Investigation into the circumstances surrounding the death of a man in September 2008 at a local hospital whilst released on bail from HMP Durham

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report of an investigation into the circumstances surrounding the death of a prisoner who had been released on bail from HMP Durham. I investigated the circumstances of the man's death under my discretionary powers.

The man died in September 2008 at a local hospital, where he had been an inpatient for nearly three weeks. He was 68 years old. He had been in custody previously, including three separate occasions in the course of 2008. I offer my sincere sympathy and condolences to all those affected by his passing.

The investigation was carried out by my investigator. An independent review of the man's medical care was carried out by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of HMP Durham for their full and ready cooperation during the course of the investigation. I am particularly grateful to the liaison officers for their assistance to my investigators.

I make two recommendations, one of which repeats that made in a previous investigation at Durham. I also highlight three examples of good practice.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

A man was remanded to HMP Durham in August 2008. He had been in prison previously, including three separate occasions in 2008. The man was initially located on the first night induction centre where he was assessed by prison and healthcare staff. He had a long history of alcohol misuse but showed no symptoms of alcohol withdrawal. However, his health was generally poor, and he had trouble eating and had poor mobility.

The man remained on the first night induction centre for a week before moving to C wing on 14 August. On 21 August, the man was moved to E wing because C wing staff were concerned about his poor mobility and thought he would find it easier to manage if located on the ground floor landing of E wing.

The following day (22 August), the man was seen by nursing staff who were worried about his mental and physical condition and his inability to look after himself properly. He was admitted to the inpatients unit where he could be helped to eat, drink, wash and dress, with all of which he struggled.

The man's physical and mental condition continued to deteriorate, and on 27 August he was admitted to the local hospital. The prison's healthcare team and the hospital team agreed to keep the man in hospital for further assessments and medical care.

On 28 August, the Security Governor authorised the removal of the man's restraints because of his poor condition. The Security Governor instructed staff to "use common sense" in their approach to restraining the man. He remained in hospital.

On 9 September, the County Court remanded the man in custody again until 30 September, pending a medical report. The report would address the question of his fitness to attend court for sentencing. The same day the Consultant Respiratory and General Physician at the local hospital wrote to the County Court and advised that the man was not fit to attend.

Two days later, on 11 September, the court granted the man bail to "reside in accommodation as directed by the local Primary Care Trust". The man remained in hospital but on bail and without prison officers present.

In the early hours of 15 September 2008, the man died on ward 6 at the local hospital. The clinical team had taken the decision not to attempt resuscitation and the man died peacefully. The Consultant Respiratory and General Physician said the man died from multi-organ failure due to sepsis and chronic obstructive pulmonary disease. (Chronic obstructive pulmonary disease is a disease of the lungs in which the airways become narrowed, limiting the flow of air to and from the lungs and causing shortness of breath.) Post mortem examination was not requested by the Consultant Respiratory and General Physician. The Coroner was informed of the man's death but decided not to make any enquiries.

The man was aged 68 and in very poor health. He had misused alcohol over a number of years, which sadly contributed to his death. Prison staff knew him to be a quiet man who kept his own company but had a dry sense of humour. My

investigator found that he had received impressive and humane care from a number of prison staff in his last period of custody. This had provided him with some comfort and dignity as he neared the end of his life.

THE INVESTIGATION PROCESS

1. The investigation was opened on 23 September 2008 when my investigator, issued notices announcing the investigation to the staff and prisoners of HMP Durham. The notices included an invitation to those who wished to contribute to the investigation to make themselves known. No prisoners came forward but a senior prison officer who had cared for the man asked to speak to my investigator.

2. My investigator made a preliminary visit to the prison on 3 October. He met the governing Governor, the chair of the local branch of the Prison Officers' Association, and the Safer Custody Officers who had been deployed to assist my investigator as his liaison officers. Unfortunately, it was not possible to meet the chair of the Independent Monitoring Board (IMB) who left a note explaining that the IMB at Durham had not been involved with the man and had not received any applications from him. (The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in custody within its prison.)

