Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Davidson, a prisoner at HMP Northumberland, on 25 June 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Darren Davidson died on 25 June 2021 of a subarachnoid haemorrhage at HMP Northumberland. Mr Davidson was 46 years old. I offer my condolences to Mr Davidson's family and friends.

The clinical reviewer concluded that the clinical care Mr Davidson received at HMP Northumberland was of a good standard, and generally equivalent to that which he could have expected to receive in the community. However, he found that Mr Davidson's long-term conditions were not consistently monitored.

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 2022**

Contents

Summary

Events

1. On 22 February 2017, Mr Darren Davidson was remanded into prison custody. In May, he was sentenced to three years and 11 months imprisonment for burglary. In June he transferred to HMP Northumberland.

2. Mr Davidson had several pre-existing health conditions including epilepsy, high blood pressure, opiate dependency, a brain aneurysm (a bulge in a blood vessel in the brain) and post-traumatic stress disorder (PTSD).

3. On 21 March 2019, Mr Davidson was released into the community. He was recalled to prison in November and charged with further offences.

4. Following his recall to prison, healthcare staff did not consistently monitor Mr Davidson's long-term medical conditions.

5. At around 9.08am on 25 June 2021, Mr Davidson collapsed on the wing. Prisoners put him in the recovery position and Prison Custody Officers (PCOs) called for help from healthcare staff. Staff called an ambulance immediately. The paramedics reached Mr Davidson at 9.13am. Despite the resuscitation efforts, it was confirmed that Mr Davidson had died in the prison at 9.56am.

Findings

6. The clinical reviewer concluded that the clinical care Mr Davidson received at Northumberland was of a good standard and generally equivalent to the care he could have expected to receive in the community. He did, however, identify some areas of concern.

7. The clinical reviewer found that there was a lapse in the monitoring of Mr Davidson's high blood pressure due to the restrictions introduced to mitigate the COVID-19 pandemic. Management of his brain aneurysm, epilepsy and thrombosis was also poor.

8. The clinical reviewer found that it was not possible to say if Mr Davidson's death could have been prevented due to the nature of a subarachnoid haemorrhage.

Recommendation

- **The Head of Healthcare should review the arrangements in place for monitoring long- term conditions including:**
    - **making use of medical technology that enables remote assessment and monitoring;**
    - **the care and treatment of prisoners with a diagnosis of epilepsy and the risks associated with sudden unexpected death in epilepsy and the need for neurological review and monitoring of the condition; and,**
    - **the care and treatment of prisoners with a history, or at risk, of thrombosis.**

The Investigation Process

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

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

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

12. The clinical reviewer and investigator interviewed four members of staff by telephone, in line with COVID-19 restrictions, on 10 September 2021.

13. We informed HM Coroner for North Northumberland of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Davidson's next of kin, his mother, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She asked several medical questions about Mr Davidson's cause of death, which the clinical reviewer has answered in his report. She also asked for a copy of this report, which we have sent to her.

15. Mr Davidson's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Northumberland

17. HMP Northumberland is a medium security prison, with capacity to hold 1348 adult men. The prison is located near Morpeth and is operated by Sodexo Justice Services under contract from the Ministry of Justice.

18. Physical healthcare and substance misuse services are provided by Spectrum Community Health. Mental health services are provided by Tees, Esk and Wear Valleys NHS Foundation Trust. Healthcare services are staffed between 7.30am to 7.30pm during the week and 8.00am to 6.00pm on the weekend. There is no in-patient facility at Northumberland.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements. They said that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, inspectors found that most healthcare needs were met.

20. In September 2020, HMIP conducted a short scrutiny visit at Northumberland. Inspectors reported that prisoner applications for primary care were triaged by senior clinical staff and same-day GP appointments were available for urgent cases. Despite some vacancies and absences, the team was delivering timely access to health care for prisoners.

Independent Monitoring Board

21. 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 published annual report, for the year 1 January to 31 December 2020, the IMB reported that there had been an improvement in healthcare services since the contract was awarded to Spectrum, with a "more cohesive approach to provision".

Previous deaths at HMP Northumberland

22. Mr Davidson was the fifth prisoner to die at HMP Northumberland since June 2019. Of the previous deaths, two were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Davidson's death and our investigation findings for the previous deaths.

Key Events

23. On 22 February 2017, Mr Darren Davidson was remanded to HMP Durham. On 26 May, he was sentenced to three years and 11 months imprisonment for burglary and affray.

24. Prior to his arrival in prison, Mr Davidson had had a diagnosis of a cerebral (brain) aneurysm. The clinical opinion at the time was that the risk to Mr Davidson was low and a "conservative management approach" was advised.

25. At his reception health screen, it was noted that Mr Davidson had a number of medical conditions and needs including epilepsy, high blood pressure, opiate dependency, a brain aneurysm (a bulge in a blood vessel in the brain) and post-traumatic stress disorder (PTSD). Mr Davidson was on medication for his epilepsy and opiate dependency and these medications were re-prescribed in prison. He restarted medication for his high blood pressure in April 2017.

26. On 19 June, Mr Davidson transferred to Northumberland.

27. On 21 March 2019, Mr Davidson was released from Northumberland on probation licence. Prior to his release he was advised to follow up his cerebral aneurysm with community health services. Mr Davidson did not follow up his cerebral aneurysm with community healthcare services once he was released.

28. On 9 November, Mr Davidson was recalled to prison for committing further offences. He was charged with burglary and possession of a bladed weapon. He was sent to HMP Durham.

