

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man, a prisoner at
HMP Frankland, in December 2014.**

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, who died from an insulin overdose in December 2014, after being found unconscious in his cell at HMP Frankland in November. He was 46 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Frankland was undertaken. Frankland cooperated fully with this investigation.

The man was remanded to prison in 1989, but was transferred, under the Mental Health Act, to a secure hospital in July 1990. He remained a secure hospital patient for over twenty years, after being convicted of the manslaughter of another patient. He was discharged to HMP Durham on 4 January 2013, and transferred to Frankland on 5 February 2014. Members of the mental health team at Frankland saw him frequently.

The man had diabetes and used an insulin pump to help manage the condition. One morning in November 2014, an officer found him unconscious in his cell. He had written a note indicating that he intended to take his life. An officer called an emergency medical code, but control room staff did not immediately call an ambulance, resulting in a delay of five minutes. Paramedics arrived, gave him emergency treatment, and took him to hospital. He never regained consciousness and died in hospital 25 days later. A pathologist found that he had died from a hypoglycaemic brain injury, consistent with the effects of excess insulin.

No one identified that the man was at risk of suicide or self-harm, either at Durham or Frankland. A consultant psychiatrist reviewed him just over two weeks before his apparent overdose and, despite one worrying comment, did not consider that he was at risk of suicide. There was no further information to suggest that his risk had increased in the intervening time and he gave no indication to his family or staff that he was contemplating suicide. I am satisfied that staff at the prison could not have predicted or prevented his actions. However, I am concerned that emergency procedures at the prison were not consistent with national instructions, a matter I have been assured has now been rectified.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded to prison in November 1989 on charges of burglary and wounding with intent. He was diagnosed with a personality disorder and on 5 July 1990, he was transferred, under the Mental Health Act 1983, to Ashworth Hospital. At Ashworth, he killed another patient and was convicted of his manslaughter in 1992. He remained in secure hospitals for more than 20 years. He had previously self-harmed, but his last recorded incident of self-harm was in 2005. He had diabetes, which was controlled by medication.
2. On 4 January 2013, the man was sent back to prison, after he had absconded from a hospital. He was sent to HMP Durham and, on 5 February 2014, he transferred to HMP Frankland. At Frankland, he had frequent interaction with the mental health team. A consultant psychiatrist saw him less than three weeks before he overdosed. He told the psychiatrist he did not want to live but would not kill himself. The psychiatrist did not consider that he was at increased risk of suicide. There was nothing to indicate that his risk increased after his consultation with the psychiatrist. Officers told us that he was looking forward to moving to a specialist personality disorder treatment unit at Frankland, although he initially had some doubts about the move.
3. One morning in November, an officer found the man unconscious in his cell and called for urgent emergency medical help. The control room did not call an ambulance until a nurse arrived and requested one. Nurses gave emergency treatment until paramedics arrived. He had left a note indicating his intention to kill himself. The paramedics took him to hospital and medical staff assessed that he had overdosed on insulin. He did not regain consciousness and died on 7 December. A post-mortem examination found that he had died of a brain injury consistent with the effects of insulin.
4. Before his overdose, the man gave no indication to his family or staff that he was contemplating suicide. We do not consider that staff at the prison could have anticipated his actions in November and prevented his death. Although it would not have affected the outcome for him, staff did not use the correct emergency code and the prison did not call an ambulance as soon as an emergency code was called. In response to a recommendation from an investigation into a death at Frankland in August 2014, the prison issued a new instruction to staff on 9 January 2015, about emergency procedures. We are satisfied this has addressed these issues and therefore do not make a recommendation.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at Frankland, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
6. The investigator visited Frankland on 15 December and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care. The investigator and clinical reviewer interviewed ten members of staff at Frankland.
7. We informed HM Coroner for Durham and Darlington of the investigation, who provided the post-mortem report. We have sent the coroner a copy of this investigation report.
8. One of the Ombudsman's family liaison officers and the investigator met the man's family to explain the investigation and to invite them to identify any relevant issues they wanted the investigation to take into account. The family gave us a detailed background of the man's time in custody and wanted to know:
 - Why was he transferred from Durham?
 - Why did he not have a job at Frankland?
 - Was he prevented from being transferred to Arnold Lodge, a medium secure psychiatric hospital in Leicestershire?
 - Had he been considered for a transfer back to a secure hospital?
 - Why was a proposed move for him to the Westgate Unit delayed?
 - Why was he not considered for the prisoners' music group that met at Frankland?

