

**The Death of a Prisoner
at HMP Durham
on 25 June 2004**

**Report by the
Prisons and Probation Ombudsman
for England and Wales**

December 2004

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Foreword

This is the report of an investigation into the circumstances of the death of a prisoner at HMP Durham on 25 June 2004. It was conducted on my behalf by one of my colleagues in the Prisons and Probation Ombudsman's office.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service, but has now been passed to the Prisons and Probation Ombudsman to bring independence and greater consistency to the task.

I would like to express my condolences to the prisoner's family for their sad loss. He was an elderly gentleman who had spent several months in the Healthcare Centre at HMP Durham. I am pleased to see my Investigator's conclusion that he received decent, affectionate and compassionate treatment there.

I extend my thanks to the doctor who conducted the clinical review. I also wish to thank the governing Governor and his staff for the help and cooperation received by my investigator in the course of his work. All staff at Durham whom he has approached during the inquiry have participated fully and readily.

STEPHEN SHAW CBE
Prisons and Probation Ombudsman

December 2004

SUMMARY

1. The prisoner was discovered dead in his cell in the Healthcare Centre (HCC) at HMP Durham at approximately 07:40 on the morning of 25 June 2004. He was 76 years old and had been in custody since 7 May 2003. He had been in the inpatient wing of the prison's HCC since September 2003.
2. The prisoner had been charged with offences of child abduction and indecent assault, but Newcastle Crown Court was awaiting further reports on him before deciding on a disposal. He appeared to be suffering from dementia and shortly before his death he was visited by a specialist from Northamptonshire who had verbally agreed to admit him to his hospital subject to the necessary funding being available.
3. A clinical review of the circumstances relating to the prisoner's death was commissioned from Durham and Chester-le-Street Primary Care Trust (PCT). The doctor who conducted the review has reported that death was apparently due to chronic ischaemic and hypertensive coronary disease. The prisoner's medical record provides detailed information about the extensive clinical care and attention he received whilst at Durham and the investigator concludes that he was cared for decently, humanely and attentively.
4. My investigator has made two recommendations at the conclusion of this report. He is grateful for the extremely courteous and helpful response he received from all members of staff with whom he had contact at Durham.

BACKGROUND INFORMATION ABOUT THE PRISONER

5. The prisoner was arrested by Northumbria Police on 6 May 2003 and appeared at Southeast Northumberland Magistrates' Court on 7 May charged with a number of child abduction and sexual offences. He was received on remand at Durham on the same date and remained in custody until 3 July 2003 when he was granted bail at Newcastle Crown Court subject to residence in a named approved premises and to strict curfew conditions. His solicitor revealed that he broke these conditions within a matter of hours and he was therefore returned to prison. He then remained continuously in custody at Durham until his death on 25 June 2004. In a telephone conversation on 2 July 2004, the prisoner's solicitor in Morpeth indicated that Newcastle Crown Court was awaiting reports before deciding on an appropriate disposal. The solicitor considered it likely that an order would have been made under the Mental Health Act.
6. The prisoner was placed on F2052SH (Self Harm At Risk Form) on 26 July 2003. The nurse who opened the form noted that discipline staff reported odd behaviour and that he was upset and fearful for his safety during interview. He appeared unfamiliar with prison routine, jargon and environment. When asked about his situation he told the nurse that he could not stand his cell on E Wing and wanted to go to A Wing. He felt low and

frightened and said that he had been threatened by two prisoners in the exercise yard. On 29 July 2003 he was moved to A Wing and the Self Harm At Risk Form was closed on 1 August 2003. It was not necessary for any further Self Harm Forms to be opened in the 11 months that remained until his death.

7. Written information about the prisoner and his behaviour at Durham is impressively detailed and there are many references to forgetfulness, disorientation and possible dementia. On 18 October 2003, for instance, an officer wrote in the Record of Events section of the prisoner's prison record thus:

"The prisoner takes part in all activities in the HCC but can be a little slow and confused and does take some coax(ing) to hurry him up."

