PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Durham in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This is the report of an investigation into the death of a man at HMP Durham in October 2010. He was 51 years old and died from a sudden and severe heart attack. I would like to offer my sincere condolences to his family and friends.

The man was remanded into custody at HMP Durham on 28 September 2010. This was his first experience of prison and at the time of his remand he was being treated by his doctor for high blood pressure, anxiety, depression, asthma and eczema. He told staff on reception to prison that he drank alcohol excessively and had done so for many years. Consequently, he was offered a supervised ten day alcohol detoxification programme. He started the programme on 29 September.

One of my Senior Investigators conducted the investigation. A clinical reviewer, Custodial Care Innovative Solutions (CCIS), undertook an independent review into the care the man received at HMP Durham on behalf of NHS County Durham. I am grateful to the clinical reviewer for her timely report. I also wish to thank the Governor of HMP Durham for the help and assistance of his staff, particularly the two officers who acted as liaison for the Senior Investigator during the investigation.

Although the man was being treated for high blood pressure by his doctor, he was not offered any medication for this on reception into the prison. He did not attend for medication concerning his alcohol detoxification programme on a number of occasions and this was not followed up by medical staff. Nevertheless, the clinical reviewer concludes that staff could not have prevented the man's death.

This man is the third prisoner to die at HMP Durham whilst undergoing alcohol detoxification in the last three years. However, I am satisfied that he was given suitable treatment and that when he was found, staff made appropriate attempts to resuscitate him. I make four recommendations. They relate to clinical matters which emerged from the clinical review, including the man's initial health assessment on reception into the prison, the management of his detoxification medication, obtaining health records from his community doctor and prison healthcare policy on cardio pulmonary resuscitation and use of defibrillators.

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.

Nigel Newcomen
Prisons and Probation Ombudsman **March 2012**

CONTENTS

Summary

The investigation process

HMP Durham

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was arrested on 26 September 2010, by Northumbria Police and charged with a number of serious offences, including assault and affray. Two days later, on 28 September, he appeared at a magistrates' court and he was remanded into custody at HMP Durham.

2. When the man arrived at the prison, nursing staff interviewed him about his health. During interview, he told a nurse that he was receiving treatment from his general practitioner (GP) for asthma, depression, hypertension (high blood pressure) and eczema. He also told her that had a history of significant daily alcohol use.

3. Later that evening, the man had an appointment with the prison doctor who issued prescriptions to allow the treatment he had received in the community to continue. During his examination of the man, the doctor did not see the nurse's entry in the man's medical notes indicating that he had been prescribed losartan (a drug used to treat high blood pressure) by his GP and therefore did not prescribe it.

4. The prison doctor assessed the man as suffering from alcohol withdrawal symptoms during examination. He offered him a medically supervised alcohol detoxification programme, to start immediately, lasting for ten days. The man agreed to start the programme however he did not attend on five separate occasions to receive medication during his short time at the prison. This was not followed up by medical staff.

5. In the early hours of a day in October, the man's cell mate noticed he was not breathing and alerted wing staff. Healthcare staff and paramedics were called but were unable to revive him. The paramedics pronounced him dead a short time later. The subsequent post mortem established that he had significant artery disease and had died as a result of a heart attack.

6. The prison's family liaison officers (FLO) notified the next of kin, the man's daughter, at her home later that day. They also assisted with the funeral arrangements and the man's property was returned to his family.

7. The clinical reviewer identified the need for improvements in some clinical procedures, but concluded that staff at Durham prison could not have prevented the man's death. I make four recommendations. They concern initial health assessments, monitoring of medication, emergency procedures and obtaining prisoners medical records from their community general practitioner.

THE INVESTIGATION PROCESS

8. The investigation into the man's death was carried out by one of my senior investigators. He opened the investigation on 7 October when he visited HMP Durham. He met an officer, the Governor and other staff including the prison's police liaison officer.

9. The prison provided the senior investigator with relevant documentation pertaining to the man's time at HMP Durham. This included his main prison record, medical records and statements made by staff at the time of the man's death. He visited the man's cell and also met the prisoner with whom he shared his cell.