29. There is no evidence that healthcare staff reviewed his long-term conditions following his recall to prison in November.

30. On 23 December, Mr Davidson transferred to HMP Northumberland. On 28 February 2020, he transferred back to HMP Durham for his trial.

31. In March, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, a national lockdown came into force across the country. In prisons, regimes were severely curtailed, a COVID-19 management strategy was implemented, and a range of services including drug and healthcare services were reduced. Face-to-face appointments were reduced, and some non-urgent appointments were cancelled.

32. On 4 May, Mr Davidson was convicted of handling stolen goods, burglary and possession of an offensive weapon and sentenced to five years imprisonment.

HMP Northumberland

33. On 2 June, following the conclusion of his trial, Mr Davidson transferred back to HMP Northumberland.

34. A nurse saw Mr Davidson for a full health assessment. His history of epilepsy, high blood pressure and opiate dependence was identified (and medication prescribed by a prison GP).

35. There is no evidence that Mr Davidson's blood pressure was measured at any time after 2 June or that future blood pressure checks were scheduled or that a care plan was created and implemented.

36. Mr Davidson was also receiving treatment for epilepsy and while the records suggest that further neurological investigations had been started, there was no specific planned follow up recorded and no evidence that a care plan was created or implemented.

Events of 25 June 2021

37. At around 9.08am on 25 June, Mr Davidson was talking with other prisoners on his wing, when he suddenly collapsed. The prisoners with Mr Davidson put him in the recovery position and alerted staff. Prison Custody Officers (PCOs) arrived within a minute and immediately called for healthcare staff and radioed a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

38. At 9.09am, the prison control room made a 999 call to the North East Ambulance Service (NEAS). Nursing staff responded to the code blue. At 9.10am, they arrived and, along with PCOs, began to give Mr Davidson CPR. A NEAS paramedic team were already in the prison treating another prisoner. A nurse asked them to attend, and they arrived at 9.13am. Paramedics and healthcare staff continued to give Mr Davidson CPR while they transferred him to the ambulance. However, all attempts to resuscitate Mr Davidson were unsuccessful.

39. At 9.56am, paramedics pronounced Mr Davidson dead in the ambulance in the prison.

Contact with Mr Davidson's family

40. At 10.30am, the prison appointed a family liaison officer (FLO). At 10.50am, the FLO rang Mr Davidson's next of kin, his mother, to break the news of his death. Over the following days and weeks, the FLO provided support and information to Mr Davidson's family, including returning his personal belongings.

41. Mr Davidson's funeral was held on 8 July 2021. In line with prison policy, HMP Northumberland made a contribution to the cost of the funeral. Prisoners on Mr Davidson's wing contributed to the cost of flowers for the funeral.

Support for prisoners and staff

42. After Mr Davidson's death, the Deputy Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues, and to offer support. The staff care team also offered support. The prison Chaplain met with the prisoners who had helped Mr Davidson when he collapsed.

43. The prison posted notices informing other prisoners of Mr Davidson'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 Davidson's death.

Post-mortem report

44. The pathologist gave Mr Davidson's cause of death as a subarachnoid haemorrhage (SAH - an uncommon type of stroke caused by bleeding on the surface of the brain). Mr Davidson also had hypertension (high blood pressure), which did not cause but contributed to his death.

Findings

Clinical care

45. The clinical reviewer found that the clinical care Mr Davidson received at Northumberland was of a good standard, and generally equivalent to the care he could have expected to receive in the community.

46. He did, however, identify some concerns about Mr Davidson's care.

Monitoring of long-term conditions

47. The primary cause of Mr Davidson's death was extensive subarachnoid haemorrhage (SAH). High blood pressure is a risk factor in development of cerebral aneurysms that could lead to SAH. Early detection of this condition may have been made more likely by continued close monitoring of Mr Davidson's blood pressure after 2 June 2020, but staff failed to consistently monitor his high blood pressure. The clinical reviewer found that this lapse in the monitoring of his chronic high blood pressure condition coincided with restrictions introduced as a consequence of the COVID-19 pandemic.

48. In interview, the interim Head of Healthcare told us that the prison healthcare services experienced resource pressures due to sick absences related to COVID-19. This, coupled with guidance from Public Health England to stand down non-priority activity, meant resource was prioritised for urgent and emergency care. The clinical reviewer acknowledged that the prioritising of urgent and emergency care was an approach which was also operating in the community. However, the clinical reviewer considered that there was no consideration given to making use of medical technology to enable remote assessment and monitoring of Mr Davidson's blood pressure.

49. Mr Davidson was diagnosed with a cerebral (brain) aneurysm. The clinical opinion in the community at the time was that the risk to Mr Davidson was low. On his release in March 2019, he was advised to have his cerebral aneurysm reviewed by community health services, but he did not do so. There is no evidence that healthcare staff reviewed his cerebral aneurysm following his recall to prison in November 2019.

50. Mr Davidson also had a history of epilepsy and thrombosis. He was receiving medication for his epilepsy but not for his thrombosis. There is no evidence that these conditions were followed up, monitored or reviewed or that a care plan was created and implemented for these conditions.

51. We make the following recommendation:

The Head of Healthcare should review the arrangements in place for monitoring long term conditions including:

- **making use of medical technology that enables remote assessment and monitoring.**
- **the care and treatment of prisoners with a diagnosis of epilepsy and the risks associated with sudden unexpected death in epilepsy and**

the need for neurological review and monitoring of the condition; and,

- **the care and treatment of prisoners with a history, or at risk, of thrombosis.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141