Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Brown, a prisoner at HMP Durham, on 12 July 2019

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 Thomas Brown died of an infection in an aortic heart valve replacement caused by an abscess around the spinal cord on 12 July 2019 while a prisoner at HMP Durham. He was 80 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that even though the standard of healthcare that Mr Brown received at Durham was variable, it was equivalent to that which he could have expected to receive in the community.

Healthcare staff did not complete appropriate care plans or carry out risk assessments to support Mr Brown's activities of daily living, pain relief and mobility. When Mr Brown started to fall over, healthcare staff did not complete a falls risk assessment.

I am concerned that Mr Brown was inappropriately restrained on two occasions when he went to hospital in the months before he died.

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 **March 2020**

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Summary

Events

1. On 10 May 2019, Mr Thomas Brown was convicted of sex offences and sent to HMP Durham. He was sentenced to 21 years in prison.

2. At his initial health screen, a nurse noted that Mr Brown had previously had bowel and lung cancer and that he had sleep apnoea, chronic obstructive pulmonary disease (COPD, a lung disease), hypertension and venous leg ulcers.

3. On 17 May, Mr Brown was sent to hospital because a nurse suspected that he had cellulitis (a serious bacterial skin infection). He was prescribed antibiotics and returned to Durham.

4. On 21 June, Mr Brown was unwell. A prison GP thought that he had an infection and prescribed him antibiotics. Later that day, a nurse arranged for Mr Brown to be sent to hospital by emergency ambulance because she thought that he may have sepsis (a severe infection). The next day, Mr Brown went back to Durham without a hospital discharge letter.

5. Mr Brown then developed back and shoulder pain and had difficulty getting out of bed. On 24 June, he told a nurse that he had nearly fallen over in his cell and on 29 June, he told a healthcare support worker that he had fallen over twice, trying to go the toilet. He was moved to the prison's inpatient healthcare unit that day.

6. On 3 July, a prison GP reviewed Mr Brown's blood tests which indicated that he may have an infection. The GP considered that he was at risk of a bowel obstruction and sepsis so he was sent to hospital by ambulance, and admitted.

7. On 11 July, a hospital consultant said that Mr Brown had carditis (an inflammation of the heart), an infected spine and had had a stroke. The next day Mr Brown died. The post-mortem examination established that he died of an infection of the heart which had developed in a replacement heart valve as a result of an abscess around the spinal cord.

Findings

Clinical care

8. The clinical reviewer said that the care that Mr Brown received at Durham was variable but equivalent to that which he could have expected to receive in the community.

9. Healthcare staff did not complete care plans for Mr Brown to support his activities of daily living, pain relief and mobility. In June, when Mr Brown started to fall over, healthcare staff did not complete a falls risk assessment.

Restraints

10. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Although Mr Brown was elderly, had poor mobility and a number of pre-existing medical conditions, including a serious lung

condition and a leg ulcer, on more than one occasion he was restrained by a single cuff when he went to hospital. We do not consider that this was justifiable.

Recommendations

- The Head of Healthcare should ensure that care plans which meet the health and social care needs of a prisoner are implemented and appropriately monitored and updated.
- The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment and the assessment is recorded and acted upon.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time, and that staff keep a full record of their decisions.
- The Governor should revise the risk assessment form for hospital escorts to ensure that prison managers are required to confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

The Investigation Process

11. 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.

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

13. NHS England commissioned an independent clinical reviewer to review Mr Brown's clinical care at the prison

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

15. The Ombudsman's family liaison officer wrote to Mr Brown's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He asked why Mr Brown was left alone for a week before his death, why he did not go to hospital or the prison inpatient unit sooner and why he had three broken ribs. We have addressed those questions in this report.

16. We shared the initial report with the Prison Service. There was one factual inaccuracy and their action plan has been appended to this report.

