



**Investigation into the circumstances surrounding the  
death of a man,  
a prisoner at HMP Durham,  
at outside hospital in November 2010**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2012**

This is a report of the investigation into the circumstances of the death of a man in November 2010 at outside hospital. He had been transferred from HMP Durham on 22 November suffering from a chest infection. He was 60 years old when he died. The post-mortem report indicated that he died from bronchopneumonia due to pulmonary emphysema.

I would like to offer my condolences to the man's family on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's sister and nephew spoke with one of my family liaison officers. I hope my report begins to offer answers to their questions. It is with regret that this report has been delayed.

The investigation was carried out by one of my colleagues. I am grateful to Custodial Care Innovative Solutions who carried out a clinical review. I would also like to thank the Governor and staff at HMP Durham for their co-operation with this investigation.

The man was remanded to HMP Preston on 6 September. Upon reception, he was identified as being a long-term heroin user and was placed on a methadone prescription. Following a court appearance, he was transferred to HMP Durham where the reception doctor noted a chesty cough and crackly chest. He was prescribed antibiotics. Five days later, he was seen as a medical emergency and was found to be short of breath associated with a chest infection. Over the next two days, he was seen daily by a nurse who felt he was unwell but not poorly enough for admission to healthcare. He was seen by the doctor on 22 November and, his condition having worsened, was admitted to healthcare. Later that day, he was sent out to hospital where his condition deteriorated over the next few days. He died at 6.28am on a day in November. While the clinical reviewer has expressed certain reservations, overall the investigation found no significant concerns about the man's care at Durham.

The man had asked for a pagan funeral and I was impressed by the efforts taken by the family liaison officers to make arrangements for his wishes to be respected. There are no recommendations.

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 CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The man was remanded to HMP Preston on 6 September 2010. He was a long term heroin user and was also suffering from arthritis. He was placed on a methadone maintenance prescription of 110 millilitres (mls) by the Integrated Drug Treatment Service (IDTS). Five days later, he had a routine review with the IDTS team and there were no concerns. He did not come to the attention of the medical team again in Preston.
2. He was transferred to HMP Durham following a routine court appearance on 15 November. Upon reception, he was seen by the GP and it was noted that he had a chesty cough and crackly chest. He was prescribed antibiotics. His methadone prescription continued.
3. During the morning of Saturday 20 November, he was seen by a nurse as a medical emergency as he was short of breath when he went to the medical dispensing hatch on his wing. His pulse, respirations and temperature were normal. His blood pressure was low. He was referred to the doctor. At 3.30pm, he was seen by the healthcare support worker and it was noted that he had not seen the doctor. He was later seen by a nurse at 5.40pm, who found him to be unwell and discussed him with the doctor who was covering Saturday duties in the prison. The doctor did not see the man but the plan was to review him the next day.
4. The following day, the nurse saw him again and assessed him as still unwell but not ill enough to need healthcare admission. She wrote in the medical record that she told the wing nurse to see him later but there is no record that a nurse saw him again that day. The next morning, at 9.44am, he was seen by another nurse and referred to the doctor for a review. At 2.13pm that afternoon, a doctor examined him and decided to admit him to the healthcare centre. He was given oxygen as his oxygen saturations were low (insufficient oxygen in the blood). Blood samples were taken to the hospital. The doctor saw him again after his afternoon surgery and then telephoned the local hospital to discuss whether he should attend the rapid assessment unit. The sister he spoke to said that she felt he should be admitted and arrangements were made to admit him later that day when a bed became available.
5. The man was taken to hospital and settled on the ward by 8.30pm with two accompanying bed watch officers. He was cuffed to one of them. He was a remand prisoner and therefore according to policy was required to be double cuffed. (Double cuffing is where two sets of handcuffs are used. One set is applied to each of the prisoner's wrists and one cuff of the second set is attached to the prisoner and the other cuff to one of the escorting officers.) He was seen on 23 November by the consultant at the hospital, who said he would be in hospital for a few days. On 26 November, his situation became very unstable and he was returned to the intensive unit. The cuffs were removed at the request of nursing staff. The man died a few days later from bronchopneumonia.

