

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Durham in December 2007**

**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 in December 2007 at HMP Durham. The man was 35 years old when he died of ischaemic heart disease.

When the man arrived in prison, 12 days before his death, he had several medical complaints including asthma and dyspepsia, but his death was sudden and unexpected. My colleagues and I would like to extend our condolences to the man's family and friends.

The investigation was carried out on my behalf by two of my investigators. A review of the man's clinical care was carried out by Durham County Primary Care Trust (PCT). I thank the clinical reviewer for his assistance. I received the clinical review on 11 June 2008 and so I apologise for the resultant delay in issuing my own report. I also thank Governor for the co-operation of his staff, in particular the liaison officer who prepared the documents and arranged the visits for my investigators.

My investigation has found that the man received a good standard of medical care at Durham. I highlight a housekeeping point in regards to recordkeeping which the clinical reviewer has noted. It is also a point that I made in an investigation into a death of a man at Durham a few weeks after the man died. Additionally, I have made two recommendations in relation to officers monitoring meal times and roll checks.

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

**August 2008**

## **CONTENTS**

|                           |    |
|---------------------------|----|
| Summary                   | 4  |
| The Investigation Process | 5  |
| HMP Durham                | 7  |
| Key Findings              | 8  |
| Issues                    | 11 |
| Recommendations           | 13 |

## **Annexes**

Clinical Review

## **Evidence Considered**

Personal prison records and history sheets  
Medical record

## SUMMARY

The man had been in custody for 12 days when he died of ischaemic heart disease, caused by coronary artery atheroma (fatty deposits on the inner lining of an artery which restrict blood flow) and left ventricular hypertrophy (increase in size of an organ).

He had an appropriate medical examination upon his reception and continued to be regularly monitored by the substance misuse team for an alcohol detoxification programme.

Ten days after arriving in custody, on 25 December, the man complained of breathlessness and chest pain. He was seen by a nurse and the following day attended a doctor's appointment. The pain was thought to be in his shoulder and unlike cardiac chest pain.

On 27 December at 8.20am, the man was reportedly unlocked for a gym induction but refused to attend, although his cellmate does not remember this. According to prison records, this appears to be the last time he was seen alive. The man's cellmate tried to wake him on several occasions to fetch his meals, but thought that he was sleeping as he had not had a lot of sleep over the previous couple of days. He was not concerned at that point to call for staff assistance. The wing officers would have locked and unlocked cell doors several times that day as well as completing at least two roll checks.

After the evening meals were collected, prisoner's cells were being locked up again. When an officer arrived at the man's cell, his cellmate reported to him that the man had been under his cover all day and had not collected any meals. The officer entered the cell to check on the man. When he pulled back the covers he believed the man to be dead, as did his cellmate, who described the colour of his body as purple. The officer called for assistance and all those who attended agreed that the man had died, because rigor mortis had set in. This was the view also of the nurses who attended and therefore, no resuscitation was attempted. A doctor arrived and confirmed the man's death at 6.26pm.

Although the man had complained of feeling unwell two days prior to his death, the clinical reviewer found that his death was sudden and unexpected.

## INVESTIGATION PROCESS

1. My investigator requested all the relevant prison records including the man's medical and core prison records. One of my investigators visited the prison and spoke to several members of staff.
2. Notices to staff and prisoners were sent to the prison to be displayed. These invited anybody with information to talk to my investigator. The second of my investigators traced and interviewed the man's cellmate who had subsequently been released from prison. The information which he provided is included in the Key Findings section of my report. No other prisoners came forward.
3. County Durham PCT was asked to carry out a clinical review into the man's healthcare whilst he was in prison.
4. HM Coroner for Darlington and South/North Durham districts was informed of my investigation. The Coroner kindly shared the post mortem with my investigators. He will receive a copy of my report.
5. The man's mother was identified as his next of kin. One of my Family Liaison Officers spoke to his mother to offer her the opportunity of involvement in the investigation. She asked that we confirm her son's cause of death. She also enquired whether her son had complained of stomach pains two days before he died and whether he saw a doctor about them. The man's mother also wanted to know if all aspects of his healthcare were investigated.
6. After receiving the draft report, the man's mother told my Family Liaison Officer that she had been informed by the man's cellmate that he had tried to wake the man at about 6.00am. She said he told her that when he got no response he alerted staff. The man's mother also said that the prison liaison officers had told her this. My investigators have looked at the evidence and spoken to the liaison officers in relation to this. There is no evidence to support staff being alerted at 6.00am, however, the findings do show that staff were alerted just before 6.00pm when they were unlocking for mealtime.

## **HMP DURHAM**

7. 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.
8. 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.
9. 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.
10. Another prisoner at Durham died two weeks after the man. Both deaths were due to natural causes. A recommendation regarding recordkeeping was made in the other report and is highlighted again in this case. However, Durham have only recently received my draft report into the other death and will not yet have had the opportunity to action the recommendations.

