

**Investigation into the circumstances surrounding the
death of a prisoner
at HMP Dartmoor, in February 2007**

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

September 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Dartmoor. The man in question was an older prisoner, and died in February 2007 at a local hospital. I offer my sincere sympathy and condolences to all those touched by his passing.

A post mortem examination revealed the cause of death to be a myocardial infarction (heart attack).

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was conducted by the Devon Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Dartmoor for their full and ready co-operation during the course of the investigation.

I make seven recommendations, five of which have arisen from the clinical review.

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

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Prisons and Probation Ombudsman

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SUMMARY

The man who is the subject of this report was received into HMP Swansea on 7 November 2003, having been sentenced to seven years imprisonment on the same day. At the time of his reception, the man's health was poor. He was in his 70s, frail and with limited mobility. He had experienced two strokes in the past, including one around a year before his imprisonment.

From November 2003 to January 2004, the man was involved in four transfers. It is not clear why he moved so regularly in such a short space of time. A further transfer took place in December 2004 when healthcare staff at HMP Usk concluded that the man was having difficulty caring for himself and would benefit from an environment with 24 hour healthcare. However, after around two weeks in the healthcare centre at HMP Parc, the man moved to a ground floor cell on a wing as he was assessed as being able to care for himself.

The man transferred to HMP Dartmoor on 20 July 2005. His blood pressure was taken around a week after his arrival and found to be high. The nurse who carried out the test asked that the man's blood pressure be monitored weekly. This request was repeated when he was seen again around one year later. However, there is no evidence to suggest that weekly checks took place during the man's time at Dartmoor.

On the morning of 3 February 2007, a nurse was called to the wing to see the man after he complained of feeling light-headed. She concluded that he might have flu and asked wing staff to keep an eye on him. That evening, the man fell out of his bed on two occasions. He sustained no injuries.

As a result of these falls, the nurse was asked by wing staff to see the man again at the start of her shift on the following day. After seeing the man, the nurse telephoned the duty doctor at Dartmoor for advice. The duty doctor suggested transferring the man to HMP Exeter where there is a 24 hour healthcare service. The nurse subsequently arranged the transfer with the duty doctor at Exeter. In the hour or so that he waited for a taxi, the man's health deteriorated. He was now shaky when standing and unable to use the toilet without the help of another prisoner.

The man arrived at Exeter at around 1.50pm. The duty doctor examined him on arrival, and thought that he might have experienced a further stroke. As a result, the man was taken directly to a local hospital for investigations. The man deteriorated significantly two days later, following a period of respiratory unrest. He did not recover and died five days later. A post mortem revealed the cause of death to be myocardial infarction (heart attack).

My investigation found that the man was treated appropriately by healthcare staff when he became ill in the last week of his life. However, I have made a number of recommendations regarding procedures at Dartmoor that could be improved.

THE INVESTIGATION PROCESS

The investigation was opened on 15 February 2007 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. One prisoner came forward as a result.

My investigator was given access to the man's prison files, including the medical record. He visited Dartmoor on 20 April 2007, and interviewed three members of staff during the course of the investigation. An independent clinical review of the man's health needs whilst he was in custody was carried out by the Commissioning and Development Manager for Prison Health for the Devon Primary Care Trust.

One of my family liaison officers contacted the man's daughter on 6 March 2007. She did not raise any issues that she wished the investigation to address.

HMP DARTMOOR

Dartmoor is a category C training prison located in the village of Princetown, Devon, with an operating capacity of 625. The prison was last subject to a full inspection by HM Chief Inspector of Prisons in February 2003. An unannounced follow up in February 2006 revealed a prison that had improved markedly in this time. Indeed, Dartmoor won the Most Improved Prison Award 2005.

Dartmoor works collaboratively with HMP Channings Wood and HMP Exeter as part of the Devon Prisons Health Partnership (DPHP). Healthcare at the prison is commissioned by Devon PCT. The prison's healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by Devon Docs, an out of hours service commissioned by the PCT. There is no in-patient facility within the healthcare unit. A dedicated nurse is based in the Vulnerable Prisoners Unit on F wing.

There have been four other deaths at Dartmoor since April 2004. Of those, two have been due to natural causes. My report into one of these deaths commended the caring manner in which prison and healthcare staff on F wing supported the man who died.