10. The National Health Service County Durham commissioned Custodial Care Innovative Solutions (CCIS) to carry out a review of the man's medical care during his time at HMP Durham. CCIS appointed a clinical reviewer and I am grateful to her for undertaking the review.

11. The senior investigator also contacted HM Coroner for Durham to inform him of the scope and nature of my investigation and to request a copy of the post mortem report. The Coroner will receive a copy of my report to assist him in his enquiries.

12. The senior investigator and clinical reviewer interviewed four medical staff at HMP Durham. The senior investigator also interviewed three prison officers. All of the interviews were recorded. He also interviewed the man's cell mate, another remand prisoner, who was released before the notes of the interview were sent to him to be signed. The senior investigator also provided written feedback to the Governor about his initial findings.

13. One of my family liaison officers telephoned and wrote to the man's daughter, his nominated next of kin. This was to explain the purpose of my investigation and to provide an opportunity to raise any issues the family had about the care the man received.

14. The man's daughter told my family liaison officer that her father had told her he was not sure about his level of medication in the prison. Her father had told her that he was given 12 tablets one day making him feel light headed and on another day he was given only four tablets. She was also worried that her father's death may have been caused by the shock of sudden alcohol withdrawal. She said that her father would not have called himself an alcoholic but that he drank every day. She added that although she had been told he died from a heart attack, she did not know he had a heart problem.

Feedback from the family

15. The man's daughter received the draft report as part of the consultation period and remains concerned about the detoxification procedures at HMP Durham. Other issues raised by his daughter have been clarified outside of this report by the investigator and the clinical reviewer.

16. We are grateful for the time the man's daughter has taken to consider the report. I hope that the findings of my investigation address her concerns and help her better to understand the circumstances of her father's death.

HMP DURHAM

17. HMP Durham is a category B prison, built in the early 19th Century, which can hold up to just over 1000 prisoners both convicted and unconvicted. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult.) The prison consists of nine wings including those specialising in drug treatment, segregation and healthcare. As a remand prisoner, the man was given a cell on B wing. HMP Durham serves courts from Tyneside, Durham and Cumbria.

18. Healthcare services at Durham are provided by North Darlington and Tees, Esk and Wear Valley NHS. It is nurse led, with access to general practitioners, and specialists such as psychiatrists and dentists etc. There is also an integrated drug treatment service and some inpatient beds.

HM Inspectorate of Prisons

19. The last full announced inspection of Durham prison by HM Inspectorate of Prisons (HMIP) was held in September 2006. The inspectorate reported that, overall, Durham was an improving establishment which was developing its new role as a local community prison serving the north east of England. There was clear and focussed management and considerable goodwill from staff.

20. There was an unannounced full follow up inspection in October 2009. Some of the recommendations were repeated from the inspection in 2006 and a number relate to similar issues to those in this investigation:

    a. Prisoners should be given written information about Durham prison at court.

    b. Prisoners should arrive at Durham before 7.30 pm; any prisoners arriving after that time should be able to make a telephone call and be offered a shower, and this should be recorded.

    c. There should be a vulnerability strategy in place to protect vulnerable prisoners during reception.

    d. New arrivals should routinely receive a telephone call.

    e. New arrivals should have access to Listeners as part of the first night and induction procedures.

    f. The inspection also described induction as good and that most prisoners felt safe. However the Chief Inspector of Prisons commented that there was no custody planning for short term and remanded prisoners.

21. Each prison in England and Wales has an Independent Monitoring Board (IMB). The board consists of members of the local community who have full access to prisoners and all areas of the prison. IMB members undertake a variety of activities in prison including the consideration of complaints made by prisoners, visits to individual prisoners, reporting on the condition of the prison and examining the treatment prisoners receive in healthcare. Each IMB produces an annual report. The last available report on Durham covers the period 1 November 2009 to October 2010.