17. Mr Brown's son received a copy of the initial report. He raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Durham

18. 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

15. The most recent full inspection of HMP Durham was in October 2018. Inspectors reported that the governance of healthcare services at the prison continued to be a complex task due to the number of different service providers. However, they considered that the inpatient unit at the prison was well managed and the regime within the inpatient unit had been enhanced since their last inspection. Effective arrangements had also been put in place for prisoners who needed social care, and the prison had made good links with local social services.

Independent Monitoring Board

16. 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 2018, the IMB reported that the recent change in the role of the prison had meant an increase in the workload of healthcare staff. They noted that the healthcare department continued to experience staff shortages.

Previous deaths at HMP Durham

17. There have been 17 deaths at Durham in the last two years, of which four were from natural causes, eight were self-inflicted and five were drugs-related. There was another self-inflicted death after Mr Brown's death. We have previously made recommendations about the inappropriate use of restraints.

Key Events

18. On 10 May 2019, Mr Thomas Brown was convicted of sex offences and sent to HMP Durham. On 3 June, he was sentenced to 21 years in prison.

19. On 10 May, a nurse carried out Mr Brown's initial health screen. The nurse noted that he had previously had bowel and lung cancer and that he had sleep apnoea, COPD, hypertension and venous ulcers on his left leg.

20. That day, a nurse completed Mr Brown's second health screen and noted that he used a continuous positive airway pressure (CPAP) machine for his sleep apnoea. The nurse noted that there were no concerns about Mr Brown's physical, emotional or mental health and that he was independent and was therefore fit to live on a standard wing.

21. On 11 May, Mr Brown's next of kin telephoned a nurse and told her that Mr Brown had oedema (a build-up of fluid which causes swelling) on both his legs and that although he needed weekly dressing changes for leg ulcers, this had not been done for two or three weeks. The nurse saw Mr Brown who told her that he was moving well around his cell.

22. On 17 May, the nurse saw Mr Brown and noted that he had blisters on the back of his left leg and both his legs were hot. He said that he felt unwell. Later that day, she arranged for Mr Brown to go to hospital because she thought that he may have cellulitis (a serious bacterial skin infection).

23. Before Mr Brown went to hospital, prison staff completed an escort risk assessment. The nurse completed the medical section and although she noted no objections to the use of restraints, she ticked the box to say there were 'other medical conditions likely to influence the escort' and noted that his mobility was limited and that he used a walking stick. A security collator assessed Mr Brown as posing a medium risk to the public and a low risk of escape. He recommended that Mr Brown should be restrained with a single cuff at all times due to his limited mobility and use of a walking stick. He recommended that an escort chain should be used for treatment. The Head of Security decided that two officers should escort Mr Brown and restrain him with a single cuff due to his poor mobility.

24. A hospital accident and emergency doctor noted that Mr Brown had a wound on the back of his leg but that the surrounding skin was not inflamed and his temperature was in the normal range. He prescribed antibiotics and sent Mr Brown back to Durham. There is no evidence that healthcare staff put care plans in place.

25. On 5 June, a prison GP noted that Mr Brown had borderline left-sided heart failure but had no immediate concerns.

26. On 21 June, a nurse saw Mr Brown as a medical emergency. Mr Brown was quite breathless but told the nurse that this was normal because he had a CPAP machine. Mr Brown said that he had felt hot and cold all night. The nurse saw that he had oedema on both legs which were warm to touch. He also had red spots on his right leg.

27. The nurse completed Mr Brown's observations. He had a high pulse rate (98 beats per minute), a high temperature (38.7 degrees), a high respiration rate (26 breaths per minute) and normal blood oxygen saturation (97%). He noted that Mr Brown had a NEWS score (NEWS, a tool to detect and respond to clinical deterioration) of 4 which indicated that his condition had deteriorated. (A NEWS score above 0 indicates a deterioration in clinical condition, with a score above 7 indicating high clinical risk. The NEWS guidelines say that a score of 0 to 4 requires a community-based – that is, not hospital - response.)

28. Later that day, a prison GP examined Mr Brown and found that he had signs of a chest infection. He prescribed him doxycycline, an antibiotic, and prochlorperazine for nausea and vomiting.

