Investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Durham

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

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.

This is the report of an investigation into the death of a man who died on 16 July 2008 from natural causes whilst in the custody of HMP Durham. He was discovered lying face down on his bed when his cell was unlocked. It appears that the man had passed away in his sleep. He was a smoker and had a history of epilepsy. The man was 45 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. I am grateful for the assistance he received from staff at HMP Durham and would ask the Governor to pass on those sentiments. A clinical reviewer was identified by County Durham Primary Care Trust to undertake a review of the man's clinical care and I also appreciate his assistance.

The clinical reviewer's clinical review raises a number of learning points that the prison health partnership will need to consider seriously. He has made eight recommendations that I have endorsed. I have made no separate recommendations of my own.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2008**

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SUMMARY

The man was born in 1962. He was 45 years old when he died at HMP Durham on 16 July 2008. The man's death was from natural causes as a consequence of a left ventricular hypertrophy (narrowing of the passageways of blood vessels in the heart resulting in the obstructed passage of blood from the left ventricle into the aorta).

The man had been remanded into custody at Durham in February 2008. He was sentenced to 18 months imprisonment in May 2008 (he had pleaded guilty to assault causing bodily harm and to witness intimidation). During his first reception health screen it was noted that the man had previously been diagnosed with epilepsy and that he was a smoker.

On 7 July, the man was released on a home detention curfew (HDC) licence. The period of HDC licence was to run from 7 July until 26 March 2009 unless the licence was revoked. On 9 July, the man was indeed returned to custody by South Tyneside Magistrates' Court as he had breached his licence conditions. On his return to Durham, the man was allocated a double cell (E1 - 4) to himself on E wing (which is also known as the First Night Centre).

The man was due to attend Newcastle Crown Court on 16 July. When his cell was unlocked at around 6:48am, he was discovered by staff lying face down on his bed. As the officers were unable to rouse him, they requested medical assistance. Healthcare staff arrived on the wing within a minute and checked for vital signs, but they could not find a pulse. When the paramedics arrived at around 7:22am they took over the man's care. They also checked for signs of life but could not find any. The paramedics informed staff that the man had died and resuscitation was not attempted.

The clinical review has identified issues relating to the provision of care for the man. The review highlights areas of practice that could be improved, and makes a total of eight recommendations for service improvement which I endorse. The prison health partnership should consider the findings from this review and develop an action plan to address the learning opportunities.

I have made no recommendations of my own.

THE INVESTIGATION PROCESS

1. The investigation was opened on 18 July 2008 when my investigator issued notices announcing the investigation to both staff and prisoners. The notices included an invitation to anyone who wished to contribute to the investigation to make themselves known to my investigator. In the event no one came forward. My investigator also studied all relevant prison records relating to the man. These included his main prison record and his medical records.

2. My investigator visited Durham on 11 September and discussed aspects of the man's treatment with staff. He interviewed three officers and a member of healthcare staff.

3. The County Durham Primary Care Trust (PCT) commissioned a General Practitioner/Reviewer to carry out a review of the man's clinical care. I am grateful to him for undertaking the review most expeditiously.

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

5. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they wanted explored and addressed. The man's family raised a number of concerns:

   - The family wanted to know why the man was in a double cell by himself considering his condition and the current prison overcrowding situation.
   - The family had asked to speak to one of the other prisoners who had been the man's friend. However, this was refused for safety reasons.
   - The family also wanted to meet the officer who had last seen the man alive. They wanted to know if the officer could tell them about the man's state of mind at that time. When the family visited the prison they were told that the officer was not on duty.
   - The family had also only had very few of the man's clothes returned to them and felt that there should have been more.

   The clinical reviewer and my investigator have explored these points. I hope that this report provides the family with a better understanding of the events leading up to the man's death.

6. I understand that the family were able to visit Durham after the man's death and were able to see his cell. In general, the man's family spoke very positively about the help and support they received from prison staff.

HMP DURHAM

7. Durham is a category B prison that houses adult male convicted and unconvicted prisoners. Opened in 1819, and rebuilt in 1881, it now has a primary role as a local prison serving courts in the North East of England. The prison has an operational capacity of 981. Durham has seven wings; all cells have integral sanitation and in-cell power.

