Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Hadwin, a prisoner at HMP Durham, on 2 February 2023

A report by the Prisons and Probation Ombudsman

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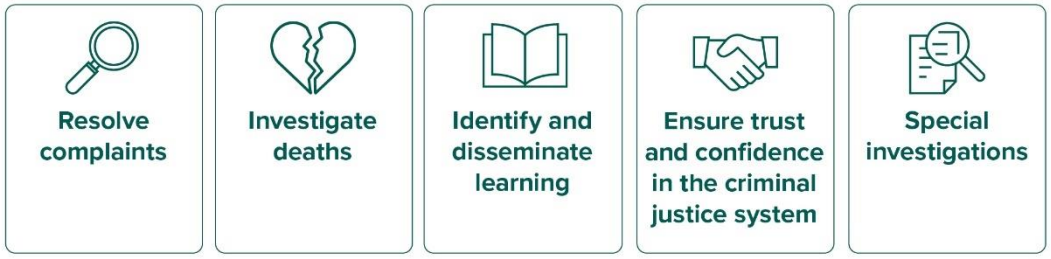
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Andrew Hadwin died of diabetic ketoacidosis on 2 February 2023 at HMP Durham. He was 39 years old. I offer my condolences to his family and friends.

On 1 February, Mr Hadwin had not taken his insulin. He said this was because he was not prescribed the correct dose. Healthcare staff were aware and action was being taken. Mr Hadwin was also being monitored as at risk of suicide and self-harm and had talked about killing himself. Mr Hadwin understood the potentially fatal consequences of not taking his insulin, however, there is insufficient evidence for us to conclude that he intended to die.

The clinical reviewer concluded that the healthcare Mr Hadwin received at Durham until 1 February was equivalent to what he could have expected to receive in the community, his care from that date was not.

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

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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Summary

Events

1. On 17 January 2023, Mr Andrew Hadwin was remanded to HMP Durham charged with multiple sexual and child neglect offences.

2. Mr Hadwin had pre-existing medical conditions, including angina, type 1 diabetes and high cholesterol. He previously had two heart attacks, and in 2020, he had an upper gastrointestinal bleed. He used a walking stick to move around and a wheelchair for longer distances.

3. During his initial health screen, a nurse noted Mr Hadwin's medical conditions. She took his blood sugar level, which was high, and his blood pressure and pulse were raised. The nurse tested his urine and the results indicated that no ketones (a type of chemical the liver produces when it breaks down fats) were present. There is no evidence that the nurse rechecked his blood pressure and pulse or that she had escalated the raised readings to a GP.

4. Mr Hadwin was subject to suicide and self-harm monitoring (known as ACCT). He said that he had frequent thoughts of suicide and had a plan for killing himself, but would not discuss this further with staff.

5. Mr Hadwin believed his insulin dose was incorrect and healthcare staff looked into it for him. A GP confirmed that he should be prescribed a higher dose but healthcare staff advised that the dose would be slowly increased. Mr Hadwin did not collect his insulin as prescribed on 1 February. A nurse spoke to him, and he confirmed he understood the potential fatal consequences of this.

6. On 1 February, Mr Hadwin complained of chest pains. Prison staff radioed a medical emergency code and control room staff called an ambulance immediately. A nurse responded and took a note of Mr Hadwin's observations, which were all within a normal range. She completed a NEWS2 assessment and concluded that he scored three. She did not refer him to a GP for further review and instructed the control room staff to cancel the emergency ambulance and asked healthcare staff to continue to monitor him.

7. At 8.42am on 2 February, a nurse saw Mr Hadwin after he complained of stomach pain. She attempted to take his blood sugar level, but it was too high to obtain an accurate reading. She administered his insulin and offered him pain relief, which he refused. She asked another nurse to arrange the GP review. There was no GP on duty at the prison that morning, so he would not have been able to see a GP until later that afternoon. The nursing staff did not consider contacting an out of hours GP or sending Mr Hadwin to hospital for further review.

8. At 11.10am, a prison officer opened Mr Hadwin's cell door. His cell mate told the officer that Mr Hadwin had been in the toilet area of the cell for approximately 30 minutes. The officer went into the toilet area and found Mr Hadwin unresponsive.

9. The officer radioed a medical emergency code and staff in the prison control room telephoned for an emergency ambulance immediately. Other prison officers responded and started cardiopulmonary resuscitation (CPR). Paramedics arrived shortly afterwards and took over Mr Hadwin's care. At 12.01pm, they confirmed that Mr Hadwin had died.

