Investigation into the death of a man in November 2004 at University Hospital, Durham whilst a prisoner at HMP Frankland

Report by the Prisons and Probation Ombudsman for England and Wales

June 2005

This is the report of an investigation into the circumstances leading to the death of a man who died on 7 November 2004 at University Hospital, Durham, whilst a serving prisoner at HMP Frankland.

I offer my sincere sympathy and condolences to the deceased's family for their loss.

I wish to extend my thanks to the Governor and his staff at Frankland for their help and co-operation during the investigation. I am also grateful to the Northumberland Primary Care Trust for the preparation of the clinical review of this man.

At first sight, the death of a 77 year old from natural causes might seem to occasion little need for investigation. However, this report has important things to say about Frankland's cell bell system and about the decision to attach a chain to the man during the short time he was in hospital. Like the clinical reviewer, I am surprised it was felt necessary to restrain such a sick elderly person until a quarter of an hour before his death. I know the Governor of Frankland feels likewise.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man who is the subject of this report was 77 years old when he died in hospital on 7 November 2004 after collapsing in his cell at HMP Frankland.

The man was arrested in January 1999 for several serious offences. Later that year he was convicted of eleven offences and sentenced to life imprisonment.

By November 2004, he was suffering from various heart conditions and his health was failing. He had been a hospital in-patient earlier in the year. He was located on wing C1 in cell 22.

In the early hours of the morning of 7 November the man pressed his cell bell to call the night patrol officer. The call was logged at 03.16 am but not noticed until 04.03 am by an Officer Support Grade (OSG) who then looked into the cell and saw him lying on the floor. Seeing that he was in distress and gasping for breath, the OSG immediately went to inform an Officer in the centre office. Having returned to the cell, both the officer and the OSG went in and made the man comfortable with a pillow and some blankets. He told the officers that he had stomach pain.

Another Officer and a Healthcare Officer arrived a few minutes later, and the man was given oxygen and an ambulance was requested. The Paramedics arrived at 04.35 am and he was taken to University Hospital, Durham. Once there he was taken into the A & E department and then to theatre for an operation, although it was decided that he was too weak and he was moved to ward 14. At 08.22 am he was pronounced dead by a doctor.

Investigation methodology

1. My investigator opened the investigation at HMP Frankland on 24 November 2004. The Governor and his staff produced the man's Core Record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation. Several members of staff were interviewed.

2. My investigator spoke with the man's next of kin, one of his sons. He stated that he did not have any concerns regarding his father's care whilst he had been at Frankland. The man's son also said that he was satisfied with the way notification of his father's death had been made and the prison's response regarding the funeral.

3. The Northumberland Primary Care Trust was asked to commission a clinical review of the healthcare that the man received whilst he was in custody.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the death of the man.

The Deceased

5. The man was born in Yorkshire on 7 January 1927. His mother died when he was 12 years old and, as his father was in the Army, he was placed in care. He left the children's home at 14, when his father remarried.

6. Having left school with no qualifications, he worked in the shipbuilding and cotton industries and spent two and a half years as an Army Signaller in Palestine. He married his first wife in 1952 and they had nine children, six girls and three boys. The marriage broke down and they were divorced in 1976. He married his second wife in 1984.

7. The man suffered his first heart attack in 1990 and another in 1994. He subsequently received treatment for his heart condition until his death.

8. He received an eight month suspended sentence in 1990 for sexual offences and then was convicted and sentenced to life imprisonment in November 1999 for eleven other serious sexual offences.

Frankland prison

9. Frankland was opened as a dispersal prison in April 1983 and now has six wings with an operational capacity of 745 prisoners. It is situated about three miles from Durham city centre. The Westgate Unit is an 80 bed unit opened in May 2004 and is used for prisoners who meet the Dangerous and Severe Personality Disorder (DSPD) criteria.

10. The establishment's performance rating is "High Performance", which is the highest level achievable. An inspection report by HM Chief Inspector of Prisons in March 2003 described Frankland as offering a safe environment, based upon good relationships between staff and prisoners, with appropriate levels of interaction and good staff understanding of individual prisoners and their needs. The Standards and Security Audit carried out during February and March 2003 gave an overall "good" rating for both categories. (Good is defined as follows: The establishment or group performs to a high standard. The evidence gives assurance that risks are being effectively managed.)