22. The report recognised the importance the prison places on addressing alcohol abuse with new initiatives and the provision of extra funding for prisoner services, which seemed to be working. The report also comments that prisoner feedback on this issue was excellent and that staff delivering substance misuse are motivated and demonstrate "a good level of understanding and requirements".

23. The man's death was the 12th by natural causes at HMP Durham since 2004 when this office took over responsibility for investigating deaths in prisons. He is the third prisoner to die at HMP Durham whilst on the supervised alcohol detoxification programme.

KEY EVENTS

24. The man was arrested on 26 September by Northumbria Police for a number of offences including assault and affray. He was remanded into Durham prison by a magistrates' court on 28 September until 4 October when he was due to appear at court by video link from the prison to court. The Magistrates believed the case against him was a strong one and were concerned about the man's behaviour towards and proximity to the witnesses.

25. The investigator contacted Northumbria Police and obtained copies of the man's custody record for the period between his arrest and court appearance. This shows him to have been in police custody from 9.50pm on 26 September to 6.30am on 28 September. The Forensic Medical Examiner (FME) examined him on 27 September at 9.30pm and prescribed one diazepam (a sedative). On 28 September, he transferred to a magistrates' court, escorted by G4S. (G4S is a private company contracted to transport prisoners between police stations, courts and prisons)

26. According to the Person Escort Record (PER), the man was in police custody on 24 September. This is an error in recording at the police station. (The PER is a form that accompanies prisoners on all journeys from police stations to courts and to prisons. It provides a full record of the escort, for example meals provided, journey times, medication issued and whether or not the prisoner has any alcohol or drug problems.)

27. The man's PER has a number of risk categories on the front sheet headed medical, security and other. The treatment given to him by the FME was not recorded on the PER. Under the security heading "custody", staff at the police station ticked a subheading entitled "violence". Under the heading "other", there is an option to tick drugs/alcohol issues. This was not ticked.

28. The man arrived at Durham prison at 2.20pm, and immediately went through the reception process. During reception, prisoners are interviewed by prison officers, allocated a prison number and forms are completed which gather information about the new prisoner, which in turn ensure the prisoner is linked in to the right services. He was 51 years old and this was his first time in prison.

29. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for prisoners. The assessment identifies risk as either raised or low, and is reviewed at regular intervals. A prison officer interviewed the man and completed the CSRA. The officer wrote on the CSRA that the man had told him he abused alcohol and had been given medication for this by his GP. He added that, if possible, the man should be in a cell with someone compatible, that he had no other concerns about him and that he assessed him as a low risk to other prisoners.

30. The man then moved on to the next phase of reception, health screening. A nurse assessed him at 3.36pm. He told the nurse about his alcohol consumption. She wrote on the man's medical notes that he consumed on average 210 units of alcohol a week and the week before he was remanded into custody he consumed 180 units. The nurse also referred him to Durham prison's specialist alcohol treatment service.

31. During his health screening the man also told the nurse that he had been prescribed medication for asthma, depression, high blood pressure and eczema. She entered the details of his medication onto his prison medical record. She wrote that he was prescribed Ventolin (a drug used to treat asthma), Betnovate cream (to treat eczema), losartan (to treat high blood pressure) and citalopram (to treat depression). The nurse also arranged for him to sign a document called "In Possession Medications Prisoner Responsibilities". This document explained to the man the expectations placed upon him if he was assessed as being suitable to keep his own medication in his cell.

32. During the interview, the nurse obtained the man's signed permission for the prison to approach his community GP in order to exchange information about his ongoing treatment. However, it appears from an entry made in the medical record by a healthcare administrator that it was only dealt with on 3 October, five days later.

33. The man was then assessed by a substance misuse worker and at the end of the assessment he was identified as requiring detoxification management concerning his alcohol dependence. At 6.34pm, the prison doctor examined the man. The doctor wrote in the medical file that the man drank up to ten pints of beer a day, had no history of withdrawal fits but had marked withdrawal effects which he described as a flushed complexion and a restless minor tremor (an involuntary shaking). He also wrote that he suffered from asthma, alcohol dependence syndrome and anxiety disorder.