6. The man had wanted a pagan funeral, something the prison family liaison officers were unfamiliar with. To their credit, and with great sensitivity, they researched and found a pagan minister who carried out the service. Prison staff attended and following his cremation his ashes were taken to his sister at her request.
7. Having considered his clinical care, use of restraints and drug treatment nothing of concern has been found and no recommendations have been made.

## THE INVESTIGATION PROCESS

8. An investigator opened the investigation by telephone on 30 November. Her liaison officer sent the documents relating to the man to the office for her to review.
9. The investigator made contact with the NHS County Durham and Darlington by email on 29 November asking for the appointment of a clinical reviewer. On 10 December, she was told that they had commissioned Custodial Care Innovative Solutions (CCIS) to carry out a review of the man's medical care during his time at HMP Durham. She emailed CCIS on 15 December and was given details of the clinical reviewer the next day. Despite the investigator's request, the reviewer indicated he was not available for joint interviews. The final review was sent in July 2011 after quality issues had been discussed at length. Unfortunately, an additional delay was caused by workload pressures in this office.
10. The investigator visited HMP Durham on 20 January 2011 and interviewed two members of the healthcare team. (Copies of these transcripts were emailed to the clinical reviewer.) In addition, she saw the cell and landings where the man had been resident. She met the Governor, the Independent Monitoring Board (IMB who monitor standards of decency in prison) chairwoman, a Prison Officers Association (POA) representative, the Head of Healthcare and the Head of Safety and Decency. None reported any concerns regarding the man's death or about Durham in general. She also met with the family liaison officer for the prison. The man's cellmate had been released from custody a few days earlier.
11. One of the Ombudsman's family liaison officers made contact with the man's sister whom he had nominated as his next of kin. He later spoke with the man's nephew who was representing the family, although he did also speak again with the man's sister at her son's request. No specific concerns were raised by them.
12. A copy of the draft report was sent to the National Offender Management Service (NOMS). They found no factual inaccuracies.
13. The man's family received a copy of the draft report as part of the consultation period. Written representations were provided by the man's sister in response to the findings of the investigation. A number of areas of concern were raised including the healthcare provided to him. His family explained that they found the findings of the investigation upsetting and difficult to read. The family added that they felt that the prison service contributed to the decline in their relative's health and ultimately to his death. Although the comments have led to no changes in the investigation report, the investigator has addressed the issues raised in separate correspondence to the man's sister.

## HMP DURHAM

14. HMP Durham is a category B prison holding just under 1000 male remand and sentenced prisoners. Category B prisoners are those who do not require maximum security but for whom escape needs to be made very difficult. The prison consists of six wings as well as segregation, healthcare and those specialising in drug treatment.
15. The Integrated Drug Treatment System (IDTS) is a national mandatory programme for prisons. IDTS aims to not only increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, but also to improve integration between clinical and CARAT (Counselling, Assessment Referral Advice and Throughcare) Services and to reinforce continuity of care from the community into prison, between prisons, and on release into the community.
16. Healthcare at Durham is provided by NHS County Durham. It is nurse lead, with access to general practitioners and specialist such as psychiatrist and dentists. There are 19 inpatient beds in the 24 hour cover healthcare unit. On Saturdays, from early morning until 5.30pm, there is a doctor present in the prison mainly to cover the new receptions, the segregation unit, and emergencies. Outside of these hours, and on Sundays, the out of hours doctor service is used.
17. This man's death is the 13<sup>th</sup> by natural causes at HMP Durham since 2004 when this office took over responsibility for investigating deaths in prison. There are no common features with this man's death.

