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 September 2014

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 at HMP Durham, on 14 September 2014, from bronchopneumonia due to the effects of diazepam. He was 32 years old. I offer my condolences to the man's family and friends.

The investigator was the investigator and a clinical reviewer reviewed the man's clinical care at Durham. The prison cooperated fully with the investigation.

In September 2013, the man was visiting a friend at HMP Durham when he was arrested and charged with smuggling drugs into the prison. On 10 September 2014, he was sentenced to eight weeks in prison and sent to Durham. Despite the circumstances of his conviction, prison staff did not identify any particular security risks or consider whether the man might try to bring drugs into the prison.

The man's cellmate shared a cell with the man from Friday 12 September, later told the police that the man had a significant amount of drugs concealed on him. Over the weekend, he and the man took some of the drugs. In the early hours of Sunday 14 September, the man's cellmate reported to staff that he was concerned about the man. Nurses monitored him at intervals but, shortly before 7.00am, an officer became concerned that the man could not be roused and called a nurse for help. Shortly afterwards, the man stopped breathing and staff called an ambulance. Resuscitation attempts were unsuccessful and, just after 7.30am, paramedics pronounced him dead.

The investigation found no evidence to indicate that the man deliberately took an overdose of drugs to kill himself, but he appears to have consumed a large quantity of drugs he had brought into the prison with him. Given the circumstances of his conviction, I am surprised that prison security staff did not identify the risk that the man might attempt to conceal drugs on his person when he knew he was likely to receive a prison sentence. Once it was recognised that the man's cellmate was suffering adversely from the effects of drugs, I am concerned that healthcare staff did not follow the procedures in the local overdose policy, including taking clinical observations. There was also some delay with the emergency response. However, it has to be recognised that the man freely embarked on very risky behaviour and ultimately was responsible for the consequences of his actions.

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 **July 2015**

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SUMMARY

1. In September 2013, the man was arrested and charged with trying to smuggle drugs into HMP Durham during a visit. On 10 September 2014, he was convicted and sent to Durham to serve an eight-week sentence. He was subject to routine reception searches, but prison staff did not identify any need for further security measures, despite the circumstances of his offence.

2. The man's cellmate said that the man had secreted a large quantity of drugs, before attending court. Over the weekend beginning Friday 12 September, the man and the man's cellmate took some of the drugs. At around 11.30pm on Saturday 13 September, the orderly officer in charge of the prison responded to a cell bell and found both men under the influence of drugs. He asked an officer to monitor them. At 1.40am, the man's cellmate rang the cell bell and said he could not sleep because the man was snoring. A nurse checked the man and considered he was under the influence of drugs but did not need any other intervention. The nurse did not take any clinical observations.

3. At 2.00am, the man's cellmate rang the cell bell again and said the man was bleeding. The orderly officer and a nurse found the man on his bed swaying and slurring his speech. The man's cellmate was also intoxicated. The nurse again believed that the man was under the influence of drugs. He was not bleeding but had vomited. The nurse and a healthcare assistant cleaned up the man. The man claimed he had taken only two sleeping tablets but his symptoms indicated otherwise. The nurse did not take any physical observations, as the local drug overdose policy requires, but agreed to monitor the man for the rest of the night. The nurse told the investigator that she did not consider that the man had overdosed.

4. At around 6.45am, the man's cellmate alerted staff that he was worried that the man was not responding. The officer radioed for help but did not call a medical emergency code, which should have resulted in the control room calling an ambulance. At around 7.00am, a nurse checked the man and found he was breathing, but his pulse was weak and she could not rouse him. She believed that she had asked for an ambulance at that stage and went to get medication to counteract the effect of an overdose. She could not find any in the nearby clinic, so she radioed another nurse to bring some. When she came back, she did not administer the drug, as the man had stopped breathing. She asked the orderly officer to call a code blue emergency. The prison called an ambulance at 7.03am. Staff administered cardiopulmonary resuscitation until paramedics arrived at 7.10am and took over emergency treatment. At 7.31am, the paramedics pronounced that the man had died.