KEY EVENTS

The man was received into HMP Swansea on 7 November 2003. His health was already poor at this time. He had experienced two cerebrovascular accidents (CVAs, a stroke) in the past. The first of these was around 1991 and the second around one year before his reception into custody. He had been a heavy smoker since a teenager, and continued throughout his time in custody.

The man participated in a first reception health screen (a routine health screen for all new arrivals into prison) on arrival at Swansea. At this he detailed his medical history, including the recent strokes. The man told staff that he took one aspirin a day for stroke prevention. He also said that he had attempted suicide in 1953, but had no thoughts of suicide or self-harm now.

On 27 November, the man transferred to HMP Parc. He was screened by a nurse in reception and said that he was fit and well. He transferred again on 19 January 2004 to HMP Usk, and returned to Parc two days later. On 26 January, he transferred again – this time to HMP Channings Wood. It is not clear why the man was involved in this number of moves in such a short space of time.

The man was seen by a nurse at Usk on 20 January 2004, the day after his arrival. The nurse recorded that the man's history of strokes had left him with impaired speech and mobility problems. He was recorded as using a walking stick and able to walk short distances only. At his reception screening at Channings Wood on 26 January, he was described as "frail".

The man saw a doctor in May after complaining of a weak bladder. On 6 September, he was transferred to Usk for a second time. His reception health screen at Usk recorded no new health problems.

On 9 December, whilst still at Usk, the man was assessed by a nurse in order to ascertain his ability to carry out daily activities. He said that he was unable to get in the shower and bath. The man was noted to be cold and, in response, said that he had difficulty dressing. In particular, he had difficulty putting on a sweatshirt to keep himself warm. The nurse recommended that the healthcare manager look at the possibility of transferring the man to an environment with 24 hour nursing care.

As a result, the man transferred to Parc on 16 December 2004. On arrival, he was admitted to the healthcare centre as an inpatient. He settled easily into the healthcare centre, and was recorded as being able to look after himself. The man was assessed as fit for normal location and, on 28 December, he moved to a ground floor cell on D wing.

Other than a fall on 1 March 2005, from which he received no injuries, the man's time at Parc was uneventful. He transferred to Dartmoor on 20 July 2005.

The man was seen on reception at Dartmoor, and was said to be as well as could be expected for a 75 year old. His blood pressure was taken on 26 July. It was high, at 175/73. The nurse asked that his blood pressure be monitored weekly thereafter. There is no evidence to indicate that these checks took place. The nurse also noted

that the man was a heavy smoker but that he had no motivation to give up despite his history of strokes.

The next year passed without any significant medical occurrences. On 19 June 2006, the man said that he had been feeling dizzy for a period of around one week. Blood tests were taken, and the results found to be normal. On 20 July, the man was assessed by a nurse as part of the elderly care clinic. He was recorded as being very underweight but able to cope with all tasks of daily living, including his job packing razors. It was again recorded that his blood pressure should be taken weekly. Again, there is no evidence that these checks were carried out.

At around 10.00am on 3 February 2007, a nurse was called to the wing to see the man as he was complaining of feeling light-headed. When she arrived, the man told the nurse that his light-headedness had just come on that morning and that he was not close to fainting. The nurse took the man's blood pressure, which was normal, and pulse, which was slightly raised. She thought that he might have flu as there was a bug going round the prison. The man denied this. The nurse advised him to take plenty of fluids, and asked wing staff to keep an eye on him.

The nurse returned to the wing to check on the man later that day. He said that he felt that she was just making a fuss, and the nurse thought that he did not appear to be the least bit worried about his health.

At 6.40pm that evening, the man fell out of his bed. He was discovered by a prison officer. As the prison was in patrol state at the time, the Orderly Officer was called out to unlock the man's cell. Two officers helped the man onto his bed. He had no injuries and did not require any medical attention.

At 8.10pm, the man again fell out of bed. The Night Orderly Officer was called out and he helped the man back onto his bed. He again suffered no injuries. The man slept through the rest of the night with no further problems.

The same nurse was on duty on 4 February. Her shifted started at 8.00am, and she was asked by wing staff to see the man shortly afterwards. The man told the nurse that he had no bruising from his falls, although he would not let her examine him. At interview with my investigator, the nurse recalled that the man was no longer light-headed and had no shortness of breath. However, the man was frightened as he knew that he was frail and could potentially hurt himself if he continued to fall out of bed.

