Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Blacklock a prisoner at HMP Durham on 12 January 2017

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 Geoffrey Blacklock died on 12 January 2017, of pneumonia and chronic obstructive pulmonary disease while a prisoner at HMP Durham. He was 68 years old. I offer my condolences to Mr Blacklock's family and friends.

Overall, I am satisfied that Mr Blacklock received a standard of care equivalent to that he could have expected to receive in the community. Despite his lung condition, which was prone to infection, Mr Blacklock continued to smoke and declined help to give up.

Although a care plan to facilitate long term management of Mr Blacklock was not prepared by healthcare staff and there was no evidence that clinical observations were taken during his daytime reviews on the day he was admitted to hospital, I agree with the clinical reviewer that neither of these issues impacted on the outcome.

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 **June 2017**

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Summary

Events

1. On 21 October 2016, Mr Geoffrey Blacklock was remanded to HMP Durham. He suffered from a number of chronic health conditions, including chronic obstructive pulmonary disease (COPD – lung disease), angina, Type 2 diabetes and high blood pressure. He used inhalers as he struggled to breathe and a walking stick to aid mobility. Mr Blacklock smoked cigarettes but declined a smoking cessation programme.

2. Mr Blacklock's community medical record showed concerns about the circulation in his left leg. A prison GP referred him to a vascular surgeon on 28 October. Over the next few weeks, healthcare staff reviewed Mr Blacklock and his circulation improved. An assessment of his social care needs and risk of falls took place. Mr Blacklock was provided with a wheelchair on 24 November.

3. On 9 and 13 December, a nurse reviewed Mr Blacklock, who was short of breath and reported pain in his back. She repositioned his mattresses to ease his breathing.

4. On 21 December, Mr Blacklock attended court and was sentenced to four years imprisonment. On 28 December, Mr Blacklock did not attend his podiatry appointment and, on 4 January 2017, he did not attend his clinic appointment with the duty doctor.

5. On 6 January, Mr Blacklock suffered an exacerbation of his COPD and inhalers did not relieve his breathlessness. A doctor reviewed Mr Blacklock and sent him to hospital via an emergency ambulance.

6. A hospital doctor told Mr Blacklock he had pneumonia on 10 January, and they treated him. Mr Blacklock refused to take his prescribed paracetamol. On 11 January, Mr Blacklock had trouble breathing and refused to continue drugs via a nebuliser. He agreed with a doctor not to be resuscitated if his heart or breathing stopped.

7. Doctors treated Mr Blacklock with end of life care. He requested that his family were not contacted. Mr Blacklock died at 10.03am on 12 January.

Findings

8. The clinical reviewer noted that the overall care Mr Blacklock received was of a good standard and equivalent to that which he could have expected to receive in the community. However, there was no evidence that clinical observations were taken during daytime reviews on 6 January when his condition worsened. The clinical reviewer states that, while this did not impact upon the outcome for Mr Blacklock, it is best practice to take clinical observations to detect and monitor a deteriorating patient.

9. A COPD care plan to facilitate long term management of Mr Blacklock was not prepared by healthcare staff at Durham. The clinical reviewer states that the absence of the care plan did not affect Mr Blacklock's care as he had received a

recent COPD review in the community prior to his custody and he was admitted to hospital when his COPD exacerbated.

Recommendations

- The Head of Healthcare at HMP Durham should ensure clinical observations are taken and recorded to ensure that a deterioration in a patient's condition is detected.
- The Head of Healthcare at HMP Durham should ensure prisoners with known COPD receive care in accordance with NICE COPD Guidance and Quality Standards.

The Investigation Process

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

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

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

13. We informed HM Coroner for Durham of the investigation who informed us of the cause of death. We have sent the coroner a copy of this report.

14. Mr Blacklock did not have any contact with his family and did not want them informed about his death.

15. The investigation has assessed the main issues involved in Mr Blacklock'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.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

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 October 2016. Inspectors reported that joint working between providers and the prison was improving and generally effective. Many health policies needed a review to update them. Prisoners with social care needs were identified and assessments completed. An appropriate range of services were provided, although there were no life-long conditions nurse-led clinics because of staff shortages. Prisoners were instead referred appropriately to other services.

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 2015, the IMB reported that new prisoners received a full healthcare assessment within 72 hours of arrival. Screening for chronic conditions had yielded a lower than expected prevalence of diabetes and cardio-vascular disease and several staff had requested special training in diabetes.

Previous deaths at HMP Durham

20. Mr Blacklock was the fourth prisoner to die of natural causes at Durham since October 2015. There were no significant similarities to the previous cases.