5. We are surprised that the prison did not identify that it was likely that the man might smuggle in drugs and put in place security measures to monitor him. We consider that healthcare staff should have taken the man's clinical observations, when they suspected that he was under the influence of drugs and monitored him. We are also concerned that staff did not call an emergency medical code as soon as they found the man unconscious, just

after 6.45am, which delayed paramedics being called and that antiopiate medication was not immediately available. We make five recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Durham about the investigation, inviting anyone with relevant information to contact him. No one responded.

7. The investigator obtained the man's clinical and prison records. NHS England commissioned a clinical review, which was carried out by a clinical reviewer of Spectrum Community Healthcare. The investigator and clinical reviewer interviewed staff and a prisoner at Durham.

8. We notified HM Coroner for Durham and Darlington of the investigation and have sent him a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation process and invite her to identify any relevant issues she wanted the investigation to consider. The man's mother asked whether the man had experienced any chest pain in the weeks leading up to his death and if he or his cellmate had used their cell bell on the day he died.

10. The man's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. They provided the PPO with a copy of Durham's Community Health policy that was in force at the time of the man's death citing concerns that the policy had not been enforced in the provision of care to the man. We have sought to address this point and a number of other additional questions by way of separate correspondence to the solicitor.

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HMP DURHAM

11. HMP Durham is a local prison serving the courts of Durham, Tyneside and Cumbria. It can hold approximately 1,000 men. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

Her Majesty's Inspectorate of Prisons

12. The most recent inspection of Durham was in December 2013. Inspectors noted that the security department had begun some good work to reduce the availability of drugs in the prison but some security procedures, such as routine strip and squat searching in reception, and the use of segregation after visits were undertaken without supporting intelligence. Despite this, the positive mandatory drug testing (MDT) rate was still nearly twice the average for comparator prisons and prisoners said it was easy to obtain drugs in the prison. The prison said that preventing trafficking of unauthorised items was the main security priority. However, only just over half of suspicion drug tests requested, had been completed in the required timeframe and despite the acute problem of drugs, there was no supply reduction strategy or action plan.

Independent Monitoring Board

13. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its annual report for the year to 31 October 2014, the IMB noted that Durham was overcrowded. The IMB noted that the prison held drug strategy meetings to review and co-ordinate all aspects from security issues through to intervention programmes and updating the prison's action to deal with illegal substance misuse. The IMB reported that intelligence reports contributed significantly to the security and safety of prisoners and had been responsible for finds of illicit alcohol, illegal drugs and mobile phones in the prison.

Previous deaths at HMP Durham

14. Since 2012, there have been six self-inflicted deaths at Durham. In five of these deaths, staff did not call the correct emergency code, which should have led to emergency ambulances being called immediately. After a death in July 2011, we made a recommendation about monitoring prisoners suspected of having taken drugs. We repeat that recommendation here.

KEY EVENTS

15. On 8 September 2013, the man was arrested for trying to smuggle subutex (a heroin substitute) into HMP Durham while visiting a prisoner. He was charged in December 2013 and convicted on 10 September 2014. He received an eight-week sentence and was sent to HMP Durham. He had been in prison before.

16. Court custody staff completed a Person Escort Record (PER), which accompanies all prisoners when they move between police stations, courts and prisons. They noted that he had been convicted of bringing drugs into prison and identified "drugs and conceals drugs" as his current and relevant risk factors. The man arrived at the prison at 4.30pm with the escort record and a warrant, which outlined the details of his offence.

17. A reception officer recorded the man's offence and noted that he had been in Durham before, in 2006. Officers conducted a routine strip search as part of the reception process, but did not find any drugs. An Operation Manager at Durham, told the investigator that staff would not search a prisoner or take other precautions, such as segregating them, unless there was specific intelligence from the court or police to indicate that he was suspected of attempting to smuggle drugs into the prison. The man then went to the first night and induction centre on F wing.

18. At 6.28pm, a mental health nurse and a healthcare support worker saw the man for an initial reception health screen. The nurse told the investigator that she saw the information on the man's escort record about drugs, but he said that he did not misuse illegal substances and had not taken any drugs in the last month. Because of this, the nurse did not ask the man to provide a urine sample to test for drugs. The man said he smoked up to 40 cigarettes a day and drank alcohol three times a week. An alcohol screening did not identify any concerns.

