Investigation into the death of a man at HMP Dovegate on 10 December 2004

Report by the Prisons and probation Ombudsman for England and Wales

May 2005

This is the report of an investigation into the circumstances leading to the death of a man, who died on 10 December 2004 at HMP Dovegate.

I offer my sincere sympathy and condolences to the man's family for their loss.

I wish to extend my thanks to the Director, and his staff at Dovegate for their help and co-operation during the investigation.

There are no recommendations arising from this investigation. There were however two actions which I feel deserve commendation as good practice. The style and tone of the Director of Therapy's information sheet for prisoners about the man's sudden death is notable for its humanity. It was also commendable that, on 12 December, the man's mother, and other family members were brought to the unit where he had resided not only to see it but also to sit and meet with other residents to remember the man.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The man who was serving a life sentence for murder was 54 years of age when he died on 10 December 2004 at HMP Dovegate.

2. He had served almost 19 years in prison despite the sentencing court recommending a 15 year tariff. He had a parole review report in February 2004 in which he was not approved for life licence. He was due to be reviewed again between February and August 2005. During his sentence he had been held in a variety of prisons designated to hold life sentence prisoners. He transferred to Dovegate on 3 March 2003 to undertake the High Intensity Programme (HIP) to address his offending behaviour.

3. The man was being treated for longstanding heart disease complicated by severe obesity. His weight was around 35 stone and his health and mobility were severely impaired by this.

4. The man was found dead in his cell in the HIP community at teatime on 10 December 2004. Paramedics attended and estimated that he had been dead for about three hours.

Investigation methodology

5. My Investigator, opened the investigation at HMP Dovegate on 21 December 2004. The Director and his staff produced the man's Core Record and a number of other documents for examination. Notices were issued to staff and prisoners informing them of the investigation.

6. My investigator visited the High Intensity Programme (HIP) Community and spoke informally with staff about the man. Subsequently he returned to speak with a prisoner who requested to speak with him regarding the man's death.

7. One of my Family Liaison Officers, contacted the man's next of kin. She was told that the family had no concerns or unanswered questions about his care or death.

8. A clinical review of the healthcare the man received whilst at Dovegate was commisioned.

9. My Investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the death.

About the man who is the subject of this report

10. The man was born in Glamorgan in 1950, the eldest of three children. His parents were self-employed local business people. After passing the 11+ he failed to achieve any educational qualifications. He left school just before his 17th birthday and went into the family business in their 'mobile shop'. Interestingly, while serving his sentence, the man achieved an M. Phil at University.

11. The man was sentenced to life imprisonment in 1986 for the murder of a shopkeeeper in the course of a theft. He was set a tariff of 15 years, which at the time of his death had expired without approval for a life licence. His next Parole Board Review was due to commence in February 2005. the man had no history of criminality before the offence for which he was sentenced to life imprisonment.

12. During his sentence the man moved to a number of different lifer units, progressing through his life sentence plan. His behaviour was always reported positively, with no breaches of prison discipline. Having been found unsuitable for the therapeutic community at Grendon, he was accepted for the high intensity programme (HIP) at Dovegate and transferred in March 2003.

13. The man made use of the Prison Service Complaints system, making 17 complaints at Dovegate in 2003 and 21 in 2004. As an articulate man, this system may have been one avenue whereby he could vent his frustration with the custodial environment. His main issues of complaint related to food, healthcare and privileges. Latterly, he was frustrated by the healthcare management's refusal to make him a special case with regard to attending the healthcare centre to see the doctor.

HMP Dovegate

14. Dovegate is a male Category B training prison. It was opened in July 2001 and is operated by Premier Prison Services, which is part of the SERCO group. They have the contract to run both sections of the prison for 25 years.

15. Dovegate was built on a former MOD brownfield site and consists of two prisons, the main prison and a Therapeutic Community. This is a discrete facility located on the same site as Dovegate main prison and sharing some of the main prison services, healthcare, gymnasium and visitors centre.

16. The report of the announced inspection by HM Chief Inspector of Prisons in April 2004 is generally positive, stating, 'there is much to commend both in the therapeutic model and in the way it has been implemented in the Dovegate TC'

Events leading to the man's death

17. The man arrived at Dovegate from Bristol on 4 March 2003. The initial assessment described him as obese, having arthritis and taking a number of medications for his heart. The nurse was unable to weigh him or take his blood pressure due to lack of suitable equipment. Unfortunately the doctor's examination report was almost totally illegible apart from a history of raised blood pressure since 1983.