Findings

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

21. On 21 October 2016, Mr Blacklock was remanded to HMP Durham, charged with sexual offences. Healthcare staff noted he suffered from a number of chronic health conditions, including chronic obstructive pulmonary disease (COPD – a long-term condition causing difficulty breathing due to the narrowing of the airways), angina (pain, usually in the chest, which occurs when the blood flow to the heart is restricted), Type 2 diabetes (where the pancreas does not produce enough insulin or the body's cells do not react to insulin) and essential hypertension (high blood pressure). He had heart bypass surgery in 1998. Mr Blacklock told the reception nurse he used inhalers as he struggled to breathe, a walking stick to help him walk, and said he was concerned about his COPD. Mr Blacklock smoked but declined a smoking cessation programme. A prison GP also examined Mr Blacklock and encouraged him to continue all medications.

22. Mr Blacklock's regular medications included salbutamol and fluticasone inhalers (for breathlessness and exacerbation of COPD), amlodipine, ramipril and simvastatin (to treat angina, high blood pressure and protect the heart), metformin (helps control blood sugar levels for diabetes), tamsulosin (improves urination in men with large prostates) and folic acid (a vitamin supplement).

23. A prison GP examined Mr Blacklock on 25 October, after receiving the medical records from Mr Blacklock's community GP, who was concerned about blood circulation in Mr Blacklock's left leg. Mr Blacklock's community GP had recently reviewed his COPD management prior to his custody. The GP found Mr Blacklock's left foot was grey in colour and could not be sure of feeling a pulse. The doctor requested blood tests. On 28 October, the GP noted the blood tests were normal and referred Mr Blacklock to a vascular surgeon.

24. On 29 October, a nurse saw Mr Blacklock and completed an initial social care form. Mr Blacklock said he had no other social care at that time. He told the nurse he managed to mobilise around the wing, but he found walking any distance difficult. The nurse completed the form to reflect this and sent it to Social Services for further consideration.

25. On 13 November, a nurse attended Mr Blacklock's cell after he had been found collapsed on the floor. On arrival she found Mr Blacklock on his bed. He appeared to be breathing well, was talking in full sentences, and had no signs of any injury. His observations were all normal.

26. On 21 November, a nurse attended to Mr Blacklock in his cell as he complained of being breathless. On examination, the nurse found him to be a good colour and talking in full sentences. She gave him some water and advised him to use his inhaler. A social worker then visited Mr Blacklock on the wing and undertook a care and support assessment. She requested that Mr Blacklock have access to a wheelchair to enable him to travel to healthcare when necessary. A wheelchair was delivered on 24 November.

27. On 25 November, healthcare support worker saw Mr Blacklock. She noted his right leg was coated with thick dry skin. She treated it and made an appointment for him to see the podiatrist for a diabetic review.

28. A prison GP examined Mr Blacklock on 30 November. He noted Mr Blacklock looked better and his feet had improved. Mr Blacklock said he still fell, and had a pain and a lump in his neck. He noted Mr Blacklock's neck was stiff but felt no lump. He applied gel to Mr Blacklock's legs and referred him for an x-ray of his neck and chest.

29. On 1 December, Mr Blacklock walked out of his appointment with the visiting podiatrist. On 9 December, a nurse attended Mr Blacklock in his cell after he complained again of breathlessness. He told her he had had pain in his back for a week and complained of having to lie flat in bed. He had two mattresses so the nurse moved one up to aid his sleeping.

30. On 13 December, a nurse attended Mr Blacklock in his cell after he complained of having pain in his back again. She noted he had not deteriorated since she last saw him, he was managing his inhalers but was producing white and yellow sputum and she referred him to a doctor.

31. A prison GP examined Mr Blacklock on 16 December, and found him not short of breath, speaking in full sentences, a good colour, not distressed and with no apparent significant discomfort. The GP noted a few scattered crepitations (a dry crackling sound) in Mr Blacklock's chest but no pain or tenderness. The GP found no significant problem and prescribed paracetamol for possible musculoskeletal pain and planned to review him if there was no improvement.

32. On 21 December, Mr Blacklock attended Crown Court, where he was sentenced to four years imprisonment for sexual offences and sent back to HMP Durham. On his return a nurse reviewed him. He told her he felt fine and would call one of the nurses if this changed.

33. On 28 December and 4 January 2017, Mr Blacklock missed two appointments to monitor his general health and when a doctor tried to visit his cell Mr Blacklock was not there.

34. At 00.33am on 6 January, a nurse attended to Mr Blacklock who was having difficulty breathing even after using his inhalers, due to his COPD. She administered a nebuliser and made an appointment for him to see the doctor. At 11.53am, a nurse saw Mr Blacklock in his cell at the request of wing staff and she noted he had been seen overnight by a nurse. Mr Blacklock complained of shortness of breath. He sat on a chair using his inhaler and told her this was normal for him as he suffered from COPD, but he said he felt slightly more breathless this day.

35. A nurse checked Mr Blacklock again at 4.01pm. Mr Blacklock told her he remained breathless and had a bowl of sputum at his feet. He was talking in full sentences but slowly. She offered him a nebuliser but he declined. She asked another nurse to check him again in the evening.