## KEY FINDINGS

11. When the man arrived at HMP Durham on 15 December, he was seen by a nurse for a reception health screen. The screening determines any current problems with physical and mental health and illnesses such as asthma, diabetes, angina and heart disease. The man only answered 'yes' to problems with asthma and said he was prescribed inhalers for the condition. In relation to substance use, the man felt that his alcohol consumption was a problem and he asked for help to deal with it. The section relating to drugs has a line drawn through it.
12. The nurse referred the man to the doctor and the Counselling Assessment Referral Advice and Throughcare (CARAT) team, a drugs intervention team. The CARAT paperwork shows that the man did not want to access the service and the reason given was that he did not use drugs.
13. The doctor saw the man later that day and noted in the medical record that the man had active problems with dyspepsia, alcoholism and asthma. He prescribed medication accordingly and placed the man on a detoxification programme for his alcohol misuse. He also made a referral to the substance misuse team.
14. Two days later, a member of the substance misuse team met the man. The record of the meeting shows that the man said that in the community, he had drunk lager and vodka from wakening until going to sleep every day and had been drinking at this level for approximately ten years. At the time of the meeting, he was not displaying signs of withdrawal, which had stopped once he received the medication on his reception. The record of the meeting also shows that the man had an allergy to hazelnuts. He did not have a reaction to other nuts, but hazelnuts caused his skin to be blotchy, his throat to swell and make breathing difficult.
15. The man was seen by the substance misuse team each day for three more days in order for them to take his medical observations and monitor his withdrawal symptoms. These were being controlled by his medication. He was offered the services of Alcoholics Anonymous (AA) but declined it at the time.
16. On 25 December, healthcare were called by wing officer support grade (OSG) to see the man after he had pressed his cell bell. The entry in the medical record is not timed, but the wing observation book shows it was at approximately 8.30pm. The man had been complaining of shortness of breath and chest pain radiating down both arms. The nurse noted that his colour was good and his breathing normal. He was advised to rest on his bed with his knees bent and the nurse would return to check on him after an hour. The medical record does not note whether the nurse checked on him again but the man's ex cellmate thinks he remembers somebody coming to the cell observation panel again. In her statement, the OSG remembered the nurse saying that the man's blood pressure was also fine and gave him some medication, although there is no record of any

medication in the medical record. His cellmate said at interview that the man was finding it difficult to sleep because of the pain in his arms but that they were talking and watching television together.

17. The following day, 26 December, the man finished his detoxification programme. He told the substance misuse worker that he now wished to be informed of the next AA meeting. The man's cellmate also remembered a nurse coming to see him that day and he thought that she told him to go and see the doctor. The man did indeed see a doctor that day about the pain he was experiencing. The medical notes indicate that, on examination, no signs of serious illness were discovered. The clinical reviewer noted that the clinician had sufficient information to exclude any serious illness (pathology) and that there were no signs of cardiac problems or exacerbation of his asthma. The pain in his chest was deemed to be unlike a cardiac chest pain as it was in the shoulder region. The man was prescribed medication (diazepam).
18. That evening the man watched television with his cellmate. According to his cellmate, the man did not complain of any pain and thought that his medication was working.
19. The next morning, the man's cellmate tried to wake him for breakfast, but got no response. His blanket was over him so his cellmate could not see him clearly. He thought that the man was still asleep because he had had difficulty sleeping during previous two days.
20. Owing to the Christmas period, on 27 December the regimes were slightly different to normal. Prisoners were not unlocked for work, but the gym was running an induction programme. An entry in the man's wing history sheet that day, written by a prison officer on the wing, records that the man refused to attend the gym induction. The entry is untimed, but the officer later said he would have seen the man between 8.15am and 8.20am. The prison officer from the wing said in his statement that he did not know the man. He was therefore unable to say if this was his usual behaviour or explain why the man did not want to attend the gym. From his recollection, the officer from the wing felt that there was nothing about the man's appearance which gave him cause for concern. The man's cellmate said he did not remember anyone speaking to the man about the gym, but it may be that he was not in the cell at the time.
21. At approximately 10.00am, the prison officer from the wing unlocked prisoners for exercise. He could not recall if the man took exercise or not. Almost two hours later, at 11.45am, prisoners were unlocked to collect their lunch. The man's cellmate said that he tried to wake him for lunch, but he thought he was still sleeping and was not worried so did not tell any staff. At 12.20pm, the prison officer from the wing completed the landing roll check. In his interview, he commented that he checked through each door observation panel to count the occupants, he said that his understanding was that he was not required to obtain a response.