We have covered these questions in this report. The family received a copy of the draft report as part of the review period. They raised a number of questions that do not impact on the factual accuracy of this report and these have been addressed through separate correspondence.

HMP FRANKLAND

9. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 prisoners. It has a specialist unit, the Westgate Unit, for up to 65 prisoners with severe personality disorders. There is 24-hour inpatient care. NHS County Durham commissions Care UK to provide healthcare services.

HM Inspectorate of Prisons

10. The most recent inspection of Frankland was in December 2012. The Inspectorate found that relationships between staff and prisoners were good. Not all available activity places were used and inspectors found that just under a third of prisoners were locked up during the working day. Inspectors noted that care for prisoners with chronic and life-long conditions was good. They also found that primary and secondary mental health care was good. Inspectors described the Westgate Unit as excellent and provided intensive and long-term interventions for prisoners with personality disorders. Officers received some mental health training. Prisoners were transferred swiftly to secure mental health settings when necessary.

Independent Monitoring Board

11. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to November 2013, the IMB noted that the Westgate Unit provided an exceptional therapeutic environment for dangerous prisoners with severe personality disorders. The IMB considered that the Westgate Unit was a centre of excellence and provided a blueprint for other prisons to follow.

Previous deaths at Frankland

12. The man's death was the fourth death at Frankland in 2014. The other three deaths were from natural causes. In the report into a death in August 2014, which was issued on 4 December, we made a recommendation about emergency procedures, which the prison has now addressed.

KEY EVENTS

13. The man was remanded to prison in 14 November 1989, charged with burglary and wounding with intent. In June 1990, he was admitted to a secure psychiatric hospital on 5 July 1990, for assessment after he was diagnosed with a possible personality disorder. In November 1990, he killed another patient at Ashworth and was found guilty of manslaughter on grounds of diminished responsibility. He received a life sentence with a minimum period to serve of ten years before he could be considered for release. He remained in secure psychiatric hospitals for more than 20 years. He sometimes harmed himself in hospital. The last recorded incident of self-harm was in 2005. He had diabetes, which was controlled by medication.
14. On 4 January 2013, the man was sent back to prison at HMP Durham, after he absconded from a hospital. At Durham, a prison GP prescribed Humalog solution (containing insulin for use in a pump, which was topped up when required), ramipril (for high blood pressure), omega-3 capsules and vitamins. He transferred to HMP Frankland on 5 February 2014. Durham is a local prison with a primary function of taking prisoners from local courts and it holds prisoners mostly serving short sentences. This was a standard transfer for a long-term sentenced prisoner such as him.
15. At Frankland, the man lived in a single cell on J Wing. He chose not to work in the prison workshops as he did not think he would be able to manage his insulin. His medical records show that between 5 February and 27 October, a diabetic nurse reviewed him 12 times, and a member of the mental health team saw him 16 times. He also saw an optician. However, during the same period, he declined to attend three podiatry appointments, two diabetes clinic appointments, a retinal screening appointment, a psychiatrist appointment and an appointment with a consultant endocrinologist (a diabetes specialist).
16. A diabetic nurse at Frankland said the man had been diagnosed with diabetes in 2003, and had been using an insulin pump for four years. He said that the man had brittle diabetes, and would have known the impact diabetes could have on his general health and the importance of regular diabetic screening. (Brittle diabetes is a form of Type 1 diabetes which can cause blood sugar levels to rise and fall rapidly.) However, it was his choice whether to attend appointments.
17. The diabetic nurse was satisfied that the man was fully competent in the using the pump, managed his diabetes well and was aware of the dangers of taking too much insulin. He collected insulin from the treatment hatch on the wing when it needed to be topped up and nurses took insulin to his cell at night, if he needed more. The nurse said that the man had found it frustrating that he was not allowed to keep stocks of his medication in his cell.
18. A consultant forensic psychiatrist told the investigator that the man had refused to attend an appointment to see him on 17 March, but came to a rescheduled appointment on 19 May. He told the psychiatrist that he would not take his own life, particularly as his brother had killed himself in 1999, and he knew the impact this would have on his mother. The psychiatrist concluded that there was no evidence that he was at risk of suicide.

