

**Investigation into the death of a man, who was a
prisoner at HMP Durham, in August 2005**

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

JUNE 2006

This is the report of an investigation into the death of a man who died from apparently natural causes at the University Hospital of North Durham on 23 August 2005. He was 35 years of age.

The man had been remanded into custody on 30 June 2005. He was held at HMP Durham, and it was there that he was taken ill on 23 August before dying later the same day.

The investigation has been undertaken by one of my investigators. I would like to thank the Governor of HMP Durham and his Safer Custody Manager for their help and co-operation during this investigation. A doctor was commissioned on behalf of Durham and Chester-le-Street Primary Care Trust to undertake a review of the man's clinical care, and I also appreciate his assistance.

The loss of a loved one is always distressing. I would like to add my personal condolences to those already expressed to the man's family by my Family Liaison Officer.

Whilst I do not feel anything could have been done to prevent the man's death, there are lessons to be learnt in the clinical management of patients in prison. I endorse the three recommendations made in the clinical review.

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

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Prisons and Probation Ombudsman

June 2006

CONTENTS

Summary	3
The investigation process	5
HMP Durham	6
Key findings	7
Recommendations	11

Summary

1. The man was born in 1969 and was 35 years old when he died at the University Hospital of North Durham.
2. On 30 June 2005, the man was remanded into custody and was received at HMP Durham later that day.
3. At his first reception health screen, it was noted that the man had undergone an operation for a heart transplant two and half years previously. He also had muscular dystrophy, a group of diseases characterised by progressive degeneration and/or loss of muscle fibre. As a result of his heart transplant, the man was prescribed a range of medication which he kept in his possession.
4. On 23 August, the man's cellmate awoke soon after 5:35am to find the man kneeling on the floor of their cell. After helping the man onto a chair, the cellmate immediately rang their cell bell to summon assistance and a Night Patrol Officer responded. When the officer observed that the man was experiencing difficulty with his breathing, he told him to sit down and used his radio to summon assistance.
5. The Night Orderly Officer arrived at the man's cell and found the man still sitting down. He noted that his pallor was grey. The Orderly Officer used his radio to call again for healthcare assistance and a nurse arrived a few seconds later. They both entered the man's cell to assess his condition and discovered that he had stopped breathing. A request was then made over the radio for an ambulance to be called.
6. The man was then carried out of his cell and cardio-pulmonary resuscitation (CPR) was conducted until the paramedics arrived at the cell at 5:50am. The paramedics continued CPR until they assessed that the man could be moved, and he was taken by ambulance to the University Hospital of North Durham. The man was escorted by two officers who were present at the hospital while attempts were made to resuscitate him.
7. The man passed away at 6:45am on 23 August 2005.
8. The clinical review noted that, as the man had undergone a heart transplant, prison medical staff - who have little experience of managing such cases - relied heavily upon guidance from specialists. The reviewer concluded that the lines of communication between the Freeman Hospital and the prison appeared to work well. He also concluded that the man's care whilst in prison could have been better managed by healthcare staff. In particular, the man's records were not flagged with clear observation guidelines and active measures were not in place to ensure medical assessments at an early stage. The review makes three recommendations, all of which I endorse.

9. During the course of the investigation, one of my Family Liaison Officers contacted the man's family. They did not raise any specific questions for the investigation to consider, but they wanted to be kept informed of our investigation findings. After the man's family received his belongings from the prison, they discovered a diary which suggested that the man had been attempting to end his life prematurely by not taking his anti-rejection medication. My investigator asked the clinical reviewer to review the medical evidence in light of this new development. The reviewer contacted the Consultant Physician in Cardiac Transplantation at The Freeman Hospital. He concluded that it was unlikely that the man had not been taking his medication.

The investigation process

10. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements from staff.
11. A clinical review was commissioned from Durham and Chester-le-Street Primary Care Trust. I am grateful to the reviewer for undertaking this review in a most timely manner.
12. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him with his enquiries into the man's death.
13. One of my Family Liaison Officers contacted the man's family. The family did not raise specific questions about the treatment the man received during the investigation. However, they contacted my office after receiving the man's belongings which contained a diary which suggested that he wished to end his life prematurely.
14. My investigator visited Durham and discussed aspects of the man's treatment with staff. The clinical review found that the man's clinical care was appropriate. However, he drew attention to some issues surrounding the management of the man's clinical condition.

