Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Brown, a prisoner at HMP Durham, on 6 September 2021

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 Stephen Brown died in hospital of pancreatitis on 6 September 2021, while a prisoner at HMP Durham. He was 50 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown arrived at Durham on 31 August 2021. He was alcohol dependent and healthcare staff monitored him twice daily for alcohol withdrawal symptoms.

On 2 September, Mr Brown complained of abdominal pain. A nurse examined him and then sent him to hospital, where he was admitted. He died four days later.

The clinical reviewer found that the care Mr Brown received at Durham was of a variable standard, with some elements of care not equivalent to that he could have expected to receive in the community.

The clinical reviewer noted two occasions when healthcare staff did not identify that Mr Brown had elevated blood pressure. She also noted that the staff monitoring Mr Brown for alcohol withdrawal symptoms did not always take a full set of clinical observations as they should have done.

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**

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Summary

Events

1. On 31 August 2021, Mr Stephen Brown was recalled to prison and sent to HMP Durham.

2. A healthcare support worker took Mr Brown's physical observations when he arrived. The blood pressure reading she recorded showed that Mr Brown's blood pressure was elevated. She took no further action.

3. During his reception health screen, Mr Brown told the nurse that he drank three to four bottles of wine a day. The nurse assessed him for alcohol withdrawal symptoms using an assessment tool, which showed he had minimal to no symptoms. She referred Mr Brown to the prison GP and to the Drug and Alcohol Recovery Team (DART).

4. The GP assessed that Mr Brown did not need a formal detoxification but that he would be monitored twice daily for withdrawal symptoms. He prescribed medication for symptomatic relief if required. He was unable to view Mr Brown's community medical record so did not prescribe any other medication. (This was prescribed by another GP the next day, but Mr Brown was taken to hospital before he was given any medication.)

5. At around 8.00am on 2 September, a healthcare support worker checked on Mr Brown as part of his alcohol withdrawal monitoring. She referred Mr Brown to the DART clinic and asked for symptomatic relief for Mr Brown. When interviewed, she said she could not recall why she had done this and did not recall that Mr Brown had reported any symptoms to her. She also recorded a blood pressure reading for Mr Brown that was significantly elevated.

6. Later that morning, Mr Brown told wing staff that he felt unwell and had abdominal pain. Staff asked for a nurse to see him.

7. Mr Brown told the nurse that he had vomited and had diarrhoea at 6.00am that morning. He also told her that he usually drank heavily and had not received any medication to ease alcohol withdrawal.

8. The nurse examined Mr Brown's abdomen and found it was swollen. She gave Mr Brown medication to help relieve his pain and to ease alcohol withdrawal. Mr Brown's condition did not improve, and so the nurse asked officers to call an ambulance.

9. Mr Brown was admitted to hospital with suspected pancreatitis. A hospital doctor then diagnosed him with alcohol induced pancreatitis and prescribed medication for alcohol withdrawal.

10. Mr Brown continued to deteriorate and was moved to the Intensive Care Unit on 5 September.

11. On 6 September, Mr Brown was put into an induced coma as he had not been responding to treatment. He died later that day after the decision was made to withdraw life support.

Findings

12. The clinical reviewer considered that the care Mr Brown received at Durham was of a variable standard, with some elements not equivalent to the care that he could have expected to receive in the community.

13. The clinical reviewer noted that there were two occasions when healthcare support workers did not identify that Mr Brown's blood pressure was elevated and did not seek advice from a nurse. Also, the reception nurse did not review the healthcare support worker's recorded observations so also did not identify Mr Brown's raised blood pressure when he arrived.

14. There was a delay in Mr Brown being prescribed medication. The clinical reviewer noted that while this did not appear to have an adverse impact on Mr Brown, this may not be the case in a future patient.

15. The healthcare staff who were monitoring Mr Brown for alcohol withdrawal symptoms did not take and record a full set of clinical observations as they should have done.

Recommendations

- The Head of Healthcare should ensure that staff are aware of NICE guideline Hypertension in adults: diagnosis and management.
- The Head of Healthcare should ensure that reception nurses routinely review the outcome of the physical observations taken by the healthcare support workers.
- The Head of Healthcare should ensure that there is a clear escalation process in place where a healthcare support worker records any clinical observation that is not within expected parameters.
- The Head of Healthcare should explore why the reception GP was unable to access the Summary Care Records on 31 August 2021 and initiate a process to avoid a future reoccurrence.
- The Head of Healthcare should ensure that all staff are reminded of Standard Operating Procedure Reception and Treatment Pathway for Substance Misusers in the North East Prisons and that full clinical observations are taken and recorded for prisoners being monitored for alcohol withdrawal symptoms.

