PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Durham in July 2013

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, a prisoner at HMP Durham. He died in July 2013 from heart failure. He was 72 years old. I offer my condolences to his family and friends.

A review of the man's clinical care whilst at the prison was undertaken. HMP Durham cooperated fully with the investigation.

The man had been diagnosed with a number of chronic ailments before he arrived at Durham in January 2013. Soon after he arrived, he began to experience chest pain and tests revealed that there was an obstruction in an artery. He made a good recovery after surgery.

In the week leading up to his death, the man had further pains in his chest, and complained of breathlessness and feeling extremely hot in his cell. Healthcare staff saw him on several occasions during that period. In July, his cell mate alerted staff that the man seemed very ill and was gasping for breath. Nurses arrived quickly but he was unresponsive. Efforts to resuscitate him were unsuccessful and he was declared dead shortly afterwards.

The investigation found that the man received prompt and appropriate medical care while he was at Durham and I am satisfied that his death could not have been prevented. However, I am concerned that when he went to hospital in February and had cardiac surgery, physical restraints were used without a fully considered risk assessment. While not directly related to the cause of his death, we also make recommendations about the need for improvements in relation to the environment for prisoners with asthma and other breathing difficulties.

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 **April 2014**

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SUMMARY

1. The man was remanded into custody at HMP Durham on 12 January 2013. He was 71 years old and this was his first time in prison.

2. The man suffered chest pains on 3 February and was admitted to hospital where he was diagnosed with obstruction of the coronary arteries. He was double handcuffed on his way to hospital and restrained by an escort chain throughout his stay, although a risk assessment had indicated that he was a low risk of escape. On 12 February, he suffered a cardiac arrest in hospital. Tests revealed that there was a blockage in the artery supplying blood to his heart. After a coronary angioplasty, he returned to the prison on 17 February.

3. On 21 July, the man complained of pain in the left side of his chest and said that he felt that he could not breathe because of the heat and lack of ventilation in his cell. He was taken to hospital for observation and returned later that day. Healthcare staff saw him eight times in the next six days as he continued to have difficulty breathing. He moved cells to try to get a cooler, better ventilated environment. On 26 July, he did not wait for a GP appointment because of the smoky atmosphere in the healthcare waiting room.

4. A few days later the man's cell mate summoned help as he appeared very ill and gasping for breath. When healthcare staff arrived he was unresponsive and they began cardiopulmonary resuscitation (CPR). Paramedics arrived shortly afterwards and continued CPR. He did not recover and was pronounced dead shortly afterwards.

5. The man was an older prisoner in poor health who had been assessed as a low risk of escape and we are concerned that the use of restraints during his hospital stay in February 2013 was not justified by a fully considered risk assessment. We make a recommendation about this issue. Although not directly related to his cause of death, the clinical reviewer considered that some aspects of his treatment for asthma could have been better and we also make recommendations about this, including the need to enforce a smoke-free environment in healthcare waiting areas.

6. Overall, the clinical reviewer concludes that the man's chronic medical conditions were generally well managed and comparable with what would be expected in the community. He received appropriate treatment for his heart condition and we do not consider that the prison could have prevented his sudden death from heart disease.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Durham on 5 August 2013. He met the manager of the wing where the man had lived and spoke to staff and prisoners. He obtained copies of his prison records, including his medical record. Notices were issued announcing the investigation to staff and prisoners at Durham, asking anyone with relevant information to contact the investigator. One prisoner wrote to him in response.

8. On 1 October, the investigator interviewed five members of staff and gave preliminary feedback on the investigation to the Governor. He interviewed the man's cellmate, who had recently transferred from Durham to HMP Northumberland.

9. NHS County Durham appointed a clinical reviewer to assess the man's clinical care at the prison.

10. The investigator informed the local Coroner of the investigation and the Coroner provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.

11. One of the Ombudsman's family liaison officers telephoned and wrote to the man's family to explain the investigation process. He did not receive a response.

HMP DURHAM

12. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria. It holds up to 990 prisoners.

13. Healthcare is provided by Care UK and GP services are supplied by The Gables Medical Group from 9.00am until 9.00pm. At the time the man was at the prison, the healthcare centre was in the process of being modernised and there were only four inpatient beds in a temporary location on B wing. A comprehensive range of primary and secondary healthcare services was still available to prisoners. The new centre opened in December 2013.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons (HMIP) last inspected Durham in October 2011. Inspectors found the overall standard of health care to be satisfactory. The care of prisoners with lifelong conditions, such as asthma, diabetes and heart disease was good. Although both the clinic and inpatient areas were clean, inspectors noted that a major refurbishment of the healthcare facilities was required.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its 2013 annual report, the IMB acknowledged that the provision of health services had been difficult while a new health centre was being completed. The IMB also noted that there were often delays in prescribing medication after a prisoner arrived at Durham and in conducting reception health screens if reception was busy. The average wait for a GP appointment was six days.

