A Report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at Hospital in April 2012, while in the custody of 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 report of an investigation into the death of a man in April 2012 at James Cook Hospital, Middlesbrough, while he was a prisoner at HMP Frankland. The man was 61 years old and died from heart failure. I offer my condolences to the man's family and friends.

An investigator was the investigator and a clinical reviewer reviewed the man's clinical care in custody. HMP Frankland cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man had suffered from a number of illnesses for a long time, including heart problems and diabetes. He had also had a stroke which affected his mobility. Prison staff had advised him to stop smoking and tried to help him manage his diabetes. The man did not always follow this advice, which impacted on his health. On 16 April 2012, the man was admitted to University Hospital of North Durham. He was treated for heart problems at the hospital but died on 22 April, after having a heart attack.

I am satisfied that the man received an appropriate standard of clinical care at Frankland. However, I am concerned that no review of his risk assessment was undertaken while he was in hospital and, as a result, the man was restrained by an escort chain until very shortly before his death.

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

CONTENTS

Summary	5
The investigation process	6
HMP Frankland	7
Key events	9
Issues	12
Recommendations	15

SUMMARY

1. The man was sentenced to 10 years and six months imprisonment in July 2009. He moved to HMP Frankland on 22 November 2010. At a routine reception health screen it was noted that he suffered from heart disease and diabetes. He had previously had a stroke which affected his mobility and he used a zimmer frame.

2. The man attended many hospital appointments while he was at Frankland, which were appropriately facilitated. Sometimes he declined to attend appointments and he also refused treatment for his diabetes. The man's lifestyle impacted on his poor health but he refused smoking cessation support and did little exercise.

3. On 16 April 2012, the man told wing staff that he was experiencing chest pains. He said that he had vomited at lunch time that day and felt ill. Officers took him to the healthcare centre in a wheelchair. Healthcare staff noted that he was pale and clammy and gave him oxygen and aspirin. An emergency ambulance was called and the man was transferred to the James Cook Hospital for treatment. The man was restrained when he was taken to hospital but, even though his condition deteriorated while he was there, no fresh risk assessment was completed to take account of the change in his condition. He remained in hospital for treatment but died in the early hours of 22 April, after suffering from a heart attack.

4. We make two recommendations about the use of restraints and contacting families when a prisoner is seriously ill.

THE INVESTIGATION PROCESS

5. The investigator visited HMP Frankland on 27 April and met the prison's family liaison officer, and a senior nurse, who cared for the man while he was ill. The investigator was shown where the man had lived before his admission to hospital and visited the prison's healthcare department. She obtained copies of the man's prison and health records.

6. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact the investigator. No one came forward in response.

7. NHS County Durham Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care at Frankland. The clinical reviewer's final clinical review was received on 29 September 2012 and is annexed to this report.

8. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation. A copy of this report has been sent to the Coroner.

9. We are sorry that the production of this report has been delayed because of staff absences due to ill health.

10. One of our family liaison officers, contacted the man's family on 28 May to explain the scope of the investigation and to invite them to identify any matters which they wished to considered. They did not raise any specific issues. Later another family liaison officer took over the role of family liaison officer and spoke to the man's brother to explain the specific remit of the investigation.

11. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate telephone conversation with the family liaison officer.

HMP FRANKLAND

12. Frankland is one of eight high security prisons in England and Wales. It holds more than 800 high risk convicted and remand male prisoners in single cells. The man was a category B prisoner (those who do not require the highest level of security but for whom escape must be made very difficult). Until April 2011, health services at Frankland were provided by County Durham Primary Care Trust. Since then, Care UK has provided healthcare services at Frankland and a number of prisons in the area. There is 24 hour inpatient care.

Her Majesty's Inspectorate of Prisons (HMIP)

13. The most recently published HMIP report followed an unannounced full follow up inspection conducted in November 2010. Inspectors found that waiting times to see a prison doctor were unacceptably long. Although prisoners with life-long (or chronic) conditions were identified, there had been no monitoring for several months. Some services had been suspended because of healthcare staff shortages. At the time of the inspection, new staff were in post and general health care services were noted to have improved.