Findings

10. Mr Hadwin had spoken of his constant thoughts of suicide and that he had a plan. On 1 February, he did not take his insulin and said he understood the potentially fatal consequences of this. However, it is not clear that his decision not to take his insulin properly in the days before his death amounted to a clear intent to die.

11. The clinical reviewer concluded the healthcare Mr Hadwin received at Durham until 31 January 2023 was equivalent to that which he could have expected to receive in the community. The care he received from 1 February 2023, was not.

12. When Mr Hadwin arrived at Durham, healthcare staff failed to complete a full set of clinical observations. The nurse had identified that his blood pressure and pulse were elevated, but she failed to investigate this further or refer Mr Hadwin to a GP for an urgent review.

13. When Mr Hadwin complained of chest pain on 1 February 2023, a nurse based her assessment of his symptoms on his medical history and did not fully assess him based on the symptoms he presented at the time. Also, when Mr Hadwin presented with concerning symptoms the next day, healthcare staff failed to escalate this to an out of hours GP or send Mr Hadwin to hospital despite there being no GP available until the afternoon.

Recommendations

- The Head of Healthcare should ensure that a full set of clinical observations are taken during reception screening in accordance with NICE guidance and any anomalies escalated to a senior clinician.

- The Head of Healthcare should ensure that all staff receive appropriate training in differential diagnosis pathways, and all pathways are considered when attending an emergency response.

- The Head of Healthcare should ensure that:

    - staff are able to decide if an urgent appointment demands an immediate response; and

    - staff know how to escalate if a further on-site clinical assessment is not available at the desired time.

The Investigation Process

14. HMPPS informed us of Mr Hadwin's death on 2 February 2023.

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

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

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

18. We informed the Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. Mr Hadwin did not name anyone as his next of kin.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS/Spectrum Community Health did not find any factual inaccuracies.

Background Information

HMP Durham

21. HMP Durham is a local prison, serving the courts of Tyneside, Durham and Cumbria. It holds approximately 1,000 male prisoners. Spectrum Community Health CIC provides primary healthcare services. Tees, Esk and Wear Valleys Foundation NHS Trust provides mental health services.

HM Inspectorate of Prisons

22. 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.

23. 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

24. 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).

25. 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

26. Mr Hadwin was the tenth prisoner at Durham to die since February 2021. Of the previous deaths, six were from natural causes and three were self-inflicted. There has been one further death since Mr Hadwin's death, which was self-inflicted.

27. In our investigation into the death of a prisoner at Durham in February 2021, we made a recommendation that urgent requests to see a GP at the prison should be actioned quickly. The healthcare provider accepted our recommendation and told us there was a standard operating procedure in place to support escalation and defensible decision making in respect of GP referrals.

28. In our investigation into the death of a prisoner at Durham in September 2022, we recommended that healthcare staff carry out a full set of observations during initial health screens. The healthcare provider accepted our recommendation and said

that the requirements for initial health screens were displayed in the reception area. The provider also reinforced the requirements in an email sent to all healthcare staff reminding them of the NICE guidance in respect of this matter. It is disappointing that we are raising these issues again in this report.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

28. On 17 January 2023, Mr Andrew Hadwin was remanded to HMP Durham charged with multiple sexual and child neglect offences.

29. At his initial health screen, a nurse noted that Mr Hadwin had arrived in prison with several pre-existing conditions which included two heart attacks in 2012 (necessitating a surgical procedure to insert a stent to improve his blood flow), angina, for which he required GTN spray (Glyceryl trinitrate used to alleviate chest pain, which he admitted he did not use correctly) and high cholesterol. Mr Hadwin told her that he had also suffered an upper gastrointestinal bleed in 2020. The nurse noted that he had mobility issues and that he used a walking stick and a wheelchair to move around.

30. The nurse made a note of Mr Hadwin's blood pressure, which she recorded as raised at 122/102mgHg (a normal blood pressure is considered to be 120/80mmHg). His pulse was also raised at 115bpm (a normal pulse rate is considered to be 60-100bpm). She did not re-check his blood pressure and raised pulse or escalate the matter to a senior clinician.

31. Mr Hadwin told the nurse that he had been diagnosed with type 1 diabetes at the age of 18 and that he was dependent on insulin. She took his blood sugar level which she recorded as 24 mmol/L (a normal blood sugar level is between 4 and 6 mmol/L). Mr Hadwin said that his usual reading was around 9 mmol/L. She then tested his urine for ketones, which would indicate that his diabetes had deteriorated. The results showed that there were no ketones present.