The Investigation Process

16. 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.

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

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

19. The investigator and clinical reviewer interviewed five members of staff on 4 and 18 October, and 1 November. The interviews were conducted by phone and video due to the coronavirus restrictions in place.

20. We informed HM Coroner for Durham of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The Ombudsman's family liaison officer contacted Mr Brown's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked the following questions (which have been answered in this report and the accompanying clinical review):

    - Is it policy that a prisoner is not allowed to take their own medication into prison?
    - Why was his daughter not allowed to deliver Mr Brown's medication to the prison?
    - What was he prescribed in prison?
    - Was he prescribed any medication immediately?
    - Did he tell healthcare about his alcohol dependency?
    - Did he receive any support/medication for his alcohol dependency?
    - What is the policy for informing next of kin when a prisoner is taken to hospital?

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

23. We sent a copy of our initial report to Mr Brown's mother and sister. They pointed out some factual inaccuracies which we have amended in this report.

Background Information

HMP Durham

24. HMP Durham is a local prison, serving the courts of Tyneside, Durham, and Cumbria. It holds approximately 1000 men. Spectrum Community Health CIC provides primary healthcare services and clinical substance misuse services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

15. The most recent full inspection of HMP Durham was in October 2018. Inspectors reported that despite the high throughput of prisoners, they all had easy access to a good range of primary care services, and waiting lists were acceptable. They found that appropriate monitoring arrangements were in place to support prisoners receiving clinical treatment for drug and alcohol dependence.

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 ending 31 October 2020, the IMB reported improvements in partnership and integrated working, GP and advanced nurse practitioner waiting times, and a reduction in healthcare complaints.

Previous deaths at HMP Durham

17. Mr Brown was the 14th prisoner to die at Durham since September 2019. Of the previous deaths, six were from natural causes, five were self-inflicted, one was drug-related, and one was from unknown causes. There were no significant similarities between our findings from our investigation into Mr Brown's death and our findings from the previous deaths.

Key Events

18. In October 1999, Mr Stephen Brown was sentenced to life imprisonment for violent offences. He was released on licence in May 2020.

19. On 31 August 2021, Mr Brown was recalled to prison after being charged with further offences and was sent to HMP Durham.

20. Mr Brown had a history of drug and alcohol misuse. He also had a wrist injury, asthma and anxiety and depression.

21. When Mr Brown arrived at Durham, a healthcare support worker took his physical observations and recorded his blood pressure as 146/97mmHg (which is elevated – a normal blood pressure is between 90/60mmHg and 120/80mmHg).

22. A nurse then carried out Mr Brown's reception health screen. Mr Brown told her that he consumed three to four bottles of wine a day. She assessed Mr Brown for alcohol withdrawal symptoms using an assessment tool and the score suggested absent to minimal symptoms. She referred Mr Brown to the prison GP for assessment and to the Drug and Alcohol Recovery Team (DART).

23. A prison GP reviewed Mr Brown. He assessed that Mr Brown did not need to be put on a formal detoxification programme, but that he would be monitored by healthcare staff and DART. He prescribed medication for alcohol withdrawal symptoms for use if needed. He did not prescribe any other medication as he was unable to view Mr Brown's Summary Care Record (important patient information created from community GP records). He sent a request for administrative staff to obtain Mr Brown's GP records, and noted that a medication review should be undertaken once they were received.

24. Mr Brown's daughter took Mr Brown's medication to Durham, but an officer told her he could not accept it. (The prison's security department advises officers not to accept medication brought in by family and friends, but prisoners can bring their own medication in when they are taken directly from court.)

25. On 1 September, healthcare staff gave Mr Brown an asthma inhaler. Later the same day, a prison GP accessed Mr Brown's Summary Care Record and prescribed his regular medication, except for a sedative which would have conflicted with the medication he had been prescribed for alcohol withdrawal. (Mr Brown never received his medication as he was taken to hospital before it was due to be given to him.)

26. On 2 September, at around 8.00am, a healthcare support worker reviewed Mr Brown. She recorded an alcohol withdrawal assessment score of 2, which indicated absent to minimal alcohol withdrawal symptoms. However, she booked Mr Brown in for a review by the DART clinic and sent a request for him to be given symptomatic relief. She also recorded a blood pressure reading of 178/127mmHg (which is significantly elevated).

