Investigation into the circumstances surrounding the death of a man at HMP Durham in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the death of a man who died on 13 January 2008 at HMP Durham. The man was 67 years old when he died.

The man died of Cor pulmonale (right sided heart failure), due to chronic bronchitis and emphysema with myocardial ischaemia (insufficient blood supply to the heart) and coronary artery atheroma (fatty deposits on the inner lining of an artery which restrict blood flow). Although receiving treatment for various complaints and awaiting respiratory tests, the man's death was sudden and unexpected. My colleagues and I would like to extend our condolences to the man's family and those close to him.

The investigation was carried out on my behalf by my two of my investigators. A review of the man's clinical care was carried out by County Durham Primary Care Trust (PCT). I received the review on 2 June and apologise for the resultant delay in publishing this report. I am grateful to the clinical reviewer for his assistance in this case. I also thank the Governor of Durham for the co-operation of his staff during this investigation.

The officers and healthcare staff who responded to an emergency call to the man's cell commenced cardiopulmonary resuscitation (CPR). They continued to do this for approximately 25 minutes before the paramedics arrived. I commend the officers and nurses for their continued efforts to try and resuscitate the man.

The clinical reviewer has made two recommendations which I endorse. I have also added one recommendation of my own.

Jane Webb
Deputy Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was remanded into custody on 27 August 2007. Shortly before this, between 7 – 14 August, he had been a patient at Cumberland Infirmary where he received treatment for alcohol withdrawal, conjunctivitis, self neglect and a possible chest infection. Earlier in the year an x-ray had reported Chronic Obstructive Pulmonary Disease (COPD). The man had a history of alcohol misuse and was a heavy smoker.

On his arrival at prison he underwent another alcohol detoxification programme. Healthcare staff requested his previous medical records which included a summary of the man's admission to hospital and notification that a follow up chest x-ray was needed. This was duly arranged for 5 October and showed long standing changes to the man's lungs.

While in prison, the man developed chest pains and shortness of breath. Latterly, he experienced panic attacks. He had the necessary chest x-ray as well as electrocardiograms (ECG) and was referred to a Rapid Access Chest Pain Clinic (RACPC). His ECGs were negative and the consultation at the RACPC determined that his chest pain was not cardiac in origin.

At the beginning of January 2008, a prison doctor referred the man for spirometry (detailed check of lung function). The clinical reviewer commented that the referral could have been made earlier, after the chest x-ray on 5 October 2007, although it was difficult to determine whether the man's death could have been prevented. He continued to smoke heavily, which is the most important factor in relation to the progression and prognosis of COPD. The reviewer also noted that the man's panic attacks might have masked the severity of his respiratory illness. The clinical reviewer has found that the man's medical complaints, with the exception of spirometry, were investigated appropriately.

The prison records, and the man's letter to his sister, show that he felt better in the weeks prior to his death. However, the night before he died, a nurse was called to his cell because he had difficulty breathing. On entering his cell, the staff found it thick with cigarette smoke. The man was given more advice about cutting down or stopping smoking. A wing officer went to see the man the following morning, on 13 January, and the records show that he was sitting up watching television.

At 10:40am on 13 January, wing officers were alerted to the man's cell by another prisoner. The man was slumped on his bed. An officer commenced CPR and was quickly joined by nurses who attempted resuscitation for 25 minutes. Paramedics arrived and took over CPR, but they too were unable to get a response and after 20 minutes, the man was pronounced dead.

The clinical review has found the man's death was sudden and unexpected. The recommendations arising from this investigation relate to appropriate medical follow up for x-ray findings suggesting underlying respiratory disease and the proper recording of healthcare interactions with patients.

INVESTIGATION PROCESS

1. My investigator requested all the relevant prison records including the man's medical and core prison records. Another of my investigators visited the prison and spoke to several members of staff.

2. My investigator, who visited the prison, also spoke to a member of the Independent Monitoring Board (IMB). The IMB member told my investigator that she had attended the man's cell when she heard the emergency code called and observed a prison officer attempting to resuscitate the man. She felt that the prison officer's actions were commendable. The IMB member added that the prison staff at HMP Durham were helpful and friendly.

3. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigator. Two prisoners asked to see my investigator. One prisoner told my investigator about the man's breathing difficulties and panic attacks. My investigator explained that the man's medical care would be explored in the clinical review.

4. Another prisoner who asked to see my investigator said that the man did not discuss his health with him, but he could see he was not a well man. On the day that the man died, the prisoner said he looked through the observation panel in the man's cell door, and saw him lying slumped against the wall with his legs hanging over the edge of his bed. Believing something to be wrong, he called for staff. The prisoner told my investigator that the officers entered the cell then called for medical assistance. He added that, in his opinion, staff responded very quickly when he asked for help.

5. County Durham PCT was asked to carry out a clinical review into the man's healthcare in prison. This was carried out by a doctor their behalf. The report was received on 2 June 2008 and is annexed to my report.

6. HM Coroner for Darlington and South/North Durham districts was informed of my investigation. The Coroner has kindly shared the post mortem with my investigators. He will receive a copy of my report.

7. The man had not given the details of any next of kin. However, after checking his mail, the prison was able to trace one of his sisters in America who told them of another sister in England. One of my Family Liaison Officers spoke to the man's sister in England to offer her the opportunity of involvement in the investigation. The man's sister did not have any concerns to raise but would like to acknowledge that the prison were very helpful and supportive after the man's death. They offered financial assistance with the funeral and the prison chaplain carried out the service.

8. The man's sister added that she had received a letter from him just before he died. In the letter he told her that he had moved to a good wing. He also said that he had some breathing difficulties but was feeling better at the time.

HMP DURHAM

9. Durham is a category B prison, which 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.

10. Healthcare services provide inpatient facilities. There are two full time doctors in the prison 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.

11. Her Majesty's Chief Inspector of Prisons (HMCIP), last inspected the prison in September 2006. HMCIP found that the new focus on the role of the prison was assisting the new management team to progress significant improvements. 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. HMCIP reported that there was a genuine desire to improve health services for prisoners.

12. The man's death followed shortly after another prisoner at the end of December 2007. Both deaths were due to natural causes. The investigation by my office into the other prisoner's death has also identified issues in relation to medical recordkeeping.

KEY FINDINGS

13. On 27 August 2007, the man was remanded into custody at HMP Durham. A nurse saw him in reception and completed the first night health screen. This includes completing an assessment form to establish a prisoner's previous and current physical and mental health. When asked if he had any medical problems such as asthma, heart disease/angina or serious illness, the man answered "no". He also answered no to problems of mobility and any concerns he might have had about his physical health. He answered "yes" to alcohol misuse and requested help to treat his alcohol problem. He told the nurse that he had recently been on a detoxification programme.

14. The nurse referred the man to the doctor because of the need for detoxification. A prison doctor saw him that day and prescribed diazepam, vitamins and thiamine as part of the detoxification treatment and recommended that the man remain in the healthcare centre. The man remained in healthcare until 18 September, when he was assessed as fit to be on a residential wing.

15. One of the prison doctors received notification that the man needed a follow up chest x-ray, following his period in hospital during August 2007. The x-ray was arranged and took place on 5 October. The appointment is not documented in the medical notes, however, the results are in the record and show the consultation date. The results showed extensive background fibrotic changes and interstitial changes (this relates to stiffness of the lungs and loss of the elasticity which restricts entry of air during respiration). There was no evidence of infection and the radiologist suggests that the changes were longstanding. The clinical reviewer has commented that it would have been appropriate to initiate investigations with spirometry and pulse oximetry (analysis of oxygen in the bloodstream) at this point and also an enquiry into any relevant occupational history. The spirometry was not initiated at this time and there is no evidence of an enquiry into the man's previous employment.

16. On 8 October, the man was seen by a prison doctor and prescribed medication for a chest infection. The medical notes record that he was smoking between 20 and 39 cigarettes a day. He attended healthcare several more times in October. The man was seen by doctors on 6 and 7 November after complaining of chest pains, pain radiating down his left arm, a shortness of breath and mild sweating on exertion. A resting electrocardiogram (ECG) was normal but a referral was made to the Rapid Access Chest Pain Clinic (RACPC) in North Durham for an exercise ECG test.