19. The psychiatrist explained that long-term, post-tariff prisoners, with mental health issues or personality disorders such as the man, have two routes back into the community: from hospital or from prison. Both require the prisoner to demonstrate that they are no longer a risk to the public. He said he had liaised with a consultant psychiatrist at a hospital and a forensic case manager, and they agreed that the Westgate Unit, the dedicated personality disorder unit in Frankland, was the most appropriate pathway for the man primarily due to his risk and dangerousness rather than this being the most expedient means to achieve return to the community. The psychiatrist said that convicted individuals with personality disorders are more typically now managed in prison rather than in a secure hospital. (On 28 July, he had discounted moving the man to Arnold Lodge psychiatric hospital as he had previously absconded from a secure unit.)
20. On 27 October, the psychiatrist saw the man for a mental health review and recorded that the Westgate Unit had accepted him on 1 October, and he would move there as soon as a place became available. He said that would go to the Westgate Unit, but this was not his choice and he described the unit as “morally wrong”. He complained about his lack of opportunity at Frankland and said that he wanted to work as a cleaner, as he had done at Durham. He told the psychiatrist that, although he did not want to live, he would not kill himself. The psychiatrist assessed that he was not at acute risk of suicide or self-harm or a risk to others. The psychiatrist discharged him from his care, but noted that he would see him in the future if necessary.
21. The man’s personal officer told the investigator that the man was polite and respectful to staff and got on well with other prisoners. He said that the only job that the man was prepared to do was as a wing cleaner. He had put his name on the waiting list but cleaner jobs are sought-after roles. He enjoyed playing the guitar and the officer said that he understood that he attended music sessions in the education department. He said the man often played cards with other prisoners during association periods. He said that the man was due to move to the Westgate Unit as soon as a place became available. He said that the man had never given any indication that he had thoughts of suicide or self-harm. He said that the last time he had spoken to him, they discussed the move to the Westgate Unit and that he had been “100% up for it”.
22. On 12 November, the man telephoned his mother. The investigator has listened to a recording of the call. He told his mother that staff had told him that he was moving to G Wing but he would refuse to move as he was due to transfer to the Westgate Unit.
23. The man’s personal officer told the investigator that there was a programme of refurbishment work throughout the prison at the time and all the prisoners on the man’s wing had to move temporarily to G Wing for a week, while the work was carried out. This would not have affected his move to the Westgate Unit.
24. The next day, two officers were conducting cell fabric checks on the wing when they arrived at the man’s cell. One officer opened the cell door and found him lying on the floor, under his bed. He was unresponsive and was breathing with difficulty. The officer radioed a code black, an emergency code used at Frankland at the time, to summon medical help when a prisoner was found unconscious.

25. A nurse was already on the wing in the treatment room. When she heard the emergency call, she took emergency equipment to the cell and arrived within two minutes. She told the investigator that the man was unresponsive, his breathing was compromised and he had a very high pulse rate of 123 beats per minute. His blood sugar was very low. She asked for an emergency ambulance as she considered that he needed to be taken to hospital.
26. Two more nurses also responded to the emergency and helped the first nurse administer emergency treatment, including oxygen and GlugaGen (which raises the blood sugar level) until paramedics arrived.
27. A custodial manager had arrived at the man's cell at the same time as the first nurse. He noticed a piece of folded paper on the bed, which was a suicide note from the man. He had written "Mam forgive me, don't hold back telling the truth about what happened to me at the Oswin Unit. I've tried and it's not helped. 25 years Mam and I'm tired and want to be with my brother. I hope I see him. Don't be sad, I'm going to be at peace. I loved being your son. Philip." (The Oswin Unit is a unit at a hospital, for patients with personality disorders. When he absconded from there in 2013, he told staff that he did so because staff were talking and laughing about him. He later said that staff there treated him inhumanely and were uncaring and unsupportive.)
28. An operational support grade who worked in the prison's control room, said that, at that time, control room staff waited for healthcare staff to confirm whether an ambulance was required before they made a 999 call. Since the man's death, the prison had issued new instructions requiring control room staff to call an ambulance immediately a medical emergency code is broadcast.
29. Ambulance service records show that they received the 999 call at 11.35am. Paramedics arrived at 11.48am and took over the man's care. They took him to hospital, where doctors admitted him to the intensive care unit and placed him on life support. Two officers accompanied him, but no restraints were used.
30. A trained family liaison officer contacted the man's family that afternoon to inform them that he had been taken to hospital. She met the family at the hospital that evening. Healthcare staff at Frankland kept in contact with the hospital. His condition was critical and his chance of recovery was very poor. She kept in contact with the family.
31. On 4 December, after an assessment by a consultant, and with the agreement of the man's family, doctors withdrew life support. He died a few days later. The prison maintained contact with the family for ongoing support and contributed towards funeral costs, in line with national guidance.