19. An officer who worked in the first night centre, interviewed the man and explained the prison's rules and procedures. He told the officer that he had no immediate concerns. The officer gave the man a smoker's pack (tobacco and papers) and the number for his prison telephone account. The officer told the investigator that he did not recall the man. The man was allocated a shared cell on F Wing.

Thursday 11 September 2014

20. The next day, 11 September, an officer recorded that the man had completed an induction questionnaire and had not raised any concerns. A member of the prison chaplaincy team saw the man and a prisoner peer support worker explained the role of the drug and alcohol recovery team (DART) and talked about the risk of drug overdose and tolerance levels. The man declined to engage with DART.

Friday 12 September 2014

21. On the afternoon of 12 September, the man made two short phone calls to his sister and his brother. He spoke to his sister about a visit from his family he was expecting on Sunday morning and told his brother that he was happy with his sentence.

22. At around 6.00pm, the man's cellmate who had arrived at the prison that day, moved into the man's cell. The man's cellmate had a history of substance misuse and nurses planned to observe him over the weekend before he started a methadone programme, as part of his drug treatment. In a statement to the police, the man's cellmate said the man had told him that, before he had gone to court on the day he was sentenced, he had inserted five packages of drugs in his anus and swallowed a further two packages. The man had said that some of the drugs were intended for other prisoners on the wing. The man's cellmate told the investigator that when he arrived in the cell, the man was clearly under the influence of drugs.

23. Shortly after arriving, the man's cellmate told the man that he felt sick because he had missed his daily dose of methadone. He said that the man reached into his trousers and pulled out a small cellophane package that contained three stacks of ten white tablets. The man referred to them as "blueys", which the man's cellmate said was another term for benzodiazepines. The man gave the man's cellmate four tablets, wrapped the rest, and put them back in his anus.

24. The man's cellmate said that for most of the evening, the man stayed in bed, sleeping, while he walked about the cell. He said he found ten more tablets in the man's tub of coffee whitener. He searched the toilet area and found another package hidden in the toilet in a clear plastic bag, with 30 tablets wrapped in stacks of ten. The man's cellmate took the tablets, swallowed ten, and kept the rest.

25. When the man woke up later that evening, he became agitated as he thought that he had lost a packet of drugs. The man's cellmate told the man that he had thrown them out of the window. The man's cellmate said that the man removed a further three packets of drugs from his anus. One of the packets was Xanax (a benzodiazepine medication used to treat anxiety and panic disorders) and another contained about 30 tablets of subutex.

26. The nurse told the investigator that, at around 10.00pm, she gave the man's cellmate some medication to help relieve withdrawal symptoms. She said that the man's cellmate looked as if he was under the influence of drugs, which she expected, and the man was sleeping at the time.

27. The man's cellmate had little recollection of the events over the next 24 to 36 hours, but said that the man continued to take drugs over the weekend.

Saturday 13 September 2014

28. Staff did not record any concerns about the man during the day on Saturday 13 September. At about 7.00pm. the day manager, handed over to a custodial manager, who was the night orderly officer in charge of the prison that night. The night orderly officer did not identify any concerns about prisoners on F Wing.

29. At about 10.00pm, the man's cellmate rang the cell bell and asked for his methadone. An officer contacted a nurse, who came to the cell and gave the man's cellmate more medication to ease his withdrawal symptoms. (The man's cellmate had appeared to be under the influence of opiates when he arrived, so was not prescribed methadone over the weekend.) The man was sleeping and snoring at the time.

30. The orderly officer happened to be on F Wing the next time the cell bell rang at 11.30pm. The cell light was on and he looked through the observation hatch and saw both prisoners sitting in the cell. He told the investigator that both prisoners looked intoxicated and excessively happy. The man's cellmate, who was nearest the door, asked the orderly officer a number of basic questions, which were out of place and his eyes looked glazed. There did not appear to be any particular reason why either the man's cellmate or the man had rung the cell bell. The orderly officer told the other officer to monitor them.