8. Durham's healthcare services provide in-patient facilities. There are two full time doctors in the prison who work on a rota basis, with locum doctors providing out of hours services. During the night there are two nurses on duty. One is located in the healthcare unit and one in the main prison.

9. Since 2004, my office has investigated seven deaths through natural causes at Durham. There was no link between the circumstances surrounding this investigation and the previous deaths.

Her Majesty's Chief Inspector of Prisons

10. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, last inspected HMP Durham in September 2006. The overall finding of the inspection was that Durham was an improving establishment, developing in its role as local and community prison. The healthcare function was found to have good systems and processes. Ms Owers reported that there was a genuine desire to improve health services for prisoners.

Independent Monitoring Board

11. In its latest report (2006-2007), the prison's Independent Monitoring Board (IMB) was concerned that there were no plans to replace the healthcare centre. When my investigator visited Durham, work had commenced on improvements to the healthcare centre.

KEY EVENTS

12. In February 2000, the man had an accident that resulted in a head injury. The man had a craniotomy (surgical incision into the skull) and a procedure was performed on the right frontal lobe of his brain. After his operations, the man was diagnosed with epilepsy and was prescribed Epilim (Sodium Valproate) to help to control his fits and Diazepam (a sedative, muscle relaxant and anti-anxiety medication). He last saw his own doctor on 20 March 2007. After the consultation, the doctor recorded that the man had not taken any medication for over a year and he had experienced several fits.

13. The man attended the Accident and Emergency (A&E) Department of the local hospital on 9 February 2008 after he had a fit. He arrived at HMP Durham two days later. The man was sentenced at Newcastle Crown Court to 18 months imprisonment on 9 May. He had pleaded guilty to assault causing bodily harm and to witness intimidation.

14. During his first screen reception on 11 February, it was noted that the man had previously suffered a head injury, been diagnosed with epilepsy and was a smoker. The prison doctor who saw him after his initial health assessment noted the unusual shape of the man's head. However, the prison doctor did not obtain a history of the craniotomy or further information on the man's compliance with his medication. The man was allowed to keep his medication in possession.

15. A second health screen interview scheduled for 15 February did not take place as the man was not in his cell.

16. On 20 February, a nurse noted that the man had tried to pick up his medication four days early. The nurse informed one of the prison doctors who advised her not to issue any further medication to the man until 24 February. The man was also listed for Durham's epilepsy clinic later on the same day but he did not attend. He had a fit during the night on 23 February but no examination or observation was noted in the man's records as having taken place.

17. The man's cell mate informed staff that he had experienced another fit at 1:30am on 12 March. A nurse noted in the man's medical record that he had slept after the fit, and at 5:30am he had seemed settled. No further clinical checks were carried out that day.

18. The man went to court on 30 April. It was recorded that he had left his medication in his cell and this was retrieved before he left Durham.

19. On 2 May, the man had two fits within 12 hours, each lasting two minutes. He also fell out of his bunk. A prison doctor saw the man and prescribed Zopiclone (this drug is used to treat insomnia and sleep disorders) and Diclofenac (an anti-inflammatory drug). There was no record of the prison doctor carrying out a head examination at this time. The prison doctor recorded that the man was:

> "… alert, orientated with mild swelling over the lateral aspect of the right eyebrow and slightly over the upper lid. Eyes – normal, slight tenderness over the upper back and neck area, no other abnormality."

20. The man's medication was reviewed on 6 May but no changes were made because of his recent fits. The man was also seen by a nurse as he had been suffering with headaches. He was given paracetamol and it was suggested that a referral should be made to the Epilepsy Nurse Specialist.

21. On 5 June, the man attended the epilepsy clinic and a nurse made a referral to the Epilepsy Nurse Specialist. It was noted that his fits had started after his head injury (in 2000) and that he had experienced a fit the previous week. There was no record of this fit in the man's medical records.

22. In her letter to the Head of Primary Care Services at Durham the Epilepsy Nurse Specialist confirmed that she had seen the man at the epilepsy clinic on 3 July. She wrote:

> "… [the man] advises me he has had 3 seizures in the last 5 months. …[the man] takes 200mg Sodium Valproate [Epilim] 3 times a day and I have advised him that he may benefit from increasing this to 400mg twice daily and would appreciate it if you could arrange for this."

