Investigation into the circumstances surrounding the death of a prisoner at HMP Doncaster, who died at Doncaster Royal Infirmary in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the death of a prisoner at HMP Doncaster. The man was found unconscious in the healthcare centre of the prison. Staff were alerted and successfully administered CPR. The man was revived and transferred to the local hospital by ambulance, but suffered further cardiac arrests en route and on his arrival at hospital. Despite continued efforts by medical staff, the man was pronounced dead. He was 35 years old.

I would like to offer my sincere condolences to the man's family and friends for their sad loss.

One of my investigators conducted the investigation on my behalf. I would like to thank the Director and Controller of HMP Doncaster prison, and their respective staff, for their co-operation and assistance with the investigation. Doncaster Primary Care Trust conducted a clinical review into the man's healthcare at Doncaster and I am also grateful for the clinical reviewer's detailed and comprehensive work.

The man had been arrested and spent 24 hours in police custody before going to prison. While in the charge of the police he complained of chest pains and was taken to hospital. He spent just a few hours in the custody of HMP Doncaster having been remanded by magistrates. He had never previously been in prison.

When his health suddenly deteriorated, staff at Doncaster tried their utmost to save him and were successful in their initial resuscitation efforts. Furthermore, speedy and positive action to trace and take his mother to hospital ensured that he did not die alone. I make no recommendations as entirely proper procedures were followed during the man's short time in Doncaster. However, staff at the prison should be commended for their effort to revive him and for the sensible and compassionate approach to the use of restraints on his transfer to hospital.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

West Yorkshire Police arrested the man on driving related matters. He spent over 24 hours in police custody during which time he was taken to the local hospital after complaining of chest pains. He had persistent chest problems and had undergone open heart surgery two years before his arrest. After a period of observation, he was discharged from hospital. He was then taken by the arresting officers to court where he was handed over to court staff and located in the cells.

Although he was initially remanded into the custody of HMP Leeds, that prison had no available spaces. The man was therefore taken instead to HMP Doncaster, arriving at 7.20pm. A member of the healthcare team conducted a health screen. A letter had been provided to alert the prison that he had been to hospital earlier in the day. It also came to light during the health screen that the man was an intravenous drug user who had been prescribed methadone in the community. In view of his need for detoxification and his heart condition, it was decided to place him initially in the healthcare centre until the doctor could see him the following day.

At around 8.00pm, the man was located on the healthcare landing in a dormitory occupied by four other prisoners. He was also placed on a 30 minute watch, which is usual for someone on detoxification. At 10.05pm, the other prisoners in the dormitory alerted the patrol officer that he had fallen from his bed and was unconscious. After calling for assistance via his radio, the officer entered the dormitory. With the assistance of other prisoners, he lifted the man onto his bed. The officer and a colleague who had arrived in the dormitory then administered CPR to the man until the arrival of nursing staff. The nurses used a defibrillator to shock him and the staff took turns in administering CPR. The man began to breathe and a pulse was eventually noted, but he remained unconscious.

After the arrival of an ambulance, the paramedics were given a full handover by the prison's nurses. Once on board the ambulance and before departing the prison, his condition deteriorated and the paramedics had to stabilise him. On arrival at Doncaster Royal Infirmary, he was taken immediately to the emergency room as his condition was considered serious.

The hospital recommended that, in view of the man's condition, his next of kin should be informed. Due to the distance involved, the police did this and they were also able to transport his mother to the hospital quickly.

Efforts to stabilise him continued but he suffered cardiac arrest over a two hour period and remained unresponsive to treatment. At 2.48am, the man's mother arrived at the hospital. Sadly, at 2.58am he was pronounced dead.

THE INVESTIGATION PROCESS

The investigation was opened at HMP Doncaster by my investigator. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with my investigator. No responses were received. The prison's liaison officer produced all relevant documents for examination, including the man's medical record.

I asked Doncaster Primary Care Trust to conduct a clinical review into the care and treatment received by the man at HMP Doncaster.

One of my Family Liaison Officers, contacted the man's family to offer them the opportunity to contribute to the investigation. Although understandably shocked by his death, the family expressed no concerns to my Family Liaison Officer about his care or treatment at Doncaster. However, they asked for him to be referred to by his Christian name throughout the body of my report.

My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation, and to request a copy of the Post Mortem. The toxicology report produced after the man's death indicates levels of opiates, cannabinoids and methadone. This suggests drug use prior to his arrival in custody. A copy of my report will be sent to the Coroner to assist with his enquiries.

My investigator returned to Doncaster and viewed the upper healthcare department. He met with the Head of Healthcare Services, and members of her team. He was also able to speak with Prison Custody Officers who had initially attended to the man.

Prior to his remand into prison custody, the man had been held for over 24 hours in police custody by the West Yorkshire Police. They will undertake a separate investigation, with input from the Independent Police Complaints Commission (IPCC), looking into his time in police custody. The police investigation falls outside my remit and I will not have access to their report.

HMP DONCASTER

HMP Doncaster is a purpose built category B local prison, privately run by Serco Home Affairs. As a local prison, it serves the courts in the immediate area and its population is largely made up of unsentenced prisoners. The prison has a dedicated healthcare facility and has implemented a drug strategy designed to support prisoners with substance misuse problems.

The most recent inspection by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, was conducted in November 2005. The inspection team found:

> "Doncaster had been receiving more prisoners from out of area however, prisoners arriving late in the afternoon or evening were dealt with in a professional manner and underwent the same reception process."

Ms Owers' report also mentions that:

> "A healthcare specialist saw all prisoners in privacy. Those prisoners with a substance dependency habit were offered allocation to the detoxification unit."