18. On 20 March 2003 the doctor recorded that the man weighed 151 kg. This equates to 23.7 stones. By 25 September 2004 he was reported to weigh 35 stones. Given the reported major problems with transporting the man to hospital on later occasions and the reported need for a special bed to accommodate him in hospital, it is likely that his weight was much closer to 35 stones than 23 stones. Once an appropriate sized cuff was obtained his blood pressure was regularly monitored and was usually around 150/90.

19. Apart from a fairly lengthy schedule of medication for his heart condition, the man had few interactions with healthcare until January 2004. However he was prescribed risperidone 4mg daily by a forensic psychiatrist, on 31 August 2003. Records do not indicate why the psychiatrist prescribed risperidone but she stopped it on 30 January 2004 because she noted that the potential benefits were no longer outweighing the possible detrimental effects. This followed the man's' transfer to Accident and Emergency at the local hospital, on 23 January 2004. He was sent there because he was presenting with a rapid pulse and breathlessness. The electrocardiogram (ECG) done by the prison healthcare team indicated he might be in atrial fibrillation. He was discharged later that night on increased dose of atenolol and a course of antibiotics with no follow up appointment. The hand-written discharge letter from the Senior House Officer (SHO) confirmed atrial fibrillation recommending the prison doctor to consider anticoagulants if it persisted. The SHO also diagnosed a chest infection for which the antibiotics had been prescribed.

20. On 2 February 2004 the man told the doctor he had been told in the hospital that he had a chest infection but the doctor found no signs of cough, sputum or raised temperature. The prison doctor wrote that he disagreed with the SHO's diagnosis. He also noted that anticoagulation should be done in hospital not in the community. On 13 February the doctor recorded chest clear and the heart in sinus (ie normal) rhythm.

21. The man next saw a doctor on 26 April 2004 when he was presenting with giddiness. The examining doctor (probably a locum) thought his atrial fibrillation had returned and was causing the giddiness. He advised a need for warfarin but did not prescribe it. He also mentioned starting on the appetite suppressant reductil, but no evidence that it was prescribed was found in the notes.

22. In June 2004 his arthritis flared up and he was prescribed the anti-inflammatory drug, voltarol.

23. On 2 July 2004 the man refused to attend healthcare on the grounds of his breathlessness on exertion. A nurse asked a doctor to visit him on the unit but the doctor was unable to do so because of the demands of his fully booked clinic. This led to him having to sign a disclaimer for refusing to attend the healthcare centre, which prompted a complaint from the man. On 5 July a nurse offered to admit the man to the healthcare centre for assessment and observation. He declined.

24. The offer was repeated and again declined, on 18 July but on 20 July he was admitted to the healthcare centre. He was prescribed a strict diet consisting of Green vegetables and fruit, skimmed milk, tea/coffee without sugar, no carbohydrate or fat and meat with fat removed. He complained of chest pain on 21 July but after a full medical examination he was advised to continue on his regular analgesia and take an antacid for indigestion. He was discharged back to the HIP unit.

25. In August 2004 the man developed infections in both his legs. This led to skin breakdown and the need for regular dressings and a course of antibiotics.

26. On 19 September 2004 the man had another episode of chest pain which was assessed and treated as indigestion related.

27. On 20 September the man suffered a fall with no apparent injuries sustained. The next day he began to complain of a painful and swollen scrotum and was admitted to the healthcare centre as an in-patient. On 24 September, a doctor assessed the man and diagnosed infection in the scrotum and abdominal skin folds. He referred the man to the NHS expressing concern that there was potential for septicaemia which could be fatal.

28. At hospital he was diagnosed as having a hydrocele, a swelling on the testes, which needed draining surgically. However there was no equipment or bed large enough to accommodate him and the NHS would need time to plan how to manage him.

29. The man returned to the prison but was transferred back to hospital on 27 September where he remained until 18 October 2004. The discharge reports show that he was suffering from iron-deficiency anaemia for which he was transfused two units of blood. He was also diagnosed as suffering congestive cardiac failure. His drug treatment was a continuation of his previous regime comprising the following:
30. Diclofenac - non-steroid anti inflammatory
31. Gaviscon liquid - antacid
32. Aspirin - prophylactic anti-platelet
33. Cetirizine - antihistamine (for allergies)
34. Orlistat - anti-obesity drug acting on the gastro-intestinal tract
35. Multivitamins
36. Atenolol - A beta-adrenoceptor drug used in hypertension, angina and arrhythmia

37. Omeprazole - proton pump inhibitor used in gastro-intestinal ulceration
38. Frusemide - diuretic
39. Enalapril - drug used in hypertension and heart failure

