

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Davies, a prisoner at HMP Durham, on 21 January 2022

A report by the Prisons and Probation Ombudsman



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 we oversee can improve their work in the future.

Mr Robert Davies died from hypertensive heart disease (which occurs as a result of chronic high blood pressure) and coronary artery atheroma (a build-up of fatty material in the artery walls) on 21 January 2022 at HMP Durham. He was 83 years old. I offer my condolences to Mr Davies' family and friends.

The clinical reviewer concluded that Mr Davies' clinical care at Durham was equivalent to that which he could have expected to receive in the community. However, she noted that his initial health screen was not completed on the day he arrived, and this seems to be a longstanding issue at Durham. No clinical observations were taken during his health screen the next day and he was not referred to the clinic for long-term conditions for management of his blood pressure. Mr Davies' secondary health screen was cancelled but not rescheduled.

When Mr Davies was found unresponsive, control room staff did not request an ambulance immediately after receiving a medical emergency code.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

January 2023

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Summary

Events

1. Mr Robert Davies was remanded to HMP Durham on 6 December 2021.
2. Mr Davies arrived late in the evening, so his initial health screen took place the next day. His health conditions included high blood pressure and suspected heart disease. A secondary health screen planned for 11 December was cancelled.
3. At 8.30am on 21 January 2022, Mr Davies' prison key worker went to his cell to introduce himself. As he opened the door, Mr Davies' cellmate said that he appeared to be dead. The officer tried to rouse Mr Davies and radioed a medical emergency code to indicate that he was unresponsive.
4. Healthcare and operational staff tried to resuscitate Mr Davies. Paramedics took over at 8.43am and performed advanced life support. They were unable to revive him and confirmed his death at 9.04am.

Findings

5. The clinical reviewer found that Mr Davies' clinical care was equivalent to that which he could have expected to receive in the community. However, there were shortcomings which the Head of Healthcare will need to address.
6. Mr Davies' clinical observations were not taken when he arrived at the prison or during his initial health screen.
7. It was recorded that Mr Davies had been diagnosed with high blood pressure, but he was not referred to the clinic for long-term conditions.
8. Mr Davies did not have a secondary health screen as his appointment was cancelled but not rescheduled.
9. We are concerned that the prison often had limited capacity to conduct timely initial health screens for prisoners who arrive in the evening.
10. There was a delay of two minutes between the medical emergency code being received and the request for an ambulance. Control room records suggest that staff waited for prison managers and the emergency response nurse to acknowledge the emergency before contacting the ambulance service. This is not in line with national and local guidance on responding to medical emergency codes.

Recommendations

- The Head of Healthcare should ensure that clinical observations are taken and recorded during initial health screens.
- The Head of Healthcare should ensure that new prisoners diagnosed with high blood pressure are referred promptly to the clinic for long-term conditions.

- The Governor and Head of Healthcare should ensure that healthcare and operational staff work together to improve the timeliness of initial health screens for late arrivals to the prison.
- The Head of Healthcare should ensure that, in line with NICE Guideline 57, all new prisoners receive a secondary health screen within seven days of their arrival. If an appointment is cancelled, the reasons should be documented, and it should be rearranged as soon as possible.
- The Governor should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

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 her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Davies' prison and medical records.
13. NHS England commissioned an independent clinical reviewer to review Mr Davies' clinical care at the prison. The clinical reviewer interviewed the Head of Healthcare and an Advanced Nurse Practitioner.
14. The investigation was suspended while waiting for the cause of death. This has delayed the initial report.
15. We informed HM Coroner for Durham of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The Ombudsman's family liaison officer wrote to Mr Davies' next of kin, his son, to explain the investigation and ask if there were any specific matters he wanted us to consider. Mr Davies' son wanted to know what time his father died and whether he had died in his sleep. We have addressed these questions in this report.
17. Mr Davies' son received a copy of the initial report. He made no comments.
18. We shared the initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

Background Information

HMP Durham

19. 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. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Durham was in November 2021. Inspectors reported that serious staff shortages had affected all aspects of healthcare provision and caused delays. Although the Head of Healthcare had a clear vision, oversight and strategic management had been affected by the lack of a deputy and the need for her to be involved in clinical delivery.
21. Inspectors also found that new prisoners often arrived late in the day and a significant number did not receive an initial health screen before going to their cells. There was insufficient GP capacity to see patients and manage the range of associated tasks. Prisoners with long-term health conditions did not always receive personalised care, or timely reviews. This had recently been addressed by the appointment of a lead nurse for patients with complex care needs.

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 31 October 2021, the IMB reported that although prisoners reported good relationships with healthcare staff, they were frustrated about healthcare provision (which had been affected by the COVID-19 pandemic).
23. The IMB had similar concerns about initial health screens and found that only a small percentage of prisoners received their second-stage health screen within seven days.

Previous deaths at HMP Durham

24. Mr Davies was the thirteenth prisoner at Durham to die since January 2020. Of the previous deaths, four were self-inflicted, two were drug-related and six were from natural causes. There has since been a further death from natural causes. We have previously made recommendations about delays in conducting initial health screens, referrals of prisoners to long-term conditions clinics and ensuring secondary health screens take place.

