INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT UNIVERSITY HOSPITAL, DURHAM, IN NOVEMBER 2005 WHILST IN THE CUSTODY OF HMP FRANKLAND

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

APRIL 2006

This is the report of an investigation into the death of man who died from natural causes at University Hospital, Durham on 2 November 2005, whilst a prisoner at HMP Frankland. He was 51 years old.

The man was serving a sentence of life imprisonment and had been in custody for over 19 years at the time of his death. He suffered a series of seizures in his cell on 9 October, when he was taken to hospital. Sadly, his physical health deteriorated whilst he was in hospital and he passed away in his sleep during the afternoon of 2 November.

This investigation has been undertaken by two of my colleagues. I would like to thank the Governor of HMP Frankland and his staff for their participation in this investigation. I once again appreciate the assistance of the doctor commissioned by Northumberland Primary Care Trust to undertake a review of the man's care. I was pleased to learn that the man's clinical care on the day he suffered the seizures was appropriate and his transfer to hospital timely.

The loss of a loved one is always distressing. I would like to add my condolences to the man's family to those already expressed by my family liaison officer.

I make two recommendations, both of which are directed to Durham and Chester-le-Street Primary Care Trust.

I also draw attention to two examples of good practice. The man who is the subject of this report was a sad and isolated man who had spent most of the previous ten years in segregation units. Despite that, during his final days of life he was treated in a kind and sensitive way by Frankland staff.

Stephen Shaw
Prisons and Probation Ombudsman **APRIL 2006**

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Summary

1. The man was convicted of murder in April 1987 and received a life sentence. After pursuing an unsuccessful appeal against his conviction, he refused to co-operate with the prison authorities. Consequently, he served a significant proportion of the 19 years he spent in custody in segregation units.

2. He was transferred from HMP Long Lartin to HMP Frankland on 19 May 2005. On 22 September, he complained to medical staff that he was experiencing abdominal pain, nausea and vomiting. He refused to be examined by a doctor and the problem was only diagnosed and treated more than a week later.

3. On 9 October, the man suffered a seizure in his cell and was taken by ambulance to University Hospital, Durham. Whilst at the hospital, he refused to accept medication or undergo tests and consequently his health deteriorated. Both prison and hospital staff made concerted efforts to persuade him to change his mind, but he continued to reject treatment. During the morning of 2 November, the man slipped into unconsciousness and he died at 5:40pm.

The investigation process

4. My investigator considered the man's prison records, including his medical records, before formally opening the investigation at HMP Frankland on 14 December 2005. On 15 December, he and his fellow investigator met with the deputy governor, and the chair of the prison's Independent Monitoring Board. Various members of staff were interviewed.

5. Prior to my colleagues arriving at Frankland, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigation team. In the event, nobody came forward.

6. One of my family liaison officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation.

7. An independent clinical review of the healthcare he received whilst in custody was carried out at the direction of the Durham and Chester-le-Street Primary Care Trust.

8. 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.

HMP Frankland

9. HMP Frankland is a maximum-security establishment holding Category A and Category B adult male prisoners. It is part of the high security directorate of the Prison Service.

10. Frankland opened in October 1980 as a temporary prison, staffed by the army. After three months the establishment was closed for modification. It reopened as a fully operational high security prison in April 1983. Two further wings were opened in 1998, bringing the establishment's certified normal accommodation (uncrowded capacity) to 653. Prisoners are held in single cell accommodation in six wings, four of which house vulnerable prisoners. Frankland is one of only six establishments assessed by the Prison Service as being a 'High Performance Prison'.

11. The most recent published inspection report by HM Chief Inspector of Prisons, dated 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. Some concerns were expressed about the nature of the relationships between staff and prisoners in the segregation unit, although it was acknowledged that maintaining a balance between care and control in this environment is particularly difficult. It was also recognised that the problems identified were not restricted to Frankland, and that the criticisms were equally applicable to other institutions in the high security estate.

12. According to the governor in charge of the segregation unit, a more recent inspection, as yet unpublished, has found that the problems described above have been effectively dealt with. In particular, relationships between staff and prisoners are said to be much improved.

13. The Standards and Security Audit carried out by the Prison Service during February and March 2003 gave an overall "good" rating for both categories. Good is defined as an establishment that performs to a high level and there is evidence which gives assurance that risks are being effectively managed.

Key findings

14. The man was arrested for the murder of his best friend during the evening of 24 October 1986. It would appear that an argument took place which resulted in the victim receiving three stab wounds to the chest. He was subsequently found guilty at Nottingham Crown Court and received a sentence of life imprisonment.

15. In the early stages of his imprisonment, the man refused to accept his conviction, maintaining that he was guilty of manslaughter not murder. He pursued an appeal, but this was turned down. Initially, prison staff and other professionals felt that he was pursuing his appeal so rigorously because he could not deal with the prospect of serving life. Over time, this opinion was revised as it became increasingly evident that he could not cope with the fact that he was responsible for killing his friend.