Sunday 14 September 2014

31. Around 1.40am, the officer answered the cell bell again. There is no record that he had monitored the man's cellmate and the man before then. The man's cellmate said he could not sleep because the man was snoring loudly. The nurse, who had come to check the man's cellmate at the same time, heard the man's loud snoring. The man then woke up and appeared to be under the influence of some substance. The nurse told the investigator that she did not think that the man needed any specific intervention at the time, but she decided to ask the substance misuse team to check him the next morning.

32. About 20 minutes later, the man's cellmate pressed the cell bell again. The officer went to the cell with a healthcare support worker. The man's cellmate said that the man was bleeding. The officer saw that the man was sitting on his bed coughing and wiping a brown watery liquid from his nose and face. The healthcare support worker was not sure if the liquid was blood and said that they needed to go into the cell to check him. The officer radioed the orderly officer and asked him and two assistant orderly officers to come to the wing. The healthcare support worker asked the nurse to come.

33. When the orderly officer and the other officers arrived, the officer was outside of the cell with the nurse and the healthcare support worker. The orderly officer opened the door and asked the man's cellmate to leave the cell while the nurses checked the man. The man's cellmate was unsteady on his feet.

The man was sitting on the bed swaying. His speech was slurred and initially he could not answer questions. The nurse considered he was under the influence of drugs. His cheeks and nose were red and there was a brown watery substance on his face, chest and stomach and on his bed and pillow. The nurse said it appeared that the man had vomited.

34. The nurse and the healthcare support worker cleaned the man and changed his bedding. He started to respond more appropriately to questions and claimed that he had taken only two sleeping tablets. He said he was "shattered" but was "on top of the world".

35. The nurses visually checked the man but did not take his clinical observations (such as blood pressure, pulse, respirations or pupil reaction). The nurse told the investigator that she did not think that clinical observations were necessary, as she did not consider he had taken an overdose. The officers and healthcare staff agreed that they would monitor the man for the remainder of the night. The man's cellmate went back into the cell.

36. The healthcare support worker told the investigator that they checked the man approximately every 20 minutes throughout the night after that. Each time, they made sure that they saw the prisoners move or that they got a verbal response from them.

37. The officer carried out a morning roll check of all prisoners on the wing, around 5.15am and raised no concerns. The nurse checked the man at 5.50pm and noted that he was lying in his bed and snoring lightly at the time.

38. At 6.05am, the orderly officer handed over to the night orderly officer as orderly officer. The healthcare support worker checked the man at 6.15am, shortly before her shift finished and noted that he was sleeping. The officer handed over to another officer at 6.15am. The nurse began her shift and the nurse told her that two prisoners on F Wing had been monitored throughout the night, as they had appeared intoxicated.

39. At 6.45am, the officer responded to the man's cellmate ringing the cell bell. He seemed confused and unsteady on his feet and asked to be let out of the cell. The officer noted that the man appeared to be asleep, but seemed very still and he asked the man's cellmate to check him. The man's cellmate shook the man but he did not respond. Despite this, the man's cellmate told the officer that the man was asleep and was okay.

40. The officer told the investigator that she was concerned that the man had not responded and thought that she should seek advice and go into the cell to check that the man was okay. At 6.58am, she radioed for the nurse and the night orderly officer. The officer said she did not think that this was an emergency at the time.

41. The night orderly officer and another officer went immediately to F Wing and opened the cell. The man was lying on the bed on his right hand side with his right arm extended and with his head resting on his arm. He did not have any

clothes on his top half and looked as if he was asleep. The officer asked the man's cellmate to stand in the toilet area while the staff checked the man. He thought that the man's cellmate appeared under influence of drugs or alcohol and asked him if either of them had taken any drugs. The man's cellmate's speech was slurred but he denied that they had taken anything.

42. The night orderly officer and another officer checked the man for signs of life. He was breathing and had a pulse but they could not rouse him. The nurse arrived at about 7.00am and examined the man. She said that he appeared to be sleeping, his skin tone was normal and he had normal breathing sounds and chest movement. However, his pulse was very weak and the nurse was also unable to rouse him. She told the investigator that, as the man appeared to be unconscious, she would have expected someone to have called the incident as an emergency, in which case she would have brought an emergency bag with her other colleagues would have come to assist.