Support for prisoners and staff

32. On the afternoon of the man's admission to hospital, a manager debriefed the staff involved in the emergency response to discuss what had happened and offered the services of the prison's care team.

33. Members of the chaplaincy team and other staff supported prisoners affected by the man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by his death.

Post-mortem

34. A Home Office pathologist for the North East of England conducted a post-mortem examination. He gave the cause of the man's death as hypoglycaemic brain injury, consistent with the effects of insulin. He noted that no natural disease had caused or accelerated his death.

ISSUES

Assessment of risk

35. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include early days in custody, previous self-harm, first time in custody, being charged with a violent offence and a history of mental health problems. All staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and act appropriately to address any concerns, including opening suicide and self-harm prevention measures (known as Assessment, Care in Custody and Teamwork, or ACCT) if necessary.
36. We have considered whether staff should have monitored the man under the ACCT process after he returned to prison. He had a personality disorder, which can be a factor that increases the risk of suicide, but had been in custody since 1989 (although most of his time had been in hospital). His records show that he had not self-harmed since 2005. We are satisfied that there was no reason for staff at Durham to have opened an ACCT when he first returned to prison in January 2013. After that, there was little to suggest that he was at heightened risk of suicide at either Durham or Frankland. In May 2014, he told the consultant psychiatrist that suicide was not an option for him, because of previous family experience and the effect it would have on his mother.
37. On 27 October, the psychiatrist assessed the man's mental state. Although he said that he did not want to live, he said that he would not kill himself. He discussed his future plans, including getting a prison job, moving to the Westgate Unit and getting an independent risk assessment from an external psychologist. The psychiatrist did not consider that the man was at raised risk of suicide. He said that he had been very surprised when he heard that he had apparently taken an overdose, as he had given no sign of his intentions.
38. The man's personal officer told us that his death had been a massive shock. He said that while the man had initially been uncertain about moving to the Westgate Unit, once he had understood more about the regime, he was looking forward to moving there. No one else at Frankland saw any signs that he was at risk and there was no evidence of other factors such as bullying. He got on well with other prisoners and staff and prisoners respected him.
39. We are satisfied that there was no reason for staff at Frankland to have identified the man as at heightened risk of suicide. In particular, we note that he saw a consultant psychiatrist less than three weeks before he overdosed. While he had some underlying risk factors for suicide, nothing happened after his consultation with the psychiatrist to suggest that his risk had increased. His actions were unexpected and we do not consider that staff at Frankland could have predicted or prevented his death.

Clinical Care

40. The clinical reviewer assessed the care that the man received at Frankland. She found he received good care from medical and nursing staff at Frankland for his diabetes. The staff supported him to manage his diabetes independently. He was offered diabetic screening appropriately, but did not always attend appointments, as was his right.
41. The clinical reviewer was also satisfied that the man received good mental health care. He had good access to mental health support and there was nothing in his clinical records to indicate that his mood or mental well-being had deteriorated or that he had suicidal thoughts.
42. We are satisfied that the care that the man received at Frankland was equivalent to that expected of an NHS patient in the community.

Emergency Response

43. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.
44. This national instruction required prisons to have a two level code system, which differentiates between a blood injury and all other injuries –usually code red, and code blue. Although the instruction came into effect on 27 February 2013, at the time of the man's emergency in November 2014, Frankland used a three code system: yellow for burns and fractures, red for blood injuries and black for unconscious or breathing difficulties. Frankland's local protocol stated the control room should call an ambulance automatically as soon as any emergency code is radioed, but in practice, control room staff waited to be instructed separately to call an ambulance.
45. In this case, this meant that there was a five-minute delay between the officer calling the emergency code and an ambulance being called. It does not appear that the delay affected the outcome for the man, but in other emergencies, such a delay could be crucial. In response to an earlier recommendation from this office, Frankland updated its emergency protocol in January 2015 to comply with the national instructions. We therefore do not make a further recommendation.