

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Franks a prisoner at HMP Birmingham on 5 August 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Franks died on 5 August 2017 of a heart attack at HMP Birmingham. He was 66 years old. We offer our condolences to Mr Franks' family and friends.

There was no indication that Mr Franks had heart disease, although he did have high cholesterol levels. Mr Franks received appropriate medication for this and for other long-term conditions, but these conditions were not reviewed annually as they should have been. We agree with the clinical reviewer that the standard of care Mr Franks received at Birmingham was not equivalent to that which he could have expected to receive in the community.

Despite a number of requests for documentation from the prison to demonstrate that they liaised with Mr Franks' family appropriately, and offered support to prisoners who may have been affected by Mr Franks' death, none was provided until after we had issued our draft report. We remind Birmingham that documentation we request following a death in custody should be provided promptly.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

March 2018

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Summary

Events

1. On 16 February 2015, Mr John Franks was sentenced to 17 years imprisonment and sent to HMP Birmingham. He had a number of pre-existing health conditions including an underactive thyroid gland, raised cholesterol levels and asthma, for which he was prescribed appropriate medication.
2. On 1 August 2017, Mr Franks complained of chest pain. A prison nurse examined him and found that apart from a slightly elevated blood pressure reading, all his clinical observations were normal. The nurse was satisfied there was no indication of a heart problem.
3. On 4 August 2017, Mr Franks experienced another episode of chest pain. He was examined by a different prison nurse. Again, apart from a slightly elevated blood pressure reading, all Mr Franks' clinical observations were normal. The nurse gave Mr Franks a dose of Peptac (a liquid that relieves symptoms of heartburn and indigestion) and asked a prison GP to review his records given that this was the second time in four days that Mr Franks had complained of chest pain. A prison GP reviewed Mr Franks' records and considered no further action was required.
4. At 7.55am on 5 August, Mr Franks' cell mate found him unresponsive and alerted prison staff, who called a medical emergency code. Nurses attended and commenced cardiopulmonary resuscitation (CPR) at 7.59am. Paramedics arrived six minutes later and continued the resuscitation attempt, but at 8.25am, they recorded that Mr Franks had died.
5. Although Mr Franks' family were informed in person of Mr Franks' death, they complained that they had to chase the prison for a financial contribution towards his funeral.

Findings

Clinical care

6. There was no indication that Mr Franks had heart disease, although he did have high cholesterol levels. The clinical reviewer considered that when Mr Franks complained of chest pain on 4 August, it may have been prudent for healthcare staff to have offered him an electrocardiograph (ECG) to assess the severity of his symptoms and rule out any cardiac event. The clinical reviewer also noted that healthcare staff did not use a National Early Warning Scores (NEWS) system to assist in assessing clinical symptoms.
7. The clinical reviewer found that Mr Franks' long-term conditions, including his high cholesterol levels, were not reviewed annually as they should have been.
8. We agree with the clinical reviewer that Mr Franks' clinical care was not equivalent to that which he could have expected to receive in the community.
9. Despite several requests for the family liaison paperwork, the prison failed to provide it. The prison also failed to provide documentation to show that

appropriate support had been offered to prisoners who may have been affected by Mr Franks' death. The relevant paperwork was provided only after we had issued our draft report.

Recommendations

- The Head of Healthcare should ensure that the National Early Warning Scores (NEWS) system, or equivalent system for a community service, for recording clinical observations is introduced as soon as possible to support clinical decision making.
- The Head of Healthcare should ensure that all primary care staff are fully trained in the use of a portable ECG machine and aware of symptoms that may indicate cardiac problems.
- The Head of Healthcare should ensure that an audit takes place of prisoners with long-term health conditions and that long-term care monitoring is put in place in line with NICE guidance.
- The Director should ensure that appropriate records are kept of all actions taken following a death in custody.
- The Director should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody, in line with PSI 58/2010.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Franks' prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Franks' clinical care at the prison.
13. We informed HM Coroner for Birmingham and Solihull of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
14. The investigator wrote to Mr Franks' son to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Subsequently, one of the Ombudsman's family liaison officers spoke to Mr Franks' granddaughter who asked why her grandfather had not had an electrocardiograph (ECG) after he had experienced episodes of chest pain prior to his death.
15. Mr Franks' granddaughter received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS identified no factual inaccuracies but they did provide some additional information that was not made available to us during the course of the investigation. We have made changes to the report to reflect this. HMPPS also provided an action plan in response to our recommendations, which is annexed to this report.