Another entry in his History Sheet for 2 November 2003 states:

"The prisoner's medical condition appears to be deteriorating, he is very forgetful and slow and at times he doesn't seem to know where he is."

8. A very important source of information is a three page letter written on 23 February 2004 by the Consultant in Old Age Psychiatry for Newcastle, North Tyneside and Northumberland Mental Health Trust. The letter was addressed to the Consultant Forensic Psychiatrist and Lead Clinician for Mental Health Services at HMP Durham.
9. In his letter the Newcastle consultant recounted that the prisoner had attended university and had then trained as a teacher. The subjects he taught were Maths and English. He presented as an elderly man who, although dressed in prison clothes, appeared "dapper" with his half moon spectacles, neatly cut hair and clean and tidy appearance. The consultant's assessment was that overall the prisoner's cognitive impairment was very mild and he would not fall within the normal category of dementia. The consultant found it difficult to think of a suitable placement for him and in the penultimate paragraph of his letter he suggested that the prisoner "would require a specialist unit with a degree of security not normally found in residential or nursing care homes in the community and with a higher staff/resident ratio".
10. The consultant's understanding was that Dr Y of Saint Andrew's Hospital in Northampton had a specialist unit for elderly forensic psychiatric patients. The prisoner's Inmate Medical Record demonstrates that Dr Y came to assess him at HMP Durham on 16 June 2004 with Dr Y indicating verbally that he would admit him to his hospital subject to funding. Written confirmation of Dr Y's assessment was still awaited at the time of the prisoner's death the following week.
11. The prisoner's solicitor informed the investigator that he had last visited his client in early June 2004. Both he and the prisoner were frustrated that it was taking so long to find a placement and it is clear from perusal of the

prisoner's Inmate Medical Record that their frustration was shared by the prison authorities.

12. The prisoner's Inmate Medical Record is a rich source of information about him. For instance, in the three weeks prior to his death there are six pages of entries in his Continuous Medical Record Notes. The entry for 23 June 2004 indicates that he moved to a new cell (from M2-5 to M2-14). On 24 June there is a long entry made during the afternoon by the Occupational Therapist and her student to the effect that he had attended the day centre for an Occupational Therapy cookery session that morning. He was described as "in a positive mood but markedly confused and found great difficulty in keeping on task. Very forgetful – not able to remember what stage of activity he had just completed even after prompting. ... quite disorientated and found moving from one area of the day centre to another confusing. Some awareness of confused state as he often attempted to cover his confusion by resorting to elaborate verbosity ... cooperative mood."
13. The Healthcare Manager revealed that the prisoner had been on association with other prisoners the night before his death and that he went for exercise periods in the open air, often pushing another prisoner who was in a wheelchair.

CONDUCT OF THE INVESTIGATION

14. On 25 June 2004 my investigator was travelling towards Durham to consult with a colleague about another investigation at HMP Holme House when he received notification of the prisoner's death. During the afternoon of 25 June he was briefed at Durham by the Healthcare Manager and by the Safer Custody Manager at the prison. The liaison person at Durham was in the Safer Custody Office there and she subsequently sent my investigator all relevant documentation relating to the prisoner. My investigator studied his prison records, Inmate Medical Record, the staff statements written after his death was discovered on 25 June 2004 and a large amount of relevant background material about procedures at Durham supplied by the Safer Custody Office.
15. On 1 July 2004 Notices to Staff and Prisoners at Durham were published advising them of this investigation. On the same date my investigator wrote to the prisoner's brother. He was asked if he had any concerns about his brother's treatment at HMP Durham.
16. On 9 July 2004 the prisoner's brother responded as follows:

"I am pleased to state that I have no complaints or adverse comments to make regarding my brother's treatment in prison."
17. On 25 June 2004 my investigator visited cell M2-14 where the prisoner's death was discovered and on 30 June 2004 he wrote to Durham and

Chester-le-Street PCT requesting a clinical review of his medical care while at HMP Durham.