11. The prison has education and workshop facilities as well as a gymnasium.

12. The Healthcare facilities can provide both 24 hour in-patient and out-patient services based on a primary care model.

Events prior to death

13. The man was remanded into custody at HMP Holme House in January 1999 to await his trial for a number of serious sexual offences. He was found guilty of 11 offences on 12 November 1999 and sentenced to life imprisonment. He was then 72 years old.

14. Upon arrival at Holme House, the man completed the reception procedure where it was recorded that he had suffered three 'heart attacks', the last being in 1994. It was also noted that he suffered from angina, chronic obstructive airways disease (COAD) and a left inguinal hernia.

15. In his clinical review, the reviewer states that in his opinion the man was appropriately treated for these conditions. He had frequent flare ups of his COAD which required antibiotic medication, which he did not always take, in addition to regular therapy.

16. In July 2000, whilst on an out-patient visit to a local hospital for his hernia, an aortic aneurysm 4.7 cm in diameter was found in the main blood vessel to his lower limbs. In November 2000 the Consultant Vascular Surgeon decided against surgery but recommended ultrasound scans at six monthly intervals with consideration of surgery if and when the diameter exceeded 6 cm.

17. The man was transferred to HMP Frankland on 18 January 2001 and his medical history was taken again. His need for a six monthly ultrasound scan was noted. Referral to the GP was recommended to arrange the scans.

18. In May 2002, the man's medical record states that a referral form for the scans was completed. No appointment was forthcoming.

19. In October 2003, it was noted that no scans had been performed and that he was not on a vascular surgeon's list for assessment. A GP referral to a vascular surgeon was subsequently arranged.

20. In December 2003, he was seen by a vascular surgeon and his aneurysm had grown to 6.4 cm. There was concern that it could compromise blood flow to the kidneys.

21. On 14 January 2004, the man was very ill and admitted to University Hospital, Durham, under the care of a cardiologist. He returned to Frankland on 27 February 2004. A letter from the cardiologist stated that the man had severe left ventricular dysfunction combined with two different kinds of cardiac arrhythmia. The doctor records this as meaning that the man was potentially at risk of sudden death due to abnormal heart rhythm. He was appropriately treated for heart failure and given medication. His condition was chronic and permanent.

22. On 9 March, the man told healthcare staff that he did not wish to be resuscitated and subsequently refused to attend two outpatient appointments.

23. He did, however, attend the cardiologist's out-patient clinic on 26 October when there was found to be an improvement in his heart condition but no improvement in his left ventricular function. That meant that he remained at high risk. At the same time, he was assessed for surgery on his aortic aneurysm. The cardiologist decided that he would represent a high risk for aneurysm repair.

24. At 3.16 am on 7 November 2004 the man pressed the cell call bell in his cell. Although that action should have alerted the night staff on the wing that he required some kind of assistance, the bell activation was not noticed until 4.03 am. The night patrol officer, an OSG, whilst on his routine patrol of the wing, saw the cell bell external light illuminated next to the cell door.

25. The man was lying on the cell floor, obviously in distress. The OSG returned to the centre office and informed an Officer that the prisoner was lying on the floor in his cell gasping for breath. Both officers went to the cell where they saw him on the floor holding his stomach.

26. Leaving the OSG to observe the man, the Officer returned to the centre office and informed healthcare and the control room of the situation and that he intended to open the cell. At 4.05 am the Officer opened the sealed key packet and both officers entered the cell. They made the man, who was complaining of stomach pains, comfortable with a pillow and blankets and put him into the recovery position.

27. A Principal Officer arrived a couple of minutes later and a Healthcare Officer a few minutes after that. The Healthcare Officer gave the man oxygen and monitored his condition. At 4.15 am the Healthcare Officer requested that an ambulance be called and the paramedics arrived at 4.35 am.

28. HMP Frankland is a high security prison and as such must employ certain procedures when emergency vehicles need to enter and exit the establishment. It is accepted that those protocols cause slight delays, especially at night.