17. In the man's wing history sheet, an officer noted on 11 November that the man was experiencing health problems and referred to the ECG earlier in the week. Just over a week later, on 20 November, the man attended the RACPC. On examination it was found that his chest was clear and his heart sounds were normal. He was given an exercise test which was stopped after less than two minutes due to the man's breathlessness. During the test he did not develop chest pain and the ECG results were negative. The

cardiovascular nurse specialist explained to the man that he did not think his symptoms were cardiac in origin.

18. Over the next month, the medical records note four further occasions when the man complained of chest pain. He was seen each time and prescribed analgesic (painkilling) medication. On 26 December, healthcare staff were called to the wing to see the man. He told them that he was having a panic attack. The nurse examined him and found his pulse to be normal and regular. The man asked for medication, which the nurse declined and told him he needed to rest. Wing staff were advised to contact healthcare again if there was no improvement in the man's condition. A prison doctor saw him the following day and prescribed medication to help the chest pain.

19. On 2 January 2008, the wing history sheet and observation book record that the man was experiencing more panic attacks. In his wing history sheet, his personal officer noted that the man was finding it difficult to cope in prison. He did not have any thoughts of self harm but was worried about his health. He told his personal officer that he was not sleeping and could not concentrate on his education course. The officer wrote in the records that the nurse was due to see him in the afternoon. Following instructions from the doctor, the man was seen by healthcare that day. He was described as being anxious about his panic attacks, but did not believe the prescribed medication was working, so he had stopped taking it. The man returned it to the nurse.

20. Two days later, on 4 January, the man's personal officer noted in his wing history sheet that he was feeling better although still anxious. The officer arranged a move to a lower landing which meant there were fewer stairs to negotiate. The man shared his new cell with another prisoner who the officer felt was mature and sensible (The man had been worried about potentially sharing with someone younger). He was also seen by a second prison doctor on 4 January, who found "occ [occasional] wheeze" and in view of the chest x-ray findings in October, referred the man for spirometry and for smoking cessation classes.

21. Returning from education on 9 January, the man was breathless and told the officers he felt faint. A nurse went to see him on the wing, although this is not documented in the medical records, only the wing observation book. The man did not feel well enough to get lunch so staff arranged for another prisoner to take his lunch to him. It was agreed that this cell mate would keep an eye on him. The following day, it was noted in the prison records that the man had another panic attack and nearly fell downstairs. Another prisoner managed to catch him and he did not sustain any injuries. A nurse attended and offered the man some paracetomol but he declined to take any, although again this is not recorded in the medical records.

22. Healthcare were called to the wing again on Saturday 12 January, after the man complained of breathlessness. When a nurse arrived he was sitting eating breakfast and was able to communicate. The nurse took his medical observations and recorded that there was no obvious cyanosis (caused by lack of oxygen in the blood). The man told the nurse that he was feeling

better but got breathless when he went to get meals at the servery. It was agreed that wing staff would arrange for his meals to be taken to him. The man was told to let the wing staff know if severe breathlessness occurred again.

23. During that night, at approximately 1.30am, the man pressed his cell bell because he was experiencing difficulty breathing. The night wing officer responded to the bell and called for healthcare to attend. A nurse on night duty attended the wing. She has noted in the medical record that the man's cell was thick with cigarette smoke. The man was advised to stand by the open window to get some fresh air and to stop or cut down on smoking. He said that he had applied to attend smoking cessation classes. The nurse was to arrange a doctor's appointment for the following Monday.

24. As she was leaving the cell she noticed that the man had a box of ibuprofen, which had been prescribed in November, and a box of diclofenac (anti-inflammatory painkiller) tablets, prescribed at the end of December. The nurse explained to the man that these should not be taken together and removed the ibuprofen from the cell. My investigator asked the nurse on night duty whether she carried out any medical observations on the man. The nurse said that she had not because she did not feel that taking his blood pressure would have changed the situation. She told my investigator that when she arrived at his cell, the man was not complaining of chest pains or struggling to breathe and had been able to move from his chair to the window. The nurse also said that the man had been apologetic for calling her to the cell. She described it as "very smoky" and that she herself had trouble breathing in it.

25. An officer from the wing started duty at 7.00am on Sunday, 13 January. The officer received a handover from the night officer which included a comment about the man requiring nursing attention overnight. She went to check on the man and, in her statement, said that when she looked through the observation panel, the man was sitting watching television and waved to her. She thought he looked tired but alright. She checked again at 7.30am and commented that he looked no different than when she had seen him earlier.