32. Mr Hadwin also told the nurse that he had harmed himself by cutting his wrists in 2012, after he had been accused of committing sexual offences, and that he had been admitted to a mental health unit in 2015. When she asked him about his current mood, he said that he had no thoughts of suicide or self-harm. She considered Mr Hadwin would benefit from a more intensive level of support and started suicide and self-harm prevention procedures, known as ACCT. She identified his concerns, namely that he was unable to contact his partner for support, who was also his co-defendant, as she had been sent to HMP Low Newton. He also told her that he felt unsafe in prison because the details of his offences were being reported in the media. She ensured Mr Hadwin had the relevant contact details of his partner and that he was moved to the prison's Vulnerable Prisoner wing. She also recorded in Mr Hadwin's ACCT document that prison staff should have hourly interactions with him as part of the ACCT monitoring process. Mr Hadwin wrote to his partner on 23 January.

33. On 18 January, a nurse saw Mr Hadwin. He told her that he had had a daily prescription for a 30ml novorapid insulin pen (a rapid-acting insulin used to treat diabetes mellitus) in the community. Because healthcare staff were unable to confirm this until they had received his community health records, they contacted an out of hours GP service for advice. The GP prescribed Mr Hadwin a 15ml dose of Novorapid and asked the nurse to ensure that Mr Hadwin's blood sugar levels were monitored regularly, and that his urine be regularly tested for any evidence of ketones.

34. In the early hours of 19 January, a nurse checked Mr Hadwin's blood sugar level, which was 19.4 mmol/L. She also tested his urine, and the results showed evidence of ketones. She spoke to another nurse, who advised her to send Mr Hadwin to hospital by emergency ambulance, which she did.

35. A pharmacist received Mr Hadwin's community health records which confirmed that from June 2022, Mr Hadwin had been prescribed 30ml novorapid. She passed the information on to staff at University Hospital North Durham.

36. At hospital, Mr Hadwin was diagnosed with diabetic ketoacidosis (DKA, which occurs when the body has insufficient insulin causing the liver to break down fat for fuel; high levels of ketones can build up to dangerous levels in your body and can be fatal) and poor compliance with his insulin. He was admitted to hospital as an inpatient and hospital staff stabilised his condition. On 23 January, Mr Hadwin was discharged from hospital and returned to HMP Durham.

37. That day, a pharmacist noted that Mr Hadwin had been discharged from hospital without an up-to-date list of prescribed medications. She continued with his existing prescription of 15ml Novorapid daily.

38. Later that day, a nurse from the prison's Mental Health Inreach Team (MHIRT) saw Mr Hadwin. Mr Hadwin told her about his mental health history and that he had no current thoughts of self-harm. However, during an ACCT case review, Mr Hadwin told the meeting that he felt more suicidal than he did before he went to hospital. He said that he had no current plans to attempt suicide and said that 'he had stuff he needed to sort out' and needed to contact his solicitor about his appeal against his sentence. Mr Hadwin continued to be managed under ACCT procedures until his death.

39. On 25 January, a GP at the prison saw Mr Hadwin after he had reported having fallen on two occasions. He noted that Mr Hadwin's breath smelt of pear drops (a sign of possible DKA). He sent Mr Hadwin to hospital by emergency ambulance. Hospital staff confirmed that Mr Hadwin had developed DKA. He was admitted to hospital as an inpatient and his condition stabilised. He was discharged back to Durham on 27 January. He was still prescribed 15ml Novorapid.

40. During an ACCT case review, that day, Mr Hadwin hold the meeting that he had too much on his mind to think about attempting suicide, but said that he did have plans and ideas on how he would do it but would not disclose anything further. He confirmed again that he had no immediate plans to attempt suicide.

41. On 30 January, a nurse saw Mr Hadwin to assess if he needed a higher level of input from healthcare staff. She noted that he had difficulty sleeping, had type 1 diabetes resulting in chronic diabetic neuropathy (high blood sugar levels cause damage to the small blood vessels supplying the nerves in the body resulting in damage), had a carer prior to being sent to prison, had been admitted to hospital due to DKA and was being managed under the ACCT process. Following her review, she referred him to the Complex Care manager for further assessment.

42. Later that day, a nurse saw Mr Hadwin. He told her that he was concerned because he still had not been prescribed the correct dose of insulin. He also complained of

bleeding from both ears and of a headache. She noted that he had no active bleeding at the time of her review. She checked his blood sugar levels, which she recorded as 25.1 mmol/L. Mr Hadwin told her that this was a reasonable level for him. She tested his urine and recorded a ketone level of 2.1. She asked another nurse to recheck his blood sugar level and his urine.