43. The nurse asked the man's cellmate if the man had taken any illicit drugs. He said that the man had been taking tablets all night. He was unsure what they were or how many tablets the man had taken, but thought they might have been temazepam (a benzodiazepine tranquiliser). The nurse said she asked for someone to call an ambulance at this point. The night orderly officer told us that he did not recall the nurse asking for an ambulance then and that he would have asked the control room for one if she had done so.

44. The nurse went to the F Wing clinic (located downstairs) to get a blood pressure machine and some naloxone, which is used to reverse the effects of opiate overdose. She was unable to find the emergency pack of naloxone in the clinic and phoned the nurse to bring some. The nurse told the investigator that when she did find naloxone in the clinic, the vial had already been partly used.

45. The nurse ran and met the first nurse on the stairwell. He gave her the naloxone. When the nurse went back into the cell she noticed a dark red-brown fluid leaking from the man's mouth. She said none of the officers had noticed this. The man was not breathing. The man was not breathing, had no pulse and his pupils were fixed. The nurse told the investigator that she then asked the night orderly officer to radio a code blue medical emergency, which indicates a life threatening situation when a prisoner is unconscious or has breathing difficulties (a code blue should alert staff to attend with emergency equipment and the control room to call an ambulance). The night orderly officer radioed a code blue and added that the prisoner was unconscious from a suspected overdose. The prison log gives the time as 7.03am. (The ambulance log records that a call was received at 7.01am.)

46. The nurse asked the night orderly officer and another officer to put the man on the floor and they moved furniture out of the cell to create more space. The nurse did not use the naloxone as the man was not breathing, but began cardiopulmonary resuscitation (CPR). She asked the nurse to bring a defibrillator, which he brought in less than a minute. They connected the defibrillator which found no shockable heart rhythm. They continued the

resuscitation attempt until paramedics arrived at the cell at 7.10am and took over the emergency treatment. At 7.31am, the paramedics pronounced the man dead.

47. The healthcare staff and paramedics checked the man's cellmate and told him that the man had died. The man's cellmate said that he had taken 20 tablets, but then began to become unresponsive. The paramedics gave the man's cellmate naloxone, but it seemed to have little effect. They took him to hospital for treatment and he was discharged back to the prison the next day.

Support for staff

48. Around 11.45am on 14 September, duty governor debriefed the staff who had been involved in the emergency response and offered support. The staff care team visited the wing to provide further support.

Support for prisoners

49. The Governor issued a notice informing prisoners of the man's death and outlining the support available to them. Officers spoke to all F Wing prisoners to offer them support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been adversely affected by the man's death.

Family Liaison

50. That morning, the man's mother, brother and sister had gone to the prison to visit him. At 9.30am, the duty governor and the prison family liaison officers, took the man's family to a private room to break the news to them. The prison offered to contribute towards funeral costs in line with Prison Service guidance. The man's funeral was held on 2 October.

Post-mortem report

51. The post-mortem examination concluded that the cause of the man's death was bronchopneumonia (inflammation of the bronchioles, or air passageways, in the lungs) caused by the effects of diazepam (a benzodiazepine tranquiliser, which, when taken in large quantities, can cause respiratory depression). The pathologist noted that the man's respiratory output had probably been compromised for some hours before his death. During this time, the man would have continued to have metabolised diazepam and it was possible that the actual level of diazepam was higher than appeared at the test. The toxicology results showed that the man had also taken benzodiazepines and cocaine, but not at fatal levels. The pathologist found a cling film wrap containing a white substance by the man's scrotum.

ISSUES

Reception Screening

52. Standard reception procedures for prisoners arriving at Durham include a strip search (which the Prison Service refers to as a 'full search'). However, it is unlikely that such searches will detect if a prisoner has drugs concealed internally and prisons are not permitted to conduct intimate internal searches of prisoners. A security manager, told the investigator that, if the prison receives specific information that a prisoner might be trying to being drugs into the prison, they will usually be taken to the segregation unit and will remain there, either until they hand any drugs over or until staff are sure that they have disposed of any drugs they might have had.