36. There is no evidence that clinical observations (blood pressure, heart rate, breathing rate, oxygen levels, temperature) were taken during the reviews.

Measuring and recording vital signs is an essential step in assessing risk of serious illness, aids diagnosis and ensures a correct course of action. Whilst this did not impact upon the outcome for Mr Blacklock, it is best practice to take clinical observations to detect and monitor a deteriorating patient. We make the following recommendation:

The Head of Healthcare at HMP Durham should ensure clinical observations are taken and recorded to ensure that a deterioration in a patient's condition is detected.

37. At 6.15pm, a nurse checked Mr Blacklock and found he had difficulty breathing. She noted Mr Blacklock's history of breathlessness had increased in severity over the past two weeks, and noting some bloodstained sputum thought he had experienced exacerbation of his COPD. She gave him a salbutamol nebuliser which had little effect and Mr Blacklock could not use his inhalers due to breathlessness. She requested an emergency review by a doctor. A prison GP attended and examined Mr Blacklock. His oxygen levels had dropped to 80% (above 92% is acceptable for a person with COPD) and he was in obvious discomfort. The GP sent Mr Blacklock to hospital by ambulance. Two officers escorted him. He was not restrained due to his reduced mobility.

38. Healthcare staff at Durham did not prepare a COPD care plan to facilitate long term management of Mr Blacklock's illness. The absence of the care plan did not affect Mr Blacklock's care as he had received a recent COPD review in the community prior to custody, and he was admitted to hospital when his COPD deteriorated. However, prisoners should have a care plan in place and regular planned reviews. We make the following recommendation:

The Head of Healthcare at HMP Durham should ensure prisoners with known COPD receive care in accordance with NICE COPD Guidance and Quality Standards.

Mr Blacklock's clinical care

39. At hospital, doctors initially admitted Mr Blacklock to the resuscitation unit and then moved him to the acute medical unit. On 8 January, a consultant told Mr Blacklock he had a chest infection and gave him intravenous antibiotics. On 9 January, the hospital informed healthcare staff that the antibiotics were not working and they had changed them. He remained on oxygen therapy and nebulisers. Mr Blacklock was not eating, but was drinking fluids.

40. Mr Blacklock continued to deteriorate. On 10 January, a doctor explained to Mr Blacklock that he had pneumonia and he was put on a nebuliser and seated upright. Mr Blacklock refused to take his prescribed paracetamol.

41. On 11 January, Mr Blacklock had trouble breathing and at 7.30am he pulled his oxygen mask off and said he did not want it anymore as he had had enough. The nurse put the mask back on, but he refused to continue drugs via a nebuliser. At 12.45pm, Mr Blacklock agreed with a doctor to a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR). (This means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

42. Doctors put Mr Blacklock on End of Life Care and gave him midazalam and morphine to help with pain, breathlessness and agitation. They made him comfortable. He requested that his family were not contacted. Mr Blacklock died at 10.03am on 12 January.

43. The Coroner decided a post mortem was not required and gave the cause of death as pneumonia, caused by COPD. Ischaemic heart disease and Type 2 diabetes were contributing factors to his death.

Mr Blacklock's location

44. As Mr Blacklock suffered from a number of chronic health conditions and was a registered disabled person on arrival at Durham, he was located in a shared cell on the ground floor of the wing and allocated the bottom bunk bed. His cell mate assisted Mr Blacklock with his daily needs and helped him to get dressed.

45. Following a social care assessment on 21 November 2016, Mr Blacklock was provided with a wheelchair to enable him to travel to healthcare when required. When Mr Blacklock significantly deteriorated on 6 January 2017, the doctor requested emergency admission to hospital where he remained until his death. We are satisfied that Durham appropriately located Mr Blacklock throughout his illness.

Restraints, security and escorts

46. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

47. On 6 January 2017, Mr Blacklock attended outside hospital by ambulance for the first time. Two officers escorted him and no restraints were used due to his reduced mobility. We consider that Durham appropriately took into account Mr Blacklock's health, age and mobility, when reaching this decision.

Liaison with Mr Blacklock's family

48. On 12 January 2017, a prison chaplain and a prison officer were appointed as Mr Blacklock's family liaison officers. Mr Blacklock was estranged from his family and said he did not want to speak to any family before he died, but mentioned he had a sister. The chaplain made contact with Mr Blacklock's sister after he died, but she wanted no involvement. The prison arranged and paid for Mr Blacklock's funeral in line with national policy. Mr Blacklock's funeral was held on 6 February.

Compassionate release

49. Prisoners can be released from custody 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.

50. When Mr Blacklock's health significantly deteriorated on 6 January, he was admitted by emergency ambulance to hospital, where he died six days later. Mr Blacklock died shortly after refusing treatment; he was acutely unwell and deteriorated rapidly. He was estranged from his family, had nowhere to live and had no outside support. Therefore it was reasonable that the compassionate release process was not considered during the short time Mr Blacklock spent in hospital.

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