3. My investigator made a tour of the prison to see where the man had been located and met the healthcare team and wing staff. My investigator spoke with a number of staff, which gave him the opportunity to learn about the man as an individual, about aspects of his care and custody, and to see first hand the custodial and care environment. He talked to the nurses about how nursing care was organised in the inpatients unit in relation to the man.

4. My investigator was given access to the man's prison and clinical records and reviewed these by constructing a chronology of significant events. He reviewed all relevant prison and clinical documents available, which included the inmate locations log, EMIS (the information technology system that healthcare staff use to record clinical information about prisoners), first night induction and first reception health screening assessments, the cell sharing risk assessment, clinical assessments and clinical records, escort and bedwatch risk assessments, bedwatch log reports, court orders, and correspondence between professionals about the man's care.

5. My investigator returned to Durham on 12 and 13 November and interviewed a number of prison staff who were involved in caring for the man. He interviewed Senior Officer (SO), Principal Officer (PO), Security Governor, Clinical Director, a prison doctor, a Mental Health Lead, two prison officers and 2 prison nurses.

6. The local Primary Care Trust commissioned an independent medical practitioner to carry out a review of the man's medical care. I am grateful to the clinical reviewer for carrying out the review expeditiously.

7. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to discuss the case with the responsible

coroner's officer. A post mortem was not requested by the man's Consultant Respiratory and General Physician at the local hospital, and the coroner's officer told my investigator that the Coroner would not be investigating this case.

8. One of my Family Liaison Officers contacted the man's sister on 20 October 2008. This gave the man's family the opportunity to discuss the purpose of the investigation and to raise any concerns or questions. The man's sister raised the following issues that she wanted the investigation to address:

- The family wanted to know why they had not been notified earlier that the man was ill and in hospital.

- She could not understand how the man had become ill so quickly, particularly as she had seen him just a few weeks previously and, although somewhat confused, he had appeared to be in good health.

- She confirmed that the few belongings the man possessed had been returned, but she was surprised to see only a bus pass and a photo in his wallet. The man's sister wondered where his pension book and bank cards were.

HMP DURHAM

9. Durham is a local prison which serves the courts and areas of Tyneside and Cumbria and houses sentenced, convicted and remand male prisoners over 21 years old. Built in the early 19th century, it has been undergoing a major refurbishment programme during the last ten years. The prison has an operational capacity of 981 prisoners and has seven wings, plus healthcare and segregation. All cells have integral sanitation and in-cell electricity.

10. The local Primary Care Trust commissions and provides primary care health services and Tees, Esk and Wear Valley NHS Trust provides specialist mental health services. There is 24 hour healthcare provision, which includes a clinical director and a general practitioner, supported by a primary care nursing team. Inpatient facilities in the prison are located on E wing, although when the man was there the inpatients unit had been temporarily relocated to B1 wing because of re-wiring work in the Healthcare Centre.

11. Since 2004, my office has investigated eight deaths due to natural causes at Durham. There was no link between the circumstances surrounding this investigation and the previous deaths.

12. Her Majesty's Chief Inspector of Prisons last inspected Durham in September 2006. The inspection found that the new management team was "driving forward some significant and much needed improvements," that "relationships between staff and prisoners were good," and that the prison was an "improving establishment".

13. The Independent Monitoring Board's report for 2006/07 said that healthcare staff provided "high quality healthcare" but the Board were concerned at the "continued failure of the Prison Service to invest in a new Healthcare Centre for HMP Durham". The report's executive summary said that, "HMP Durham operates under a range of severe constraints. These relate particularly to the fact that the predominantly Victorian buildings are tightly confined within the city centre site which provides little scope for improvement" When my investigator visited Durham the re-wiring work had been completed the previous weekend, so staff and prisoners had been able to return from B wing to the Healthcare Centre.

KEY EVENTS

14. On 6 August 2008, the local County Court remanded the man into custody because he had breached a court order from 7 July prohibiting him from entering a specified address and the area surrounding that address. The man was taken into the custody of Durham Constabulary. Later that evening he was examined by a police doctor who found that he had a "significant alcohol history but no evidence of withdrawal, no treatment required".