Previous deaths at HMP Durham

16. We have investigated a number of deaths at Durham. The man was the fifth prisoner to die since 2012. None of the circumstances were similar to those of his.

KEY EVENTS

17. On 12 January 2013, the man was remanded into custody by a Crown Court charged with attempted murder of his wife. He was taken to HMP Durham. He was 71 years old and had not previously been in prison.

18. A nurse carried out an initial reception health screen when the man arrived at Durham. She noted that he had a number of pre-existing medical conditions, including rheumatoid arthritis, asthma and type two diabetes. He had coronary heart disease for which he had had coronary artery bypass surgery. A prison GP had received his medical records from his home GP and reviewed him later that day. He referred him to a number of specialist clinics at Durham for ongoing monitoring and care.

19. On 1 February, a nurse went to the man's cell after he had complained of chest pain radiating down his left arm. The nurse examined him and administered oxygen in an attempt to relieve his symptoms. He then decided to send him to hospital by emergency ambulance. After being assessed at hospital, he was discharged back to the prison later that day with a diagnosis of possible angina attack or general musculoskeletal chest pain.

20. On 3 February, the man again complained of chest pain which was not alleviated by his GTN spray (glycerol trinitrate spray, to help the symptoms of angina and heart pain). A nurse attended and sent him by emergency ambulance to hospital.

21. Before the man went to hospital, the prison carried out a risk assessment to consider the security measures required. The section of the assessment for healthcare staff was not completed. He was assessed as being a low risk of escape and medium risk to the public or hospital staff if he did escape. Despite the low risk of escape, the Head of Residential Services instructed that two staff should accompany him and use double handcuffs while he was being transported and an escort chain in hospital. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. An escort chain is a long chain with a handcuff at each end attached to the prisoner and an officer.)

22. Staff at the hospital examined the man and diagnosed acute coronary syndrome (obstruction of the coronary arteries). He was admitted to hospital and later that day an angiogram (an X-ray of the blood flow around the heart) revealed that he had a blockage in the blood supply to the heart muscle which would require a surgical procedure to correct.

23. On 12 February, the man suffered a cardiac arrest while having an X-ray. A nurse administered cardiopulmonary resuscitation (CPR) and he recovered.

24. The man was transferred to hospital on 15 February, where doctors decided that he needed a balloon angioplasty. (This is a procedure where a deflated balloon on a catheter is passed through the arterial system to the blocked coronary artery. The balloon is then inflated which opens up the artery. A stent is then inserted to keep the artery open.) He recovered well and returned to the prison on 17 February

25. The man continued to make good progress. Healthcare staff monitored him regularly and made changes to his medication in line with specialist advice.

26. On 10 May, the man told a doctor that he had passed two clots of blood in his urine. The doctor concluded that this was probably related to his medication and arranged to review him the next week after some adjustments to his prescription. On 17 May, the doctor reviewed him and referred him to the urology department at hospital for further investigation, although he had not experienced any further urinary bleeding. The doctor asked the pharmacist to review his medication and issue him with blister packs so he would find it easier to manage.

27. At 12.10pm the next day, a nurse went to the man's cell, as he had been experiencing pain in the left side of his chest. His cell mate thought he might have lost consciousness for a while. She decided to send him to hospital by emergency ambulance. His risk assessment was similar to the previous one with the same requirement for restraints. Hospital staff concluded that he had suffered from musculoskeletal chest pain, probably as a result of the surgery he had had in February, and he was discharged the next day. Healthcare staff continued to monitor him closely. He attended routine appointments and appeared to be making good progress.

28. On 21 July, a nurse responded to a code blue emergency radio call (which is used to signify a prisoner has breathing difficulty or is unconscious). The man complained of pain in the left side of his chest and told the nurse that he felt he could not breathe because of the heat and poor ventilation in his cell. She asked if he would like to move cells but he declined. She gave him his inhaler, but noted that his inhaler technique was poor. He told her he was using it in line with advice given to him by a GP. She decided that, because of his medical history, it would be wise to send him to hospital by emergency ambulance for observation. He returned to the prison later that day.

29. Later that day, a nurse reported the man's concerns about the heat and lack of ventilation in his cell to an officer and asked if an alternative cell could be found for him. She also referred him to the prison's asthma clinic for guidance on using his inhaler.

30. On 26 July, the man did not attend a scheduled appointment with a prison GP. He told a healthcare support worker that he had been asked to go into a waiting room where other prisoners were smoking, although it was a non-smoking area routinely patrolled by prison officers. He had told the officers that because of the smoke, he wanted to wait elsewhere. He was told there was no other area available and he therefore asked to return to his cell. She arranged for him to see a GP later that day.