23. On 7 July, the man was released from Durham on a home detention curfew (HDC) licence. The objective of HDC is to assist offenders to manage their return into the community. They are subject to a curfew and are fitted with an electronic tag that monitors their movements. They are also supervised by a Probation Officer during the period they are on licence. The period of the man's HDC licence was from 7 July until 26 March 2009 unless the licence was revoked.

24. While on HDC the man was liable to be recalled to prison if he breached the conditions of this licence. These were if:

- He was absent from his curfew address
- He committed violence against or threatened the supplier of the monitoring equipment or any of his staff with violence
- He damaged or tampered with the monitoring equipment
- He withdrew his consent to the monitoring arrangements
- His whereabouts could not be electronically monitored at his curfew address
- It was necessary to recall him to prison in order to protect the public from serious harm
- He committed an offence or breached any other requirement of his probation supervision.

25. On 9 July 2008, after he breached his licence conditions by visiting his victim, the man was returned to custody by South Tyneside Magistrates' Court. On his return to Durham, he was allocated a double cell (E1 – 4) on E wing (also known as the First Night Centre) to himself. The man was allocated the double

cell because there was spare capacity at the prison and because he was a smoker.

26. At the man's health screen interview on 9 July, one of the prison doctors noted that the man had been previously prescribed Diazepam and Tramadol (an analgesic used for treating pain). The prison doctor re-prescribed Epilim (200mgs three times per day) and paracetamol. A second health screen scheduled for 15 July did not take place as the man was not in his cell.

27. On 15 July from 7:30am until 7:30pm, Officers A and B were on duty on E wing. At around 7:20pm, Officer B carried out a count of the prisoners on the wing (this is known as a roll check). The man was located in one of the 16 cells on the ground floor (also known as the "1s landing") of E wing. In his statement to the Governor, Officer B did not recall speaking to the man when he carried out his count.

28. At 8:00pm, an Operational Support Grade (OSG) and Officer C commenced their night duty. At approximately 8:30pm, the OSG printed off a list of prisoner movements for the following day. He then informed the man (in cell E1 - 4) that he was on the list as he was going to court the following day. According to the OSG's statement to the Governor, the man gave him a verbal acknowledgement and then got back into bed. The OSG said that the man gave no indication of feeling unwell.

29. At approximately 5:30am, the OSG carried out a roll check on the first (2s landing) and second (3s landing) floors of E wing. Officer C did the same task on the ground floor. In his statement to the Governor, Officer C said that when he carried out the roll check he did not attempt to get a response from the man. Officer C had intended to obtain a response prior to 6:15am as the man was on the morning discharge list. This did not happen as Officer A returned to duty, and relieved Officer C and they conducted a handover of duties. Officer C confirmed that no issues had arisen during the night and he then left the wing. Officer A then carried out another roll check. When he checked the man's cell he noted that the man was lying face down on his bed.

30. When interviewed as part of this investigation, Officer C said:

> "At around about 5:50am I believe I rang the Night Orderly Officer and he would have been stationed at the gate at the time to report my numbers, the wing numbers. And then at around about five or 10 minutes later I was actually relieved by the day staff, the early duty staff, around about the 6 o'clock mark, which was prior to my intention to go back and, of waking him up … there was nothing during the course of the night to make me, to raise any concerns of anybody's safety or welfare."

31. At around 6:40am, Officer F arrived on the wing to unlock prisoners who were required to report to court that day and to take them to Reception. After spending about five minutes talking to Officer A in the wing office, Officer F

started to unlock the cells of the prisoners who he was going to take to Reception. When interviewed as part of this investigation, Officer F said:

> "I'd opened one cell. I started on the 1s [also known as the ground floor of the wing], obviously it was the 1s, and that cell was, … [the man's] cell was on the 1s. So I think it was 1-2, I wouldn't be certain on that, and then I moved on and … [the man's] was the second one. So obviously you're making noises as you go in because you're trying to rouse somebody. So opened the door, hollered 'time to get up for court' and no response. Obviously then I make a noise, I bang the door hopefully for a response. Normally somebody says, 'Morning, it's time get up, yes.' No response again. He was just laid on his bunk face down. There was about four inches of his shoulders down from the … sheets … So like all you could see was his head and about, as I say, six inches or four inches of his shoulders … I was verbal rousing then at that time and there was no response. I was then started to feel obviously there's no movement whatsoever; I mean you normally get a stir or something like that. So that was when I put my hand on his shoulder, obviously to feel him, but my hand was freezing cold and he felt warmer than my hand, that's why I wasn't too concerned, obviously like for the obviously split seconds or so. So I felt him and he was, as I say, he was warmer than my hand but it was a cold morning and my hands were cold. So obviously I then got, obviously still no response. Then I got hold of his shoulders, I was going to give him a shake and then I obviously realised he was rigid … All I did was obviously got hold of him, obviously like that and then obviously realised straightaway and that's when I, well what I did I've opened my cuff and felt him with part of my arm that was warm and that's when he felt cold to me. Obviously then I knew it was, you know it was my first thing that he was dead."

32. As Officer F suspected that the man had passed away, he went to the wing office and asked Officer A for assistance. Officer F asked Officer A to try and get a response from the man. After Officer A left the wing office, Officer F telephoned Durham's control room and asked them to put out a "Code Black" (which means that there is an unconscious prisoner and medical assistance is required) call over the prison communication network.

33. In his statement to the Governor, Officer A said when he entered the man's cell he was lying face down on his bed. He noticed that the skin on the man's back was mottled and very pale. Officer A touched the left side of the man's neck in an attempt to locate a pulse. The man's skin was cold to the touch and Officer A presumed that he was dead.

34. The Night Orderly Officer (radio call sign Oscar One) was in charge of the security of Durham during the early hours of 16 July. The Night Orderly Officer was in Reception when he heard the call for assistance over his radio and he left immediately to go to E wing. He was accompanied by the Night Officer Assistant (radio call sign Oscar 3).

35. The two night duty nurses, Nurse G (radio call sign Hotel 1) and Nurse H (radio call sign Hotel 2) from the prison's Healthcare, attended very quickly after they heard the call for assistance over the prison radio. They were joined soon after by the Night Orderly Officer. The control room called for an ambulance at 6:57am. As the healthcare staff could not find any signs of life they left the man in the same position and left the cell.

36. When interviewed as part of this investigation, Nurse G said:

> "I think it might have been about 6:15am or 6:30am. I went off up to Reception because obviously you go up there to dispatch the west coast. And if any inmates require medication or Methadone or anything like that, that's administered up there prior to them leaving the prison. When I got there and gone about my duties I got the call over the radio network for a Code Black, which Code Black is unconscious, basically unconscious inmate. So I dropped everything and made my way down to E wing as fast as I could. And when I got there I was directed to the cell that … [the man] was in … When I got there Hotel 2, who was … [Nurse H], had arrived as well at the same time. We checked obviously, we checked for signs of life and upon checking it was evident that there were no signs of life unfortunately. Because, from recollection … [the man's] body was cold, blue, we couldn't get a pulse, there was no pulse or anything like that. And obviously rigor mortis had appeared to set in. So both myself and ... [Nurse H] on that evidence alone, because there were no signs of life, head down into the pillow, we tried to turn him, unfortunately we couldn't turn him. But on that basis we did, we thought well there was no point in trying to resuscitate. We made the decision to leave him as he was for dignity and also the fact we didn't know what caused the death. So we didn't really want to disturb any evidence or any evidence there could have been."

37. Officer A remained outside and maintained a record of all visitors to the cell. The Duty Governor arrived on the wing at 6:57am and took charge. The prisoners who were due to report to Reception were taken off the wing at 7:04am.

38. Paramedics arrived on the wing around 7:20am. The paramedics were joined by the Head of Primary Care Services at Durham and they all entered the man's cell. The paramedics checked for signs of life. The paramedics informed staff that the man was dead and resuscitation was not attempted. Screens were placed around the man's cell door and the cell was locked.

39. The prisoners on E wing were told about the man's death and were also asked whether they required anything or wanted to speak to a Listener. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.) The officers who had found the man and the healthcare staff were offered support from the prison's care team.

40. A Senior Officer (SO) was appointed as Durham's Family Liaison Officer. She contacted the family via telephone during the afternoon of 16 July. This was because the family were on holiday abroad at the time. The SO later met with family during the following week (on 23 July) after they returned from holiday. The family visited Durham on 31 July and saw the man's cell. Someone from the prison chaplaincy and the SO escorted them during their visit. The SO maintained contact with the family and assisted with the funeral arrangements. Durham also offered financial assistance with the costs of the funeral.

