Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Dunn a prisoner at HMP Durham on 21 October 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr David Dunn died on 21 October 2015, from heart disease and chronic kidney disease, while a prisoner at HMP Durham. He was 67 years old. I offer my condolences to Mr Dunn's family and friends.

I am satisfied that Mr Dunn received a good standard of care in prison including appropriate end of life care. However, I am concerned that restraints were used for hospital visits in the last months of Mr Dunn's life without properly considered risk assessments that took full account of his poor physical health and limited mobility. The Governor needs to ensure that all staff authorising restraints understand the legal position.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. On 4 September 2006, Mr David Dunn received an indeterminate sentence for public protection. He spent most of his sentence at HMP Northumberland.

2. Mr Dunn had severe kidney disease, heart disease, high blood pressure and a circulation disorder that impaired his mobility. He had regular dialysis treatment and medication for his other conditions. Mr Dunn's health declined over time and he moved to Durham for 24 hour nursing care in July 2015.

3. At Durham, Mr Dunn continued to attend outpatient appointments for dialysis. In August he spent two weeks in hospital with pneumonia and doctors also treated him for an erratic heart rate. His health deteriorated over the next two months. In October, a specialist nurse began a palliative care plan. Mr Dunn decided he did not want to be resuscitated if his heart or breathing stopped.

4. Around 5.40 am on 21 October, a healthcare support worker checked Mr Dunn who said he could not move. His breathing was very laboured and she called for help. Two officers arrived and found Mr Dunn slumped over the armrest of the toilet in his cell. They moved him to the bed, put him in the recovery position, and requested an emergency ambulance.

5. A nurse examined Mr Dunn, and found he was not breathing. In line with Mr Dunn's wishes, she did not attempt resuscitation. At 6.15am, a paramedic arrived and confirmed Mr Dunn's death.

Findings

6. Healthcare staff at both Northumberland and Durham effectively managed Mr Dunn's chronic health problems, in line with national guidelines. As his health declined, staff began appropriate palliative care plans and he received a good standard of end of life care. We are satisfied that the care Mr Dunn received in prison was equivalent to that he could have expected to receive the community.

7. Mr Dunn attended hospital numerous times for dialysis and outpatient appointments for which managers decided he should be restrained. We do not consider that the use of restraints in the last months of life, including for dialysis, was justified by properly considered risk assessments.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Dunn's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Dunn's clinical care at the prison.

11. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Dunn's sister to explain the investigation. His sister did not have any specific matters she wanted the investigation to consider.

13. The investigation has assessed the main issues involved in Mr Dunn's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

14. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

15. Mr Dunn's sister received a copy of the initial report and indicated that she was satisfied with the findings.

16. The initial report was shared with the coroner. The coroner pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Durham

17. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria, which holds approximately 1,000 men. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Durham was in December 2013. Inspectors reported the standards of healthcare were satisfactory. There were appropriate opportunities for primary care and support for lifelong conditions. Inspectors found that the new healthcare centre and inpatient care of patients with lifelong conditions, such as asthma, diabetes and heart disease, was good. Individual treatment was provided at nurse-led clinics. The prison worked in partnership with Macmillan Cancer Support to offer palliative and end of life care.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2014, the IMB reported that healthcare services met with the standards prisoners could expect to receive in the community. New prisoners received a full healthcare assessment within 72 hours of arrival.

Previous deaths at HMP Durham

20. Mr Dunn was the second person to die from natural causes at Durham since January 2013. We have raised the issue of the unjustified use of restraints, especially during life saving treatment, before.

Findings

The diagnosis of Mr Dunn's terminal illness and informing him of his condition

21. On 4 September 2006, Mr David Dunn received an indeterminate sentence for public protection for sexual and drug offences, with a minimum term to serve of three and a half years. The Parole Board had never considered Mr Dunn was suitable for release. He served most of his sentence at HMP Northumberland.

22. Mr Dunn's health was poor. He had stage five (very severe) kidney failure, coronary heart disease, hypertension (high blood pressure) and peripheral arterial disease (a circulation disorder). His other conditions meant he was not suitable for a kidney transplant and he attended hospital regularly for dialysis appointments at hospital. His other chronic conditions were managed with medication and regular reviews. He smoked cigarettes and, despite help, never succeeded in giving up.