16. In due course, the people working with him became increasingly aware that he believed he deserved to suffer indefinitely for what he had done. In June 1989, he cut his throat with a broken razor blade, leading to a hospital admission. Further episodes of serious self-harm took place in February 1990 and October 1995, the latter resulting in him losing more than three pints of blood and another spell in hospital. During one of these periods in hospital, he successfully managed to remove his handcuffs.

17. In March 1993, the man collapsed and suffered what was apparently a tonic-clonic (or grand mal) seizure whilst a prisoner at HMP Wakefield. After the incident, he disclosed to staff that he had suffered "four or five" other 'fits' since the mid-1970s. The underlying cause of the seizures was never established, although one theory put forward at the time was that they were related to his previous substance misuse. He apparently had no further seizures until 9 October 2005.

18. Having decided that punishment was all he deserved, the man set about acting in ways that would ensure he was denied anything other than the most basic prisoner privileges. He consistently refused to participate in prison activities and refused to work. He would not co-operate with prison regimes, refused to participate in assessment boards or interviews with professionals, and on more than one occasion assaulted prison officers. The nature of his behaviour meant that the Prison Service had no choice but to hold him away from the main prisoner population. From May 1997 until his admission to University Hospital, Durham on 9 October 2005, the man was located exclusively in segregation units. On more than one occasion, he stated that he preferred being segregated from the rest of the prison population. He further increased his sense of isolation by refusing visits, not responding to letters and declining to use the telephone. He also specifically asked his supervising probation officer not to contact any member of his family on his behalf.

19. The man arrived at Frankland from HMP Long Lartin on 19 May 2005 as an authorised 'Seg to Seg' transfer (meaning that he was received at Frankland without undergoing the reception procedures that apply to prisoners on 'normal' location). One of the routines of the segregation unit is that prisoners are seen on a daily basis by medical staff from the Healthcare Department. Upon his arrival, his attitude of deliberate non-compliance continued, as shown by his refusal to attend eight out of the ten 'segregation reviews' that took place and his appearances at adjudication (disciplinary hearings). He also rebuffed concerted efforts made by the psychology team and other staff members to engage him more fully in prison life.

20. On 22 September, the man was seen by medical staff from the Healthcare Department after complaining to segregation unit officers of abdominal discomfort, nausea and vomiting. However, he refused to be examined by a doctor and did so on a further two occasions before 30 September. On 30 September, he consented to an examination and was found to be experiencing tenderness in the abdomen. He was given Cimetidine medication to suppress the secretion of acid in the stomach.

21. On 2 October, the man was forcibly removed from his cell after attempting to assault a prison officer. Whilst detained in a special cell, he complained of abdominal pain unrelated to his forcible removal but refused the medication that was offered. He returned to his usual cell later in the day.

22. At around 9:15am on 9 October, he was seen in the segregation unit by a Registered General Nurse (RGN), as part of the day-to-day 'rounds' conducted by the Healthcare Department. Upon entering the unit, the nurse was informed by segregation staff that the man was ill. He made his way to the cell and saw that the man looked poorly. He asked him how he was feeling and the man responded by saying that he could not see and he felt unwell. Being concerned about the man's condition, the nurse decided that the on-call General Practitioner (GP) needed to be called in order to assess him more fully. As the details of the on-call doctor service are retained in the Healthcare Department, the nurse had to make his way back through the prison from the segregation unit in order to speak to the GP.

23. Having made contact with the on-call GP, the nurse outlined his concerns about the man's well-being. He says that he asked the doctor to come to the prison "straight away", and in his experience they normally did so.

24. At approximately 10:00am, the nurse received a telephone call from a prison officer on the segregation unit who stated that the man looked worse and seemed to be experiencing some sort of 'fit'. The nurse summoned the assistance of one of his colleagues from the Healthcare Department, and together they made their way to the segregation unit, taking an emergency resuscitation pack with them.

25. Upon entering the cell, the nurse noticed that the man was still on his bed but was mumbling incoherently. He used an approved method of pain stimulus to make an assessment of his state of consciousness. This did not elicit a response. Almost immediately, the nurse observed the man experience some sort of physical convulsion which lasted for approximately 40 seconds. As he did not want him to cause himself any damage, he and his colleague set up a 'protective barrier' with their legs so that the man could not kick the wall adjacent to the bed.

26. When the convulsions first started, the nurse immediately asked a member of segregation unit staff to phone for an ambulance. When they subsided, the other member of staff fitted an airway to enable the man to breathe more easily. He became noticeably calmer and the nurses observed him until the paramedics arrived at the cell around 10.15am. The nurses then briefed the ambulance crew and the man was removed from the prison, arriving at University Hospital, Durham at 10.50am. He was seen by a doctor at 10:57am and at 11:10am restraints were applied with the approval of the doctor. Prison officers were stationed at the man's bedside as an escort and would attempt to engage him in conversation right up until his death on 2 November.