41. The post mortem report records the man's death as being due to natural causes, as a consequence of a left ventricular hypertrophy (narrowing of the passageways of blood vessels in the heart resulting in the obstructed passage of blood from the left ventricle into the aorta).

ISSUES CONSIDERED

Clinical care

42. A review of the man's medical care was undertaken by a clinical reviewer on behalf of County Durham Primary Care Trust. The review found that the man suffered from epilepsy, a significant chronic long-term disease. From the medical records, it was clear that the man was seen regularly by healthcare staff.

43. The reviewer had a number of concerns about the care provided to the man. He noted that, during the first health screening process (on 11 February 2008), the prison doctor did not take a past history of the man's head injury or compliance with his medication. There was also no explanation for the "unusual shape of head" comment recorded by the prison doctor on the medical record. The reviewer has recommended that a more detailed past medical history should be recorded.

    A more detailed past medical history should be recorded, especially for prisoners with long term conditions and, if necessary, information should be requested from primary care.

44. Second health screen interviews were not carried out when the man was received into Durham on 11 February and 9 July. It was recorded that on both occasions that the man was not in his cell when the interview was due to take place. The reviewer recommends that when this situation arises it should be followed up and a record made of the action taken.

    Prisoners who do not attend for second health screen interview should be followed up and a record made of the action taken.

45. The reviewer noted that, when the man's previous medical records were received by Durham, they were not brought to the attention of doctors or recorded in the prison medical record. Neither the reviewer nor my investigator could find any evidence that any clinician had reviewed the man's General Practitioner's (GP's) records or included the summary of the past medical history onto the prison's medical computer record. There was also no action taken to confirm the doses of medication the man was taken when he arrived at Durham. The reviewer has recommended that action be taken to address these two issues.

    When General Practitioner's (GP's) medical records are received they should be seen by the Lead Clinician as soon as practicable and, where appropriate, important past medical history should be included in the prison medical records. This would enable all clinicians dealing with medical problems to have a full medical history available at all consultations.

If doses of medication for prisoners with long term conditions are not available, clinicians should urgently request this information from primary care with the consent of the prisoner.

46. The reviewer noted that the man was not assessed by a clinician after his fits on 23 February, 12 March and in early June. There was also no record of a head examination after the man had two fits on 2 May and fell out of his bed. The reviewer has recommended that, following a fit, a prisoner should be examined by a doctor or specialist nurse. This is to ensure that no injuries had been sustained and to review medication.

Prisoners with a history of epilepsy should be examined by a doctor/specialist nurse as soon as practicable to review medication and to ensure that no injuries have been sustained following a fit. Investigations should be carried out if appropriate.

47. The man was refused medication on 20 February as he had attended four days early to collect it. He had a fit on 23 February which the reviewer concluded may have been related to his medication not being prescribed for three days. The reviewer noted that compliance with taking medication was not mentioned by any clinician and no checks were carried out. The dose of Epilim (the man's epilepsy medication) was not mentioned in the man's GP's records received by Durham on 12 March. There were also no enquiries made by healthcare staff regarding the actual dose the man was being prescribed.

48. Neither the reviewer nor my investigator could find any evidence that the dose of Epilim was changed after the man was seen by the Epilepsy Nurse Specialist on 3 July. The reviewer has noted that when a new prescription was issued on 9 July it was for the previous dosage (200mgs three times per day).

49. The reviewer has recommended that the Epilepsy Nurse Specialist should review prisoners whose epilepsy is not well controlled, and blood tests should be carried out to check compliance. The reviewer says that alterations to dosages of medication should be recorded and prescriptions re-issued after any changes. The reviewer also recommends that prisoners with long term conditions should have a review date recorded in their medical records.

Prisoners with epilepsy which is not well controlled should be reviewed regularly by the Epilepsy Nurse Specialist, compliance with medication should be checked and, if necessary, blood tests should be carried out to check compliance and ensure that the blood levels are within the appropriate ranges.

Any alteration to the dose of medication recommended by a clinician or by the Epilepsy Nurse Specialist should be recorded and prescriptions should be re-issued to comply with the new recommended dose.