27. Shortly before 9.00am, a substance misuse specialist performed a remote review of Mr Brown's records. A healthcare support worker had told him that Mr Brown had complained of nausea, but he could not recall who had told him. (A

healthcare support worker had no recollection of Mr Brown reporting that he had nausea or abdominal pain to her and could not recall asking for symptomatic relief for him.) The specialist prescribed a medication used to treat nausea.

28. Later that morning, Mr Brown told a Supervising Officer (SO) that he felt unwell and had abdominal pain. She called for a nurse.

29. At around 11.00am, a nurse attended Mr Brown's cell. Mr Brown told her that he had vomited and had had diarrhoea at 6.00am. He also told her that he usually drank heavily and had not received any medication to ease his alcohol withdrawal symptoms.

30. The nurse examined Mr Brown's abdomen and found it was swollen. She gave Mr Brown medication to help relieve his pain and to ease alcohol withdrawal symptoms. When Mr Brown's condition did not improve, the nurse asked officers to call an ambulance.

31. The SO called a medical emergency code over her radio, and the control room called an ambulance at 11.08am.

32. After 20 minutes, officers asked for an update on the ambulance and were told the ambulance had been diverted.

33. The ambulance arrived at around 12.30pm, and shortly after 1.00pm, Mr Brown was escorted to hospital using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).

34. Mr Brown was admitted to hospital with suspected pancreatitis. A hospital doctor then diagnosed him with alcohol induced pancreatitis and prescribed medication for alcohol withdrawal.

35. On 5 September, the hospital told the prison that Mr Brown's condition was deteriorating, and he had been moved to the Intensive Care Unit. The officers with Mr Brown at hospital sought permission to remove his restraints, as hospital staff needed to work on him. This was granted and restraints were removed.

36. On 6 September, Mr Brown was put into an induced coma as he had not been responding to treatment. He died later that day after the decision was made to withdraw life support.

Contact with Mr Brown's family

37. On 5 September, the prison appointed a family liaison officer (FLO). She visited Mr Brown's ex-wife that evening to tell her that Mr Brown was very ill in hospital. Mr Brown's ex-wife said she would contact Mr Brown's mother. The FLO made contact with Mr Brown's mother after his death to offer her condolences and support. The prison contributed to the funeral costs in line with policy.

Support for prisoners and staff

38. A prison manager checked on the welfare of the escorting officers who were with Mr Brown when he died.

39. The prison posted notices informing other prisoners of Mr Brown's death and offering support.

Post-mortem report

40. The post-mortem report concluded that Mr Brown died of multiorgan failure caused by acute pancreatitis.

Findings

Clinical care

41. The clinical reviewer considered that the care Mr Brown received at Durham was of a mixed standard, with some elements not equivalent to the care that he could have expected to receive in the community.

42. The clinical reviewer was concerned that the healthcare support worker who took Mr Brown's blood pressure when he arrived at Durham, did not recognise that it was elevated. The reception nurse did not review the readings, so she too failed to identify that Mr Brown had elevated blood pressure when he first arrived. Also, on the morning of 2 September, a healthcare support worker failed to recognise that Mr Brown's blood pressure was significantly elevated and did not escalate to a nurse. We recommend:

    The Head of Healthcare should ensure that staff are aware of NICE guideline Hypertension in adults: diagnosis and management.

    The Head of Healthcare should ensure that reception nurses routinely review the outcome of the physical observations taken by healthcare support workers.

    The Head of Healthcare should ensure that there is a clear escalation process in place where a healthcare support worker records any clinical observation that is not within expected parameters.

43. The clinical reviewer noted that there was a delay in Mr Brown being prescribed medication. While this did not appear to have an adverse impact on Mr Brown, this may not be the case in a future patient. We recommend:

    The Head of Healthcare should explore why the reception GP was unable to access the Summary Care Records on 31 August 2021 and initiate a process to avoid a future reoccurrence.

44. The clinical reviewer noted that Mr Brown was monitored twice daily for alcohol withdrawal symptoms. Staff used the appropriate assessment tool each time, which indicated that he had absent or minimal withdrawal symptoms. However, staff did not always take a full set of physical observations as they should have done. We recommend:

    The Head of Healthcare should ensure that staff are reminded of Standard Operating Procedure Reception and Treatment Pathway for Substance Misusers in the North East Prisons and that full clinical observations are taken and recorded for prisoners being monitored for alcohol withdrawal symptoms.

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