Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Earl a prisoner at HMP Durham on 30 March 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.

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

Mr Raymond Earl died on 30 March 2017, of respiratory sepsis due to pneumonia while in the custody of HMP Durham. Mr Earl was 81 years old. I offer my condolences to Mr Earl's family and friends.

Healthcare staff at Durham regularly reviewed Mr Earl and appropriately managed his co-morbidities; they provided prompt access to treatment. I am satisfied that the care Mr Earl received was equivalent to that which he could have expected to receive in the community.

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
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 22 December 2016, Mr Raymond Earl attended Crown Court and was remanded into custody for sexual offences. He was sent to HMP Durham. Mr Earl had a history of high blood pressure, steroid induced diabetes, peripheral oedema (fluid retention causing swelling), chronic kidney disease and severe obesity.

2. On arrival at Durham, Mr Earl told a nurse that he had several medical conditions but did not have any medication with him. He was unsure of what his community doctor had prescribed. The nurse requested his community GP (General Practitioner) summary record. While Durham awaited confirmation of his medications, a prison doctor prescribed him suitable medications in lower doses.

3. In January, Mr Earl told a prison nurse he was experiencing breathlessness, but was not struggling to breathe. She took his clinical observations and told him to tell the doctor at his next appointment. He saw a prison doctor two days later but did not tell him that he was struggling to breathe.

4. In February, Mr Earl complained of breathlessness to a prison nurse again. She took his clinical observations and told him to discuss it with the doctor at his next appointment. He complained again and another nurse saw him, booked an earlier doctor's appointment and arranged for him to go to hospital if his breathing deteriorated.

5. Mr Earl told a prison doctor that he had been struggling to breathe for two weeks. The doctor took his clinical observations, planned to monitor his symptoms and review him two weeks later.

6. A prison nurse saw Mr Earl using a broken wheelchair on 24 February. He told her that he had not needed one in the community, but found it hard to mobilise since his health declined at Durham. She referred him for a health and social care assessment; there is no record that the assessment was completed.

7. On 3 March, a prison nurse saw Mr Earl after he fell out of bed. She took his clinical observations and found that his oxygen levels were low. She sent him to hospital, who discharged him with a diagnosis of hypothermia.

8. On 28 March, Mr Earl told a nurse that he was urinating frequently. She took a urine sample and the results confirmed that he had a urine infection. The nurse prescribed antibiotics. The next day, staff attended Mr Earl's cell to assist him with getting dressed. Mr Earl became unresponsive but he regained consciousness after two minutes. A prison doctor sent him to hospital.

9. Mr Earl remained in hospital until his death on 30 March 2017.

Findings

10. We agree with the clinical reviewer that the care Mr Earl received at Durham was equivalent to that which he could have expected to receive in the community.

11. A prison nurse observed that Mr Earl was using a broken wheelchair. Staff did not formally issue Mr Earl with a wheelchair. Staff were unable to confirm who provided him with the wheelchair and how long the wheelchair had been in his possession. We are concerned that Mr Earl had access to unsuitable and potentially dangerous equipment, which was not specifically catered to his needs.

Recommendations

- The Governor should insure that equipment provided by the prison is regularly inspected and any broken items are removed from use, promptly repaired or destroyed.

The Investigation Process

12. 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.

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

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

15. We informed HM Coroner for County Durham and Darlington of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Earl's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They said they were concerned that a wheelchair Mr Earl had been given was unsuitable. That he was not receiving treatment appropriate to his conditions and HMP Durham showed a lack of concern in relation to Mr Earl's breathlessness.

17. The investigation has assessed the main issues involved in Mr Earl'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.

18. Mr Earl's family received a copy of the initial report. They did not make any comments.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Durham

20. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 men. G4S provides primary healthcare. The prison's inpatient unit has six beds with 24-hour healthcare, and provides a regional service for HMP Durham, HMP Northumberland and HMYOI Deerbolt.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the provision of healthcare was reasonable, with some excellent mental healthcare. Primary care service was assessed as reasonably good and secondary care as very good. Inspectors found that the inpatient healthcare unit provided compassionate care in a good environment. Interactions between healthcare staff and prisoners were very good. Nurse-led clinics for lifelong conditions, such as asthma, diabetes and heart disease, did not take place due to staff shortages, although a senior nurse ensured that physical checks and made referrals where necessary. External health appointments were well managed.

Independent Monitoring Board

22. 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 2016, the IMB reported that the recruitment of nurses to the healthcare unit continued to be a significant issue, with agency nurses and overtime used to cover this. Despite the staff shortages, primary care services delivered a good standard of care. The IMB noted that the unit was usually fully occupied, which caused a shortage of inpatient beds.

Previous deaths at HMP Durham

23. Mr Earl was the sixth prisoner to die of natural causes at Durham since January 2016. There are no significant similarities to any of the previous deaths at HMP Durham.