18. In view of the extensive contacts between the prisoner and his solicitor, my investigator made telephone contact with the solicitor on 2 July 2004 which transpired to be the day of the prisoner's funeral. The solicitor spoke with affection of his client, but also spoke of his frustration at the delay in finding a venue outside the penal system to which the prisoner could be transferred so that his outstanding court case could be concluded.

ESTABLISHMENT PROFILE

19. Durham Prison opened in 1819 and was rebuilt in 1881. Since then it has maintained its primary role as a local prison serving courts in the North-East. The prison contains both remand and sentenced prisoners.
20. Her Majesty's Chief Inspector of Prisons made a full unannounced inspection of the prison in August 2003 and published her report in November 2003. She described Durham as

“a very complex prison, holding Category A men and women (the highest security category), as well as operating as a local prison, and running a closed supervision centre for some of the most dangerous prisoners in the prison system.”

21. The Chief Inspector observed that Durham was operating under great population pressure but the inspection found that, nevertheless, it was providing a fundamentally safe and decent environment.
22. The prison offers a range of healthcare facilities, including a 19 bed inpatient unit where the prisoner was located at the time of his death. The prison has 24 hour qualified nursing care cover.

THE DISCOVERY OF THE PRISONER'S DEATH ON 25 JUNE 2004

23. The prisoner was received at Durham on 7 May 2003 charged with four offences of child abduction and four offences of indecent assault. He had been held in the prison's HCC for several months prior to his death and at the time of his death occupied cell M2-14 into which he had been moved just a few days previously. This cell was of generous dimensions because it was normally occupied by two HCC cleaners but the prisoner was its sole occupant.
24. At approximately 07:40 on 25 June 2004 an officer opened the prisoner's cell to summon him for breakfast. He found him lying on his bed but he was not moving, did not respond to the officer's voice and appeared to be dead. The

officer summoned the assistance of the nursing staff who were on duty beside him in the HCC.

25. At the officer's request the Inpatients Manager in the HCC entered the prisoner's cell at approximately 07:40 and found him to be pallid and motionless. In a memorandum to the Governor of Durham about the incident the Inpatients Manager wrote:

"The prisoner's pupils were fixed and dilated, I could not detect a pulse or breath sounds. It was my opinion that he was dead and had been for at least an hour."
26. At some time between 07:43 and 07:50 the Healthcare Manager entered the prisoner's cell. His statement times his arrival at approximately 07:50, though a memorandum to the Governor from the Healthcare Senior Officer times the Healthcare Manager's entry to the cell at approximately 07:43.
27. Before the Healthcare Manager made his way to the prisoner's cell he gave instructions that an ambulance should be called in response to a question from an officer. When the Healthcare Manager entered the cell with the Inpatients Manager he saw the prisoner on his bed "cocooned" in blankets and a towel. In discussion with the investigator the Healthcare Manager explained that this was the prisoner's normal practice for retiring to bed. The Healthcare Manager observed that the prisoner's pupils were dilated, no breathing or carotid pulses were found and pallor was present.
28. The Healthcare Manager was aware that the doctor was expected to arrive and when questioned if an ambulance was still needed he advised that it should be cancelled.
29. The prison doctor certified death at 08:07 and made an entry to that effect in the Continuous Medical Record section of the prisoner's Inmate Medical Record.
30. The log maintained in the prison's Emergency Control Room indicates that an ambulance was called at 07:52 and then cancelled one minute later.

ARRANGEMENTS IN RESPONSE TO THE PRISONER'S DEATH

31. The prison made rapid and efficient arrangements to contact the necessary parties. These included the police, the coroner and the Independent Monitoring Board.
32. On arrival at Durham on 7 May 2003 the prisoner named his brother as his next of kin. The prisoner was in regular contact with his solicitor. On the morning of his death the chaplain spoke with his solicitor from whom he obtained the phone number of the prisoner's brother. The chaplain broke the news of the prisoner's death to his brother by telephone.

33. The prisoner was a devout Roman Catholic and after the coroner's officer had opened his cell at 12:15 a Sister administered the last rites and he was then removed from the prison at 13:45 by the undertaker.
34. He had been a long time resident of the prison's HCC and other prisoners in HCC were promptly informed of his death. A debrief, chaired by the prison's Deputy Governor was held on the morning of 25 June 2004 to consider how the incident had been handled and to identify whether there were any learning points. A two page note was taken of the discussions at that meeting.