15. The next day, on 7 August, the man was received at HMP Durham and initially located on E wing, which is the first night, induction and initial assessment unit. He went through the usual reception process and was seen by first night officers and reception nurses who carried out first night induction and initial assessment, cell sharing risk assessment, health screen assessment and housing assessment. The man told reception staff that his mother was his next of kin but he had not seen her for some time.

16. My investigator found that the first reception health screen documents had been only partially completed. In interview, the nurses who undertake reception duties explained the health screening process. The registered nurse interviews each new prisoner and partially completes the first reception health screen document, whilst a healthcare assistant inputs more detailed clinical information into the clinical IT system (EMIS). This was the case when the first reception health screen was completed for the man.

17. The man had a long history of alcohol misuse and dependence but did not show any signs or symptoms of alcohol withdrawal when received into prison. His past medical history was not identified at the first reception health screen at any of the man's three admissions into Durham during 2008 (on 5 June, 25 July or 7 August). The clinical IT system (EMIS) stores prisoners' medical histories and clinical information from previous periods in custody, but the nurses did not search his electronic clinical record to source relevant information about the man's past medical history and particularly his history of alcohol misuse.

18. The health assessment identified that "due to age has limited mobility", but no specific healthcare issues or alcohol problems were identified at this point by either the first night induction staff or healthcare staff. When my investigator interviewed medical staff, they confirmed there were no signs of alcohol withdrawal or related problems. The clinical reviewer, has found that, "his alcohol problem was not clear at his reception on 7 August. He showed no signs of alcohol withdrawal thereafter and the problem only came to light when the GP records became available – too late for any action by the prison team."

19. On 7 August, the reception nurses completed the health screen assessment documents. They also inputted the same information and additional clinical information into EMIS (as described in paragraph 19 above). The clinical record documents that the man had trouble eating and drinking, had poor mobility and a history of alcohol misuse.

20. The man remained on E wing for a week before moving to C wing on 14 August. A week later, on 21 August, the man moved to E wing because C wing staff were concerned about his poor mobility. They thought that he would find it easier to manage if he was located on the ground floor landing on E wing. The man's health and general condition quickly deteriorated, and he was seen by the nurses and referred to the Clinical Director and the prison doctor for further examination.

21. On 22 August, the man was seen by a Staff Nurse who found that he was "disorientated in time, place and person and was living in squalor with non-existent self-care" in his cell. Food left uneaten from the previous day was found in the cell. The Staff Nurse arranged for the man to transfer immediately to the inpatients unit for observations and care. He was admitted to the inpatients unit on B1 wing, which was temporarily being used for inpatient beds because the Healthcare Centre was being re-wired at the time. Nursing staff helped him to eat, drink, wash and dress, as he struggled to do this for himself.

22. The man was due to appear at the local County Court on 26 August but, after the Staff Nurse saw the man in reception, she wrote to the court to say he was unfit to attend. He was returned to B1. The court adjourned sentencing and he was remanded in custody until the next hearing, scheduled for 9 September.

23. The man's physical and mental condition continued to deteriorate and, on 27 August, he was admitted to the local hospital. The prison's healthcare team and the hospital team liaised and agreed that he should remain in hospital for further assessments and medical care.

24. The Clinical Director wrote to the man's hospital doctor on 27 August, saying that the prison medical team considered the man "might be at the start of a dementia; he is confused, disorientated and incontinent of urine and faeces". The Clinical Director had by this time received medical history summaries from the man's GP in the community. The clinical reviewer has found that, "there was some difficulty in retrieving these records, as he had not been registered with a GP at all for one year. They did not become available to the clinical team until after his admission to hospital."