The nurse concluded that the man's cold might have got into the eustation tubes (tubes in the ear that determine balance), which would therefore have affected his balance and led to the falls. She telephoned the duty doctor and left a message for her call to be returned.

At 10.30am, the duty doctor returned the call. After a discussion of the man's symptoms, she suggested transferring him to HMP Exeter where there is a 24 hour healthcare service. The nurse subsequently telephoned the duty doctor at Exeter to arrange the transfer.

The man left for Exeter in a taxi at around 12.00 noon. The nurse stayed with him until the taxi came, and thought that he deteriorated in this time. He was now quite shaky when standing, and needed the help of another prisoner to go to the toilet. As a result of his difficulty in standing, the man was taken out to the taxi in a wheelchair.

The man arrived at Exeter at around 1.50pm. He was seen on arrival by the duty doctor, who noted that he was unable to rise or walk unaided. The duty doctor noted weakness to the man's right side, and made a provisional diagnosis of possible bronchopneumonia or a further stroke. He therefore decided to transfer the man to a local hospital for investigations and an urgent chest x-ray.

Two officers escorted the man during his time at the local hospital, and he was initially restrained by an escort chain. Two days after his admission, at around 3.00am, the man experienced a period of respiratory arrest (sudden slowing down or stopping of breathing) and the duty governor gave permission for the escort chain to be removed. It was not reapplied prior to his death.

At around the same time, a nurse requested that the prison inform the man's next of kin of his condition. The man did not have any contact with his children during his time in custody, and no telephone number was held for them. As such, South Wales police were contacted and asked to inform the man's son of his father's illness. He was visited by the police on that morning, but told them that he did not wish to have any contact with the prison or hospital regarding his father.

On the following day, the man's daughter telephoned the prison. She gave a message that she asked be passed to her father, but did not want any further contact with either him or the prison. The message was passed onto the man later that day by the prison chaplain.

The man's condition remained very poor. Four days later, at 6.15am, he was checked by a nurse and noted to be breathing with some difficulty. At 7.35am, he stopped breathing and death was pronounced at 7.40am. A post mortem revealed the cause of death to be myocardial infarction (heart attack). It also indicated that the man suffered from cerebral infarctions and terminal bronchopneumonia.

When she had telephoned four days earlier, the man's daughter had asked not to be contacted at home in future. The prison chaplain attempted to contact her on her mobile telephone on the day of her father's death, but was unable to do so. He eventually spoke to her on the following morning. The man's funeral took place around a month later, with the prison making the arrangements and meeting all of the costs.

ISSUES

Issues raised in the clinical review

The clinical review, conducted by the Devon Primary Care Trust, concludes that the man's treatment by the nurse on the weekend of 3-4 February 2007 was appropriate and reflected his presentation at the time. He takes the view that the nurse's assessment did not suggest a serious illness. The clinical reviewer considers, however, that "an examination at HMP Dartmoor by the duty doctor may have alleviated the need to transfer to HMP Exeter". He therefore makes the following recommendation:

Patients being transferred either to acute hospitals or in need of 24 hour prison healthcare due to their physical health needs should be routinely examined by a doctor prior to transfer, unless the patient transfer is necessitated by an emergency.

The clinical reviewer notes that the man was frail and elderly when he was received into prison for the first time in November 2003. He had been a heavy smoker since a teenager, and continued to smoke in custody despite efforts to persuade him to quit. The man also had limited mobility and a history of strokes. Given his ill health and the length of his sentence, the clinical reviewer concludes that there was a "significant possibility that the man would die in custody".

The healthcare manager should set up a chronic disease management clinic and ensure that those patients with a significant medical history are reviewed on a regular basis whilst in custody.

The clinical reviewer also considers the accommodation available to older prisoners. He writes as follows:

"As prisoners increase in age and frailty, standard ordinary accommodation may not be appropriate. Reasonable adjustment may be made in locating people flat, but they may need assistance with hygiene and toileting, together with social care that is not ordinarily provided. From a humanitarian perspective, the number and age of prisoners is increasing and therefore considerations should be given about the appropriateness of accommodation. 24 hour healthcare may not be the appropriate place for such prisoners, but there is an inevitability that is where many will be managed."

The clinical reviewer makes the following recommendation:

HM Prison Service should give consideration to the appropriate accommodation of elderly and frail prisoners serving lengthy sentences.