53. The man was arrested trying to smuggle drugs to a friend in prison and had been on bail for some time before he attended court for sentencing. He would have expected a custodial sentence and it is apparent that he had prepared for this by packing himself with drugs – either to sell to other prisoners or for his own consumption. While the prison received no specific intelligence from other agencies that the man had drugs secreted on him, his escort record identified that he had been convicted of bringing drugs into the prison (as did his warrant) and noted his risks as "Drugs and conceals drugs." As the offence happened at Durham, the prison should have been fully aware of this. We consider that the circumstances of his arrest should have prompted staff at Durham to consider whether to undertake additional checks on the man, such as a targeted search of his cell shortly after he arrived. There is no evidence that anyone considered whether his history of smuggling drugs, the opportunity provided by his sentence and the information from the escort record should have led to additional security measures.

54. The most recent inspection report highlighted that illegal drugs were a problem at Durham. Inspectors noted that the prison needed to develop a strategic approach to supply reduction and recommended that the prison should develop an up-to-date drug supply reduction strategy. Durham's existing drug strategy, dated September 2013, pre-dates the inspection. The strategy highlights reception as one of five main routes for illegal drugs into the prison, and gives guidance on what to do if someone is suspected of concealing drugs. However, there is no guidance for staff on what information they should consider to assess whether a prisoner might be concealing drugs. We consider that the strategy should direct security and reception staff to consider whether a prisoner's offence might indicate a higher risk of attempting to smuggle drugs into prison and whether additional scrutiny is required. We make the following recommendation:

The Governor should ensure that all prisoners convicted of offences involving the supply of drugs are appropriately screened to assess the risk of potential drug smuggling and to determine whether additional security measures are needed.

Monitoring prisoners suspected of taking drugs

55. The healthcare staff who saw the man on 12 – 13 September told the investigator that they were aware of the prison's policy on dealing with prisoners suspected of taking an overdose. However, they said that they were not sure of the contents of the policy. The policy supplied to the investigator and clinical reviewer was written in 2008 and was last reviewed in October 2009 by the then County Durham Primary Care Trust. It states that, if a member if staff suspects that a prisoner has taken a potentially harmful substance, they should request a clinical assessment. The assessment should include details of the suspected drug, but also the prisoner's presentation, including their level of consciousness, blood pressure, pulse and breathing rate. (The investigator has since been provided with a further drugs policy which, although undated, was said to have superseded the 2008 drugs policy and therefore in force at the time of the man's death.)

56. Although there were two nurses present, neither appears to have considered the man's symptoms of vomiting, his poor speech and unsteadiness. The nurses did not make a clinical assessment or take baseline clinical observations while they were in his cell. This was a missed opportunity, which might have provided a better indication of the man's condition. The nurses did not follow the overdose policy. We raised similar concerns in the investigation into the death of a prisoner at Durham in July 2011. In response to that recommendation, NOMS told us that the clinical lead for drug and alcohol rehabilitation at Durham had cascaded information about drug induced unconsciousness throughout the medical team at Durham. However, it does not appear that staff routinely follow the policy. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners suspected of drug intoxication have a healthcare assessment, which includes clinical observations, and that staff monitor them in line with the prison's overdose policy.

Emergency equipment

57. The nurse was not immediately able to find naloxone in the F Wing clinic and, when she was able to locate some, found that the vial had already been used. While it does not appear that the delay in obtaining naloxone would have changed the outcome for the man, in other circumstances this could have been crucial. We understand that the prison has addressed the issue of naloxone and the duty nurse now carries a narcan pen on them at all times. This is a prefilled syringe that allows for rapid administration of the drug to counteract the affects of an opiate overdose. However, during the investigation, we found a number of items of emergency equipment that had not been checked for some months. It is important that all emergency equipment is checked regularly and available for use when needed. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

Emergency response

58. Prison Service Instruction 3/2013 (issued February 2013) requires that governors must have a medical emergency response code protocol, which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency; ensure that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. The PSI explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Durham issued a Governor's Notice to staff dated 24 June 2014, about the use of the emergency codes. The notice states that code blue should be used when a prisoner is found unconscious. It does not explicitly state that the control room should call an ambulance when an emergency code is used, as the national instruction requires.

