Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Loader a prisoner at HMP Frankland on 9 April 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

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

Mr Peter Loader died on 9 April 2017 of a heart attack at HMP Frankland. Mr Loader was 57 years old. I offer my condolences to those who knew him.

Mr Loader had several health conditions which increased his risk of having a heart attack. The investigation found that the care provided to Mr Loader at Frankland was of a good standard and equivalent to that which he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. Mr Peter Loader was sent to prison in March 2012. He was moved to HMP Frankland in March 2014.

2. When Mr Loader arrived at Frankland, a nurse noted his diagnosis of essential hypertension (high blood pressure that does not have a known cause) and angina. Mr Loader had a history of alcohol abuse and was a heavy smoker. A prison GP explained the risks of smoking with hypertension but Mr Loader declined help to stop.

3. Prison GPs prescribed appropriate medication to Mr Loader and recorded his blood pressure on a regular basis. His blood pressure remained high throughout his time in prison.

4. At 1.30pm on 9 April, Mr Loader complained of chest pain and prison staff called an emergency ambulance. After the paramedics arrived, Mr Loader collapsed and became unresponsive. Paramedics took him to hospital but he died at 3pm, as a result of a heart attack.

Findings

5. Mr Loader had several medical conditions which increased his risk of having a heart attack. The clinical reviewer considered that the prison GPs managed Mr Loader's high blood pressure appropriately, in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

6. We agree with the clinical reviewer that the care provided to Mr Loader was of a good standard and equivalent to that which he could have expected to receive in the community.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Loader's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Loader's clinical care at the prison.

10. We informed HM Coroner for Durham and Darlington of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

11. The investigator wrote to Mr Loader's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Frankland

13. HMP Frankland is one of eight high security prisons in England and Wales. It holds up to 844 men. There is 24-hour inpatient care. G4S Forensic & Medical Services provide general nursing services and substance misuse services. Spectrum Healthcare provides GP and pharmacy services.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Frankland was in February and March 2016. Inspectors reported that, although health provision was reasonably good, staffing issues were impacting on care delivery. However, prisoners had access to a range of primary care services and visiting specialists. Prisoners with long-term conditions received regular reviews by appropriately trained staff.

Independent Monitoring Board

15. 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 November 2016, the IMB commented that there had been considerable capital expenditure in healthcare. The uptake on the smoking cessation initiative had increased significantly through the appointment of a dedicated lead nurse.

Previous deaths at HMP Frankland

16. Mr Loader was the fourth person to die from natural causes at Frankland since January 2016. There were no significant similarities with the circumstances of the previous deaths.

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Key Events

17. On 2 March 2012, Mr Peter Loader was remanded in custody for sexual offences and sent to HMP Forest Bank. On 16 April, he was sentenced to 10 years in prison. On 28 March 2014, he was moved to HMP Frankland.

18. At an initial health screen at Frankland, a nurse noted that Mr Loader had a history of essential hypertension (high blood pressure which does not have a known cause such as being overweight, kidney disease or diabetes), angina (a chest pain that occurs when the blood supply to the muscles of the heart is restricted), asthma and epilepsy. Mr Loader told the nurse he had a family history of cardiovascular disease and he had abused alcohol in the community. Prison GPs prescribed medication to manage his medical conditions including a daily dose of ramipril for hypertension and a glyceryl trinitrate (GTN) spray to relieve the symptoms of angina. Mr Loader was a heavy smoker and declined help to stop.

19. Throughout 2014 and 2015, healthcare staff saw Mr Loader regularly in accordance with the National Institute for Health and Care Excellence (NICE) guidelines for the management and treatment of high blood pressure. His blood pressure readings remained high. Prison GPs explained to Mr Loader the effects of heavy smoking on his blood pressure but Mr Loader continued to decline help to stop.

20. In April 2015, Mr Loader complained to a prison GP that he felt depressed. The GP completed a physical and mental health review and prescribed antidepressant medication. She referred Mr Loader to the mental health team who saw him on a regular basis.

21. On 6 January 2016, Mr Loader had a routine electrocardiogram (ECG – a test that checks the electrical activity of the heart) with normal results.

22. On 21 September, Mr Loader had a routine appointment with a nurse. Mr Loader said he had suffered an angina attack three weeks before, which he relieved by using his GTN spray. The nurse advised him to seek urgent medical help if his GTN spray did not quickly relieve his chest pain.

23. On 12 October, a prison GP assessed Mr Loader because he felt tired. The GP arranged a full set of blood tests and a urine test with normal results. Mr Loader said he had lost weight and the GP made a referral for an abdomen and renal tract ultrasound.

24. On 29 November, a prison GP saw Mr Loader who complained of feeling dizzy. The GP prescribed medication and recorded Mr Loader's blood pressure as 180/82 (high).

25. On 23 December, the results of an ultrasound showed that Mr Loader had an underlying diffuse liver disease. Mr Loader refused to discuss the results and a prison GP made a further appointment for 6 January 2017. Mr Loader failed to attend this appointment. The GP wrote to Mr Loader to explain the results of his ultrasound and made a further appointment for 7 February. Mr Loader did not

attend this appointment and there is no record that he saw a GP to discuss the ultrasound results before he died.

Events of 9 April 2017

26. At 1.30pm on 9 April, Mr Loader rang his cell bell because he had chest pain that was not relieved by his GTN spray. A senior officer attended and radioed an emergency code blue (which is used to indicate a prisoner has chest pain and difficulty in breathing). The control room immediately called an emergency ambulance. Two nurses arrived at Mr Loader's cell at 1.35pm. One of the nurses recorded Mr Loader's pulse and oxygen saturation as normal and his blood pressure as high (148/78).

27. At 1.43pm, the paramedics arrived and took control of Mr Loader's care. An ECG result showed that Mr Loader had suffered a heart attack. At approximately 2pm, Mr Loader collapsed in his cell and became unresponsive. The paramedics started cardiopulmonary resuscitation (CPR), which they continued in the ambulance. They left the prison at 2.39pm. Two officers escorted Mr Loader in the ambulance and did not use restraints. A prison manager telephoned Mr Loader's son, his nominated next of kin, but was unable to contact him. Mr Loader died in hospital at 3pm.

Contact with Mr Loader's family

28. At 3.30pm on 9 April, the prison appointed a prison officer as family liaison officer. He arranged for a family liaison officer at HMP Buckley Hall to visit Mr Loader's son, his nominated next of kin.

29. At 5.45pm, the family liaison officer at Buckley Hall arrived at the home of Mr Loader's son but he was not there. She also visited the home of Mr Loader's brother but he was also out.

30. The family liaison officer at Frankland telephoned Mr Loader's son at 7pm and told him Mr Loader had died. He offered condolences and support. He arranged to meet Mr Loader's son at the hospital's chapel of rest on 10 April. He remained in contact with Mr Loader's son until Mr Loader's funeral on 8 May. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

31. After Mr Loader's death, a prison 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.

32. The prison posted notices informing other prisoners of Mr Loader's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Loader's death.

Post-mortem report

33. The Coroner told us that Mr Loader had died from an acute myocardial infarction (heart attack).

Findings

Clinical care

34. The clinical reviewer noted that Mr Loader had several cardiovascular risk factors, including hypertension, angina, smoking and a history of excessive alcohol consumption. The clinical reviewer found that prison healthcare staff managed Mr Loader's medical conditions appropriately, in line with NICE guidelines.

35. The clinical reviewer concluded that the standard of care provided to Mr Loader was of a good standard and equivalent to that which he could have expected to receive in the community.

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