29. That day, a nurse saw Mr Brown and noted that he was short of breath, that his lips were cyanosed (blue) and that he had not passed urine since the previous day. Mr Brown told her that he felt unwell, was cold and had vomited several times. She recorded a NEWS score of 2 but was unable to get a blood oxygen saturation reading. She sent Mr Brown to hospital by emergency ambulance because she thought that he may have sepsis.

30. The prison did not provide us with an escort risk assessment or an escort record and we have therefore seen no evidence to know if Mr Brown was restrained when he went to hospital.

31. On 22 June, Mr Brown went back to Durham. A nurse noted that there were no discharge notes. There is no evidence that healthcare staff arranged to monitor Mr Brown more frequently.

32. On 24 June, a nurse saw Mr Brown as a medical emergency. He was lying on his bed and told her that he had not taken his paracetamol since lunchtime. She told him to take his paracetamol regularly and to drink plenty of fluids. Mr Brown told her that he had nearly fallen over that morning and had back pain and a pain near his shoulder blades. She asked the night shift team to monitor Mr Brown.

33. On 26 June, a nurse saw Mr Brown who told her that he had chronic pain in his middle and lower back. He said that he had not moved since the previous day, except to go to the bathroom. Mr Brown was able to lower his left leg but complained of pain in his right leg. She noted that Mr Brown had a NEWS score of 2 and referred him to a Nurse Practitioner or prison GP for pain relief.

34. On 28 June, a prison GP saw Mr Brown who was in a wheelchair. He was able to stand up with support. The prison GP noted tenderness around Mr Brown's central and lower back muscles. Mr Brown walked a few steps. He diagnosed an acute muscle strain and prescribed co-codamol and diazepam for pain relief.

35. On 29 June, a healthcare support worker went to Mr Brown's cell. He told her that he was unable to get out of bed because of back spasms, had been unable to move since the previous evening and had fallen twice, trying to go to the toilet. She spoke to a nurse who arranged for Mr Brown to be moved to the healthcare inpatient unit to promote his independence. He moved to a cell in healthcare. There is no evidence that healthcare staff completed a falls risk assessment.

36. On 2 July, a nurse saw Mr Brown who had vomited bile and said that he felt dizzy, shivery, was breathless and felt generally unwell. She noted that he had a NEWS score of 4. She spoke to another nurse, who asked a prison GP to review him urgently. The prison GP saw Mr Brown and noted that he had a mildly swollen and soft abdomen and had mild discomfort. The prison GP noted that this might have been due to an intestinal (bowel) obstruction. The prison GP spoke to a Registrar at the hospital who advised him to send Mr Brown to hospital. An ambulance was called but Mr Brown told paramedics that he did not have abdominal pain and refused to go to hospital.

37. On 3 July, a prison GP reviewed Mr Brown's blood tests. which showed the possible presence of an infection. On the prison GP's advice that Mr Brown was at risk of a bowel obstruction and sepsis, a nurse arranged for him to be sent to hospital by ambulance.

38. Before Mr Brown went to hospital, prison staff completed an escort risk assessment. The nurse completed the medical section and did not object to the use of restraints but noted that Mr Brown had limited mobility, heart disease, COPD and sleep apnoea. She also noted that Mr Brown had an active PEEP (Personal Emergency Evacuation Plan) due to his reduced mobility. A security collator assessed Mr Brown as posing a medium risk to the public and a low risk of escape and recommended that he should be restrained and escorted by two officers. The Head of Operations decided that he should be escorted by two officers and restrained by a single cuff.

39. Mr Brown stayed in hospital. Hospital staff carried out a CT scan and said that he may have an infection of the large intestine.

40. At 3.00pm on 5 July, the Projects Manager, authorised officers to remove Mr Brown's restraint.

41. On 8 July, a nurse telephoned hospital staff who said that Mr Brown had had a stroke and had a chest infection and fractured ribs. There is no documentation in the hospital records to suggest that Mr Brown's fractured ribs were due to a pathological fracture (a broken bone caused by disease rather than an injury) or his previous fall.