31. Shortly after he returned to his cell, the man complained again of being short of breath and of feeling hot. A nurse took him to a cooler, more ventilated area, where he recovered. Later that day, he was moved to another wing which was thought to have better ventilation. However, later that day, another nurse was called to his cell as he continued to complain of feeling hot and being unable to breathe due to the lack of ventilation in his cell, which he thought was affecting his asthma. She made sure that he had his inhaler and left the cell.

32. Later that evening, a nurse went to the man's cell again after he told prison officers that he was short of breath and feeling hot. She told him that the cells all had the same level of ventilation and there was nothing more she could do. She noted that he was unhappy with her response.

33. At 12.35am on 27 July, the man's cell mate pressed the emergency cell bell because he was unwell and complaining of lack of air in the cell. A nurse attended. She recorded that he did not appear breathless and had used his inhaler. She was called back to his cell at 12.47am, when she found him lying on the floor. She noted that his oxygen levels and pulse were normal. She later recorded in his medical record that she was not convinced he had collapsed and thought that he might have fabricated this so he could be sent to hospital.

34. At 7.50am that morning, a nurse went to see the man, who was complaining he was unable to breathe. He gave him oxygen and noted that he made a good recovery. He later went out to the exercise yard with other prisoners to get some relief from the heat of the wing. At 11.14am, he collapsed in the exercise yard. The nurse took him in a wheelchair to a medical room, checked his pulse and gave him some water to drink. After a short while his condition improved. He arranged for him to move to a different cell in an attempt to find a cooler environment.

35. The nurse was called to the man's cell again at 5.00pm. He told him that he had vomited after taking his medication. The nurse noted that there was no food present in the vomit, only tablets. He noted that the man had just eaten his lunch and could not explain why there was no food present. He referred him to the doctor for a medication review.

36. On the day of the incident, at 1.05pm, the man's cell mate pressed the cell bell. He had heard the man gasping for breath and said he appeared to be in a "very bad state". A nurse attended and was unable to get a response from him. At 1.10pm, the nurse radioed a code blue emergency and the control room called an ambulance immediately. The cell mate was taken to another cell. Another nurse responded to the code blue and brought a bag containing emergency equipment. Another nurse also went to the cell. They helped the first nurse move him from the cell to the landing where there was more room and began cardiopulmonary resuscitation (CPR). They attached a defibrillator to him but it did not advise he should be shocked. The healthcare staff therefore continued to administer CPR.

37. Paramedics arrived at 1.23pm. Further attempts at CPR were hampered as the man's mouth continually filled with blood and paramedics were unable to clear his airway. The healthcare staff and paramedics discussed the situation and decided to stop CPR. At 1.36pm, the paramedics confirmed his death.

38. After the man's death, his cell mate was supported by prison officers and healthcare staff.

39. The man had nominated his daughter as his next of kin, and at 5.50pm, the prison chaplain, who acted as the family liaison officer, and a supervising officer went to her home to inform her of his death. She said that she would let the rest of his family know, but asked the chaplain to inform her mother. He tried to contact her that evening by telephone, but was unsuccessful.

40. The next morning, the chaplain noted from his phone that the man's wife had tried to contact him and he had missed the call. He eventually managed to speak to her at 10.20am. She said that she was angry that she had learnt of her husband's death from her granddaughter and that the prison had not

informed her. He expressed his condolences, outlined what had happened and explained that he had informed her daughter first as she was nominated next of kin. She was not satisfied and ended the call.

41. The funeral was held on 7 August. Representatives from the prison attended. The prison contributed to the cost of the funeral in line with national guidance.

42. A post-mortem examination established that the cause of the man's death was congestive cardiac failure due to ischaemic heart disease as a consequence of coronary artery atheroma (hardening of the arteries).

ISSUES

Clinical care

43. The clinical reviewer has made a number of observations and recommendations on clinical matters which the Head of Healthcare will need to consider. Not all are repeated in this report.

44. He noted that the man's chronic medical conditions were generally well managed at the prison and comparable with the health provision available in the community. He thought that the response to, and management of, his acute health problems and his final illness were generally appropriate, timely and at least comparable to what could be expected in a community setting.

45. We are satisfied that the man's treatment and the handling of his medical care at Durham were prompt and appropriate. However, some areas for learning not directly related to the cause of his death are set out in the clinical review and about which we do not make recommendations in this report.