23. Mr Dunn's health gradually declined and, on 25 June 2015, he was admitted to hospital, where doctors diagnosed a chest infection and a minor heart condition. He remained in hospital until 20 July. When he was discharged, he needed full time care so, on 22 July, he transferred to the inpatient unit at HMP Durham which has 24-hour nursing care. Mr Dunn was weak from the chest infection and staff began a care plan to monitor his fluid and food intake, his weight and his medical observations.

24. On 4 August, a prison GP spoke to a kidney nurse specialist at the Freeman Hospital to establish the extent of Mr Dunn's condition and the long-term prognosis. The nurse told the GP that Mr Dunn's recent hospital admission had been a set back and he would take a long time to recover.

25. Mr Dunn was admitted to hospital again on 7 August with chest pain. Doctors diagnosed pneumonia and prescribed antibiotics. In hospital, doctors also treated Mr Dunn for atrial fibrillation (an irregular and often abnormally fast heart rate). On 22 August, the hospital discharged Mr Dunn back to Durham.

26. On 26 August, the healthcare manager spoke to Mr Dunn about his failing health. Mr Dunn accepted that his illness was life limiting. The next day, a prison GP spoke to a consultant nephrologist (a kidney specialist) about Mr Dunn's ongoing care and noted his likely shortened life expectancy, especially if his heart function continued to deteriorate.

27. We are satisfied that hospital and prison healthcare staff kept Mr Dunn informed of his condition and supported him throughout ad he was fully aware that his severe kidney disease and his heart condition limited his life expectancy.

Mr Dunn's clinical care

28. Mr Dunn received treatment for his ongoing medical conditions, including outpatient appointments for dialysis. The clinical reviewer noted that Mr Dunn's chronic kidney disease, peripheral arterial disease, chronic heart disease and hypertension were all managed in line with national guidelines. Staff ensured that Mr Dunn was supported to manage his complex illness, especially his

dialysis programme. There was excellent communication between staff at both prisons with the hospitals responsible for the management of Mr Dunn's chronic kidney disease and heart disease.

29. On 16 October, a Macmillan palliative care nurse visited Mr Dunn and noted that he appeared to have a good insight into his illness. The nurse set up a palliative care plan which included support for his physical, emotional and spiritual needs; pain relief; and aids to ease any discomfort. They discussed his views about resuscitation and Mr Dunn decided he did not want to be resuscitated if his heart or breathing stopped. His decision was formally recorded in his medical record.

30. On 20 October, at the start of her night shift, a healthcare support worker went to check Mr Dunn, who said he was in pain. She arranged for a nurse to administer pain relief at 9.30pm. At 12.30am on 21 October, she checked Mr Dunn and noted that he was in bed, asleep and breathing.

31. At 5.20am, the healthcare support worker checked Mr Dunn, who was using the toilet. She called to him and he said he was all right. About 20 minutes later, she checked Mr Dunn again. He told her he could not get up from the toilet and she noted his breathing was laboured and slow. She telephoned the night manager to ask for help. Two officers arrived at 5.45am and opened Mr Dunn's cell. They found him slumped over the armrest of the toilet and lifted him onto the bed and into the recovery position. An officer radioed the control room to ask for an emergency ambulance.

32. Around 6.00am, a nurse arrived and examined Mr Dunn. He was not breathing and she could find no signs of life. In line with Mr Dunn's wishes, staff did not try to resuscitate him. At 6.15am, paramedics arrived and confirmed Mr Dunn's death.

33. A post-mortem examination found that Mr Dunn had died of cardiac failure caused by ischaemic disease (heart disease) and contributed to by chronic kidney disease.

34. The clinical reviewer noted that there was a rapid deterioration in Mr Dunn's condition. Once it became evident that Mr Dunn's kidney disease was not responding well to active treatment and his cardiac function was deteriorating it was appropriate to implement palliative care plans. We are satisfied that Mr Dunn received good end of life care and healthcare staff frequently reviewed his pain relief ensuring Mr Dunn died pain free.