HMP Durham

15. Durham prison was built in the early 19th century and has been undergoing a major refurbishment programme over the last nine to ten years. It has an operational capacity (maximum crowded capacity) of 670, and serves as the local prison for the courts in the area. Durham runs an integrated regime, which means that it does not separate vulnerable prisoners from the main prison population.
16. After the evening roll call at 8:15pm to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.'
17. When the night patrol officer arrives on the wing, a hand-over is given by the officer on evening duty and a sealed packet containing keys is passed from one to the other. The keys in the sealed packet are only to be opened in an emergency. When the officer on duty the next day arrives, he or she receives a hand-over from the night patrol officer and another roll check is carried out before the night patrol officer leaves the wing.
18. The prison's healthcare is provided by Durham and Chester-le-Street Primary Care Trust seven days a week. They work with a medical officer providing primary health care and weekly or monthly administration of medication to prisoners who have been assessed as capable of holding it in their own possession. They administer medication on a daily basis to other prisoners, when either they are considered to be at risk or the medication is unsuitable to be held in their cell. Prisoners who require in-patient nursing care are transferred to outside hospital or to another prison.
19. Her Majesty's Chief Inspector of Prisons (HMCIP) carried out an unannounced inspection of Durham in 2003. Her report described a 'safe prison'. It noted that there had been major improvement in healthcare and went on to report that 'the relationships between staff and prisoners were consistently good'.

Key Findings

20. When the man first arrived in Durham, it was noted that he had a number of health problems including muscular dystrophy and had recently undergone a heart transplant. He was deemed fit enough to be located in a first floor double cell in B wing and to do sedentary work as a Data Entry Clerk.
21. On 11 July 2005, the man attended the Freeman Hospital for a range of tests including a cardio (heart) biopsy and an electro-cardio-gram (ECG). He also attended a consultation with his doctor.
22. On 26 July, the man's medication was reviewed following discussion between prison healthcare and the Freeman Hospital and repeat blood tests were scheduled for 20 August.
23. On 16 August, a Healthcare Officer saw the man as he had been feeling unwell for a few days, but nothing abnormal was detected. The man was seen the following day by a nurse who noted that, although feeling better, he now had a sticky eye.
24. On 19 August, blood samples were taken as requested by the Freeman Hospital and sent for analysis.
25. On 20 August, the man complained of being unable to sleep and that his heart kept missing a beat. The nurse advised him to make an appointment to see the prison doctor. The man did not follow the advice and healthcare staff did not follow up the matter.
26. At around 5:35am on 23 August, the man's cellmate awoke to find the man kneeling on the floor. The cellmate immediately rang the cell bell to summon assistance and then helped the man onto a chair. The Night Patrol Officer answered the cell bell and looked through the observation panel in the door. The officer has an up to date first aid qualification. He saw that the man was having difficulty with his breathing and told him to sit down. The man was able to reply to the officer who appropriately assessed that his condition was such that the night patrol keys should not be used to enter the cell. Instead he used his radio to request assistance from the Night Orderly Officer (Oscar 1) and Nurse (Hotel 1).