34. The doctor prescribed chlordiazepoxide (a drug used to treat people who abuse alcohol and suffer from anxiety) to be taken under supervision, at 6.45pm and a further dose at midnight to help ease his withdrawal symptoms. He also prescribed salbutamol (a drug used to treat asthma), citalopram and betamethasone (also known as Betnovate which is described earlier).

35. A substance misuse staff nurse examined the man on the morning of 29 September following the referral from the substance misuse worker. Durham prison operates two alcohol detoxification programmes, one lasts for seven days the second for ten days. A further nurse interviewed him and explained his care plan to him which he then signed. The man started the ten day programme which required him to be supervised taking chlordiazepoxide four times a day. Chlordiazepoxide is a sedative which can be misused, therefore prisoners are not allowed to keep it in their possession. He was also prescribed 300 mgs a day of thiamine (a vitamin). The substance misuse staff nurse wrote in the man's record that he had a craving for alcohol, "sweats", and a tremor.

36. On his first night in prison, the man took two doses of chlordiazepoxide. The following day, 29 September, he should have continued his planned programme of four tablets a day, one in the morning, one at lunchtime, one in the afternoon and one at night. However, he did not attend for his morning dose but did receive the remaining three doses for that day.

37. The man moved to a ground floor cell on E wing, the induction wing for new prisoners. Staff on E wing are experienced in managing new prisoners with alcohol or drug misuse histories and there are trained substance misuse staff on duty at all times. The prison case note history for the man on 29 September states "Alert Hold Against Transfer and Medical Hold made active". This means he was not to be transferred to another prison because he was undergoing medical treatment at Durham. He appears to have settled well into the regime on E wing and did not come to the attention of staff in any negative way.

38. Healthcare staff at the prison used the "Benzodiazepine Withdrawal Custody Health Observation Scale" to monitor the man. This requires staff to observe a number of symptoms through clinical monitoring such as perspiration, pulse rate, tremor, insomnia and record their findings in his medical record.

39. The man did not attend for his morning doses on 30 September, 1 and 2 October. He missed a further dose on 3 October at midday. The clinical reviewer comments in her report that the man's symptoms were not checked against the scale on the three subsequent days. This happened despite an entry on 28 September on the medical record made by the substance misuse staff nurse which states "monitor closely".

40. In total, the man missed five doses of chlordiazepoxide during the detoxification programme. His medical record show entries made by healthcare staff stating that he did not receive the medication on the above dates because he was receiving visits.

41. On a day in early October at 9.30am, a healthcare support worker assessed the man. She wrote in his medical file that he was feeling better but that he was unhappy that he was not getting prescription medication and not sleeping. She completed the entry with "To monitor".

42. The next day, just before 1.45am, the man's cell mate was awoken by the volume on the cell television. He told my investigator that he could not hear the man snoring, which was unusual. He decided to get down from his bed and in doing so noticed he was lying on his side with his head slightly off his bed. He also noticed fluid on the floor directly under his mouth. He then rang the cell bell to alert staff to the man's condition. (All cells are fitted with a cell call bell that can be pressed by a prisoner to alert a member of staff that they require help or assistance.) He also told the investigator that he had noticed the man was using his inhaler more than usual that day.

43. An Operational Support Grade (OSG) was on duty on E wing that night. He was in the wing office at 1.45am when he heard a cell bell ring. He checked the cell bell panel in the office and saw that cell E1-02, the man's cell, required

assistance. (An OSG is a member of prison staff at a grade below prison officer. They work in many areas of the prison, normally where there is little or no contact with prisoners.)

44. The OSG went to the cell, switched on the cell light and spoke to the man's cell mate through the cell observation panel. The cell mate told the OSG that he believed the man was not breathing.

45. The OSG called Oscar 1 (the call sign for the night duty prison manager) over the radio and asked for a nurse (call sign Hotel 1) who was on duty in healthcare to attend the wing. The prison radio was on "open" meaning all staff on duty can hear messages over the radio. The nurse wrote in her statement to the Governor that she arrived on the wing and observed the man through the observation panel. The OSG did not open the cell door immediately. OSGs at HMP Durham are not trained in self defence and have instructions not to enter cells, especially shared cells, without the support of other officers.

