5. NHS County Durham appointed a clinical reviewer to review the man's clinical care at Frankland.

6. The investigator contacted Her Majesty's Coroner to inform him of the investigation and request a copy of the post-mortem report. The investigation report will be sent to the Coroner.

7. One of our family liaison officers contacted the man's family to inform him about the investigation and to invite his family to identify any matters they wished the investigation to consider. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP FRANKLAND

8. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 convicted and remand male prisoners. There is 24 hour inpatient care. NHS County Durham commission Care UK to provide healthcare services at the prison.

HM Inspectorate of Prisons

9. The most recent inspection of Frankland took place in December 2012. In their report, inspectors said that, although prisoners often waited too long for GP appointments, life-long and chronic conditions were well managed. Inspectors judged that arrangements for palliative care and end of life care for the terminally ill were of a high standard.

Independent Monitoring Board

10. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their latest published annual report for 2012,the IMB said:

> 'Healthcare is available equally to all prisoners. …Outpatient care is generally provided in a reasonable time but staffing levels do give rise to some problems and there are delays with doctor's appointments. Priority cases are always dealt with promptly. Inpatient care is provided according to clinical need with treatment at outside hospitals where necessary and with appropriate security requirements.'

Previous deaths at Frankland

11. The man's death was the seventh from natural causes at Frankland since January 2012. There was a further death one week after the man's death. In three of these cases, we recommended that the Governor ensure that risk assessments for the use of restraints fully take into account the prisoner's medical condition and how that affects the risk. We make a similar recommendation again in this report.

KEY EVENTS

12. The man was born in March 1967. On 23 July 2004, the man was remanded into custody at HMP Preston charged with murder. On 10 February 2005, he was convicted and sentenced to life imprisonment. He had served previous prison sentences.

13. On 23 March 2005, the man transferred to HMP Frankland. During his time at Frankland, the man worked in the upholstery workshop and had a small number of friends on the wing. The man had virtually no contact with healthcare. He was not on any prescribed medication and his last intervention with a member of healthcare was on 7 September 2009, when he saw the dentist and had a tooth extracted. The man had not nominated anyone as his next of kin and throughout his entire time in custody he made no telephone calls and received no mail. He refused to attend any courses designed to reduce his risk of re-offending.

14. On 5 February 2013, at 5.55pm another prisoner, found the man having difficulty breathing. He summoned help from staff. An officer went to his cell and when he saw the man, he immediately radioed a 'Code Black'. (At Frankland this was a request for urgent medical assistance when a prisoner was found not breathing). The officer told the investigator that he had found the man sitting on his bed and clutching his chest. The man said that he could not breathe. He tried to get the man to lie down but he remained restless.

15. A nurse immediately responded to the emergency call and, after assessing the man, requested an emergency ambulance. A nurse asked staff to help move the man to the healthcare centre using a light wheelchair in readiness for paramedics arriving.

16. By the time staff had moved the man to the healthcare centre, the paramedics had arrived. The man was taken straight to the ambulance. The paramedics attempted to stabilise the man's condition as he had become unconscious before departing to hospital.

17. A risk assessment was completed which concluded that the man was a low risk of escape and low risk of being helped to escape. He was assessed as a medium risk to hospital staff and a medium risk to the public should he escape. The nurse signed the medical section of the assessment, but did not answer questions about whether there was a medical objection to the use of restraints or whether his medical condition would affect the man's ability to escape. However, he noted that restraints should be removed if the man's condition deteriorated. The duty governor, authorised that the man should be accompanied by two officers and that an escort chain (a two metre chain with a cuff at each end) be used at all times.

18. When they arrived at University Hospital of North Durham, hospital doctors requested that the restraints be removed so they could assess and treat the man including taking X-rays and scans. One of the escort officers contacted Frankland and spoke to a Principal Officer (PO) to obtain permission to remove the restraints. The PO then spoke to the duty governor who said the man should continue to be restrained by an escort chain. He did not consult the doctors.

19. At 11.00pm, the man was moved to the hospital's intensive care unit and medical staff again asked for the restraints to be removed. The other escort officer, contacted the prison to tell the PO that the man had been moved to intensive care and that the doctor had asked for the restraints to be removed. The PO refused to authorise the removal of the restraints but on this occasion did not contact the duty governor and did not speak to the hospital doctors.

20. At 3.40am, the man died still handcuffed and chained to a prison officer. The officer reported to the PO that the man had died. He was then authorised to remove the restraints.

21. After staff returned to Frankland, a debrief was held. The staff who were at the hospital with the man were offered the support of the care team.

22. As the man had not nominated anyone as his next of kin, the family liaison officer at Frankland contacted the police to ask them to trace any of the man's relatives. The police established that the man had two children, both of whom were minors, and his ex-partner had changed her name and moved area on his conviction. The man's ex-partner did not want anything to do with the man's funeral and did not want her children to attend the service. Frankland arranged and paid for the man's funeral and the prison chaplain conducted the service.