However, the Inspectorate found that:

> "Medication was not provided consistently for substance misusers on their first night in custody. The detoxification regime was inadequate for many prisoners, and very few were offered methadone maintenance programmes."

The healthcare services at Doncaster are provided independently of the local PCT, although there are good links between the two. Staff from the local PCT often take placements at Doncaster as part of their personal development.

KEY FINDINGS

Events leading up to the man's death

He was arrested by West Yorkshire Police and charged with driving offences. Whilst still in police custody, he complained of having chest pains and was taken to the local hospital. He was seen in the Accident and Emergency Department and the Medical Assessment Unit. Hospital records indicate that he had a history of heart failure and was a known intravenous drug user who had also been prescribed methadone. Following the examination, he was discharged from the hospital. The care given to him during this time is summarised in the clinical review.

The police then took the man to court where he was handed into the custody of court staff at 3.38pm. After an appearance at court, he was remanded into the custody of HMP Leeds until 1 June 2007. As Leeds had no available beds when the court staff attempted to book him in, they allocated him to HMP Doncaster.

He arrived at Doncaster at around 7.20pm. On reception, a letter informing medical staff of his referral to hospital was handed over and a full medical screening was carried out. The letter indicated that blood tests had been carried out, but no results were given. For this reason and in light of his previous medical history, the man was advised that he would be placed in healthcare. This would enable him to be closely monitored until he could be seen by a doctor and detox nurse the following day. Staff obtained his consent to obtaining his previous medical records and he was placed on a five day detoxification programme.

The man was taken to the healthcare unit at around 8.00pm. He was allocated to a dormitory that usually held ten prisoners but was only occupied by four other prisoners at the time. He was monitored at half-hourly intervals.

At 10.05pm, prisoners in the dormitory alerted the duty Prisoner Custody Officer (PCO), that the man had collapsed on the floor and hit his head. The PCO called for assistance via his radio and entered the dormitory. With the assistance of other prisoners, the man was lifted onto his bed. By this time, another PCO had arrived from the ground floor. The two officers then started Cardio Pulmonary Resuscitation (CPR) until the arrival of nursing staff. A defibrillator (a device that delivers a measured electrical shock to arrest fibrillation of the heart) was connected to the man and staff took turns to administer CPR. He began to breathe independently although he remained unconscious, and oxygen was administered. The staff continued to perform CPR. A pulse was noted, along with some movement and at this point they ceased the chest compressions.

The control room requested an ambulance which arrived at 10.24pm. The paramedics were given a full handover by the nursing staff and took over the man's care. In the ambulance, he continued to have further difficulties, requiring treatment by the paramedic team before the ambulance could depart from the prison. Given his condition and the ongoing treatment, the prison's Assistant Director decided that no restraints should be used. At 10.45pm, after paramedics were satisfied that the man was stable, the ambulance finally left the prison to take him to the local hospital.

He arrived at 11.00pm and, owing to the seriousness of his condition, was immediately taken to the emergency room. Given how ill he was, and the time and the distance from his family, the Assistant Director decided that using the police would be the quickest way of contacting and transporting them to the man's bedside.

At 11.58pm, his condition deteriorated further and it was again necessary to defibrillate him when he went into cardiac arrest. The man began to breathe briefly but quickly suffered a further cardiac arrest. The medical team continued to administer treatment, and at 12.14am a faint pulse was noted. However, at 12.37am he went into cardiac arrest for the third time since arriving in the emergency room. Efforts to defibrillate him continued over the following two hours, but he was unresponsive to treatment.

The man's mother was brought to the hospital by police officers at 2.48am. Sadly, at 2.58am, he was pronounced dead by the doctor attending to him.

Events following the man's death.

Serco conducted an internal investigation into the man's time in custody and the circumstances surrounding his subsequent death.

As he had been in police custody less than 24 hours before his death, West Yorkshire Police also conducted an investigation. I understand the findings were that police actions did not contribute towards his death in any way. However, a copy of the police report has not been made available to the Ombudsman's investigation team.

The Director of HMP Doncaster, wrote to the man's family to offer his condolences and the opportunity for them to visit the establishment if they so wished.

ISSUES CONSIDERED

Transfer to Hospital

The investigation found that the prison had acted entirely appropriately in not applying restraints when the man was transferred to hospital, given the seriousness of his condition. This decision had to be made very quickly. I am delighted that compassion and good sense were used. Leaving aside the sheer unlikelihood of him being able to make a sustained escape attempt, and the negligible threat he would have posed to the community, the decision not to apply restraints improved the ability of the paramedics to administer treatment en route to hospital. I regret that such good sense is not always displayed when prisoners are taken seriously ill.

The Deputy Director should be commended for taking the swift decision not to use restraints.

Clinical Review

Doncaster Primary Care Trust conducted the clinical review, of his reception at HMP Doncaster, the report says:

> 'He was appropriately placed on a five day detox watch ensuring that he was checked every 30 minutes and arrangements were made for him to see the detox nurse … the care received from the duty officer and the clinical team seems to have been excellent and every effort was made to revive him. The appropriate equipment seems to have been quickly available and in working order.'

It is recommended in the clinical review that:

Prison staff should be commended for their efforts to save the man's life.

I am pleased to endorse this view.

GOOD PRACTICE AND COMMENDATIONS

1. **The Deputy Director should be commended for taking the swift decision not to use restraints.**

2. **Prison staff should be commended for their efforts to save the man's life.**

Prison's Response

I can confirm that the Director has written personally to the Deputy Director on his decision not to use restraints and the staff involved in resuscitation were each awarded with a certificate of commendations.