



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in November
2014 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 investigation report into the death of a man in November 2014, while a prisoner at HMP Frankland. He died from acute inflammation of the lungs, elevated blood potassium levels and an obstruction of the large arteries in his legs. He was 67 years old. I offer my condolences to his family and friends.

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

The man received an indeterminate prison sentence in April 2006 and had been at HMP Frankland since May 2007. He had several chronic conditions that were initially stable. In February 2012, he experienced pain and numbness in his legs and feet, and doctors diagnosed peripheral vascular disease.

In February 2014, the man developed an infection in his left foot that doctors diagnosed as cellulitis, a bacterial infection. Despite treatment and some initial improvement, his condition deteriorated and he was taken to hospital as an emergency on 29 October. The next day, surgeons amputated his left leg. He died several days later.

The clinical reviewer considered that staff should have considered referring the man to hospital when his condition began to deteriorate in the early summer of 2014 and it is not clear that an urgent referral a GP requested a week before his admission to hospital in October, was ever actioned. She was concerned that he had no care plan to manage his foot problems but, overall, she was satisfied that he received a standard of care in prison for his chronic conditions which was equivalent to that he could have expected to receive in the community.

The man was restrained during his admission to hospital, even though his mobility was very poor. Restraints were removed for surgery to have his leg amputated, but, they were reapplied when he regained consciousness. While there had been some concerns over his behaviour in hospital and a manager did authorise the removal of the restraints the next day, I am not satisfied that this sequence of decision-making was based on appropriate risk assessments which fully took into account his health and mobility. I have raised this issue with Frankland before.

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. In April 2006, the man received an indeterminate prison sentence and was sent to HMP Durham. In May 2007, he moved to HMP Frankland. He had a history of depression, osteoarthritis and chronic obstructive pulmonary disease, which healthcare staff at Frankland monitored and managed throughout his time at the prison.
2. In February 2012, the man reported pain and numbness in his left foot and a doctor diagnosed peripheral vascular disease (a narrowing of the arteries supplying blood to the legs). The doctor prescribed medication and his condition improved temporarily, but he continued to experience pain in his hips, legs and feet and walked with the aid of a stick.
3. On 2 August 2012, a consultant vascular surgeon examined the man. He concluded his condition might be traumatic rather than vascular. The consultant discharged him but advised further tests. In mid-October, he began to use a wheelchair.
4. The man's condition remained relatively stable during 2013. However, in February 2014, a prison doctor diagnosed cellulitis (a bacterial infection) and eczema in his left foot, and prescribed antibiotics. Despite some initial improvement, his condition worsened and the infection spread to his other foot. In June, a doctor advised he should be admitted to the prison's healthcare centre, but he declined.
5. In August, the man told a podiatrist his feet were much better but by October his condition had deteriorated significantly. On 22 October, a prison doctor noted he should be referred urgently to a vascular surgeon. It is not clear that the referral was made. On 29 October, a prison doctor referred him to hospital as an emergency. The next day, surgeons amputated his left leg.
6. Two prison officers escorted the man to hospital and restrained him using handcuffs and an escort chain. A prison manager authorised the removal of restraints during surgery, but they were reapplied afterwards and not removed until 9.45am the next day. He died in hospital from bronchopneumonia, hyperkalaemia (raised blood potassium levels) and peripheral vascular disease which had led to the surgical removal of his leg.
7. The clinical reviewer considered that the man's overall standard of care was equivalent to that he might have expected to receive in the community, but identified some areas for improvement. She considered that referral to a vascular specialist should have been considered earlier, and at least by June 2014. There was a lack of formal care plans to manage the wounds on his foot and some delay prescribing pain relief medication on one occasion. We are also concerned that he was restrained in hospital without a fully considered risk assessment to justify this. We make three recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Frankland, informing them of the investigation and inviting anyone with relevant information to contact him. Two prisoners contacted the investigator and named others who wanted to see him.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He interviewed seven members of staff and three prisoners at Frankland in December. He informed the prison of the initial findings of the investigation.
10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. She participated in some of the interviews.
11. We informed HM Coroner for Durham and Darlington of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.
12. One of the Ombudsman's family liaison officers contacted the man's ex-wife on 4 December to explain the investigation. She asked the investigator to consider why the prison had not contacted her while he was in hospital, before he died.
13. The man's family received a copy of the draft report. They did not make any comments. The prison has submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP FRANKLAND

14. HMP Frankland is one of eight high security prisons in England and Wales. It holds more than 800 men. There is 24 hour inpatient care. Care UK provides healthcare services.