25. The Clinical Director wrote a second letter on 27 August outlining the relevant clinical information that he had just received from the GP. The information from the GP was that the man suffered from:

> "chronic obstructive pulmonary disease, but did not appear to have been on recent treatment, essential hypertension, his blood pressure noted to be of the order of 136/89 and no medication, past history of heavy alcohol usage although he did appear latterly (2006 onwards) to cut down on this; at one time was noted he was drinking 122 units per week, in November 2003 his haemoglobin was noted to be 9.9; he appears to have

been treated with ferrous sulphate but there does not appear to have been any investigation of this"

26. This is medical information which makes reference to the man's blood pressure, his red blood cell count, and the medication he was given to help his medical problems arising from heavy alcohol use.

27. The prison's Security Governor authorised the removal of restraints on 28 August because of the man's poor condition. Two officers continued to provide an escort for the man and also assisted with his personal care, such as at mealtimes. The Security Governor instructed staff to "use common sense" in their approach to restraining him. An entry in the bedwatch log for the same day recorded that the man had "lashed out" when female nurses attended him.

28. The man's condition remained poor over the following days but restraints were not re-applied by prison staff. On 4 September the Principal Officer undertook a routine "management check", as is required when a prisoner is on a hospital bedwatch. The Principal Officer wrote to the Security Governor to report that the man was:

> "lying on a pressure relieving bed, was doubly incontinent; two nurses were attending to him; could not sit up in bed; appeared very frail; had lost weight, around seven stone; skin showing signs of pressure sores around the ankles and elbows. Staff reported that the man had been asleep for most of the day; not able to communicate more than an occasional few words which were often inappropriate. He was in a confused state but could respond to simple commands; deteriorating health. Not likely to be fit for court proceedings or adjudication for foreseeable future; is not mobile; is not presenting an immediate risk to staff, patients or the public in the current nursing environment; not currently able to contact any victimised parties or those subject to restraining order."

29. The Principal Officer recommended to the Security Governor that, "bail may be considered as appropriate considering the man's current physical and mental state and his restricted access to the victim of his offences. A multidisciplinary case review needed to consider the possibility of long-term elderly mentally ill care."

30. On 5 September, the local County Court decided that the hearing on 9 September would be cancelled and that the man's solicitor should file a report from a doctor about his fitness to attend court for sentencing.

31. The Security Governor also wrote on 5 September to the Governor and requested permission to pursue an application for bail, "as he [the man] is extremely unwell at present … As he is a remand prisoner, I have no option other than to man the hospital with two staff 24 hours per day … His condition

would not allow him to get off his bed without assistance." The Security Governor could not obtain either probation or legal advice at that time.

32. Over the course of the next few days the nurses and prison officers continued to look after the man. Prison staff noted in their bedwatch log during the second week of September that he was restless or sleeping for much of the time. He was also very agitated at times, and refused to cooperate with nursing care or take his medication. On some occasions he was aggressive and needed to be restrained by prison staff.

33. The Security Governor asked the court to clarify the man's custodial status from 9 September because the court date had been cancelled and the prison needed legal authority to continue detaining the man. The same day, the local County Court remanded the man in custody until 30 September, pending a medical report to address the question of his fitness to attend court.

34. The man remained in the local hospital. Bedwatch prison staff wrote in their reports during the second week of September that he was "very agitated, not sleeping, deteriorating, drip fitted, refusing to drink, and not communicating". Hospital staff explored options to provide care for the man in the longer term, but thought that was not possible to arrange a nursing home placement if he remained in custody.

35. On 10 September the prison's Mental Health Lead and Staff Nurse visited the hospital to review the man's condition. They received a comprehensive hand-over from the ward sister. They noted that there had been, "significant deterioration in the man's condition that morning, potentially life threatening. He remained in a frail and poorly condition, receiving oxygen therapy and intravenous fluids, unable to mobilise, receiving direct care from his bedside." The prison's Mental Health Lead requested a brief medical report from the hospital team to summarise the man's condition, his care and his treatment needs. The prison's Mental Health Lead also noted that the two bedwatch prison officers demonstrated a "high level of professionalism, care and empathy", for example he observed one "officer encouraging and assisting the man with his drink and lunchtime meal". The prison's Mental Health Lead described how the prison staff's kindly assistance and interaction promoted the man's comfort and dignity during his last few days.