The man's breathing difficulties and environment

46. On 26 July, the man twice told officers that he was short of breath and felt hot. Nurses examined him in his cell but thought that he did not need treatment. That night he again complained to a nurse that he was hot and finding it difficult to breathe. She did not find any evidence of this and thought that he might be fabricating his symptoms. The clinical reviewer considers that the nurse's decision not to give treatment did not affect either the outcome for him, or his clinical care. When interviewed, the nurse said that she was satisfied that she did not observe any breathing difficulties at the time but she accepted that she could have recorded her observations more sensitively. On the morning of 27 July, he complained of the same symptoms. Another nurse gave him oxygen, which appeared to help.

47. There are numerous entries in the man's medical records before the events of 26 and 27 July, noting that he found it difficult to cope with the heat and lack of ventilation in his cell. Durham is a large Victorian prison and does not have a modern ventilation system. When interviewed, staff confirmed it was extremely hot in the residential areas of the prison at that time and poor ventilation was a problem.

48. There was a delay in moving the man after a nurse's request on 21 July and it appears that it was not possible to find a cell with adequate ventilation. While we understand that some efforts were made to move him to a more comfortable environment, it is a concern that a prisoner with acknowledged respiratory difficulties did not have a suitably ventilated cell. We appreciate the constraints of an old building but there is no evidence that remedial or supplementary measures such as providing an electric fan for the cell were considered. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prisoners with diagnosed respiratory problems are held in adequately ventilated cells in conditions which are not detrimental to their health.

Healthcare centre waiting room

49. On 26 July, the man did not attend a scheduled GP appointment as he did not want to sit in a waiting room where other prisoners were smoking. He was told there was no other alternative and returned to his cell.

50. The investigator established that the waiting area should be a no smoking area. Prison officers patrol the area outside the waiting area. When interviewed, the Head of Healthcare agreed that the waiting area should be smoke-free, and said that officers had been asked to search prisoners for tobacco. However, prisoners had continued to smoke in the area and officers said that they were unable to establish who was smoking.

51. It is a reasonable expectation that the no smoking rule in the healthcare waiting room should be rigorously enforced. It is a supervised public area and it is inappropriate for any prisoner to smoke there and put the health of other prisoners and staff at risk. We make the following recommendation:

    The Governor should ensure that the no smoking rule in the healthcare waiting areas is enforced.

Use of restraints

52. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

53. The man attended hospital both as an outpatient and for some inpatient stays. He was assessed as a low risk of escape, medium risk to hospital staff and a medium risk to the public should he do so. There was no input from healthcare staff and, therefore, staff did not take his health into consideration when assessing his level of risk as the court judgement requires. Although assessed as a low risk of escape, he, an older prisoner with multiple health problems, was subject to the use of double handcuffs while being escorted and an escort chain was used while he was in hospital.

54. At 11.00am on 12 February, the man suffered a cardiac arrest while an inpatient at hospital. The log of events, kept by staff accompanying him, indicated that the escort chain remained in place even when hospital staff were trying to resuscitate him. While carrying out a routine management check later that day, a senior member of staff was informed of the incident. At no time was consideration given to removing his restraints.

55. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that the prison fully considered the man's, with appropriate input from healthcare staff about how his conditions affected his risk. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.

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ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that prisoners with diagnosed respiratory problems are held in adequately ventilated cells in conditions which are not detrimental to their health.	Accepted	All cells in HMP Durham meet the mandatory requirements for ventilation. The Estates Department have an anemometer to measure ventilation of all cells to provide additional reassurance that minimum standards of ventilation are achieved. In the future event of any prisoners diagnosed with respiratory problems struggling in cells on normal location, they will be assessed for suitability to be admitted to the new Healthcare Centre Inpatient facility which has cells with air conditioning to assist with reducing the in-cell temperature.	Completed	
2	The Governor should ensure that the no smoking rule in the healthcare waiting areas is enforced.	Accepted	A Notice to Staff (NTS) and Notice to Prisoners will be issued to reinforce that prisoners must not smoke in these areas. Staff will be instructed through the NTS to challenge and deal with any breaches of this rule.	April 2014 Head of Residential and Safety.	
3	The Governor should	Accepted	Managers will be instructed to ensure that risk		

	ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time. Unless there are exceptional circumstances restraints should not be used during life saving treatment.		assessments fully take into account the individual circumstances of the prisoner and the risk they present at that time, whilst balancing the need for decency with security and protection of the public. Risk assessments for prisoners in hospital are dynamic and the use of restraints is reviewed, as necessary, to take into account any significant changes in circumstances. Specific ongoing consideration is given to medical opinion as to the use of restraints and the prisoner's condition and treatment, with reductions in the level of restraint as necessary. Such reviews form not only part of the daily management check, but are conducted on the basis of continuous assessment of risk by the escorting staff in attendance.	April 2014 Head of Security	