26. At approximately 10.00am, the officer and a second prison officer were on the wing exchanging prisoners bedding for clean linen. The first officer asked the man if he wanted clean bedding but, because he had only recently moved to his cell, he declined. The officer saw the man again at approximately 10.15am when unlocking the prisoners on the wing. She remembered that the man was lying down on his bed, and although he did not speak, he raised his head when she told him it was time for association.

27. About 25 minutes later, at 10.40am a prisoner looked into the man's cell through the observation panel. He saw the man slumped on the bed with his legs hanging over the edge. He saw two officers nearby and asked them to check on the man. The second officer, who had been exchanging bedding, and a third prison officer responded. The third officer opened and entered the cell. He called the man's name to try to gain a response and checked for a

pulse. The second officer called for assistance over the prison radio and went to alert the wing managers. An ambulance was also requested.

28. A senior officer quickly returned to the cell with the prison officer. They placed the man on the floor and the prison officer commenced cardiopulmonary resuscitation (CPR). Two staff nurses arrived shortly afterwards and took over the resuscitation attempts. The nurses used the defibrillator which instructed CPR but no shock was advised.

29. The defibrillator was used twice more with the same instructions. CPR was carried out until the paramedics arrived at 11.01am and took over. They tried to resuscitate the man for 20 minutes and during that time could not feel a pulse. After 20 minutes at 11.22am, the paramedics stopped resuscitation attempts. The prison doctor arrived and pronounced the man's death.

30. The prison held a 'hot-debrief' for staff involved in finding and trying to resuscitate the man. All staff were offered the support of the care team.

ISSUES CONSIDERED

31. The man presented no problems for staff on the wing. The wing staff called for medical assistance when necessary and arranged for meals to be taken to the man when he felt unable to go to the servery. On the morning of 13 January, the night staff gave a handover to day staff regarding the man's condition overnight and he was checked several times during the morning. My investigation does not raise any issues or concerns in relation to these matters.

Clinical care

32. The man had regular contact with the healthcare staff at Durham. The clinical review has found that, with the exception of spirometry, his care and treatment was appropriate. Steps were taken to ensure that the man's previous medical history was received from his community doctor and, the necessary chest x-ray follow up resulting from a hospital admission was arranged.

33. The clinical reviewer has noted however, that radiology findings of fibrosis should have prompted an enquiry into any relevant occupational history which might have been significant. There is no record that this was done. This said, given the man's post mortem findings it might not have made a difference to his treatment, but it is still recommended best practice.

    The Head of Healthcare should ensure that clinicians at HMP Durham enquire into any relevant occupational history after radiology findings of fibrosis.

34. The reviewer also commented that as a result of the x-ray findings, a more proactive approach could have been considered. The reviewer could not determine if relevant tests for example, spirometry, would have prevented the man's death, given that he continued to smoke heavily, which is the most important factor in determining the progression and prognosis of COPD. However, the referral should have been made after the chest x-ray in October.

    The Head of Healthcare should ensure that clinical staff consider a more proactive approach to x-ray findings which suggest a significant underlying respiratory disease.

35. The healthcare unit at Durham operates a computerised medical record system. My investigator found that on some occasions notes were made solely on the paper record and at times, no notes of healthcare contact were recorded. It is important that all healthcare contact is recorded and chronological to ensure that it gives an accurate and continuous history of a patient's needs and treatment. Two different systems can cause confusion and leave room for error.

    The Head of Healthcare should regularly audit the clinical records to ensure that they comply with national guidance.

RECOMMENDATIONS

The clinical reviewer has made two recommendations which I endorse. I also add a recommendation of my own.

1. The Head of Healthcare should ensure that clinicians at HMP Durham enquire into any relevant occupational history after radiology findings of fibrosis.

   HMP Durham has accepted this recommendation and an action plan is in place.

2. The Head of Healthcare should ensure that clinical staff consider a more proactive approach to x-ray findings which suggest a significant underlying respiratory disease.

   HMP Durham has accepted this recommendation and an action plan is in place.

3. The Head of Healthcare should regularly audit the clinical records to ensure that they comply with national guidance

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