Background Information

HMP Birmingham

17. HMP Birmingham is a local prison which holds up to 1,450 men. It is managed by G4S Care and Justice Services. Birmingham and Solihull Mental Health Foundation Trust provides 24-hour health services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services. The prison has two 15 bed healthcare wards, one for prisoners with physical health issues and one for those with mental health issues.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Birmingham was in February 2017. Inspectors reported that despite chronic nursing staff shortages, primary healthcare services were reasonably good and both healthcare wards offered very good support to patients with complex physical and mental health needs.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 June 2016, the IMB reported that waiting times to see a GP were comparable to those in the community and emergencies were seen within an acceptable time frame.

Previous deaths at HMP Birmingham

20. Mr Franks was the eleventh prisoner to die at Birmingham since January 2016, the ninth from natural causes. Two prisoners have died since Mr Franks' death, both of natural causes. There were no similarities between Mr Franks' death and previous deaths at the prison.

Key Events

21. On 16 February 2015, Mr John Franks was sentenced to 17 years imprisonment for historic sex offences and sent to HMP Birmingham.
22. Mr Franks had a history of an underactive thyroid gland (hypothyroidism), raised cholesterol levels (hypercholesterolemia) and asthma. At his initial health screening, on 16 February 2015, the nurse noted Mr Franks' long-term conditions and requested his community health records. Later the same day, a prison GP saw Mr Franks and prescribed him an inhaler to control his asthma. On 18 February 2015, after the receipt of Mr Franks' community records, a prison GP prescribed Levothyroxine, a thyroid replacement therapy, to control Mr Franks' thyroid stimulation levels.
23. As part of the initial health screening process Mr Franks had a blood test on 12 March 2015. This test confirmed Mr Franks had raised cholesterol levels. A prison GP prescribed Atorvastatin to assist in reducing the levels of cholesterol in Mr Franks' blood stream. This was the only blood test that Mr Franks had during his time in prison.
24. On 1 August 2017, Mr Franks experienced chest pain, but said he did not want to see healthcare staff. Prison officers insisted that healthcare staff attend and within 30 minutes of their call, a nurse examined Mr Franks. Mr Franks said that he had pain in his chest which went into his right arm and that he felt clammy. The nurse noted that Mr Franks was not clammy when seen and did not have shortness of breath. Apart from a slightly elevated blood pressure reading, all his clinical observations were within normal range. In the nurse's clinical opinion there was no evidence that Mr Franks' chest pains were cardiac related and he advised Mr Franks to contact healthcare if he suffered similar symptoms.
25. On 4 August, Mr Franks had a further episode of chest pain and a nurse attended. Mr Franks' symptoms were similar with pain radiating into the right arm. There was no evidence of shortness of breath and again Mr Franks' observations were within normal range, apart from slightly raised blood pressure. The nurse gave Mr Franks a dose of Peptac (a liquid to relieve heartburn and indigestion). In the nurse's clinical opinion there was no evidence that the chest pain was cardiac related but he requested that the prison GP review Mr Franks' notes, given that this was a second episode of chest pain within days. Later that day, a prison GP reviewed the notes and made an assessment that no further action was required.
26. At 7.55am on 5 August, Mr Franks' cell mate found Mr Franks lying unresponsive on the bottom bunk in their cell. He alerted prison officers using the cell bell. A prison officer attended and called an emergency code blue (which indicates a prisoner is unconscious or has difficulty breathing). Nurses attended and at 7.59am started cardiopulmonary resuscitation (CPR). They attached a defibrillator to Mr Franks which advised 'no shock' and that CPR should continue. Paramedics arrived at 8.05am. Four further defibrillator assessments were made, each confirming that CPR should continue. Paramedics continued with a further 10 cycles of CPR and administered adrenaline (to stimulate the heart) and

intravenous fluids. Paramedics were unable to resuscitate Mr Franks and at 8.25am, they recorded he had died.