27. The Night Orderly Officer was the first to arrive at the man's cell in response to the officer's request. He unlocked the door and entered the cell, telling the man that nurse was on her way and observing that the man's breathing was erratic. Another officer also responded to the call for assistance and stayed at the cell door speaking to the cellmate. Officers noted that the man's pallor was quite grey. One of the officers used his radio to make another request for assistance from the nurse and she arrived within a few seconds. Together they entered the cell and assessed the man's condition. As they could not find a pulse or evidence that the man was breathing, a radio was used to request that an ambulance be called.
28. While the resuscitation bag was collected from the medical room, staff carried the man out of his cell to the landing outside and CPR was carried out until the paramedics arrived at the cell at 5:50am.
29. The paramedics continued CPR until their heart monitor showed some activity, and they then assessed that the man could be moved. He was then placed on a chair lift and taken from the wing. The man's cell was closed and his cellmate moved into another cell. The ambulance departed from the prison at 6:09am. Mechanical restraints were not used when the man left the prison, and he was escorted by two officers to the University Hospital of North Durham. Both officers were present while hospital staff unsuccessfully attempted to resuscitate the man.
30. At 6:46am the hospital doctors pronounced that the man was dead.
31. The duty governor immediately informed that the man had died. The police were asked to inform the man's family of his death. A member of the prison chaplaincy and the duty Governor, representing the Governor, later contacted the family to offer their condolences and support.
32. The prison maintained contact with the family and offered to assist with arranging the funeral and providing financial help. The prison also arranged for transport to enable the man's relatives to attend his funeral, which took place on 31 August.
33. When one of the officers was asked by the investigation team about the prison's support for staff involved in the care of the man, and he said that he thought it was good.
34. The post mortem report concluded that the cause of death was due to natural causes as a consequence of rejection of a transplanted heart as treatment for muscular dystrophy.

35. The man entered prison with very complicated physical health problems having recently undergone a heart transplant. The man's condition was being monitored and assessed regularly by the prison healthcare staff. The man was taking a lot of medication related to the transplant, and his dosages were carefully observed due to the relative complexity of the case and the potential for adverse reactions.
36. The man was deemed as fit to work and was employed as a Data Entry Clerk; the limitations imposed by his condition were noted by instructional staff.
37. The prison acted appropriately and sympathetically by not using mechanical restraints when the man was taken to hospital and I commend their actions.
38. The Clinical Reviewer concluded that the man's care while he was in prison was appropriate and that medical issues were dealt with in a timely manner. He drew attention to some issues concerning the management of the man's clinical condition.
39. The man had undergone heart transplantation, and the reviewer observed that most nurses and clinicians have little experience of the complexities of the management of such cases. They therefore rely heavily on guidance from specialists. The reviewer noted the good lines of communication which appear to work well between Durham prison and the Freeman Hospital.
40. The reviewer pointed out that best practice in NHS Primary Care involves flagging the records of the highest risk patients such as the man. These should indicate simple observation parameters, which should be deployed if the individual feels unwell and include guidelines on when to inform doctors.
41. On 20 August, the man complained of missed heartbeats and was advised to book an appointment with the doctor. The man did not follow this advice and in consequence no medical assessment took place. The reviewer noted that patients should take responsibility for their own care and follow advice given by healthcare professionals. However, in this case there should not have been reliance on patient compliance and steps should have been taken to ensure that a medical review took place.
42. After the man's family received his belongings from the prison, they discovered a diary which suggested that the man had been attempting to end his life prematurely by not taking his anti-rejection medication. My investigator asked the clinical reviewer to review the medical evidence in light of this new development.

43. The reviewer contacted a Consultant Physician in Cardiac Transplantation at The Freeman Hospital. He noted that the man had been taking his medication, Ciclosporin, and commented that the potency in his blood test, four days prior to his death, was quite high. He concluded that the abrupt discontinuation of the man's medication would have been unlikely to have caused rejection for at least a week or more. He added that blood tests taken on the day of the man's death suggested that there may have been cardiac dysfunction for a number of days preceding the man's death. Therefore it was unlikely that the man had not been taking his medication.

Recommendations

Healthcare

I accept the recommendations of the clinical review, which are summarised as:

- 1) All relevant information concerning a patient's health or management should be recorded in the medical record and, if this is not immediately possible because of time constraints or accessibility, information recorded elsewhere (e.g. in wing diaries) should be transposed at the earliest opportunity. This could be tasked to administrative support staff.
- 2) Records of complex or high-risk patients should be flagged and, where appropriate, should contain brief guidance for nursing staff.
- 3) The PCT should review the way handover procedures are managed at the end of shifts in order to ensure that important issues are carried forward and actioned. The PCT, working with the healthcare team, should address the governance issues that the management of this case has highlighted.