HM Inspectorate of Prisons

15. The most recent inspection of Frankland was in December 2012. The Inspectorate noted that security was normally applied proportionately. Health services provided a high quality of care for patients with chronic diseases and life-long conditions, but waiting times for the GP and some specialist services were too long. Staff shortages inhibited the development of services. The Care Quality Commission took part in the inspection, and 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

16. 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 said the quality of healthcare services was good and Frankland had reduced the number of staff vacancies that had affected the delivery of services earlier in the year. The IMB was very positive about palliative care at the prison.

Previous deaths at HMP Frankland

17. The man was the seventh prisoner to die from natural causes in the last two years at Frankland. We have raised the issue of the use of restraints without appropriate risk assessments before.

KEY EVENTS

18. On 3 April 2006, the man received an indeterminate sentence for public protection, with a minimum period to serve of 30 months before he could be considered for release. (This was subsequently increased after two further convictions in 2008.) He was sent to HMP Durham and from there, moved to HMP Frankland in May 2007.
19. The man had a history of depression, osteoarthritis in his hips and chronic obstructive lung disease. He took antidepressant, anti-inflammatory and pain management medication including fluoxetine, amitriptyline, paracetamol and codeine. He used salbutamol inhalers to relieve the symptoms of his lung disease and he walked with the aid of a stick.
20. Healthcare staff at Frankland managed the man's various medical conditions and regularly reviewed his medication, which he kept in his cell. He attended a number of hospital appointments for minor procedures and consultations.
21. The man had smoked from the age of 15. While in prison, he was given help to give up several times but, after short periods of not smoking, he started again.
22. On 17 May 2011, the man told a doctor he had pain in his hips and lower limbs. The doctor diagnosed spinal stenosis (a narrowing of the spinal canal) and peripheral vascular disease (a narrowing of the arteries supplying blood to the legs). He arranged blood tests and an orthopaedic referral.
23. A consultant orthopaedic surgeon examined the man on 29 July and diagnosed osteoarthritis. He prescribed anti-inflammatory and pain management medication and advised against standing or walking for long periods. He discharged him back to the prison healthcare service.
24. On 24 February 2012, the man told a doctor he had numbness in his left foot. The doctor noted that the pulse in both his feet was feeble and the capillary refill time slow. He diagnosed peripheral vascular disease and arranged for blood tests, which showed high levels of cholesterol. He prescribed aspirin and simvastatin to lower his cholesterol.
25. On 19 April, the man told a doctor he had pain in his left foot, close to his big toe. The doctor diagnosed gouty arthritis and prescribed diclofenac (a non-steroidal anti-inflammatory drug).
26. On 2 August, a consultant vascular surgeon assessed the man's ongoing circulatory problems affecting his legs and feet. He concluded that the condition might be traumatic (as a result of an injury) rather than vascular. He discharged him from his caseload, but advised the prison to perform blood tests and a diabetes check. There is no record that either was done.