The clinical reviewer also makes the following two recommendations regarding notetaking and the upkeep of the medical record for prisoners at Dartmoor:

Patient record entries should be objective and clearly written, duly signed and with the name and designation of the practitioner.

The medical record should be maintained in chronological order with discrete sections for filing information.

The man's blood tests

The man was seen by a nurse for a routine check on 26 July 2005, around one week after his arrival at the prison. His blood pressure was taken and was high at 175/73. The nurse asked that his blood pressure be monitored weekly. The man was seen again on 20 July 2006. It was again recorded that his blood pressure should be taken weekly.

Despite there being two separate requests for the man's blood pressure to be taken on a weekly basis, there is no evidence to suggest that such tests took place during his time at Dartmoor. Certainly, no records were kept of any readings.

The healthcare manager should ensure that systems are in place to regularly monitor and record the blood pressure of those patients for whom it is deemed necessary.

Uncertainty surrounding the date on which the man was seen by nursing staff

In the medical record, the nurse noted that she was asked to see the man by wing staff on 3 February 2007. She confirmed that this was the correct date when interviewed by my investigator. A statement submitted by the nurse for the prison's Significant Event Analysis also makes clear that she saw the man on the day before he was transferred to Exeter (which was 4 February).

My investigator spoke to an officer on the man's wing during the course of the investigation. The officer remembered asking nursing staff to see the man when he was unwell. However the officer was certain that these events took place on 2 February 2007, as he did not work on 3 February. However, he did not record these events in the wing observation book.

A prisoner who was a friend of the man came forward to speak to my investigator during the course of the investigation. He recalled that the man was seen by a nurse four days before the night in which he fell out of bed (which is recorded in the wing observation book as being 3 February 2007).

It is clear that the man was seen by a nurse on the morning of 4 February 2007, as he was transferred to Exeter a few hours later. It is also clear that he was seen by her on one occasion prior to this. What is not certain, however, is the date on which this occurred - or whether the man was seen on another occasion in the preceding days by a member of healthcare staff.

From the available evidence, I think it is likely that the nurse did see the man on the morning of 3 February, as this visit was recorded in the medical record. However, nothing was recorded in the wing observation book regarding any requests to or visits by healthcare staff. It is not clear, therefore, whether the man was seen by healthcare staff on any other occasion in the week prior to this. There is no entry in

the medical record to suggest that this was the case, and it is possible that the wing officer and the prisoner were mistaken about the date or the person involved when interviewed.

The Governor should remind wing and healthcare staff to note all significant events in the appropriate record.

RECOMMENDATIONS

Patients being transferred either to acute hospitals or in need of 24 hour prison healthcare due to their physical health needs should be routinely examined by a doctor prior to transfer, unless the patient transfer is necessitated by an emergency.

Accepted – Instructions to nursing staff requesting a doctor to attend prior to transfer of a prisoner to an Accident and Emergency Dept. at outside hospital, or 24 hour prison hospital, have been given.

The healthcare manager should set up a chronic disease management clinic and ensure that those patients with a significant medical history are reviewed on a regular basis whilst in custody.

Accepted – This clinic is being resourced, with protocols under development.

HM Prison Service should give consideration to the appropriate accommodation of elderly and frail prisoners serving lengthy sentences.

Accepted – Prison managers are aware of the complex and diverse needs of the older prison population. They seek to meet the needs of individual prisoners and give proper consideration to issues of health, suitability of the prison environment and of the regime when allocating accommodation. The Prison Service recognise that this can sometimes be difficult to achieve and age is only one of the factors that must be taken into account when managing a prisoner's needs.

Patient record entries should be objective and clearly written, duly signed and with the name and designation of the practitioner.

Accepted – Staff have been reminded to write clear information in prisoner records.

The medical record should be maintained in chronological order with discreet sections for filing information.

Accepted – As above staff have been additionally informed that they should ensure that such entries are in chronological order. Staff are reminded of this at regular briefings.

The healthcare manager should ensure that systems are in place to regularly monitor and record the blood pressure of those patients for whom it is deemed necessary.

Accepted – New protocols are being developed to identify and highlight patients who require regular medical observations, plus recording and appropriately filing outcomes.

The Governor should remind wing and healthcare staff to note all significant events in the appropriate record.

Accepted – A Notice to Staff will be issued to ensure that this important point is raised with all staff.