42. On 11 July, a hospital consultant told a nurse that Mr Brown had carditis (an inflammation of the heart), an infected spine and had had a stroke. The next day, Mr Brown died. A post-mortem examination established that he died of an infection in a replacement heart valve as a result of an abscess around the spinal cord.

Contact with Mr Brown's family

43. On 10 July, Mr Brown's family, including his son, visited him in hospital.

44. On 12 July, the Acting Head of Residence and Services, appointed an officer as the family liaison officer (FLO) and a Senior Officer as the deputy family liaison officer. At 6.30pm, the officers visited Mr Brown's next of kin and offered their condolences. Mr Brown's next of kin said that the hospital had told him that Mr Brown had died.

45. The family liaison officers remained in contact with Mr Brown's next of kin.

46. Mr Brown's funeral took place on 30 July, and Durham contributed to its cost in line with national instructions.

Support for prisoners and staff

47. After Mr Brown's death, the Acting Head of Residence and Services debriefed the staff who were on duty at the hospital when Mr Brown died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

Post-mortem report

49. A post-mortem examination established that Mr Brown died of endocarditis of an aortic valve replacement (an infection in a replacement heart valve) as a result of a paraspinal abscess (an abscess around the spinal cord) following a fall.

50. The pathologist noted that the most likely source of the infection was a paraspinal abscess which might have occurred after the fall, although it was difficult to assess with any degree of certainty. The pathologist said that Mr Brown did not have any broken ribs.

Findings

Clinical care

51. The clinical reviewer found that the care that Mr Brown received at Durham was of a variable standard but overall, was equivalent to that which he could have expected to receive in the community.

52. The clinical reviewer is satisfied that healthcare staff arranged for Mr Brown to be moved to the inpatient unit for increased observation and nursing support on 29 June, and that when his health deteriorated further, they escalated their concerns to a prison GP who appropriately arranged for him to be sent to hospital.

53. However, we are concerned that healthcare staff did not complete care plans or carry out risk assessments for Mr Brown to have support with his activities of daily living, pain relief and mobility. We make the following recommendation:

    The Head of Healthcare should ensure that care plans which meet the health and social care needs of a prisoner are in place and appropriately monitored and updated.

54. Despite the fact that Mr Brown told healthcare staff that he had nearly fallen over on 24 June, and that he had fallen over twice going to the toilet on 29 June, they did not complete a falls risk assessment. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners at risk of falls have an appropriate risk assessment and the assessment is recorded and acted upon.

55. The clinical reviewer makes a number of further recommendations which the Head of Healthcare will need to address.

Use of restraints

56. 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 a prisoner's health and mobility.

57. 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, including the risk to the public in the event of an escape, and the prisoner's risk when he has 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. The judgement found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

58. Although Durham provided no evidence to say whether or not Mr Brown was restrained when he went to hospital on 21 June, we know that he was restrained

with a single cuff when he went to hospital on 17 May and 3 July. On 17 May, the decision to use a single cuff included a healthcare assessment that Mr Brown's mobility was poor and the security assessment that he posed a medium risk to the public. On 3 July, just over a week before Mr Brown died, the decision to restrain him included a healthcare assessment that he had limited mobility for which he needed a personal evacuation plan, heart disease, COPD and sleep apnoea, but again noted his medium risk to the public.

59. Mr Brown was 80 years old, he had a number of serious pre-existing medical conditions and poor mobility and had fallen over in his cell in the weeks before he died. We are therefore concerned that the prison's decision-making process did not take into account the state of his health, mobility and age in considering his risk, as required by the High Court judgment.

60. While we recognise that a senior manager reviewed the restraint decision while Mr Brown was in hospital and agreed to remove the cuff six days before he died, we can see no justification for restraining Mr Brown when he went to hospital given his age, reduced mobility and poor health at the time and the fact that he was accompanied by two prison officers. We make the following recommendations:

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

The Governor should revise the risk assessment form for hospital escorts to ensure that prison managers are required to confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

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