27. On the advice of the consultant vascular surgeon, a doctor prescribed aspirin and lisinopril (used to treat high blood pressure) on 1 October. The man's medical notes indicate that he began using a wheelchair around this time.
28. Throughout 2013, the man's condition remained fairly stable. On 10 January 2013, he told a doctor that he had arthritic pain in his hips, left ankle and left wrist, but could move around the wing without his wheelchair. He said the pain in his hips mainly occurred when he stood for long periods. Circulation tests showed impaired blood flow in his left leg but normal flow in the right. He could stand unaided and had full and pain-free hip rotation. His left foot was red and warm. She referred him for X-rays of his pelvis and spine and for a physiotherapy consultation. She changed his pain relief medication from tramadol to paracetamol.
29. On 22 January, a physiotherapist saw the man and gave him an exercise programme to increase his lower limb strength. The X-rays requested by the doctor were taken. On 12 April, a doctor told him that the X-rays showed osteoarthritis of the spine and hips. He did not report any new problems. He continued with his current medication plan, taking paracetamol to manage his pain.
30. On 2 August, a clinical manager reviewed the man's lung disease. He said he had started smoking again and did not want help to stop. He had smoked on and off throughout his time in prison. He said his chest was alright and he did not need to use his inhaler. However, the results of a lung function test showed a slight deterioration in his condition. At a follow-up appointment in September, he told the clinical manager that since he had begun to use his wheelchair, his chest had been better, but he said he became short of breath when carrying out everyday tasks.
31. On 20 February 2014, a doctor diagnosed that the man had mild cellulitis (a bacterial infection) in his left foot and prescribed flucloxacillin, an antibiotic and steroid cream. On 13 March, the doctor noted a slight improvement, but prescribed a second course of antibiotics.
32. On 27 March, the man told a doctor that he had 'pins and needles' in his left foot, particularly at night. His foot infection had not cleared but had improved slightly. The doctor prescribed flucloxacillin and penicillin. He stopped the penicillin after the man developed an allergy. When he examined him on 9 April, he noted no signs of cellulitis.
33. The man continued to experience problems with his legs and feet. On 15 May, a podiatrist cleaned and dressed his foot after he had developed an infection in his toe nails, an ulcer between his toes and cracks in the skin on his left heel. The podiatrist agreed that he should be reviewed in four weeks and should be referred to the vascular surgeon if his condition did not improve.
34. On 21 May, a nurse noted broken skin on the heel and between his toes when he changed the dressing on the man's left foot. His foot was red and

inflamed, with evidence of cellulitis. The nurse referred him to the GP. On 6 June, a doctor saw him and stressed the need to keep his foot elevated. He prescribed clindamycin (an antibiotic used to treat serious bacterial infections) and recommended he should move to the prison's inpatient unit, but he did not want to go.

35. The man had a single cell on the first floor of A Wing. Other prisoners told the investigator that he was happy on the wing and would not have wanted to move. Frankland operates a buddy system, with selected prisoners paid to support other prisoners who need help with daily tasks. He had a buddy who cleaned his cell, brought him his meals, and took him for treatment and to collect his medication.
36. Healthcare staff reviewed the man regularly over the next few weeks. On 31 July, he told a podiatrist that, despite soreness between the toes, his feet were much better. On 8 August, he told a doctor that he would like to attend light gym sessions and the doctor referred him for a physical activity programme.
37. Podiatrists and other healthcare staff continued to see the man regularly to monitor and clean and dress his ulcerated foot. Despite this, his condition showed little improvement.
38. The man's foot and general health deteriorated significantly from October 2014. On 16 October, he told a doctor that his current painkillers did not help and the doctor planned to prescribe gabapentin as an alternative. A podiatrist examined him half an hour later and asked the prison doctor to consider referring him urgently to the consultant vascular surgeon for further investigation of the restricted blood supply to his foot.
39. On 19 October, the man told a nurse that he had fallen over in his cell. This was the first of a number of falls that he reported.
40. As a result of the podiatrist's request, a doctor examined the man on 22 October. She noted he should be referred urgently to the consultant vascular surgeon, but there is no record that a referral was sent and no evidence of a referral letter in his medical notes.
41. On 26 October, a nurse saw the man, at the request of wing staff, who thought he had deteriorated. He told her that he could not sleep because of the pain in his foot. He said he had not yet received the gabapentin a doctor had recommended the previous week. She noted further deterioration of his foot and arranged for the dressing to be changed.
42. On 28 October, a doctor examined the man, after he told a nurse that he could not bear his weight and had recently fallen. The doctor prescribed gabapentin and arranged blood tests. He noted the outcome of the consultant vascular surgeon's previous assessment of the man in August 2012 and that he should be referred to the consultant again if the tests results indicated a need. He asked that the man should be referred to an occupational therapist.