Post-mortem examination

23. A post-mortem examination carried out by a consultant pathologist, on 10 February 2012, showed that the man's cause of death was ischaemic heart disease caused by coronary artery atheroma (fatty deposits in the artery which supplies blood to the heart).

ISSUES

Clinical care

24. The clinical reviewer noted that the man had very little contact with healthcare staff at the prison except for a period in 2004-5 when he had refused food and fluid at various times. The clinical reviewer noted that the man had been invited to attend routine health screen checks which might have provided an opportunity to have reviewed his risk factors for heart disease. However, he declined to attend these checks.

25. We are satisfied that the standard of care made available to the man was equivalent to that he could have expected in the community. The man exercised his right not to attend health checks.

Emergency response

26. The clinical reviewer was satisfied that the initial response to the man's illness was appropriate, and that the prisoner and officer had acted quickly to ensure that healthcare staff attended. The nurse had then arrived quickly and with appropriate equipment.

27. The nurse was the only member of healthcare to attend the emergency. The clinical reviewer spoke to a senior nurse at Frankland who said that a second responder usually attended emergencies. It is not clear why this did not happen on this occasion and the clinical reviewer has suggested that the local policy about this is reviewed. As the clinical reviewer is satisfied that the man's care was not compromised and the emergency response was appropriate we do not make a formal recommendation in this report.

28. The clinical reviewer found that the emergency ambulance was called appropriately without any significant delay. The Governor will wish to note that shortly after the man's death a new Prison Service Instruction (PSI 03/2013) was introduced which requires ambulances to be called automatically when an emergency code is called in circumstances similar to these.

Use of restraints

29. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process.

30. The man was assessed as a low risk of escape and medium risk to the public should he do so. He was unconscious and under the care of paramedics before the ambulance left the prison. When he left the prison he remained unconscious and was accompanied by two prison officer escorts. In such circumstances it is difficult to see how the risk assessment which required him to be restrained by an escort chain was justified or that it fully took into account

his health and condition. The medical section of the risk assessment was not completed as required.

31. Hospital doctors twice asked for restraints to be removed, once when the man arrived at hospital and tests needed to be undertaken and again when he was transferred to intensive care. Each request was denied, despite that the fact that the man remained unconscious and latterly was in intensive care. In 2010, a concordat between the National Offender Management Service and the NHS about hospital escorts recognised that the final decision to remove restraints must be taken by the duty governor. However, where medical staff request that restraints are removed the concordat requires the duty governor to take the decision after discussion with the escorting and clinical staff. When the first request to remove restraints was made this was passed to the duty governor but he did not discuss the situation with the doctor as the concordat requires. The second request was not passed to the duty governor and the principal officer did not discuss the issue with doctors to get an up to date opinion about the man's condition and how this affected his risk.

32. The National Security Framework states that a fresh risk assessment is required each time a prisoner is moved or their clinical condition is reviewed in order to assess the appropriate level of restraint for transportation to or from hospital and during the prisoner's stay at hospital. There was no appropriate review the man's risk, taking into account medical opinion, and he remained restrained until after he died.

33. It is wholly unacceptable that the restraints were not removed until after the man had died. This was inhumane and must also have been distressing for the escort staff. The risk assessment did not take into account the guidance of the High Court so that medical opinion was considered and the assessment was not appropriately reviewed as the man's condition changed. We have made recommendations to the Governor of Frankland three other times in the last 18 months about similar issues. Although the prison has accepted the previous recommendations, it does not seem that this is being translated into appropriate action. This is also apparent in investigations at other high secure prisons. We therefore direct this recommendation to the Deputy Director responsible for high secure prisons.

The Deputy Director of Custody for High Security Prisons should ensure that there are appropriate arrangements and guidance in all high secure prisons which ensure risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

RECOMMENDATION

The Deputy Director of Custody for High Security Prisons should ensure that there are appropriate arrangements and guidance in all high secure prisons which ensure risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

The Prison Service accepted the recommendation and made the following comment:

The DDC of High Security Prisons reiterated the implications of the Graham Judgement in relation to hospital escorts and bedwatches to all High Security Governing Governors, including Frankland, at a Senior Managers Board Meeting held on 15 August 2013.

With regards to Frankland, a new risk assessment process, which includes a revised management checklist, was introduced following the death of the man to ensure that risk assessments for prisoners taken to hospital are based on a consideration of the individual's circumstances and the actual risk the prisoner presents at the time.

The new risk assessment process also takes into account those prisoners who are deemed seriously ill or at the end of life with the aim that security arrangements around hospital escorts will be dynamic and the use of restraints will be reviewed, as necessary, to take into account any significant changes in circumstances.