Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reginald Wood a prisoner at HMP Durham on 25 August 2018

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*

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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 I oversee can improve their work in the future.

Mr Reginald Wood died of heart disease on 25 August 2018 while a prisoner at HMP Durham. He was 83 years old. I offer my condolences to Mr Wood's family and friends.

Mr Wood had complex and chronic healthcare needs, including dementia. Although Durham was not the ideal environment in which to deliver the care he required, I am satisfied that the healthcare Mr Wood received at Durham was good and equivalent to that 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.

Sue McAllister, CB
Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. On 5 January 2018, Mr Reginald Wood received a seventeen-year sentence for sexual offences. He was sent to HMP Durham.

2. When he arrived at Durham, Mr Wood had had a coronary artery bypass and had several chronic health conditions, including diabetes, hypertension (high blood pressure), severe obesity, urinary incontinence and some memory loss. He required support with all aspects of daily living and used a Zimmer frame and wheelchair to mobilise.

3. He was located in the prison's inpatient healthcare unit and remained there until his death.

4. In January, February and July he was seen by a psychiatrist, and he was regularly reviewed by the prison's inhouse mental health team. Assessments confirmed that he had significant cognitive impairment consistent with dementia.

5. On 24 January, an assessment was made of Mr Wood's needs with the involvement of community social care services. Some equipment aids were provided as a result.

6. During March, the prison attempted to transfer Mr Wood to HMP Holme House which would have been better equipped to meet his complex needs, but no bed was available.

7. On 20 April, Mr Wood was assessed by a physiotherapist who encouraged him to do strengthening and falls-prevention exercises. Mr Wood declined to participate in exercises and it was noted that he had deteriorated further.

8. On 9 May, Mr Wood fell out of bed and fractured a vertebra in his lower back. He was taken to hospital but no treatment was required and he returned to Durham. His bed was lowered and a second mattress was placed on the floor, and an electronic bed was ordered. Further assessments were carried out and various measures and equipment were put in place to meet his needs. As he now needed to be nursed in bed, the Governor approved an open door policy which meant healthcare could be delivered promptly when needed.

9. On 15 May, following a multidisciplinary team meeting, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was put in place and Mr Wood was placed on the Gold Standards Framework (GSF, a palliative care programme). A further attempt was made to transfer him to Holme House but there was still no bed available.

10. Mr Wood continued to deteriorate over the following months. His needs were regularly discussed at multidisciplinary meetings and he received full nursing care.

11. On 25 August, Mr Wood became very unwell and was reviewed by a prison GP who called for an ambulance. Mr Wood died in his cell that afternoon with the ambulance crew present.

Findings

Clinical care

12. Although Durham was not the ideal environment to care for an elderly prisoner with such complex health and social care needs, we share the clinical reviewer’s view that the standard of care Mr Wood received at Durham was equivalent to that which he could have expected to receive in the community.

13. We make no recommendations.

The Investigation Process

14. 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.

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

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

17. We informed HM Coroner for Durham and South Darlington of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

18. The investigator wrote to Mr Wood's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

19. The investigation has assessed the main issues involved in Mr Wood'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.

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

Background Information

HMP Durham

21. 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

22. The most recent inspection of HMP Durham was conducted in October 2016. Inspectors reported that the provision of healthcare was reasonable, with some excellent mental healthcare. The 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. They noted that interactions between healthcare staff and prisoners were very good. They reported that 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 referrals were made where necessary. External health appointments were well managed.

Independent Monitoring Board

23. 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 2017, the IMB reported that the recruitment of nurses to the healthcare unit continued to be a significant issue, with agency nurses and overtime used as cover. Despite the staff shortages, primary care services delivered a good standard of care.

Previous deaths at HMP Durham

24. Mr Wood was the twelfth prisoner to die of natural causes at HMP Durham since January 2015.

Key Events

25. On 5 January 2018, Mr Reginald Wood received a seventeen-year sentence for sexual offences. He was sent to HMP Durham.

26. Mr Wood had had a coronary artery bypass and when he arrived at Durham he had several chronic health issues, including diabetes, hypertension (high blood pressure), severe obesity, urinary incontinence and some memory loss. He required support with all aspects of daily living and used a Zimmer frame and wheelchair to mobilise. He had a history of falls at his care home before coming into custody.

27. When he arrived at Durham, a nurse carried out a first night reception screening. This identified his diabetes and reduced mobility. She noted that Mr Wood's GP would be contacted to confirm his medication. Mr Wood was then located in the prison's inpatient healthcare unit and he remained there until his death.

28. The following day, because of his history of falls, Mr Wood was referred to a physiotherapist. Care plans, such as a diabetic assessment plan and falls assessments, were drawn up, although there is no evidence in his notes to show that these plans were implemented until May 2018.

29. On 9 January, Mr Wood's medication was prescribed and he was seen by prison GP. Mr Wood was not on any existing medication for his diabetes and a full set of bloods were requested due to his complex medical history.