Prisoners with long term medical conditions should have a review date recorded in their medical records.

Concerns raised by the family

50. The man's family raised a number of concerns that my investigator discussed with HMP Durham. The family wanted to know why the man was in a single cell considering his condition and the current prison overcrowding situation. The Diversity and Safer Custody Manager at Durham confirmed that the man was allocated a double cell to himself. The Diversity and Safer Custody Manager wrote in response to the concerns raised by the family:

> "This was because there were spaces available in the jail that night and as he was a smoker it was felt that it would be better to leave him on his own rather than double him up, possibly with a non-smoker, simply to create a space that was not needed at that time. His medical records did note that he was epileptic but there was no recommendation that he should be located in shared accommodation. The CSRA [cell sharing risk assessment] process had assessed … [the man] as presenting a low risk to other prisoners. Therefore … [the man] could be located in either a single or double cell depending on availability and to some extent, his preference."

51. My investigator checked the CSRA and confirmed that this was properly conducted. There was no recommendation made by healthcare staff during the first health screening process that the man should not be left in a cell by himself. The post mortem report also stated that the man's death was not caused by his epilepsy.

52. The family had asked to speak to one of the other prisoners who had been the man's friend. However, when they visited Durham this request was refused for safety reasons. The Diversity and Safer Custody Manager confirmed that the family did ask to speak to a prisoner who was the man's "friend" but they did not give a specific name as to who this might have been. The Diversity and Safer Custody Manager wrote:

> "I discussed this request prior to the visit with Gov [Governor] … and for several reasons this did not happen. 1. The visit was over lunchtime which was during a patrol state where all prisoners were locked in their cells. 2. … [the man] had only been on E wing a couple of days and as it was the first night centre the majority of prisoners would have been moved around the establishment or to other jails since he had died. 3. As no specific name of a prisoner was given … as to who he may have been friends with and although generally prisoners at the time found him a friendly guy and were upset as to his death it was felt that no-one would be able to talk … with any genuine feelings."

53. I understand the wider considerations referred to by the Diversity and Safer Custody Manager and that Durham did not know for sure who the prisoner was. I therefore offer no criticism of their actions. However, I would hope that any

prison would try to accommodate the wishes of the family as much as possible if these circumstances were to recur.

54. The family also wanted to meet the officer who had last seen the man alive. They wanted to know if the officer could tell them about the man's state of mind at that time. The Diversity and Safer Custody Manager confirmed that he told the family that the officer was not on duty when they visited Durham. The Diversity and Safer Custody Manager did ask Officer B if he would speak to the family if they came back. However, Officer B did not wish to do this (principally because the only reason he was the last officer to see the man alive was that he did the head count on the wing the night before). Officer B felt he would not be able to contribute anything as he did not recall speaking to the man. In his statement to the Governor, the OSG said that at around 8:30pm on 15 July he told the man that he was going to court the following day. The man acknowledged this and then got back into bed. As previously mentioned, the OSG said that the man gave no indication of feeling unwell.

55. The family had also said they had received very few of the man's clothes, other than a cap, an overall and some underwear, and they felt that there should have been more. The Diversity and Safer Custody Manager confirmed that all of the property from the man's cell was returned to the family. The clothing he was wearing at the time of his death was returned to the family by the undertaker. The Diversity and Safer Custody Manager double-checked and confirmed that the prison did not hold any other property relating to the man. The Diversity and Safer Custody Manager said that he had explained to the family that the man had been released on HDC and then returned to custody a few days later. He therefore came back into prison with very little property and with no time to get any more sent in.

56. In general, I am pleased to report that the family spoke positively about the family liaison officers at Durham and said that they had been very supportive. The family also said that they visited the man's cell and found some peace from doing this.

CONCLUSION

57. The man was released from custody on 7 July 2008 on HDC but returned to HMP Durham on 9 July having breached the terms of his licence. He died of natural causes seven days later.

58. I commend Durham for the support they gave to the man's family after his death. It has been both pleasing and encouraging to share the positive comments of a bereaved family about how they were treated after the death of their loved one.