27. The man was diagnosed with a kidney infection on 10 October, and on 12 October he was seen by a consultant who stated that he expected him to remain in hospital for "one or two days". However, his condition deteriorated and by 18 October the source of the infection had still not been traced. At this point, his compliance with the medication regime started to wane and on 19 October, against medical advice, he refused to have a 'Venflow' airway installed in his neck. On 20 October, he again refused to have an intravenous line fitted. Meanwhile, his physical health continued to get steadily worse.

28. On 22 October, the man was spoken to by nursing staff at University Hospital and was encouraged to comply fully with medical treatment. Later in the day, a doctor explained to him that he might die if he did not allow the hospital to treat him.

29. Over the next few days, the man accepted medication intermittently but he did not comply fully. On 26 October, he was spoken to again by a doctor who explained the importance of submitting to treatment. However, he continued to only accept medication sporadically and he refused to give blood samples. His condition deteriorated.

30. On 31 October, a doctor explained to him that his condition was now very serious. He was also visited and spoken to by a prison officer on the segregation unit who had a good relationship with him. This course of action was instigated by a senior officer from the segregation unit and was sanctioned by the governor. The express purpose of the prison officer's visit was to try and persuade the man to accept treatment. During the course of their 20 minute conversation, the officer

emphasised to him that his condition was now so grave that he would die if he did not let the doctors treat him. The man indicated that he was aware of the consequences of refusing medical care and then requested that the officer ask him no more questions. The man declined to provide the prison officer with the details of next of kin who could be contacted in the event of his death.

31. At 4:45pm on 31 October, authorisation came from the prison to remove the man's restraints. This is good practice in that it meant that the man could die with a degree of dignity. The decision was made at a relatively late stage because of concerns originating from his previous successful attempt to remove his restraints whilst under prison escort.

32. At 7:10am on 2 November, the man slipped into unconsciousness and at 5:40pm he quietly died. A doctor formally pronounced his death at 6:45pm.

33. Due to his refusal to provide the prison with the details of next of kin, his family was not formally informed of his death by Frankland until 8:00am on 4 November. This was after his supervising probation officer had telephoned them with the news. This course of action had been previously agreed between his supervising probation officer and his line manager after the deputy governor at Frankland had informed them of the man's imminent death. Their decision was based on a desire to respect the man's wishes regarding family contact.

Issues arising from the investigation

Contact between prison healthcare and University Hospital

34. Frankland's Local Instruction on the management of hospital bedwatches (2.20) states that 'healthcare staff are expected to maintain regular contact [with the hospital] to ensure continued outside hospital care is required and [to] consider support plans for the eventual return of the prisoner'. In the case of the man who died, senior officers from the Healthcare Department maintained telephone contact with the local hospital, although I have not been able to ascertain how frequently this happened. Currently, the details of these discussions are not routinely recorded in the clinical records. Such a situation limits the usefulness of obtaining the information in the first place and means that subsequent support plans are based on the personal knowledge of the staff.

    Durham and Chester-le-Street Primary Care Trust should implement a system whereby clinical discussions that take place between Healthcare staff and hospital staff are recorded in the clinical record.

Clinical Records

35. The Clinical Review conducted on behalf of Durham and Chester-le-Street Primary Care Trust comments on the chaotic and disorganised state of the man's clinical records. It states that there is no way of identifying what the key features of his medical history were and concludes that records of this standard are potentially clinically dangerous. I endorse the recommendation made in the Clinical Review that medical record keeping across the prison estate needs to be addressed and improved as a matter of urgency. In particular:

    Clinical staff at Frankland should be reminded of the importance of good record-keeping and of the views expressed in the Clinical Review.

36. The Clinical Review also comments negatively upon the apparent lack of contact between the prison Healthcare Department and the hospital after the man became an in-patient on 9 October. As outlined above, the Healthcare Department did actually maintain telephone contact throughout the duration of the man's stay. However, the fact that the details of these discussions were not recorded in his clinical records undermined the value of obtaining updates on his condition. I therefore reiterate my earlier recommendation to Durham and Chester-le-Street Primary Care Trust concerning the recording of clinical discussions.

Recommendations

To the Primary Care Trust

1. Durham and Chester-le-Street Primary Care Trust should implement a system whereby clinical discussions that take place between Healthcare staff and hospital staff are recorded in the clinical record.

2. Clinical staff at Frankland should be reminded of the importance of good record-keeping and of the views expressed in the Clinical Review.

Good practice

4. Regularly reviewing the need for restraints and eventually removing them altogether when the man's health deteriorated significantly ensured that he died with dignity.

5. The efforts made by the prison officer to persuade the man to accept clinical treatment were another example of good practice. He and the senior officer who instigated this action should be commended by the governor.