36. Prison and hospital staff continued to liaise. On 10 September, hospital staff told prison healthcare staff that the man's blood pressure, blood glucose and oxygen saturation levels were poor, and they were concerned that he might be dying. The hospital staff asked the prison for permission to contact the man's next of kin so that the issue of resuscitation could be discussed with them. The hospital consultant ultimately took the decision not to attempt resuscitation.

37. The Consultant Respiratory and General Physician at the local hospital wrote to the local County Court on 11 September to advise that the man was not fit to attend court. The prison doctor and the Consultant Respiratory and General Physician noted their "clinical impression that the man is suffering from dementia as [they] could find no evidence of malignant disease". It was recorded that the man was "still not eating and required a lot of care from nursing input". The hospital intended to have the man assessed by a psychiatrist specialising in the care of older people. The Consultant Respiratory and General Physician reiterated that prison "is not a suitable place for the man at the present time".

38. The same day (11 September), following successful representations by the Security Governor made directly to the judge, the local County Court granted the man bail to "reside in accommodation as directed by the local Primary Care Trust (hearing listed for 15 September to remain on list) as set out on the court order". Later that day, a second Senior Officer arrived at the hospital with the relevant bail papers but the man was unable to sign them due to his poor condition. The bedwatch was discontinued from this point and the man remained in the hospital on bail.

39. Four days later, on the morning of 15 September, prison healthcare staff received a telephone call from ward 6 at the hospital to tell them that the man had died peacefully during the early hours of that morning. The man had been in hospital for nearly three weeks.

40. Two days after the man died, the Consultant Respiratory and General Physician wrote to the Clinical Director at HMP Durham, with the medical summary of the man's case:

> "68 year old man was admitted to UHND from prison for severe confusion, general deterioration and weight loss; severely ill; evidence of severe sepsis, hyponatraemia and hypoalbuminaemia; ultrasound and T scans showed gallstones and paralytic ileus, but no evidence of cancer; severely under nourished; deficient in B12 and folic acid; treated with blood transfusion, broad spectrum antibiotics, multiple vitamin replacement and (shortly before death) had cortisone, but deteriorated inexorably. Decided not to attempt resuscitation by other means. He died peacefully, and post mortem examination was not requested."

41. The prison staff that cared for the man were supported by the prison's care team. The bedwatch officers were commended by the Governor for their care and support of the man.

ISSUES

Clinical care

42. As noted earlier, the clinical review was conducted by the appointed clinical reviewer on behalf of the local Primary Care Trust. The clinical reviewer concludes that:

> "The man was suffering from multiple pathologies and he deteriorated and died very rapidly. It is likely that his mental state had been deteriorating for some time (months at least, possibly years) before his admission to prison. His poor physical health probably resulted, at least in part, from his lack of self-care due to mental infirmity and chronic alcoholism. (It is possible that his intellectual deterioration and its accompanying aggression contributed to his offending behaviour.)
> The early symptoms of dementia are very difficult to recognise, particularly in the absence of information from relatives or carers and I do not consider that, if present, they would have been easy to spot during his very brief stay on remand in 2007. His alcohol problem was not clear at his reception on 7 August 2008.
> He showed no signs of alcohol withdrawal thereafter and the problem only came to light when the GP records became available – too late for any action by the prison team."

Durham's healthcare team

43. The man suffered from numerous and serious health problems. I judge that, as soon as the man's needs were recognised by the prison's healthcare team, he received competent and timely care throughout his remaining time in custody at Durham. After admission to hospital, the prison's healthcare team continued to work with hospital staff to ensure that his needs were met as well as possible. All of this was good practice. This conclusion is supported by the clinical reviewer in his independent clinical review.

Completion and recording of clinical information on reception

44. My investigator found that the first reception health screen documents were only partially completed and were not of the required standard. The nurses explained that during the health screening process, a registered nurse interviews the prisoner and partially completes the first reception health screen document, whilst a healthcare assistant inputs more detailed clinical information directly into the clinical IT system.