46. The night duty prison manager (Oscar 1) opened the cell when he arrived on the wing. In his statement to the Governor, he estimates his arrival at the cell as 1.46 am. He unlocked the cell to allow access for the nurse who had earlier asked her colleague to collect the emergency bag, oxygen a defibrillator and bring them to E wing. (A defibrillator is a machine which delivers controlled electric shocks to the heart.)

47. An OSG who was on D wing overheard the emergency call and offered to assist, as she had previously trained as a first responder. (A first responder is someone trained in first aid and on call to respond to emergencies.) In her statement to the Governor, she wrote she was also familiar in the use of defibrillators.

48. Other officers arrived at the cell. One of the officers asked his colleague to take the man's cell mate to the Listener suite. (Listeners are prisoners trained by Samaritans to offer confidential emotional support, 24 hours a day to fellow prisoners in distress. The Listener suite is a room set aside to enable this to take place.) Another officer supported the work of the nurses by passing equipment into the cell as and when requested by one of the nurses.

49. One of the nurses – Nurse A - examined the man for signs of life. In her statement to the Governor she said she could find no pulse or signs of breathing and the man's pupils were fixed and pinpointed. She noticed that his skin was cyanosed, meaning that his skin had a blue tinge. She tried to insert an airway into his mouth. However this was not possible because his teeth were clenched. She then attempted cardio pulmonary resuscitation (CPR) but this had no effect. The OSG that had come over to help from D wing, who by this time was outside the cell, overheard a nurse – Nurse B - say that she had not used a defibrillator before. She offered to help and passed the defibrillator pads to Nurse A. The nurse then began to follow the instructions on the defibrillator. Unfortunately, it registered "non shockable rhythm", meaning the man's heart showed no signs of activity.

50. An officer was on night duty in the control room at HMP Durham that night. He wrote in his statement to the Governor that at 1.50am a code blue call came through from E wing requesting an emergency ambulance be called. (Code blue is a radio call sign that indicates a prisoner has breathing or respiratory problems. This enables staff to respond with the appropriate equipment.) The officer requested the emergency ambulance at 1.51am and recorded in his statement that the paramedic arrived at the gate at 1.56am.

51. An OSG who was also on duty in the control room told my investigator that she went to the prison gate to allow the paramedics into the prison. She opened the main gate and the paramedic drove the response car into the holding area. Unfortunately, there was an electrical fault on the next gate which meant that the paramedic's vehicle was stuck between the main gate and the internal gate, which allows vehicles access to the main prison. The OSG was then instructed to allow the paramedic into the prison on foot and escort him to E wing.

52. Once the gate was fixed, an OSG, who had been given the keys to the paramedics' vehicle, moved it into the main compound within the prison. In interview, the officer estimated that it took no longer than three minutes for her to allow the paramedic into the prison and escort him to E wing, where he met two officers who were waiting at the entrance to the wing.

53. Nurse A said in her statement that the paramedic arrived at the cell at approximately 2.10am and attached an electrocardiograph (ECG) monitor which registered a flat line. (An ECG is a machine that measures heart activity.) She added that at 2.20am a second paramedic crew arrived and pronounced the man dead.

54. The duty governor organised a hot debrief at 7.00am on the day of the man's death. This is a meeting for staff to discuss issues and any lessons learned following serious events within the prison. Staff and prisoners at HMP Durham were informed of the man's death by way of notices placed around the prison. The man's cell mate was offered support from the Listener's and Samaritans.

55. Two prison family liaison officers visited the man's next of kin, his daughter, at 11.00am at her home to break the news of his death. He was buried on 15 October 2010 and I understand the prison contributed to the costs of his funeral.