43. In the early hours of 31 January, a nurse saw Mr Hadwin. He told her that he still had a headache, but that he felt fine. She noted there was no sign of bleeding from his ears, and he had not vomited. He told her he had not eaten anything due to not getting the correct does of insulin. She checked his blood sugar level and recorded it as 20.9 mmol/L. She also tested his urine for evidence of ketones and noted the level was 1.4, lower than his last test. She referred Mr Hadwin to a GP for further review.

44. Later that day, another GP at the prison saw Mr Hadwin. The GP noted that there was some discrepancy as to what level of insulin Mr Hadwin should be prescribed. He decided to review Mr Hadwin's prescription of 15ml Novorapid once his fasting blood glucose level had been established and also after his blood sugar level had been tested prior to every meal for the next three days.

45. Following an ACCT case review on 31 January staff recorded that Mr Hadwin had not self-harmed or attempted suicide since being in prison, but reported constant thoughts of suicide. An officer asked Mr Hadwin what it was that was stopping him and what he was using as a protective factor. Mr Hadwin said that he had nothing to do it (attempt suicide) with. He said he still had plans but again would not elaborate on what they were.

46. At 2.51pm on 1 February, Mr Hadwin complained of chest pains. An officer radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and control room staff called an emergency ambulance immediately. A nurse responded. She took a note of Mr Hadwin's observations, which were all within a normal range. She completed a NEWS2 assessment (National Early Warning Score a system for identifying acutely ill patients) and concluded that he scored three, which meant that a clinician needed to see him. She tested his blood sugar level, which was 23.5, but there is no evidence that she tested for ketones. She considered the pain he was experiencing was in fact stomach pain that was radiating to his chest. She instructed that the emergency ambulance be cancelled, and that healthcare staff review him again later that day.

47. At 5.17pm, a nurse actioned her colleague's request and saw Mr Hadwin. She noted that there was no record of him attending the medication hatch for insulin that day and considered that the pain he had experienced was due to him not complying with his insulin regime. She asked him what he thought the possible consequences of his non-compliance with prescribed medications might be. He said that he understood that he may die. She took a note of his observations, which were within a normal range and referred him to a GP for further review. There is no evidence that she tested his blood sugar levels and ketones as part of her observations.

48. Later that day, a Custodial Manager (CM), a security manager at Durham, telephoned the healthcare department. He spoke to the nurse and asked her to ensure that Mr Hadwin was only sent to hospital for further review if it was

absolutely necessary. She told him that Mr Hadwin had been reviewed and that there were no immediate concerns.

Events of 2 February

49. On 2 February, Mr Hadwin complained of stomach pains again and a raised breathing rate. At 8.42am, a nurse took his observations and recorded his temperature as 35.6 degrees Celsius, his pulse raised at 140bpm, respiratory rate as 18 breaths per minute and his oxygen saturation level as 96%. She attempted to record his blood sugar level, but it was too high to obtain a reliable reading. She recorded his NEWS2 score as four. She considered that a GP needed to see him urgently. She administered his insulin and offered him pain relief, which he refused. She told him she would arrange for an urgent GP review and advised him to ask healthcare staff for further assistance should his condition worsen.

50. Because she was dispensing medications at the time of her review, she asked another nurse to make the urgent referral to the GP on her behalf. The other nurse asked a member of the healthcare administration team to request an urgent GP appointment, which they did. However, there was no GP on duty at the prison until the afternoon. None of the healthcare staff involved contacted an out of hours GP or considered sending Mr Hadwin to hospital for urgent review. They did not appear to know how to escalate their concerns to senior healthcare staff and as a result, accepted an afternoon GP appointment.

51. At 11.10am, an officer opened Mr Hadwin's cell so that he and his cell mate could go for lunch. The officer could not see Mr Hadwin in the cell. Mr Hadwin's cell mate told the officer that Mr Hadwin had been in the toilet area of the cell for approximately 30 minutes. The officer called Mr Hadwin's name, but Mr Hadwin did not respond. He went into the toilet area and saw Mr Hadwin slumped to one side on the toilet. He checked for a pulse but found none. He radioed a code blue and control room staff telephoned for an emergency ambulance immediately.

52. Two officers responded to the code blue. The officers moved Mr Hadwin onto the floor of his cell and began CPR. A nurse responded, taking with her an emergency grab bag and defibrillator. Two more nurses also responded. Assisted by officers, they moved Mr Hadwin out of his cell and on to the landing. They then took over CPR. A nurse attached the defibrillator to Mr Hadwin's chest, and it advised no shock and to continue CPR.