Mr Dunn's location

35. Mr Dunn's chronic kidney disease and heart disease was managed well at Northumberland. However, as he became more unwell and required 24-hour nursing care, staff arranged for him to transfer to Durham which could provide the additional care needed.

36. The clinical reviewer noted that the decision to transfer nursing care for Mr Dunn from Northumberland to Durham was appropriate. The care he required and received at Durham was in line with the approach taken in a community setting.

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. It found that using handcuffs to restrain a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that this would be likely also to be regarded as inhumane, unless justified by other relevant considerations.

38. On 30 July 2015, officers took Mr Dunn to hospital for an appointment with the renal specialist. By this time Mr Dunn's health had deteriorated significantly. The risk assessment showed that he was considered a medium risk to the public and low risk of escape. There were no medical objections to the use of restraints and it was noted there were no medical conditions or impaired mobility that restricted Mr Dunn's ability to escape. A prison manager decided that officers should use double handcuffs at all times to restrain Mr Dunn. Another prison manager decided that this could be reduced to an escort chain when Mr Dunn was receiving treatment or using the toilet. (An escort chain is a long chain with a handcuff at either end, one attached to the prisoner and the other to an officer.) An officer noted on the escort record that Mr Dunn "could not walk, wheelchaired up to renal ward".

39. On 7 August, Mr Dunn attended a dialysis appointment. A risk assessment showed no change in the level of risk. A prison manager noted Mr Dunn used a wheelchair and decided an escort chain should be used for the transfer and be removed for treatment. However, for seven dialysis appointments and one echocardiogram appointment between 27 August and 22 September, various prison managers decided officers should use double handcuffs and an escort chain during treatment. The assessed level of risk never changed.

40. For an outpatient appointment on 28 September, the healthcare section of the risk assessment noted that Mr Dunn used a wheelchair, had impaired mobility and was short of breath. A manager decided that officers should use double handcuffs on the way to and from the hospital and an escort chain in the hospital. Officers used the same level of restraint during two dialysis appointments on 29 September and 6 October.

41. The security manager told us, it was Durham's normal procedure for a category C prisoner to be double cuffed on the way to hospital. He said the manager authorising the use of restraints would then allow the removal of the cuffs or application of an escort chain for treatment. In the case of dialysis, he suggested that the use of an escort chain would have been the most

appropriate measure as it would not impact on the treatment, while keeping the appropriate level of security to prevent escape. He said restraints were normally removed completely only for procedures such as an MRI scan where metal cannot be used.

42. Double cuffing entails the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like Mr Dunn, the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified. There was little evidence that there was any consideration of how his health or mobility affected his risk. We cannot see how restraining Mr Dunn for any of his appointments from July 2015 could have been justified by an objective risk assessment. The 2007 High Court judgment makes it clear that a prisoner should not be restrained for life saving treatment (such as dialysis) without proper justification. We are very concerned that staff at Durham seem to have little awareness of the legal requirements for using restraints and that double cuffing appears to be the default position for escorting all prisoners, even category C prisoners. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with Mr Dunn's family

43. After Mr Dunn moved to Durham, members of the chaplaincy team visited him every day. One of the chaplains, a trained family liaison officer, spoke to Mr Dunn most days. A deputy family liaison officer also kept in close contact with Mr Dunn.

44. On 15 September, the chaplain spoke to Mr Dunn about his family and if they were aware of his ill health. Mr Dunn said his next of kin was his sister and she was aware he was ill; they had spoken on the telephone and she had visited him. Mr Dunn said he was grateful for the support of the family liaison officers.

45. The morning Mr Dunn died, the chaplain and deputy family liaison officer visited his sister to inform her of his death and offer their condolences and support. The chaplain remained in contact with Mr Dunn's family.

46. Mr Dunn's funeral was on 16 November and the prison contributed to the costs in line with national policy.

Compassionate release

47. Prisoners can be released before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

48. On 27 August, a prison GP spoke to Mr Dunn's consultant nephrologist about his treatment and life expectancy. Although the consultant confirmed that it was likely that Mr Dunn would have a shortened life expectancy, he was not able to give a firm prognosis. Without a firm prognosis of less than three months the prison was unable to complete a compassionate release application.

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