29. The man was placed onto a stretcher and put in the ambulance. The Officer who opened the cell and another officer were briefed regarding the escort duty and an escort chain was attached to the man. The ambulance left Frankland at 4.56 am, arriving at University Hospital five minutes later. In the A & E department the escort chain was removed so that the medical staff could treat the man.

30. An immediate operation on the man was considered by the medical staff but rejected due to his severe ill health. He was then moved to room 6 in ward 14. Once he was comfortable in the bed, the escort chain was reapplied. About 7.40 am the escort duty was handed over to two other officers. At 8.10 am, due to concerns about the man's condition, the escort chain was removed. The man died at 8.22 am.

31. The man’s next of kin, one of his sons, had been told that his father had been taken to hospital and was later informed of his death by the prison Chaplain. He requested that the prison pay for his father’s funeral, which was agreed. One of the man’s daughters was also informed by the prison a short while later.

Clinical review

32. As part of the Ombudsman's investigation, the Northumberland Primary Care Trust undertook a clinical review. Its purpose was to review the medical care and highlight to the investigation team any medical issues relating to the man's time in prison custody. A doctor examined the man's Inmate Medical Record (IMR), other prison records and records at the University Hospital**.**

33. My investigator interviewed members of the healthcare team at Frankland and requested that the doctor make further enquiries at University Hospital in an effort to explain the missed ultrasound appointments. It seems that that there was a breakdown in communication between the Hospital and the Healthcare department at Frankland, both expecting the other to make the appointments but neither doing so.

34. It is the doctor's opinion that the missed ultrasound scans did not contribute to the man's death. With the serious cardiac problems that he had, surgical intervention was not a viable option. Similarly, although there was a delay in staff finding the man, caused by the cell bell fault, his death was inevitable.

Problems with the cell bell

35. The delay in response to the man pressing his cell bell for attention and it being answered was noted by the Governor, and he instructed that an internal discipline investigation be conducted by a governor grade member of staff. The investigation is now complete and the conclusion is that there was an intermittent fault with the cell bell system. My investigator noted during conversations with wing staff that previous faults had been noted by them but not reported as they believed that the electronic system was self reporting.

36. The installing company examined the system and concluded that there was both a hardware and software fault. Parts were ordered but repairs were not completed until the start of February 2005.

37. When my investigator returned to Frankland in January 2005 he found that, although the fault in the cell bell system was known, no contingency plans had been implemented.

Conclusions

38. The man was to be given six monthly ultrasound scans, but none were undertaken between his arrival at Frankland in January 2001 and December 2003. I believe that this was as a result of a breakdown in communication between University Hospital and Frankland. However, I accept that, because in the event surgical intervention was not an option, the delay in conducting a scan did not contribute to the man's death.

39. The fault on the cell bell meant that there was a delay between the man pressing the bell, and help being summoned by the prison. Again I accept that his death was inevitable. But I am concerned that the cell bell fault meant that he suffered some pain and discomfort for longer than was necessary. The lack of a contingency plan after the fault was noted meant that a similar emergency situation as occurred with the man could have gone unnoticed at any time.

40. Before he left Frankland in the ambulance an escort chain was attached to his wrist. It was removed during treatment at the hospital but reapplied once he was in a side room on the ward. The chain was only removed some 12 minutes before the man was pronounced dead.

41. That a sick and elderly man should be taken to hospital secured by a chain is often part of the necessary paraphernalia of security outside the prison walls. I accept that staff used the least oppressive form of restraint.

42. However, no account appears to have been taken of his age or infirmity, with the decision to use the escort chain being taken out of caution rather than necessity. The Governor told my investigator that its use on this occasion could not be justified and that he has taken steps to improve the decision making process in future similar cases. I have included a formal recommendation in support of the Governor's initiative.

Recommendations

43. The Healthcare manager should review systems for monitoring medical out-patient appointments or referrals for specialist investigations, to ensure that the medical treatment required by a prisoner is received in a timely manner.

44. The Governor should introduce a contingency plan to cater for any future break down of the electronic cell bell system.

45. The Governor should remind staff of the need for a balanced risk assessment regarding the use of restraints on seriously ill prisoners leaving the establishment.