56. The man died from acute left ventricular failure (heart failure) and coronary heart failure (inadequate blood circulation resulting in death of the heart tissue). The post mortem report stated that he had significant artery disease and scarring of the heart. During interview, the prison doctor said it was likely that the man was unaware of his heart condition as he did not mention it during their consultation but had mentioned other ailments. The doctor said that had he known of the heart condition that would not have changed the treatment prescribed.

ISSUES

Clinical care

57. The clinical reviewer carried out a clinical review of the medical treatment and care given to the man at HMP Durham, on behalf of NHS County Durham. She reviewed all medical records and interviewed medical staff, as well as visiting the healthcare wing.

58. The clinical reviewer considers it unlikely that the man's heart attack could have been prevented by the staff at HMP Durham. However she comments that the man was in a stressful situation having arrived at HMP Durham after being held in police custody since 26 September. She considers a number of factors might have triggered the man's heart attack, and that other factors could have had a similar effect had he still been in the community. The clinical reviewer also comments that the healthcare centre provided a satisfactory environment for emergency alcohol detoxification and that the medical supervision and staffing were adequate.

The man's initial health assessment

59. The nurse who conducted the man's healthscreen recorded that he had been prescribed losartan in the community. However, this was not prescribed when he went into prison. The clinical reviewer states that it was unfortunate that the prison doctor did not prescribe losartan. In interview, he explained to the clinical reviewer and the investigator this was an error he believed was caused by the presentation of information on the electronic record, during a short consultation in a busy surgery. He said he had told the prison of the deficiencies in the system and the frequent confusion caused by not being able to read the information properly on the computer. The clinical reviewer believes that until the IT system is rectified this could be addressed by printing off the document for the first GP consultation. I therefore endorse the clinical reviewer's recommendation:

> **The Head of Healthcare should ensure that prisoners' initial assessment documents should be printed and made available to the doctor at the first consultation.**

The management of the man's medication

60. The man's daughter raised concerns about her father's comment to her that he was unsure about the dosage of his prescribed tablets. He had been assessed as suitable to have his medication in his cell except for his chlordiazepoxide. Therefore he had responsibility for taking his prescribed citalopram four times a day, thiamine up to 300mg a day, as well as his asthma and eczema medication. He was also supervised taking chlordiazepoxide and signed his care plan 29 October which set out the treatment plan for him. It is possible he became confused about the amount of prescribed medication he was supposed to take each day. The clinical reviewer also points out that during the ten day treatment, the dosage reduces every day so there is a daily variation in the number of

tablets.

61. The man did not attend for the chlordiazepoxide to be dispensed on five separate occasions. In interview, the substance misuse staff nurse told the clinical reviewer that prisoners who missed doses of chlordiazepoxide might not be followed up. The man missed medication prescribed to counteract his detoxification from alcohol. It appears that it was not always intentional, but because of a conflict with his visits time. Whilst it was the man's right not to take his medication, I endorse the clinical reviewer's recommendation:

> **The Head of Healthcare should ensure that prisoners on alcohol detoxification programmes who miss the dispensing of medication because they are off the wing should be followed up by healthcare staff as soon as possible and offered the opportunity to take their medication.**

Emergency procedures: CPR and use of defibrillator

62. The OSG heard a nurse say that she had not used a defibrillator before. The clinical reviewer comments that does not appear to have impacted on the man's care, however this could impact on future emergencies. I therefore endorse her recommendation:

> **The Head of Healthcare should check that there is a robust system in place to ensure all healthcare staff are trained in emergency procedures**.

The man's time in police custody

63. Within the man's police custody record is his detainee medical record which shows that he was examined by a Forensic Medical Examiner (FME) at 9.30pm on 27 September and prescribed one diazepam to be taken at 11.00pm. The FME also wrote on the man's record "hypertension". The remainder of the medical document is illegible and it is not possible to gauge whether or not he was offered further medication during the time spent in police custody. It is unfortunate that the man's treatment was not recorded on the PER as this may have ensured staff on reception to the prison noticed the FME's note regarding hypertension and prescription for diazepam. Prison healthcare staff could then have been alerted to the treatment he had received at the police station.