14. A further inspection took place in December 2012. At the time of writing, the full report had not been published. However, the Care Quality Commission took part in the inspection and has published its findings. They found that the services operated by Care UK were of a good standard and working relationships with other partners helped them to deliver effective care.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report, covering December 2011 to November 2012, the Frankland IMB noted:

> "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. All of the National Health Service (NHS) screening programmes are provided. This includes bowel screening, NHS health checks, retinal screening and abdominal aorta aneurysm scan."

Previous deaths at Frankland

16. This office has investigated 45 deaths at Frankland since 2004 (including two deaths that occurred after the man's). We have previously made

recommendations about the use of restraints when prisoners are taken to hospital.

KEY EVENTS

17. The man was born on 1 April 1951. On 28 July 2009, he was convicted of rape, sentenced to 10 years and 6 months imprisonment and sent to HMP Belmarsh. On 28 September, he was admitted to Basildon and Thurrock University Hospital with heart problems and had three coronary artery bypasses. The man had a long history of type 2 insulin dependent diabetes. He had also suffered from a stroke and used a leg brace for support.

18. The man transferred to HMP Full Sutton on 5 November 2010 and then to HMP Frankland on 22 November 2010. At his reception health screen at Frankland, it was noted that he took a range of medication and used a zimmer frame. He said that he became breathless quickly and could only walk short distances. He was referred to the doctor and given repeat prescriptions for his diabetes, high blood pressure, heart disease, breathing problems and pain. Physiotherapy staff saw the man and encouraged him to move around more. They showed him how to use his zimmer frame to help him stand from a sitting position. A full care plan was drawn up and the man went to live in a standard cell on B wing.

19. On 18 June 2011, it was noted in his medical record that the man refused a blood sugar test and would not take his insulin. There are subsequently a number of other references to him not taking his insulin as prescribed during his time at Frankland. His diet was regarded as poor and he twice refused invitations to help him stop smoking.

20. The man's cholesterol level was tested on 10 January 2012, when it was at the upper end of the normal range. On 17 January, he refused to attend a hospital dermatology appointment for an assessment of ulcers on his feet and legs. Because he refused to attend, the hospital did not offer any further appointments.

21. On 23 February, healthcare staff treated the man's ulcers. An examination revealed that his right foot was considered as 'high risk' and his left foot was considered 'at risk' because of his poor diabetic control. He was treated with creams, twice weekly, and nurses encouraged him to use his insulin correctly. Healthcare staff at Frankland continued to treat the man's ulcers frequently.

22. At a routine appointment on the morning of 16 April, a Staff Nurse noted that his wounds were dry and healing well. Later that day around 2.00pm, staff on B wing telephoned the healthcare department to say that the man was suffering from chest pains. A Healthcare Officer (HCO) went to see the man on B wing and decided that he should be treated in healthcare. He took the man to the healthcare department in a wheelchair. The notes in the man's medical record were made retrospectively on 17 April and did not record the exact time of the call to healthcare or the time that the HCO arrived on the wing.

23. The man told healthcare staff that he had vomited at lunch time that day and now had bad chest pains. The senior nurse noticed that the man was pale

and ‘clammy’. She gave him oxygen and aspirin buccal (injected into his cheek) as she thought he could be having a heart attack. She tried to conduct an ECG (electrocardiogram, which measures electrical activity in the heart) test but was unable to do so as the man could not remain still. An ambulance was called at 2.10pm. The man was subsequently taken to University Hospital North Durham and arrived there at 3.05pm.

24. A risk assessment was carried out before the man’s transfer to hospital to determine the level of restraint and escort required. There were a number of intelligence reports indicating that the man had tried to manipulate female staff and had been rude and aggressive to nurses. Because he had denied his offence throughout his sentence, it was decided that his risk to the public had not reduced. He was assessed as a low to medium risk and it was decided that he should be escorted by two officers. The senior nurse agreed with this risk assessment. The officers were instructed to restrain the man by an escort chain. (This is an approximately six foot long chain with a handcuff at each end attached to the prisoner and an officer.)