## KEY EVENTS

18. The man was born in May 1950. He was described in his prison records as a pleasant and respectful man. He had applied for work and education whilst in custody.
19. He was remanded into HMP Preston on 6 September 2010 following an appearance at a magistrates' court for an offence of conspiracy to supply class A drugs. He was due to stand trial at a crown court on a date to be fixed.
20. On his Person Escort Record, (used to share information between the police, escort services, courts and prison service), he was identified as having drug and alcohol issues and given medication at the police station for opiate withdrawal. In his cell sharing risk assessment, (to identify whether a prisoner is a risk to others) he was identified as a low risk to others and himself. Upon reception, the first night health screen was completed. The man declared he had hepatitis C and that he suffered from arthritis. He was a long standing smoker of heroin and was receiving a prescription of methadone of 110mls (a high dose) in the community but in addition used heroin on top. He was also prescribed amitriptyline (antidepressant), co-codamol (pain killer), lanzaprazole (anti-ulcer indigestion drug) and Gaviscon (for indigestion).
21. The man was referred to the doctor for his substance misuse but declined a referral to the mental health team. He had said that he had suffered from depression and anxiety ten years previously whilst in HMP Durham but had no thoughts of self-harm. He was assessed as fit for a normal residential unit and work. After five days, he had a routine ITDS appointment review which was the last time he came to the attention of medical staff whilst in Preston.
22. The man moved to HMP Durham on 15 November, following a court appearance at a crown court. Upon reception, he was seen by a doctor who noted that he had a chesty cough and crackly chest. He prescribed an antibiotic, amoxicillin, for a chest infection and continued his other prescriptions.
23. On 16 November, the man was seen by the drug consultant from the IDTS team and he continued on his methadone prescription of 110 mls. Over the next few days, he had a number of routine ITDS appointments, none of which showed any cause for concern with his maintenance treatment for substance misuse.
24. On Saturday 20 November, his medical records say that 'healthcare emergency response re SOB [short of breath] @hatch this morning. 'Methadone to be omitted this morning until seen by Doctor. I/C (in-charge nurse) informed. For follow up'. The nurse noted that the man had a chest infection. His pulse, respirations and temperature were normal. His blood pressure was 94/74 which borders on being a low reading (his blood pressure on 6 September upon reception into HMP Preston was 110/81). Later, at 3.30pm, he was seen by a health care support worker who noted 'at time of

tea time arrangements [he] has yet to be seen by the Dr, continue with omitting with methadone until he has been seen by Dr in light of how he was presenting this morning'. Records show that he was given methadone later that day.

25. Later, at 5.40pm, a nurse visited the man in his cell. She wrote 'feels unwell in himself, pyrexial (fever) and c/o [complaining of] aches and pains and feeling unwell in himself, coughing with green sputum, no wheeze, no SOB at rest, discussed with [doctor]'. The nurse planned to review him again the next day. In interview, the nurse had said that she spoke with a doctor who was the doctor on duty that Saturday and still in the prison, about the man to confirm her assessment. Although she did not have a clear memory of seeing the man, she did recall him using the word 'yucky' to describe how he felt and she remembered he looked very elderly. Nevertheless, in her judgement she was satisfied that the antibiotics were working.
26. On 21 November, at 11.15am, the nurse again saw the man as a follow-up from the day before. He remained unwell but in interview she said 'clinically there wasn't a lot to be concerned about at that time'. Had she been concerned, she would have been able to arrange for him to move into the healthcare unit. In the medical record she recorded:

'chest air entry and exit heard through all lung fields, slight crep upper right, still feels unwell, productive cough with green sputum, encouraged to drink fluids and continue with antibiotics. Wing nurse will review again this afternoon, plan: review again tomorrow, IC (nurse in charge) informed'.
27. There is no record of anyone seeing him later that day. The next day, 22 November, the man saw a nurse at 9.44am who noted: 'seen in cell to give methadone, has remained in bed, pad mate getting him meals, but not eating much, trying to drink plenty of fluids, still Dyspnoea (shortness of breath) on exertion. Plan; still taking antibiotics as prescribed, for dr review today'.
28. According to the medical record, the man was seen by a doctor at 2.13pm. In interview, he said that if he had been asked to see him specifically in the morning he would have done so but he was asked to see him at some point that day. He said:

'I suppose it's one of these things where in retrospect, because we know he was very ill, we could have seen him earlier. I think the problem that I've got as a doctor is that I don't know how ill he is until I've seen him. And I suppose retrospectively it's always nicer to have seen people earlier than you actually did.'
29. The doctor recorded in the medical record:

'History: review of chest  
Examination: SoB at rest. Productive sputum –clear. Very pale. No ankle swelling at present but describes swelling over last few weeks. Coarse

crackles both lung fields and very moist bases. JVP (Jugular Vein Pressure) not raised.  
Plan; check bloods. CXR (chest x-ray) Admit HCC (healthcare centre).  
Make comfortable Back rest if possible Check sats (saturation levels).  
Urgent CXR'

30. In interview, the doctor explained that:

'because of the swelling over the last few weeks made me wonder if he might have a degree of heart failure. When I examined his chest he had a lot of noises in both lungs and he was particularly moist at the bases of the lung, that is there appeared to be a fair amount of fluid at the bases of both lungs. I make an entry to the effect that his Jugular Vein Pressure (JVP) wasn't raised. JVP is a vein in the neck which stands out, or stands up, in cardiac failure. So I had an idea in my head that as well as the chest infection he might have a degree of cardiac failure. But there were no definite pointers to that.'

31. After the doctor arranged for him to be admitted to the healthcare centre, bloods were taken and sent by taxi to the hospital in line with normal practice and as a matter of routine. The medical record suggests that the results were received within 20 minutes which the doctor explained must have been an error to record the results coming back so quickly, and the time is likely to be when the sample left the prison.

32. At 3.30pm, an entry in the medical recorded:

'[The man] has been admitted to healthcare for observation and care. No back rest available but I have requested he is given extra pillows to allow him to sit comfortable in bed and assist his breathing. [The doctor] wishes to see him on a daily basis. He was given oxygen on admissions as oxygen saturation was low. Admission for care.'

33. The same nurse made another entry at 3.57pm having taken various readings which were all low:

'BP recorded at 79/52. Pulse 82 and oxygen stats 83%. Discussed with [doctor] who will see him after surgery and will consider sending him to hospital. Low blood pressure reading.'

34. The doctor said that after his afternoon surgery he phoned the local hospital to discuss sending him to the rapid assessment unit. However, the sister he spoke to advised that it would be preferable to admit him into hospital. The doctor completed a referral letter (a copy of which was not on file but he confirmed with the hospital that it had been received although they would not provide him with a copy). At 5.49pm, an entry in the MR states '[The doctor] has made arrangements for [the man] to be admitted to Ward 3 at UHND for observation'.

35. Another entry at 6.14pm, said 'settled and comfortable at time of report sats (readings) remain above 95%.....however they drop off rapidly when oxygen is removed. Awaiting phone call from UHND ward 3'. By 8.30pm, the man had been taken to hospital and was located onto ward 3. For the purposes of the bed watch, he was assessed as requiring two officers accompanying him known as a 'standard escort'.
36. According to the bed watch records, on 23 November, the man was taken to the toilet but could not make it alone so was placed in wheelchair and upon return to bed started to vomit. At 11.40am, he was seen by the consultant who said he had a bad chest infection and this was in hospital for a few days. On 24 November, he was seen by a doctor and told that there were shadows on both sides of chest and fluid in lungs. He was told that he would be in hospital over the weekend. On 25 November, he had a CT scan (used to monitor or diagnose different health conditions) and later had a visit from friends.
37. On 26 November, bed watch staff were told that his situation was unstable and serious. At 12.55pm, he was moved to the intensive unit. The bed watch officer contacted the prison to ask for the man's family to be contacted and subsequently his nephew phoned the hospital and prison to discuss his uncle's health. Entry on the bed watch log says that 'cuffs removed at the request of ITU (intensive unit) staff after risk assessment and the OK from security'. On 27 November, at 8.00am, the Governor told bed watch staff that the man's condition had become terminal and he was to be allowed visits by his family if they were able to attend, which they were unable to do. He died shortly thereafter.
38. The man had given his sister's details to be listed as his next of kin. The family had already been made aware that he was very ill in hospital by the prison. Following his death, the sister on the ward telephoned his family to break the news. At 8.40am the prison FLO telephoned the man's sister to explain what would happen next. She asked that the prison arrange the funeral locally and that they would try and attend if possible.
39. The man had requested a pagan cremation which staff arranged and two family liaison officers from the prison attended. The funeral expenses were paid by the prison. His property was returned to his sister's home in person by one of the prison staff.