Obtaining the man's medical records

64. The man signed a consent slip on Wednesday 28 September for the prison to approach his community GP in order to exchange health information. However according to his medical records, the consent form was faxed on 3 October. There is no evidence in the evidence provided to the investigator that the prison received any information from the man's GP or that the matter was to be followed up by prison staff. Any delay in treatment could impact severely on a prisoner's health. I therefore recommend:

The Head of Healthcare should ensure that there is a clear policy with time limits to obtain medical notes of remanded prisoners from their community GP and other sources if appropriate.

The mechanical failure of the internal prison gate

65. I do not believe the delay in opening the internal prison gate for the paramedics caused any significant delay in assisting the man. However, the investigator asked his liaison officer at HMP Durham to comment about the reliability of the internal gate. He received a response stating that "although from time to time there are faults on the gate mechanism, this is the exception and is dealt with as soon as the fault occurs."

CONCLUSION

66. The man was remanded into custody for the first time aged 51. He disclosed to prison healthcare staff that he abused alcohol very heavily. His GP had been treating him for high blood pressure and depression prior to his reception in to prison.

67. After health screening, the man started a supervised ten day alcohol detoxification programme. He missed five out of a total of twenty doses as the dispensing times coincided with visits from friends and family. I am concerned that the missed doses of chlordiazepoxide were not followed up by healthcare staff. Whilst the man's death was sudden and could not have been foreseen it is regrettable that the planned medical supervision of his detoxification from alcohol was interrupted and not followed up.

68. The man died of a heart attack and the resulting post-mortem report found that he had severe heart disease. Whilst the clinical reviewer comments that the stress of arrest and imprisonment combined with the sudden detoxification from alcohol could be seen as contributory factors, she also believes that it is unlikely that the man's heart attack could have been prevented by healthcare staff at HMP Durham. I concur with her view and my recommendations cover incidental clinical matters which require improvement.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners' initial assessment documents should be printed and made available to the doctor at the first consultation.

   The National Offender Management Service partially accepted this recommendation and commented;

   Initial reception screen template will be discussed with TPP/Systm1 to improve the readability of the displayed information

   HMP Durham healthcare operates a clinical IT system which enables us to be paperless wherever possible. This provides us with one record which is electronically auditable and protects both CAREUK and the patient against information loss. In order to safeguard against information governance breaches and maintain the credibility of the clinical IT system GP's will be offered the facility to print out the initial documents if they wish to do so

2. The Head of Healthcare should ensure that prisoners on alcohol detoxification programmes who miss the dispensing of medication because they are off the wing should be followed up by healthcare staff as soon as possible and offered the opportunity to take their medication.

   The National Offender Management Service accepted this recommendation and commented;

   Medication is administered 3 times per day when prisoners are on the wing. The exceptions to this are those prisoners at court. In this instance a court pack is prepared and given to the escorting company for self-administration by the prisoner at the required time(s)

   CARE UK will continue to work in partnership with HMPS to ensure that the prison regime does not inadvertently exclude prisoners from accessing medications/healthcare interventions

3. The Head of Healthcare should check that there is a robust system in place to ensure all healthcare staff are trained in emergency procedures.

   The National Offender management Service accepted this recommendation and commented;

   There is an on-going in house training programme for AED/BLS

   2 staff identified to attend further AED/ training September BLS

   CARE UK annual mandatory training for BLS is also in place. Monthly audit in place

   Care UK emergency scenario audit is completed bi-annually

Newly appointed staff will be familiarised with the type of AED in use at HMP Durham (as it may differ from the type they have used elsewhere)

4. The Head of Healthcare should ensure that there is a clear policy with time limits to obtain medical notes of remanded prisoners from their community GP and other sources if appropriate.

The National Offender Management Service accepted this recommendation and commented;

Formal protocol will be developed and signed off at the clinical governance group

Healthcare staff will be reminded of their job role in relation to requesting notes from GP's

Time limits for community GP's to respond to Offender health requests will be raised with the North East Offender commissioners at next prison partnership board