Key Events

24. On 22 December 2016, Mr Raymond Earl attended Crown Court and was remanded into custody for sexual offences. He was sent to HMP Durham. Mr Earl had a history of high blood pressure, steroid induced diabetes, peripheral oedema, chronic kidney disease and severe obesity.

25. On arrival at Durham, a nurse saw Mr Raymond to complete his health screening. He told her he had high blood pressure, diabetes, arthritis and previously had leg ulcers, which had healed. Mr Earl saw a prison doctor later that evening. He told the doctor that he was taking multiple medications but had not brought them with him. The doctor examined Mr Earl and recorded that he did not have any acute clinical concerns. He requested a summary of Mr Earl's medication from his community General Practitioner (GP).

26. The prison doctor saw Mr Earl again on 24 December. He recorded that Mr Earl's community GP had not provided the details of his medications. He noted that Mr Earl needed a walking stick to mobilise. He requested Mr Earl's medical details again and prescribed him ramipril (used to treat high blood pressure and congestive heart failure) while he waited for a response.

27. On 26 December, prison doctor saw Mr Earl. He examined Mr Earl and found that he had an infection of the left calf. He took his blood pressure and blood sugar levels, which were above the normal range and diagnosed Mr Earl with cellulitis (infection of the deeper layers of skin and underlying tissue) of the leg. The doctor prescribed gliclazide (which increases the amount of insulin the body produces) and recorded that Mr Earl's community GP should be contacted to confirm his medication.

28. On 28 December, a prison doctor prescribed Mr Earl some medication, as he had not received the community GP medication summary. He recorded that Mr Earl had previously had dialysis and chronic kidney disease. Healthcare staff received Mr Earl's community GP summary on 3 January 2017.

29. A nurse saw Mr Earl on 7 January, after he complained of breathlessness. She noted that he was not struggling to breath and was able to speak in full sentences. She examined him and found that his blood pressure was high, his pulse had an irregular rhythm but his oxygen saturation was normal. Another nurse recorded that Mr Earl had an appointment with a prison doctor two days later. Mr Earl saw a prison doctor on 9 January; he did not tell him about his shortness of breath but instead complained of other medical concerns.

30. On 10 February, a nurse saw Mr Earl after he complained of breathlessness. She examined him and found that his blood pressure was high but his oxygen saturation was normal. She told him that he had an appointment with a prison doctor on 13 February and he should discuss his concerns then. Another nurse saw Mr Earl that evening after he complained of breathlessness again. She took his observations and recorded that he was not pale, clammy, nauseous, vomiting or in pain. She requested that a nurse from Durham's inpatient unit see Mr Earl the next morning with the intention of getting an earlier GP appointment. She reviewed him after an hour, she told him to inform staff if he felt worse. She planned to send Mr Earl to hospital by ambulance if his condition deteriorated.

31. A prison doctor saw Mr Earl on 13 February, following concerns about his shortness of breath. Mr Earl said he had been experiencing breathlessness for two weeks, which was worse when lying down. He recorded that Mr Earl was struggling to breathe when resting but was able to speak and his chest was clear. He planned to observe Mr Earl and review him two weeks later.

32. On 23 February, a nurse attended a code blue emergency call (indicating a prisoner with breathing problems). On arrival, she saw Mr Earl in bed complaining of shortness of breath. He was speaking in sentences, had normal oxygen saturation and pulse but his blood pressure was high. She recorded that there were no signs of shortness of breath and took no further action.

33. A nurse saw Mr Earl on 24 February, after a prison officer requested a new wheelchair for him. She found him sitting in a broken wheelchair without the left side support. She asked him if it was his wheelchair, he said it was not and he had not needed one before arriving at Durham. He told her he found it hard to mobilise as his health had deteriorated. She told him that the wheelchair he was using was dangerous, and arranged for an occupational therapist to assess Mr Earl. On 27 February, a prison doctor referred Mr Earl for a new wheelchair, as he was unable to walk long distances unaided.

34. A social worker saw Mr Earl on 1 March to assess his care and support needs. Because it was lunch time, she arranged to complete the assessment at a later date. There is no record she completed the assessment.

35. On 28 February, a prison officer informed a nurse that Mr Earl had collapsed in his cell. He did not complain of an injury but he did inform her that his health had deteriorated since he arrived at Durham and had been falling more often. She referred him for a blood test and a fall assessment, and admitted him to healthcare for observations.

36. On 3 March, at 4.59am a healthcare support worker assisted Mr Earl into bed. She recorded that he was at risk of a fall.

37. A nurse saw Mr Earl at 7:32am on 3 March, after he had fallen during the night and appeared confused. She recorded that his blood test results showed abnormalities, he had a fever and his oxygen saturation level had fallen. Mr Earl went to hospital by ambulance. He returned to Durham that afternoon with a diagnosis of hypothermia, which was suspected as being due to lying on a cold floor.