## **ISSUES**

### **Substance Misuse**

40. According to the clinical reviewer the man's drug dependency was very well assessed and the methadone appropriately prescribed. He comments that there does not seem to be any indication that his drug dependency was either a causative factor for his respiratory illness or that it had any adverse effect on the outcome of his respiratory illness.

### **Respiratory condition**

41. In relation to the initial treatment of the man's respiratory illness, the clinical reviewer suggests this was appropriate. The clinical reviewer states that he is unsure of the clinical picture passed onto the doctor on the morning of 22 November when he was asked to re-assess the man's overall care. He suggested that the deteriorating picture with low blood pressure and increasing breathlessness may have suggested the need for an earlier assessment being carried out than the timing of 2.13pm.
42. The doctor told the investigator that he would have seen him earlier had he been told he needed to see him urgently. However, he was not referred as an emergency. The reviewer said that the clinical picture found from 2.13pm until 4.00pm also seemed to suggest that an urgent transfer to hospital was required, independent of blood tests or chest x-ray results. In interview with the investigator, the doctor explained that he admitted him to healthcare and arranged for blood tests and a chest x-ray. He telephoned the local hospital and, on their advice, he arranged for him to be admitted that day once the hospital had a free bed. On balance, the actions taken by the doctor appear defensible and his judgement call understandable under the circumstances.
43. The clinical reviewer was not significantly critical of the actions of staff, but made one recommendation suggesting the healthcare team at HMP Durham might benefit from carrying out their own self-reflective review of healthcare practice.

### **Family Liaison**

44. The FLO from the prison mentioned to the investigator that he was not told about the man being in hospital. Ideally, he would have liked the FLO team to have been told by prison healthcare staff when the news from the hospital made it clear that he was not going to live very long. The FLO spoke about being able to make contact with the family at that stage to introduce himself and explain what would happen in the event of the man's death, something which we would consider good practice. However, the man's condition was only described as terminal the day before his death. (The man's family had been informed of his hospital admission by the prison on the afternoon of 26 November when it became clear that his situation was serious.) The investigator drew this to the attention of the Head of Healthcare and was assured that a protocol had been put in place to ensure that this did not

happen again. We are, therefore, not minded to make a recommendation about this issue.

45. The man had requested that he have a pagan funeral and we are impressed that the prison FLOs researched and found a pagan minister who carried out the service. His family were not able to attend and two of the FLOs went as representatives from the prison. His ashes were returned to his sister.

## CONCLUSION

46. The man's substance misuse was treated appropriately in custody. On transfer to Durham, he was diagnosed with a chest infection and prescribed antibiotics. As his condition deteriorated, he was examined by a senior primary care nurse on 20 and 21 November. In discussion with the doctor, it was agreed that he was responding to treatment. Nevertheless, his condition deteriorated and he was eventually seen by the doctor on 22 November who secured an admission to hospital that day.
47. Staff responded to the man's complaints of ill health promptly and appropriately. Observations were taken regularly as his condition deteriorated. While the clinical reviewer has expressed certain reservations, overall the investigation found no significant concerns about the man's care at Durham.