Contact with Franks' family

27. On the morning of Mr Franks' death, two senior managers and the Family Liaison Manager visited his family to offer condolences and support.
28. Mr Franks' family told the Ombudsman's family liaison officer that they had to chase the prison for a contribution towards the cost of Mr Franks' funeral.

Support for prisoners and staff

29. After Mr Franks' death, a senior manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
30. The prison posted notices to inform other prisoners of Mr Franks' death and offer support. The Safer Custody Manager told us that prison staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Franks' death.

Post-mortem report

31. A post-mortem examination indicated that the cause of Mr Franks' death was a thrombosis of the right coronary artery (a blood clot in one of the arteries that supplies the heart, leading to a heart attack), and coronary artery atherosclerosis (a narrowing of one of the arteries that supplies blood to the heart).

Findings

Clinical care

32. Mr Franks was examined by two prison nurses when he experienced chest pain on 1 and 4 August. Both nurses were of the opinion that Mr Franks' symptoms did not indicate heart problems. He was also reviewed on paper by a prison GP, who concluded that no further action was required.
33. The clinical reviewer concluded that the use of the National Early Warning Scores system (NEWS - a scoring tool used to assist clinical decision making when taking physical observations) would have been prudent, as would offering an ECG to assess the severity of Mr Franks' symptoms and rule out a heart problem.
34. There was no indication that Mr Franks had heart disease, but he did have high cholesterol levels. This was confirmed by a blood test in March 2015 and he was prescribed appropriate medication. However, no repeat blood tests were ever undertaken. The clinical reviewer found that Mr Franks' long-term conditions, including his high cholesterol, hypothyroidism and asthma, should have been reviewed annually. The Head of Healthcare said that GP reviews were often missed because there was no mechanism for flagging on SystemOne (the electronic medical record) when a GP review was due and that a system for rectifying this was being explored. However, the clinical reviewer noted that SystemOne could provide regular reports showing those prisoners with long-term conditions whose annual reviews were due.
35. The clinical reviewer concluded that the standard of clinical care Mr Franks received at Birmingham was not equivalent to that which he could have expected to receive in the community. We agree and make the following recommendations:

The Head of Healthcare should ensure that the National Early Warning Scores (NEWS) system, or equivalent system for a community service, for recording clinical observations is introduced as soon as possible to support clinical decision making.

The Head of Healthcare should ensure that all primary care staff are fully trained in the use of a portable ECG machine and aware of symptoms that may indicate cardiac problems.

The Head of Healthcare should ensure that an audit takes place of prisoners with long-term health conditions and that long-term care monitoring is put in place in line with NICE guidance.

Contact with Mr Franks' family

36. We are satisfied that the prison contacted Mr Franks' family immediately after his death and offered support. However, Mr Franks' family told us that they had to chase the prison for a contribution towards the funeral costs, which should have been offered. Despite a number of requests for the relevant documentation to show the support provided to Mr Franks' family following his death, the prison

failed to provide any until after we had issued our draft report. The documentation provided showed that prison staff had explained to Mr Franks' family that the prison would make a financial contribution to the funeral costs and that £3,000 was paid, in line with national guidance.

Support provided to staff and prisoners

37. Despite a number of requests for documentation to show that support was offered to prisoners who may have been affected by Mr Franks' death, none was provided until after we had issued our draft report. Although the Safer Custody Manager provided confirmation in an email that all prisoners on an ACCT were reviewed following Mr Franks' death, we were not provided with any documentation completed at the time to show this action was completed. We make the following recommendation:

The Director should ensure that appropriate records are kept of all actions taken following a death in custody.

Lack of documentation

38. We are concerned that documentation we requested during the course of our investigation was not provided to us, despite chasing a number of times. It was provided only after we had issued our draft report. We therefore make the following recommendation:

The Director should ensure that the Prisons and Probation Ombudsman is promptly provided with all requested documents following a death in custody in line with PSI 58/2010.

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