25. On 19 April, the man had an angioplasty and a stent was inserted. (An angioplasty is an operation to widen arteries. A stent is a tube inserted into the artery to keep it open so blood can pass through it unrestricted.) The next day, the man told the escorting officers that, although he still felt sick, he felt better after the operation. Healthcare staff telephoned the hospital each day and were updated about his condition. They recorded the updates in the man’s clinical record.

26. Another ECG was completed on 20 April. The hospital doctor was concerned about the results and told the man that he thought he should stay in hospital.

27. The man’s health deteriorated overnight and at 8.30am on 21 April the doctor asked if the man could have his family to visit him because he had “taken a turn for the worse.” The escort officers contacted the prison and as the man’s brother had been the only family member to keep in touch with him during his time in prison his details were given to nurses at the hospital at 9.00am. At 9.45am, a nurse informed the escort officer that she had spoken to the man’s brother but he was unable to attend the hospital. Despite the deterioration in his condition there was no review of the level of restraint and the man remained handcuffed to an officer with an escort chain.

28. At 12.55pm, a nurse informed the escort officers that the hospital was concerned about the man’s kidney function and fluid on his lungs. It was said that he was likely to be in hospital for another two or three days.

29. At 1.00am on 22 April, the man complained of pain in his chest and shoulders. According to the bedwatch notes, a doctor gave him some medication (it is not clear what this was) as he thought the man was having a heart attack. A nurse asked the two escorting officers to remove the escort chain to allow hospital staff to treat the man. The restraints were removed. Hospital staff tried to resuscitate the man but were unable to do so. His death was formally pronounced at 2.00am.

30. The escort officers notified the duty governor that the man had died. The prison family liaison officer was informed at 2.20am.

31. The two officers remained at the hospital until formalities had been completed and then returned to the prison, where they were seen by a senior manager and the prison's care team who offered support. Both officers were then allowed to go home early.

32. The man had named his son as his next of kin. The only address the prison had was in Chelmsford, where the man had lived before his imprisonment. Because of the distance, the family liaison officer contacted HMP Chelmsford and asked if they could send a family liaison officer to inform the man's son of his father's death. At 4.10am, staff from HMP Chelmsford telephoned Frankland to say they did not have a member of staff free to inform his son at that time, but that someone would be sent when staff came on morning duty.

33. Staff from HMP Chelmsford visited the address they had been given for the man's son later that morning, but found the house derelict. As the man's brother had been contacted by the hospital, a manager informed him of the man's death by telephone and offered support. The family liaison officer also contacted the man's brother by telephone later that morning.

34. The man's brother said that he had telephoned the man's son but he had found out about his father's death. The man's son agreed that his uncle should deal with any issues arising from his father's death and the family liaison officer then liaised with the man's brother. The prison provided financial assistance for the funeral.

ISSUES

Clinical care

35. The man saw healthcare staff often for a number of conditions. He was treated twice a week for his leg and foot ulcers when he refused to have treatment at hospital. He declined help to give up smoking. His insulin control was poor, as was his diet, indicated by his high cholesterol level, but he was given support and guidance to help him take responsibility for this. He was taken to hospital for appointments when they were required. The clinical reviewer, states that:

    "The root cause of the man's symptoms appears to be numerous lifestyle factors which significantly increased his risk of a myocardial infarction [heart attack]. Key lifestyle factors appeared to be a refusal to accept support to stop smoking; poor adherence to insulin therapy reflected in poor diabetic control; and abnormal lipid profile which is a reflection of poor adherence to a healthy diet." (An abnormal lipid profile is an indicator of cardiovascular disease.)

36. The clinical reviewer had no serious concerns about the standard of healthcare provided to the man. We agree with the clinical reviewer's view and believe that the prison made reasonable attempts to help the man live as healthy a life as possible. His health concerns were treated appropriately.

Response when the man complained of chest pain.

37. The man complained of chest pain when he was on B wing on 16 April. It was not recorded what time this was. However, according to the senior nurse, healthcare staff were called immediately and the HCO attended. The HCO decided that the man would be best treated in the healthcare department so he took him there in a wheelchair. When he arrived in the healthcare centre, about a minute and half later at 2.10pm, the senior nurse immediately asked for an emergency ambulance.