53. Paramedics and helicopter emergency responders (HEMS) arrived shortly afterwards and took over Mr Hadwin's care. They administered eight shots of adrenalin and a saline drip. However, Mr Hadwin did not respond.

54. At 12.01pm, a HEMS doctor confirmed that Mr Hadwin had died.

Contact with Mr Hadwin's family

55. When he arrived at Durham, Mr Hadwin told staff that he had no next of kin. Due to the nature of Mr Hadwin's offending behaviour, he did not have any contact with his family.

56. Prison staff contacted HMP Low Newton and a senior manager there notified Mr Hadwin's partner of his death.

Support for prisoners and staff

57. After Mr Hadwin's death, the Duty Governor carried out a post-incident debrief with the staff involved in the emergency response. The staff were also offered welfare checks following the incident.

58. The prison posted notices informing other prisoners of Mr Hadwin'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 Hadwin's death.

Post-mortem report

59. The pathologist gave Mr Hadwin's cause of death as diabetic ketoacidosis.

Findings

60. Throughout his time at Durham, Mr Hadwin was subject to suicide and self-harm monitoring procedures. He told staff that he had thoughts of suicide and a plan of how he would kill himself, which he would not divulge. However, he also said he had too much on his mind to sort out to kill himself.

61. Mr Hadwin was concerned that he was not being prescribed the correct dose of insulin. Healthcare staff were aware and taking action to rectify this. On 1 February, Mr Hadwin did not take his insulin. A nurse discussed this with him and he confirmed that he understood the potentially fatal consequences of this. We consider there is insufficient evidence to conclude that Mr Hadwin's poor compliance with his insulin prescription in the days before his death amounted to an intent to die.

Clinical care

62. The clinical reviewer concluded that the initial healthcare Mr Hadwin received at Durham was equivalent to what he could have expected to receive in the community, but the care he received from 1 February was not. She identified some aspects of his care where improvements could have been made.

Initial health screen

63. NICE (National Institute for Care and Health Excellence) Guidance NG57 (Physical health of people in prison), states that a full set of clinical observations should be completed when a prisoner arrives in custody. The guidance also states that if a prisoner's blood pressure or pulse are recorded as raised during the health screen, the test should be repeated, or the results escalated to a senior clinician.

64. When a nurse carried out Mr Hadwin's initial health screen on 17 January 2023, she recorded his blood pressure and pulse as raised. However, neither was rechecked or escalated to a senior clinician as it should have been. There is also no evidence that she completed a full set of clinical observations, as she should have done. We recommend:

    The Head of Healthcare should ensure that a full set of clinical observations are taken during reception screening, in accordance with NICE guidance and any anomalies escalated to a senior clinician.

Diagnosis of Mr Hadwin's condition

65. When Mr Hadwin complained of chest pain on 1 February 2023, a nurse reviewed him. However, she did not consider that there may have been another reason for the symptoms he presented with, not related to his previous heart and gastrointestinal concerns. In particular, she did not apparently consider his unstable diabetes and history of DKA when assessing him. We recommend:

    The Head of Healthcare should ensure that all staff receive appropriate training in differential diagnosis pathways, and all pathways are considered when attending an emergency response.

66. The nurse reviewed Mr Hadwin again at 8.42am on 2 February, after he again complained of stomach pains. She asked a colleague to make an urgent referral for a GP appointment on her behalf. Her colleague asked a member of the admin team to action the request. When it became clear that the soonest a GP could examine Mr Hadwin was later that afternoon, no one considered contacting the out of hours GP service for advice, or calling an ambulance. An urgent GP appointment should demand an immediate clinical response. We recommend:

The Head of Healthcare should ensure that:

- **staff are able to decide if an urgent appointment demands an immediate response; and**
- **staff know how to escalate if a further on-site clinical assessment is not available at the desired time.**

67. The clinical reviewer made other recommendations about defensible decision making and record keeping, which we do not repeat in this report, but which the Head of Head of Healthcare will need to address.

Good Practice

68. Two nurse should be praised for the way they conducted their part in the ACCT process. Both of them, correctly, determined that what an individual says they intend is only one factor, and not a very reliable one, in assessing the likelihood of self-harm. They both considered all of the surrounding risks and Mr Hadwin was cared for under ACCT for the entirety of his time at Durham. This good practice should be widely shared with other staff.

Inquest

69. The inquest, held from 28 to 31 October 2024, concluded that Mr Hadwin died from natural causes related to type one diabetes. Self-neglect was listed as a contributory factor due to his refusal to take insulin to treat his diabetes, and his actions were in an attempt to take his own life. There were failing in the testing of his ketones on 1 and 2 February which also contributed to his death.

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