43. On 29 October, a nurse examined the man after he had fallen in his cell again. Wing staff had told her that he had been confused and acting strangely, but he appeared alert and orientated when she examined him. He still could not bear his weight and agreed to be admitted to the healthcare centre, for assessment.
44. At 4.42pm, a locum GP reviewed the man in the prison's inpatient unit. He could not lift his leg or bear weight. She referred him to hospital for additional medical assessment and investigation. At 6.30pm, an ambulance took him to hospital, with two prison officers as escorts.
45. A hospital escort risk assessment was completed in which a healthcare officer recorded that the man's medical condition did not restrict his ability to escape, although he also recorded that the man was unable to walk. He noted that the man's health had deteriorated over recent days and that he was unable to bear his own weight or raise his legs without support. The healthcare officer noted that restraints need not be removed during any procedure but that a longer escort chain would be beneficial. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
46. A Supervising Officer (SO) completed the security part of the risk assessment. He assessed the man as a medium risk to the public, on a scale of high, medium and low, and low risk in all other areas, including his potential to escape. He recommended a two officer escort and the use of restraints, including during transport in a secure vehicle. He told the investigator that he would not necessarily have known him or his medical condition.
47. On the basis of the information in the assessments a senior manager decided that the man should be restrained by handcuffs and an escort chain
48. On 30 October, hospital doctors amputated the man's left leg. Restraints were removed before he went into surgery, but were reapplied once he returned to the ward. The senior manager authorised their removal the next day and he was not restrained again.
49. On 31 October, the prison's clinical team manager obtained an update from a nurse at the hospital and discussed whether the prison should contact his next of kin. The nurse advised that he was poorly but stable at that time. She said they would contact the prison if his condition deteriorated.
50. On 1 November, a nurse contacted the hospital for an update on the man's condition. A nurse told her that he had been for a renal scan and chest X-ray, but there had been little change since the previous day and he remained resting in bed. He died soon afterwards.

Liaison with the man's family

51. The man had not nominated a next of kin so the prison had not been able to inform anyone of his admission to hospital and it does not appear that he asked anyone to be informed. Members of his family had been victims of his offences and he had had no contact with his family after his conviction.
52. A manager at the prison acted as the prison's family liaison officer after the man's death. She found an address and telephone number in his prison records for his ex-wife, but this was no longer current. Probation staff had no other records. Eventually, at the request of the coroner, the police traced her.
53. The manager contacted the man's ex-wife on 12 November and discussed funeral arrangements. The Governor wrote to offer his condolences. The manager kept in contact with her until the funeral, which was on 5 December 2014. The prison paid the costs of the funeral.

Support for prisoners and staff

54. The Governor issued a notice to prisoners and staff, informing them of the man's death, and the support available. Staff reviewed the cases of all prisoners subject to suicide and self-harm prevention procedures, in case they had been affected by the news.
55. A senior manager debriefed prison and healthcare staff involved in the man's care, about the circumstances of his death. He offered staff appropriate support and wrote to offer support to staff who could not attend the debrief.

Post-mortem

56. A post-mortem report concluded that the man died of bronchopneumonia, hyperkalaemia (excess potassium) and peripheral vascular disease.

ISSUES

Clinical care

57. The clinical reviewer noted that the man's records indicate that he had significant input from healthcare staff, who saw him at least 57 times in the last twelve months of his life. Nurses dressed his wounds and dispensed medication and GPs saw him frequently and reviewed his routine medication and chronic obstructive pulmonary disease as expected. He had care from a podiatrist. While the clinical reviewer considered there was some room for improvement in relation to the management of his foot problems, and his pain, she concluded that the overall standard of healthcare that he received at Frankland was equivalent to that he might have expected to receive in the community.
58. The man's general health and his foot had deteriorated seriously in the two weeks before his final admission to hospital. Healthcare staff described his foot as ischaemic, red, very cold and rigid with a number of ulcers on his toes and foot. The GP said his condition was very painful. He had serious symptoms and, on 16 October, a podiatrist had requested the GP consider an urgent referral to the vascular specialist.
59. A doctor saw the man on 22 October. Despite recording in the medical record that he should be referred urgently to the consultant vascular surgeon, there is no evidence that this was done. We asked the Head of Healthcare to confirm that a referral had been sent but she said that there was nothing in his records to indicate that this had been done and no evidence of a SystmOne task to arrange this. (SystmOne is the electronic medical record used in prisons.) Although this did not affect the outcome for him, as he was admitted to hospital as an emergency a week later, it is a concern that an urgent referral does not appear to have been actioned. We make the following recommendation

The Head of Healthcare should ensure that all clinicians understand and use the appropriate referral process and that all urgent referrals to specialists are recorded and monitored.