22. After lunch, prisoners were unlocked in preparation for the activities taking place that afternoon. The prison officer on the wing could not remember if the man was due to go anywhere. The man's cellmate went to his own gym induction. The next roll check was at approximately 4.10pm. The officer on the wing confirmed that he followed the same routine for the roll check as earlier in the day. Twenty minutes later, the prison officer on the wing finished his shift and left the prison.
23. A different officer took over duties on the man's wing at 4.30pm. The officer usually works in reception, but on 27 December was detailed to work on D wing. At approximately 5.45pm, the officer was locking the cells after dinner. He was outside the man's cell and asked his cellmate if the man had picked up his meal. The man's cellmate told the officer that the man had not had dinner and was in his bed (top bunk) where he had been all day. The officer asked him to give him a shake and wake him. The cellmate tried, but got no response.
24. The prison officer then approached the man himself but also got no response. He noted in his statement that he pulled back the blanket and it appeared that the man was dead. The man's cellmate was in the cell at the time and also thought that the man was dead. The officer felt for a pulse and described the man as "cold to the touch". He called for assistance from another officer who was on the opposite landing. The other officer also checked the man and then went to get the senior officer (SO).
25. The senior officer went to the cell and on the way contacted healthcare for assistance. Two nurses responded to the call. The first nurse arrived and went into the man's cell, with the second nurse following shortly behind. The nurses checked for vital signs but could not find any. In her statement, the first nurse described the man as "freezing" and both nurses agreed that he had died. The first nurse telephoned a prison doctor at home. The prison doctor arrived at the prison and confirmed the man's death at 6.26pm.
26. In line with contingency plans, the prison held a 'hot de-brief' with staff who were involved in responding to the events in the man's cell. Staff and prisoners were offered the support of the care team. The man's cellmate was moved to an area in the prison where he knew people. He mentioned that he was left out on the landing for quite a long time before he was moved. Staff placed him on a self harm monitoring form as a precaution. They also reviewed all other prisoners who were subject to self harm monitoring.

## **ISSUES**

### **Clinical care**

27. When the man arrived at Durham on 15 December 2007 he received a full assessment for his medical conditions. He started, and completed, an alcohol detoxification programme and received medication for his other medical conditions. The clinical reviewer found these medical decisions to be appropriate.
28. The man was regularly monitored and examined during the course of his detoxification programme, which he completed on 26 December 2007. After complaining of chest pains on 25 and 26 December, which appeared to originate from the shoulder area, his medical observations were taken and his blood pressure and pulse found to be satisfactory. His breathing was normal and his colour reported to be good. The clinical reviewer noted that the man was examined appropriately, which I note was during the Christmas holiday period when staffing levels are generally lower.
29. After his examination on 26 December, the doctor found that given his present symptoms, the man did not have a serious illness. The clinical reviewer commented that based on the findings of the examination along with the lack of abnormal physical signs and the man's lack of distress and ongoing pain, that this was a reasonable conclusion to have made without undertaking further investigation. An appropriate management plan was developed.

### **Record keeping**

30. Durham's healthcare unit operates a computerised medical record system. As with the other recent death at Durham, my investigator found that some entries were made solely on the paper record and at times, no notes were recorded, including prescriptions. On one occasion, on 26 December a nurse was unable to log on to the computerised records. The clinical reviewer found this an unacceptable practice. I reiterate the importance of recording all healthcare contact and prescriptions chronologically to ensure that it gives an accurate and continuous history of a prisoners' medical needs and treatment.
31. The prison will have only recently received the report into the other man's death and therefore will not have had time to action the points in my previous report. However, I highlight this again for the attention of the Head of Healthcare and the Governor.

### **Roll Checks**

32. This investigation has been unable to accurately determine when the man died. From the evidence supplied by prison staff it would appear to have been anytime after 8.00am on the morning of 27 December, although his

cellmate believes it may have been earlier because he did not witness an officer talk to the man about the gym induction.

33. Whatever the time of death, it was certainly early on 27 December. It is worrying that a man was potentially lying dead in a cell all day, despite numerous occasions when staff unlocked and locked his cell door and carried out roll checks.
34. It would be easy to criticise the officer carrying out wing duties that day for not noticing that the man had not taken his meals or come out of his cell. However, the man was in a shared cell and his cellmate was present for most of the day. It was therefore reasonable for the officer to assume that there were no problems.
35. My investigator asked for the local and national policy on roll checks, but at the time of drafting this report, a copy has not been made available. The recent training manual for new prison officers teaches them to obtain a response from individuals during roll checks however, without the local policy I cannot confirm if this is the practice at Durham or indeed across the prison estate.

**The Governor of Durham should satisfy himself that the local policy on roll checks is in line with national policy and training.**

36. There was also no way for staff or anyone else to identify whether the man took his breakfast or lunch meals, apart from his cellmate's reports. No register is in place at Durham which would monitor prisoners collecting their meals. Such systems are common practice in some other jails and they allow staff to monitor problems such as food refusal or potential ill health. They also provide an additional security check to ensure that prisoners are where they are supposed to be.

**The Governor of Durham should to consider implementing a meal collection checking system at Durham.**

## **RECOMMENDATIONS**

1. The Governor of Durham should satisfy himself that the local policy on roll checks is in line with national policy and training.

HMP Durham are still looking into this matter.

2. The Governor of Durham should consider implementing a meal collection checking system at Durham.

HMP Durham has accepted this recommendation and a checking system is due to be in place by the end of September 2008.

I also bring to the Governor and Head of Healthcare's attention the comments made in paragraphs 32 and 33 regarding recordkeeping.

I am pleased to note that the Governor has accepted the housekeeping points and an action plan is in place.