45. Although the man had a long history of alcohol misuse and dependence, he did not show any signs or symptoms of withdrawal when he arrived at Durham. His past medical history had not been identified at the first reception health screen by the nurses on any of his previous admissions during 2008. The clinical IT system stores prisoners' medical histories and clinical information from previous custodial episodes, but reception nurses did not scrutinise the man's electronic clinical record to retrieve relevant information

about his medical history, especially his history of alcohol misuse and dependency.

The Head of Healthcare at HMP Durham should review procedures to ensure that all clinical and health information is accurately and comprehensively recorded on one integrated system so that a prisoner's medical history can be retrieved during the first reception health screen.

Meal checking system

46. On 22 August, the man was seen by a Staff Nurse who observed that he was "disorientated in time, place and person and was living in squalor with non-existent self-care" in his cell. Food left uneaten from the previous day was in the man's cell. I made a recommendation following a previous death in custody investigation at Durham in December 2007 that a "meal checking system" should be implemented by September 2008. A meal checking system was subsequently established but this should include closer monitoring of whether food is eaten, especially in relation to vulnerable, disabled or elderly prisoners.

The Governor should ensure that my recommendation in a previous investigation in December 2007 is fully implemented with a meal checking system fully established.

Contact with the man's family

47. Although the man was in hospital for nearly three weeks, his health deteriorated quickly in the last few days. The prison's healthcare team and prison management were unable to confirm for my investigator the date when they contacted the man's sister.

48. The clinical reviewer has confirmed the prison doctor's assessment that the man, "was suffering from multiple pathologies and he deteriorated and died very rapidly. It is likely that his mental state had been deteriorating for some time before his admission to prison. His poor physical health probably resulted, at least in part, from his lack of self-care due to mental infirmity and chronic alcoholism."

The man's property

49. The man's wallet and other personal items were given in a sealed packet to his sister by the prison's Safer Custody Liaison Officer after the funeral. After further checks, the prison confirmed that there was no more property at the establishment which belonged to the man. I regret that I am unable to provide any more information to alleviate the family's concern.

Conduct of the officers on bedwatch duty

50. I believe that Bedwatch Officers demonstrated a high level of professionalism and care towards the man. This included encouraging and assisting him to eat and drink and remain safe and comfortable whilst in hospital, and also ensuring that the hospital nurses were fully assisted while attending to him. This kindly assistance and interaction promoted the man's comfort and dignity during his last few days.

Conduct of the Security Governor

51. I have judged that the Security Governor showed a high level of professionalism and leadership. This was demonstrated by his authorising the removal of the man's restraints because of his poor condition and instructing staff to "use common sense" in their approach to restraining the man and through making representations directly to the judge to request that bail was granted.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Durham should review procedures to ensure that all clinical and health information is accurately and comprehensively recorded on one integrated system so that a prisoner's medical history can be retrieved during the first reception health screen.

   Durham have accepted this recommendation. A clinical IT system is in place and the introduction of a new clinical IT system (SystemOne) is under negotiation.
   Reception screening tool templates have been developed and are being fully implemented. The target completion date for this is July 2009.

2. The Governor should ensure that my recommendation in a previous investigation in December 2007 is fully implemented and a meal checking system is fully established.

GOOD PRACTICE

Durham's healthcare team

1. As soon as the man's needs were recognised by the prison's healthcare team he received proactive, competent and timely care throughout his remaining period of custody at Durham before he was admitted into hospital. The prison's healthcare team continued to work with hospital staff to ensure that the man's needs were met as best and as fully as practicably possible.

Conduct of the officers on bedwatch duty

2. The Bedwatch Officers demonstrated a high level of professionalism and care towards the man. This included encouraging and assisting the man to eat and drink and remain safe and comfortable whilst in hospital, and also ensuring that the hospital nurses were fully assisted while attending to him. This kindly assistance and interaction promoted the man's comfort and dignity during his last few days.

Conduct of the Security Governor

3. The Security Governor showed a high level of professionalism and leadership. This was demonstrated by his authorising the removal of the man's restraints because of his poor condition and instructing staff to "use common sense" in their approach to restraining the man and through making representations directly to the judge to request that bail was granted.