60. The clinical reviewer noted that the ulcers on the man's foot did not heal despite antibiotic treatment, the input of podiatry and wound dressing. She found that the dressing of his wound was sporadic. While this might have been indicative of his need, she considered that he should have had a nursing care plan to ensure his care was systematic and evidence based. She was also concerned that there was a delay in supplying him with gabapentin for pain relief, after a doctor planned to prescribe it on 16 October
61. The clinical reviewer considered that healthcare staff should have considered sooner, the possibility of critical limb ischaemia developing. She believed that it is possible that his death might have been prevented had he been assessed by a vascular team and offered surgical intervention earlier. She considered that there was evidence of deterioration from the beginning of 2014 and by

June 2014 a referral should have been made. She noted that this would have been more likely if National Institute for Health and Care Excellence (NICE) guidelines for Lower Limb Peripheral Arterial disease had been followed. (NICE clinical guidelines contain recommendations for the NHS on the best way of treating and caring for people with specific diseases and conditions.) We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff manage prisoners with chronic and complex conditions, in line with relevant NICE guidelines, implement appropriate care plans which ensure effective pain relief, and refer to secondary specialist services when indicated.

Restraints, security and escorts

62. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.
63. The man's risk assessment indicated his health had deteriorated in recent days, he had recently fallen and appeared to be confused and disoriented. He was unable to walk, bear his own weight or raise his legs. He had medium to low risk factors, including a low risk of escape. He was escorted to hospital by two officers and handcuffed and chained to an officer.
64. Two officers stayed with the man and the level of restraints remained the same. The escort officers recorded his behaviour that night as 'deplorable' and said he kept trying to remove medical equipment and his handcuffs.
65. At 2.20pm on 30 October, the man had surgery to amputate his leg. Officers removed his restraints, but reapplied them immediately afterwards. It is not clear from the documents whether the officers reapplied both the handcuffs and escort chain but one of the escort officers told the investigator that he recalled that they used only the escort chain. Despite his amputation, he remained restrained until 9.45am on 31 October.
66. Prison Service guidance is that security measures must be proportionate to a prisoner's individual circumstances and restraints are not normally necessary on an escort when the prisoner's mobility is severely limited. We do not consider that the risk assessments properly took into account the man's chronic physical condition and lack of mobility, particularly after the

amputation of his leg. There is a need for all those involved in making decisions to ensure that they take a prisoner's health and mobility fully into account in risk assessments and that staff follow the guidance in the 2007 High Court judgment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all clinicians understand and use the appropriate referral process and that all urgent referrals to specialists are recorded and monitored.
2. The Head of Healthcare should ensure that healthcare staff manage prisoners with chronic and complex conditions, in line with relevant NICE guidelines, implement appropriate care plans which ensure effective pain relief, and refer to secondary specialist services when indicated.
3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understands the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that all clinicians understand and use the appropriate referral process and that all urgent referrals to specialists are recorded and monitored.	Accepted	The Head of Healthcare has written to the Medical Director for the Gables Medical Group to ensure that all clinicians understand and use the appropriate referral process. All clinicians have also been reminded that all urgent referrals to specialists must be recorded and monitored.	Completed Head of Healthcare / Gables Medical Group
2	The Head of Healthcare should ensure that healthcare staff manage prisoners with chronic and complex conditions, in line with relevant NICE guidelines, implement appropriate care plans which ensure effective pain relief, and refer to secondary specialist services when indicated.	Accepted	All long-term condition patients will be managed in line with national guidance and the community model. Care plans will continue to be drawn up for individual patients where this is considered to be appropriate. Not all patients under chronic disease management have care plans in place as it is encouraged that with advice, and support, some patients are able to self-manage their condition. The Head of Healthcare has written to the Medical Director for the Gables Medical Group to ensure that referrals are made to secondary specialist services where indicated.	Completed Head of Healthcare / Gables Medical Group
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk	Accepted	Risk assessments for prisoners taken to outside hospital from HMP Frankland are now based on a consideration of the individual's circumstances/current condition and	Completed The Governor /

	assessments for prisoners taken to hospital understands the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.		the actual risk that the prisoner presents at the time of transfer.	Head of Healthcare / Head of Security
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