59. Although the man's care was equitable to that he would have received in the wider community, the findings of the clinical review and my own investigation highlight that improvements to medical practices at Durham still need to be made. The concerns raised by the clinical review mostly relate to the care of prisoners with epilepsy but others are applicable to the general prison population. I endorse the recommendations from the clinical review. They will need to be addressed by the County Durham Primary Care Trust in partnership with the Governor of Durham.

RECOMMENDATIONS

1. A more detailed past medical history should be recorded, especially for prisoners with long term conditions and, if necessary, information should be requested from primary care.

   Partially accepted - The prison regime and arrival time of new prisoners does not always allow for in depth consultations. The aim of the first reception screen is 'to keep the prisoner safe for the first 24 hours in prison'. Clinicians and healthcare workers should be reminded to make a professional judgement on first reception screen as to what depth of follow up is required e.g. an appointment the next day. Reminder to be cascaded to medical staff. Reminder to be cascaded to nursing and healthcare staff. System already in place for prison General Practitioner to request administration department to contact General Practitioner practices or relevant other for information

2. Prisoners who do not attend for second health screen interview should be followed up and a record made of the action taken.

   Accepted - A reminder should be cascaded to healthcare workers who are detailed secondary screening duties that an entry should be made on EMIS as to why the prisoner did not attend and consideration should be given to whether or not that decision was made by the prisoner with informed consent. Healthcare workers should take into consideration clinical indications when deciding what follow up is required and this should also be documented. Reminder to be cascaded to nursing and healthcare staff.

3. When General Practitioner's (GP's) medical records are received they should be seen by the Lead Clinician as soon as practicable and, where appropriate, important past medical history should be included in the prison medical records. This would enable all clinicians dealing with medical problems to have a full medical history available at all consultations.

   Partially accepted - It is current practice that information from GP's is scanned onto EMIS. Consideration to be given by the Lead Clinician and Administration manager as to resources needed to review & summarise all received GP medical records. Once resource need has been identified consideration should be given to requesting extra funding for GP and administration time.

4. If doses of medication for prisoners with long term conditions are not available, clinicians should urgently request this information from primary care with the consent of the prisoner.

   Partially accepted - Current practice for prison GP's to request administration department to fax GP's as soon as practical – the morning following first reception. Clinicians would prescribe on first reception screen for prisoners presenting with reliable self explained history of long term conditions, confirming via GP the following morning. Where family present at the prison gate or at visits with unusual or vital medication (for a new reception prisoner)

which is verifiable e.g. HIV medication; insulin - correctly packaged & named/labelled, healthcare would liaise with the family to utilise that medication in cases of urgent need/outside pharmacy hours.

5. Any alteration to the dose of medication recommended by a clinician or by the Epilepsy Nurse Specialist should be recorded and prescriptions should be re-issued to comply with the new recommended dose.

   Accepted - Protocol to be drafted to ensure this process is followed. Where specialist nurses are non-medical prescribers (NMP), consideration should be given to whether or not they should instigate the prescription process. There may be difficulties with cross Primary Care Trust (PCT) working and prescribing policies, these issues should also be addressed. Where visiting NMP's are allowed to prescribe for prisoners a record of their signature should be kept within the pharmacy.

6. Prisoners with epilepsy which is not well controlled should be reviewed regularly by the Epilepsy Nurse Specialist, compliance with medication should be checked and, if necessary, blood tests should be carried out to check compliance and ensure that the blood levels are within the appropriate ranges.

   Partially accepted - There are well established links with the Specialist Nurse. Reminder to be cascaded to nursing and healthcare staff regarding the availability of visiting specialist nurses.

7. Prisoners with a history of epilepsy should be examined by a doctor/specialist nurse as soon as practicable to review medication and to ensure that no injuries have been sustained following a fit. Investigations should be carried out if appropriate.

   Partially accepted - A qualified nurse is assigned the emergency first response radio on a 24 hour basis and can be summoned via radio to any prisoner who has had a seizure or other emergency. The prisoner is examined at this time and referred on as appropriate. Any injuries sustained by a prisoner are recorded on F213 form and an entry should be made on EMIS, referrals and investigations are made on individual clinical needs. A reminder to be cascaded to nursing and healthcare staff.

8. Prisoners with long term medical conditions should have a review date recorded in their medical records.

   Accepted - Reminder to be cascaded to medical staff. Reminder to be cascaded to nursing and healthcare staff and visiting specialist nurses.