59. The officer, the night orderly officer and nurse responded quickly to the other officer's request to attend the wing at 6.58am. When they arrived, they found the man unconscious, but they did not call a code blue until 7.03am. The nurse recalled that she asked for an ambulance to be called shortly after she arrived at the cell. However, there is no record of this and the night orderly officer did not recall the nurse asking for an ambulance then and said that he would have asked the control room for one if she had done so.

60. As a result, there was at least four minutes between staff realising that the man was unconscious, and the control room calling an ambulance. This was too long. We have made recommendations about similar issues in six previous investigations at Durham, but note that the Governor's notice issued in June 2014 still does not explicitly state that an ambulance should be called immediately after an emergency medical code is received. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an appropriate emergency medical code immediately when indicated and that the control room calls an ambulance automatically, as soon an emergency code is received.

61. The nurse had gone to collect some naloxone during which at some point the man stopped breathing. None of the officers present, including the night orderly officer had received any recent first aid training or refresher course or seemed aware that the man had stopped breathing. Although it is unlikely to have changed the outcome for the man, even in prisons with 24-hour healthcare provision, there should be sufficient numbers of officers on duty

who have up to date first aid training so that they can assist in emergencies. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times.

Clinical care

62. The clinical reviewer noted that the man had no significant identified healthcare issues and appeared to be generally in good health. However, he was concerned that the nurses missed opportunities to get a clearer understanding of the man's condition by not taking clinical observations. This might have helped detect earlier, the deterioration in the man's condition on the night of 24 September.

RECOMMENDATIONS

1. The Governor should ensure that all prisoners convicted of offences involving the supply of drugs are appropriately screened to assess the risk of potential drug smuggling and to determine whether additional security measures are needed.

2. The Governor and Head of Healthcare should ensure that prisoners suspected of drug intoxication have a healthcare assessment, which includes clinical observations, and that staff monitor them in line with the prison's overdose policy.

3. The Governor and the Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

4. The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an appropriate emergency medical code immediately when indicated and that the control room calls an ambulance automatically, as soon an emergency code is received.

5. The Governor should ensure that there are sufficient first aid trained staff on duty at all times.

PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

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 should ensure that all prisoners convicted of offences involving the supply of drugs are appropriately screened to assess the risk of potential drug smuggling and to determine whether additional security measures are needed.	Accepted	All prisoners currently receive a full search on entry into custody and any findings either through the search or intelligence are acted upon. In addition the Local Security Strategy will be reviewed (reception searching) to consider additional security options in this scenario.	30th June 2015	
2	The Governor and Head of Healthcare should ensure that prisoners suspected of drug intoxication have a healthcare assessment, which includes clinical observations, and that staff monitor them in line with the prison's overdose policy.	Accepted	The Head of Health Care is reviewing this policy to update and ensure that prisoners suspected of drug intoxication have a healthcare assessment to include clinical observations and appropriate monitoring. The updated policy will be re-issued to staff to sign to confirm they are aware of this. The updated policy will ensure that staff record all monitoring on System One. The Head of Healthcare will randomly check System One for compliance	30th June 2015 Healthcare	
3	The Governor and the Head of Healthcare	Accepted	This has now been completed and regular checks are	Completed 30th	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	should ensure that there are regular recorded checks of all emergency equipment.		now carried out and this is documented and signed for with an appropriate management check in place.	March 2015 Healthcare	
4	The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including calling an appropriate emergency medical code immediately when indicated and that the control room calls an ambulance automatically, as soon an emergency code is received.	Accepted	All staff both directly and non-directly employed will be required by their manager to be able to demonstrate their understanding of the emergency codes. They will then be required to sign to this effect. In addition strategically placed notices are in all offices and all staff are to be issued with personal cards as an aide.	30th June 2015 Safer Prisons	
5	The Governor should ensure that there are sufficient first aid trained staff on duty at all times.	Accepted	The People Hub will prioritise first aid training on all training days and monitor this to ensure there are sufficient staff in all departments and of all disciplines trained. This will be reviewed regularly by the People Hub manager	30th September 2015 Corporate Services	