40. The man continued on the above medication without incident until the day of his death.

41. On 10 December 2004 about 4 pm an officer looked into the man's cell and told him that he had mail. He got no response, but thinking that he was asleep, as he often was, did not disturb him. At approximately 5.15 pm, nursing staff were called to make an emergency response to the High Intensity Programme unit after another officer, could not rouse the man when he failed to appear to collect his tea meal. An ambulance was called. At 5.18 pm a Nurse found no signs of life - no pulses, no breath sounds, pupils fixed and dilated, skin mottled to both legs, stomach and arms, nails blue. The man was on his side and due to his weight the nurses could not turn him on to his back to commence Cardio-pulmonary resuscitation (CPR). Paramedics attended at 5.39 pm and declared that the man had been dead for some time - later estimated to be three hours. The Paramedic pronounced life extinct at 5.43 pm.

42. Post mortem findings were that death was due to ischaemic heart disease and hypertensive heart disease with severe obesity as a contributory factor.

43. My investigator was contacted by one of the man's fellow prisoners, who had seen the notice of the investigation displayed around the prison. He had concerns about the medication that the man had received. Apparently the man had told him that Healthcare was not issuing him medication which he believed the doctor had prescribed. This allegation was examined by the clinical reviewer.

Clinical Review

44. My investigator requested that the person who carried out the clinical review, investigate the concern raised by the prisoner about the man not receiving the medication that he believed the doctor had prescribed.

45. The man was prescribed risperidone 4mg daily on 31 August 2003. The doctor stopped this on 30 January 2004 because she noted that the potential benefits were no longer outweighing the possible detrimental effects. The clinical reviewer says that perhaps the man did not fully appreciate why the risperidone was stopped from which, in his view, he probably derived some benefit.

46. On 23 January 2004, the man went to Accident and Emergency on 23 January 2004. He was discharged later that night on an increased dose of atenolol and a course of antibiotics with no follow up appointment. The hand-written discharge letter from the Senior House Officer confirmed atrial fibrillation recommending the prison doctor to consider anticoagulants if it persisted. The SHO also diagnosed a chest infection for which the antibiotics had been prescribed.

47. On 2 February, the prison doctor found no signs of cough, sputum or raised temperature. The prison doctor wrote that he disagreed with the SHO's diagnosis. He also noted that anticoagulation should be done in hospital not in the community. On 13 February the doctor recorded chest clear and the heart in sinus (ie normal) rhythm. The reviewer says it is possible that the man had expected a further course of antibiotics and mentioned this to his fellow prisoner as a complaint. It is also possible he believed the prison doctors were refusing him medication prescribed by the hospital doctor, namely anticoagulants, as well as antibiotics.

48. On 26 April, the man complained of giddiness. During the course of the examination, the doctor mentioned starting on the appetite suppressant reductil but no evidence that it was prescribed was found in the notes. The review comments that the complaint mentioned by the prisoner may have related to the reductil. Perhaps the man thought he had been prescribed it whereas the doctor’s entry was more in the way of a possibility for consideration. If he articulated his thought to the man, it could have sounded like an actual prescription was being made.

Findings and conclusions

49. The care the man received in Dovegate was similar to that which he would have received had he been in his own home under the care of community health services. He was referred for secondary care in a timely and appropriate way. The reports from Queens Hospital indicated that he had been treated according to his clinical needs and informative discharge reports were sent after each admission.

50. The man entered the prison system with chronic conditions of high blood pressure and asthma both of which were attributed to or at least complicated by, his severe obesity. He was prescribed medication appropriate to his chronic diseases and also to help him manage his weight. From the evidence, diet was a major concern to the man and the staff. It may be that there was a misunderstanding whereby his diet was so restricted that it was lacking in protein and iron. It is possible that this contributed to his iron deficiency anaemia for which he was treated with a blood transfusion.

51. It was unfortunate that the man was not found until he had been dead for some time, thereby eliminating any possibility of resuscitation. However his obesity would have made cardio-pulmonary resuscitation very difficult.

52. The prison staff responded appropriately at every level once the incident had occurred. The family were contacted and the man's mother, sister and brother-in-law visited the High Intensity Programme Unit on 12 December.

53. Another prisoner said that the man thought he was not being issued with all the medication that he had been prescribed. Although there is nothing in the clinical review that can be regarded as conclusive, I think there are three occasions on which the man may have been disappointed enough to mention to his fellow prisoner that medication, apparently promised or prescribed, had failed to materialise.

RECOMMENDATIONS

54. I have no recommendations to make following this investigation.