Key Events

25. Mr Robert Davies was convicted of sexual offences on 6 December 2021 and remanded to HMP Durham. (On 21 December, he was sentenced to 18 years and 8 months in prison.)
26. Mr Davies arrived at the prison in the evening. As it was late and there were a number of prisoners to be processed, his initial health screen was deferred until the following morning.
27. In line with the national policy during the COVID-19 pandemic, Mr Davies was required to self-isolate. He was allocated a cell on F Wing, the Vulnerable Prisoners' Unit, which had also been designated as the reverse cohorting unit. (After the isolation period, he remained on that wing.) The nurse who was responsible for the triage of new prisoners spoke to Mr Davies through his cell observation panel to check if he had any immediate needs.
28. The triage nurse informed an advanced nurse practitioner that Mr Davies had been prescribed medication for a heart condition. The advanced nurse practitioner advised that he should be prioritised, and his GP record was requested urgently.
29. At his health screen the next day, a nurse noted that Mr Davies' existing health conditions included high blood pressure and an enlarged prostate gland. Suspected heart disease was also noted. No clinical observations were taken or requested.
30. An appointment for a second-stage health assessment on 11 December was cancelled. The reason was not recorded, and it was not rescheduled. There were few significant entries about Mr Davies' physical health over the next few weeks.

Events of 21 January 2022

31. The early morning check of prisoners took place and was signed off at 6.50am. Nothing remarkable was reported.
32. At 8.30am on 21 January 2022, Mr Davies' prison key worker went to meet him for the first time. As the key worker opened the cell door, Mr Davies' cellmate said that he was just about to press the cell bell, as Mr Davies seemed to be dead. (Mr Davies' cellmate declined to make a statement so we do not know when he was last seen alive.)
33. The key worker shook Mr Davies, with no response. He then radioed a code blue emergency (which indicates that a prisoner is unresponsive or has breathing difficulties) and asked colleagues nearby to alert nurses who were already working on the wing. A nurse arrived while he was checking to find a pulse. Healthcare staff began cardiopulmonary resuscitation (CPR) and operational staff, including the key worker, assisted. They used a defibrillator which found no shockable rhythm.
34. Paramedics arrived at 8.43am. They performed several cycles of CPR and advanced life support. The resuscitation attempts were unsuccessful, and the paramedics confirmed Mr Davies' death at 9.04am.

Contact with Mr Davies' family

35. At 9.50am, the prison's family liaison officer informed Mr Davies' son of his death and explained the procedures to be followed.
36. Mr Davies' funeral was held on 22 February. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

37. After Mr Davies' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
38. The prison posted notices informing other prisoners of Mr Davies' 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.

Post-mortem report

39. A post-mortem examination confirmed that Mr Davies had died from hypertensive heart disease and coronary artery atheroma.

Findings

Clinical care

40. The clinical reviewer concluded that Mr Davies' clinical care at Durham was of a reasonable standard and equivalent to that which he could have expected to receive in the community. However, she found some weaknesses in clinical processes, which we summarise below.

Reception health screen

41. The clinical reviewer found that no clinical observations were taken when Mr Davies arrived at Durham, or during his initial health screen. Some routine blood and urine tests were also overlooked. Although Mr Davies' health conditions were identified and recorded, he was not referred to the clinic for long-term conditions for management of his blood pressure.
42. Mr Davies was one of 12 men (out of a total of 27) who did not have initial health screens when they arrived on 6 December. The Head of Healthcare explained that, generally, those who arrive after 7.30pm are seen the next day, unless there is an immediate or obvious risk.
43. We share the clinical reviewer's concern that Durham was often unable to conduct timely initial health screens for late arrivals. HM Chief Inspector of Prisons and the IMB have also previously identified this as a concern. We recommend:

The Head of Healthcare should ensure that clinical observations are taken and recorded during initial health screens.

The Head of Healthcare should ensure that new prisoners diagnosed with high blood pressure are referred promptly to the clinic for long-term conditions.

The Governor and Head of Healthcare should ensure that healthcare and operational staff work together to improve the timeliness of initial health screens for late arrivals to the prison.

Second-stage health assessment

44. National Institute for Health and Care Excellence (NICE) Guideline 57, *Physical Health of People in Prison*, states that every prisoner should have a second-stage health assessment within seven days of their arrival. It is unclear why Mr Davies' assessment was cancelled and there is no evidence of any attempt to rearrange it. We recommend:

The Head of Healthcare should ensure that, in line with NICE Guideline 57, all new prisoners receive a secondary health screen within seven days of their arrival. If an appointment is cancelled, the reasons should be documented, and it should be rearranged as soon as possible.

Emergency response

45. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes* and Durham's *Staff Information Notice 68.21* requires staff to call an ambulance immediately when an emergency code is called over the radio network. The PSI is clear that there the control room should not wait for healthcare staff or an operational manager to confirm that an ambulance is required, as it can be cancelled if not needed.
46. The control room log has three successive entries, noting that the duty governor, operational manager, and emergency response nurse had each acknowledged the code blue immediately at 8.30am. In the line below those entries, it was noted that the request for the ambulance was at 8.32am and this accords with ambulance service records. A prison representative explained that one member of the control room staff usually deals with the acknowledgments, while another contacts the ambulance service.
47. While two minutes might not be considered a lengthy delay and does not appear to have affected the outcome for Mr Davies, a time lapse could be critical in other circumstances. We also acknowledge that the time recorded might have reflected the connection time or the end of the call. However, given the sequence of the entries on the log, we need to be satisfied that control room staff are clear that requesting an ambulance is a priority and further authorisation is unnecessary. We recommend:

The Governor should ensure that staff in the communications room request an ambulance immediately when a medical emergency code is called.

Inquest

48. At the inquest, heard on 1 February 2023, the Coroner concluded that Mr Davies died from natural causes.

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