30. Between 10 and 12 January, Mr Wood suffered three falls but was found to be uninjured. Although anti-slip socks were given to him, he continued to fall, normally without injury.

31. On 16 January, a mental health assessment was completed by a nurse and a psychiatric appointment took place on 19 January. The psychiatrist, recorded that there was a need for a co-ordinated approach to manage Mr Wood's physical and cognitive issues. On 2 February, he carried out a follow-up assessment and noted risk factors which could contribute to brain changes and dementia.

32. Mr Wood remained on the prison's in-house mental health caseload. He was regularly reviewed and these reviews confirmed significant cognitive impairment consistent with dementia. Mr Wood also had two further psychiatric reviews in February and July.

33. On 20 April, Mr Wood was assessed by physiotherapist who put him on a basic strengthening programme. Weekly reviews were planned. She encouraged Mr Wood to do strengthening exercises and falls-prevention exercises but Mr Wood was reluctant to engage. During follow-up appointments, Mr Wood declined to engage in exercises. She noted that he had deteriorated further.

34. On 9 May, Mr Wood fell out of bed and fractured a vertebra in his lower back. No specific treatment was required and pain relief medicine was prescribed when he returned to Durham from hospital. His bed was lowered and a second mattress was placed on the floor in case of further falls.

35. Two days later, a nurse carried out several assessments including moving and handling, pressure sore risk and a falls assessment. Equipment and measures were put in place to assist Mr Wood based on the high risk that he posed and an electronic bed with a pressure relieving mattress was ordered.

36. On 15 May, at a multidisciplinary meeting, a Do Not Attempted Resuscitation (DNAR) order was put in place. (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.) Mr Wood was also placed on the Gold Standards Framework (GSF), a palliative care programme, and on the end of life register.

37. Mr Wood continued to deteriorate over the following months and his needs were regularly discussed at multidisciplinary meetings. He received full nursing care from the healthcare staff at Durham. From May, the Governor authorised an open-door policy for Mr Wood's cell which meant care could be delivered promptly in the event of emergency.

38. On 25 August, at approximately 11am, healthcare staff noticed that Mr Wood had become unwell. A prison GP was informed and told healthcare staff to watch for any further deterioration. At 2.41pm, Mr Wood's condition deteriorated. His abdomen had become swollen and he had started vomiting 'coffee ground' fluid. The prison GP visited Mr Wood and spoke to the local hospital who advised that a 'blue light' (emergency) ambulance should be called.

39. An ambulance was called at 2.57pm and arrived at HMP Durham at 3.50pm. (As it was initially thought that Mr Wood was suffering from a suspected perforated ulcer, the estimated time for the arrival of the ambulance was two hours.) After the ambulance crew had arrived, Mr Wood deteriorated further and he stopped breathing. Mr Wood was pronounced dead at 4.29pm.

40. A post-mortem examination found that the cause of Mr Wood's death was heart disease which was caused by pulmonary emphysema (lung disease) and diabetes.

Mr Wood's location

41. Mr Wood was cared for in the healthcare department throughout his time at Durham. The physical environment at Durham made delivering care to Mr Wood challenging for the health and social care staff. For example, the layout of his cell minimised the amount of mobility aids which could be used.

42. Attempts were made in March and again in May to secure a bed at HMP Holme House which had the facilities to manage his complex physical and social care needs better, but no bed became available before his death.

Contact with Mr Wood's family

43. At approximately 4.40pm, a member of staff from HMP Durham was assigned to be the family liaison officer (FLO). She checked Mr Wood's records and noted that his wife was his next of kin but that there was no contact telephone number for her. After discussing this with another member of staff, she was told that Mr Wood's wife had died since Mr Wood had been in custody. There were no other

contacts listed for Mr Wood. The police identified that Mr Wood had a daughter but they did not have her full contact details.

44. The following day, the FLO asked the police to try to contact Mr Wood's daughter. The police did so but she said she did not want any contact from the prison. Various other family members were contacted but no one wanted to get involved with the funeral process and all were happy for the prison to make the necessary arrangements for Mr Wood's funeral.

45. On 31 August, the prison was notified by the coroner's office that Mr Wood's wife was alive, although she too did not want anything to do with the funeral or the inquest. The FLO contacted Mr Wood's wife who asked to be informed of the date of the funeral, although she did not wish to attend.

46. On 6 September, the FLO told Mr Wood's daughter and wife the details of his funeral. This took place on 11 September and was conducted by the prison's chaplain. The prison made contributions to the funeral in line with guidelines.

Support for prisoners and staff

47. After Mr Wood's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

48. The prison posted notices informing other prisoners of Mr Wood's death and offered support.

Findings

Clinical Care

49. Although Durham was not the ideal environment in which to deliver the care Mr Wood needed, we share the clinical reviewer's view that the care Mr Wood received was of a good standard and equivalent to what he would have received in the community. In the last stages of Mr Wood's life, his care was co-ordinated effectively using the GSF.

50. Although there were some delays in the assessment of Mr Wood's needs, the clinical reviewer was satisfied that this did not affect his care.

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