CLINICAL REVIEW

35. On 30 June 2004 the investigator wrote to the Prison Healthcare Development Manager at Durham and Chester-le-Street PCT, requesting a clinical review relating to the circumstances of the prisoner's death. The review was forwarded by her office on 19 August 2004. The review was conducted by a doctor who sets out his wide ranging qualifications for the task in the Introduction to his report.
36. The clinical reviewer explains that at the time of writing a post-mortem report had not been received, but on 15 July 2004 he telephoned the Home Office pathologist who performed the autopsy and received a verbal report. The pathologist's verbal report stated:

"Death was due to chronic ischaemic and hypertensive coronary disease. We are awaiting toxicology."
37. The clinical review also refers in the paragraph headed Post-Mortem Cause of Death to the fact that the prisoner had been thought to be suffering with dementia, but this may have been fabricated in view of the weight of his brain.
38. The Summary of the clinical review observes that the prisoner's medical records provide a comprehensive account of his management and treatment from reception at Durham on 7 May 2003 until his death on 25 June 2004.
39. The reviewer commends the clarity and organisation of the prisoner's medical record. He also comments on the "extensive and far reaching efforts made to investigate the cause of the prisoner's altered mental state and behaviour" following his recall to prison on 5 July 2003 after a very brief period on bail.

FINDINGS

40. At the time of his death the prisoner was a 76 year old man who had been resident in the inpatient wing of the HCC at Durham since September 2003.

41. He was widely assumed to be suffering from dementia, although the clinical review suggests this may have been fabricated in view of the weight of his brain.
42. At the time of death Newcastle Crown Court was awaiting reports on the prisoner so that an appropriate disposal could be decided. He had been visited at Durham on 16 June 2004 by a doctor from a hospital in Northamptonshire and the doctor had given a verbal indication that he would admit him to his hospital subject to funding.
43. The prisoner appeared fairly well on 24 June when he attended an Occupational Therapy session during the morning and went on association with other prisoners during the evening.
44. It appears that he died in his sleep during the night of 24 to 25 June 2004 and he was discovered dead in his cell by an Officer at approximately 07:40 on 25 June.
45. The prisoner was reviewed on 21 June 2004, just four days before his death, by the Head of Primary Care Medicine at Durham, when his condition was noted as being satisfactory and no new symptoms or complaints were observed.
46. The clinical review commends the clarity and organisation of the prisoner's medical record and reports that extensive and far reaching efforts were made to investigate the cause of his altered mental state and behaviour, and it would appear that his asthma was controlled.
47. An ambulance was called at 07:52 but was then cancelled one minute later by the Healthcare Manager. This seems a perfectly reasonable and appropriate decision for the Healthcare Manager to take as rigor mortis had set in and he did not want precious ambulance resources to be wasted.
48. It was not feasible for news of the prisoner's death to be broken to his family in person. The telephone calls made to his brother and sister by the prison chaplain on the day of his death were an appropriate and practical method of conveying the necessary information as rapidly as possible.

CONCLUSION

49. I conclude that the prisoner received decent, affectionate and compassionate treatment during the many months he spent in the HCC at Durham. The meticulous details contained in his medical record, particularly those relating to the last weeks of his life, testify to the care and professionalism of the prison's response to him.

RECOMMENDATIONS

1. The recommendations contained in the clinical review should be studied with care by both the Governor of HMP Durham and Durham and Chester-le-Street PCT. If the recommendations are accepted, an action plan should be drawn up indicating when, how and by whom the necessary action will be taken.
2. There was discussion at the debrief on the morning of 25 June 2004 chaired by the Deputy Governor of the arrangements for cancellation of an ambulance. It seems wasteful to summon an ambulance when it is clear to a senior healthcare professional that a prisoner is already dead and the Governor is invited to review his contingency plans to establish whether guidance about this matter should be included in them.