38. On 20 March, a prison doctor saw Mr Earl to discuss his swollen right hand. On examination, she found his pulse was irregular and ordered an electrocardiogram (which measures the electrical activity of the heart). Another prison doctor saw Mr Earl two days later and discussed the results of his ECG. He diagnosed him with atrial fibrillation (a heart condition that causes an irregular and often unusually fast heart beat) and prescribed him rivaroxaban (a medicine used to prevent blood clots from forming due to an irregular heart beat).

39. On 28 March, Mr Earl told a nurse that he was not feeling well and was frequently urinating. She took a urine sample, which tested positive for a possible urine infection. Another nurse confirmed that Mr Earl had a urinary tract

infection (UTI) and prescribed him trimethoprim (an antibiotic used to treat bacterial infections).

40. On 29 March, a nurse recorded that Mr Earl had appeared confused and his room smelt of urine. At 9.00am, staff went to his cell to assist him with getting dressed. Mr Earl became unresponsive and the left side of his mouth started to droop. He became responsive again after two minutes but continued to present as confused with slurred speech. A prison doctor sent Mr Earl to hospital by ambulance.

41. Mr Earl remained at hospital, where he died on 30 March 2017.

Contact with Earl's family

42. On 30 March, Durham appointed a family liaison officer. She attended Mr Earl's next of kin's address with a prison officer. On arrival, Mr Earl's family told her that a member of hospital staff had already informed them. She spoke to Mr Earl's family on 6 April and arranged for them to visit Durham.

43. Mr Earl's funeral was held on 25 April. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

44. After Mr Earl's death, the Head of Safeguarding debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

45. The prison posted notices informing other prisoners of Mr Earl's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Earl's death.

Cause of death

46. HM Coroner for County Durham and Darlington confirmed Mr Earl died from respiratory sepsis due to pneumonia, with underlying chronic kidney disease, hypertension, diabetes and cardiac failure.

Findings

Mr Earl's clinical care

47. Mr Earl told healthcare staff that he had several medical conditions. He did not bring any of his medication with him so staff requested a summary of his medications from his community GP. Staff continued to chase the GP summary of medication over the next 12 days. During that time, healthcare staff were unaware of the complexity of Mr Earl's medical needs, but reviewed him regularly, monitored his medications and took regular observations. A prison doctor prescribed a lower dosage of medication until he received confirmation of his prescribed medications.

48. Durham admitted Mr Earl to the healthcare unit after a fall in order to offer him further support. The next day Mr Earl became increasingly more confused and unsteady on his feet. Nurses and healthcare support workers regularly reviewed and checked on him. After his fall, a prison nurse arranged for him to go to hospital where hospital doctors diagnosed with hypothermia.

49. The clinical reviewer concluded that healthcare staff provided Mr Earl with prompt access to treatment and healthcare staff regularly reviewed him. Prison doctors made appropriate referrals for further tests and assessments in line with national guidelines. Care plans were in place to manage Mr Earl's medical conditions and he was able to attend his outpatient appointments.

50. Mr Earl was mobile prior to his arrival at Durham. Shortly after his arrival his health deteriorated, he continued to have complications with leg ulcers and relied on a wheelchair to mobilise. At the end of February, a prison nurse observed that Mr Earl was using a damaged wheelchair where the left side support was missing. When challenged, Mr Earl stated his health had deteriorated considerably during his time in custody and needed a wheelchair because the wounds on both his legs made it hard for him to mobilise. The Head of Healthcare said that healthcare staff did not give Mr Earl the wheelchair and the prison GP did not send a wheelchair referral until the nurse raised concerns.

51. Each wing in the prison has wheelchairs available to help immobile prisoners around the prison. The wheelchairs are not assigned to specific prisoners, but are available for general use (to transport prisoners to and from the wings). Safer Custody staff suggested that this was how Mr Earl became in possession of the broken wheelchair. The Head of Healthcare said when a prisoner requires a wheelchair they should be referred to wheelchair services, who assess their suitability and measure the prisoner in order to supply the appropriate size. We would have expected Durham to remove a broken wheelchair from the wing and not allow prisoners to use it without undertaking the appropriate assessments. Staff should regularly inspect the condition of its mobility equipment. We are concerned that Mr Earl had access to and was able to use a potentially dangerous wheelchair without earlier intervention from prison staff or healthcare.

52. We agree with the clinical reviewer that the general care Mr Earl received was the equivalent to the care to which he could have expected to receive in the community. However, we are concerned that staff were unaware that Mr Earl was using unsuitable and potentially dangerous equipment to mobilise, which

was not specifically catered to his needs. We make the following recommendation.

The Governor should insure that equipment provided by the prison is regularly inspected and any broken items are removed from use, promptly repaired or destroyed.

Restraints

53. 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.

54. Staff did not restrain Mr Earl during his hospital appointments or his transfer to hospital on 29 March. Each escort risk assessment indicated that he was not restrained because he was in poor health and needed a wheelchair or walking stick to mobilise. We are satisfied that the decisions not to restrain Mr Earl were appropriate.

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