38. The senior nurse observed that the man was pale and clammy and thought he was having a heart attack. She gave him aspirin and tried to perform an ECG while they were waiting for the ambulance, but was unable to complete this because the man could not keep still. She also gave the man oxygen and 2mg of aspirin injected into his cheek. Notes in the clinical record were not completed until the 10.38 the next day, 17 April, by a nurse. The senior nurse explained that she had made hand written notes at the time but that because of work commitments they were not put on the computer until the day after.

39. The clinical reviewer states:

    "The precise time of onset of the man's symptoms of chest pain should have been recorded. It is possible that there was a delay in referring the man to hospital in that he was transferred to the prison healthcare wing prior to emergency transfer to hospital. Current NICE (National Institute of

Clinical Excellence) guidance for chest pain recommends that an ECG should be taken as soon as possible, but it should not delay transfer to hospital."

40. The investigator contacted the prison to ascertain if there was an emergency call from B wing and if so, at what time and what the healthcare response time was. The senior nurse said that it would have taken about a minute and a half to go between B wing and healthcare. The clinical record states that the man was admitted to Accident and Emergency at hospital at 3.05pm.

41. The clinical reviewer makes one recommendation in the clinical review which the Head of Healthcare will wish to consider about the need to record the time that prisoners first report chest pain. He also comments that staff should be encouraged to make entries at the time of assessing a patient because retrospective notes can affect continuity of care. Nevertheless, we are satisfied that the man appears to have received prompt treatment when he reported his chest pain.

Restraints

42. The Prison Service has a duty to protect the public when escorting prisoners to hospital, while treating prisoners with humanity and dignity. The level of restraints used should be appropriate to all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

43. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. The judgement also required that risks during stays in hospital needed to be assessed separately from travel to and from prison and should be reviewed regularly during a hospital stay or when circumstances changed.

44. A risk assessment was carried out when the man was taken to hospital. The senior nurse completed the medical assessment and noted that the man's physical condition would not prevent him from escaping unaided. There were also a number of security reports that the man had previously been rude and aggressive to female nursing staff. He had also been inappropriate when a female officer was interviewing him. Due to these risks, he was assessed as a low to medium risk and was escorted by two officers and restrained using an escort chain. Nursing staff approved this level of restraint. When the man was treated at hospital, the escort chain was removed. However, no reviews of the level of restraints took place while the man was in hospital and, although the escort chain was removed when he received emergency treatment just before he died, he remained restrained until this time. Given the deterioration in his health, and the likelihood that his risk of escape and to

the public had diminished accordingly, the use of restraints should have been reviewed earlier. We make the following recommendation:

The Governor should ensure that use of restraints for prisoners in hospital is fully justified by a risk assessment that take into account and records how the prisoner's health and physical condition impact on the risk of escape and that assessments are reviewed regularly, and whenever there is a change in circumstances.

Family liaison

45. Prison Service Instruction 2011/64 gives guidance that prisons should ensure that they arrange for an appropriate member of staff to engage with the next of kin of a prisoner who is either terminally or seriously ill. Prison Rule 22 also requires governors to inform the prisoner's spouse or next of kin "at once" if a prisoner becomes seriously ill. Although the man's health deteriorated quite quickly before his death, he had been in hospital for several days and had undergone surgery. In these circumstances we believe that he should have been regarded as "seriously ill" several days before he died. Efforts should have been made to contact his family earlier rather than waiting until his health had deteriorated. The prison also left this responsibility to the hospital rather than contacting his family themselves. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22 and Prison Service Instruction 2011/64, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

RECOMMENDATIONS

1. The Governor should ensure that use of restraints for prisoners in hospital is fully justified by a risk assessment that take into account and records how the prisoner's health and physical condition impact on the risk of escape and that assessments are reviewed regularly, and whenever there is a change in circumstances.

2. The Governor should ensure, in line with Prison Rule 22 and Prison Service Instruction 2011/64, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.