

**Investigation into the circumstances surrounding the
death of a man in January 2011
whilst in the custody of HMP Dorchester**

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

March 2012

This is the report of an investigation into the death of a prisoner at HMP Dorchester, who died in January 2011. Having breached his licence conditions, he was recalled to custody in November 2010. He was transferred to HMP The Verne, in December, but moved back to HMP Dorchester two days later. During one evening of January 2011, his cell mate asked for assistance from staff. When staff arrived at the cell they discovered that he was very unwell. He was taken to Outside hospital where he passed away two days later in January. A post mortem recorded the man's death as being due to natural causes, as a consequence of pulmonary oedema (fluid on the lungs) and pneumonia caused by emphysema (a long term lung disease). He was 43 years old.

I would like to offer our sincere condolences to his family and to all those affected by his death.

The investigation was undertaken by a PPO senior investigator. We would like to thank the Governor and his staff for their assistance during the investigation. I apologise that the report has been delayed.

A clinical review into his medical care at Dorchester was commissioned from Dorset Primary Care Trust. They appointed a doctor to conduct the review, which concludes that his clinical care was equitable with that he would have received in the community.

I have made one recommendation about health screening procedures at Dorchester.

The recommendation made in the draft report has been accepted by HMP Dorchester. I have included the prison's response to the recommendation at the end of this report.

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Prisons and Probation Ombudsman

March 2012

SUMMARY

1. The man was born in 1967. He was 43 years old when he died in January 2011 at a local hospital. He had been taken ill two days before his death and he was suspected to have taken an illicit drug. However, following post mortem and toxicology reports his cause of death was given as fluid on the lungs (pulmonary oedema) and pneumonia caused by emphysema (a long term lung disease).
2. The man was released on licence in August 2010 but returned to custody in November 2010. During his first reception health screening interview at HMP Dorchester, it was recorded that he had history of alcohol and drug dependency. As it was recorded that the man had said he might hurt someone if he had to share a cell, it was recommended he be allocated a single cell as he might be a danger to another prisoner. His cell sharing risk assessment (CSRA) stated that he was high risk.
3. On 14 December, as part of his sentence progression, he was transferred to HMP The Verne. His CSRA was revised before he left Dorchester to low risk. However, staff at The Verne decided that he should not be accepted at the prison as he did not satisfy their published criteria for prisoners as he had a high CSRA risk assessment within the past three months. He was subsequently held in the segregation unit at The Verne and returned to Dorchester on 16 December. (Segregation units are small, separate units within the prison for prisoners who cannot be managed on the main wings for some reason. Segregated prisoners are held in single cells and have a restricted regime.) When the man returned to Dorchester he was located in a shared cell with another prisoner.
4. Around 9.15pm on 15 January, staff attended the man's cell after his cell mate rang the cell bell for assistance. As he appeared very unwell, staff asked for medical assistance and an ambulance was also called. After paramedics had carried out an assessment, he was taken to hospital under escort. Before the man left the prison he stated to staff that he had taken an illicit medication. This was later confirmed by his cell mate.
5. The escorting arrangements for the man were determined by an initial security risk assessment which concluded that restraints were to be used and two officers were to be at his beside. This was revised on 16 January and the restraints were removed and not re-applied. During the early hours of 17 January, the man's condition worsened and he was pronounced dead by a hospital doctor at 6.30am.
6. The clinical review carried out by a doctor, on behalf of Dorset Primary Care Trust, considered the care provided for the man. In the doctor's view, the quality of care given to him was equitable with that he would have received in the community. However, I have made a recommendation about the health screening procedures for new prisoner when they arrive at Dorchester. Although it had no bearing on the cause of his death, we have concerns about

the manner of his transfer and return from HMP The Verne. The Ombudsman's office has previously raised concern about the use of the segregation unit at The Verne for prisoners who do not meet the acceptable criteria for the prison. However, no recommendation is made about this issue, instead it is suggested that the new Governor of The Verne liaises with HMP Dorchester to avoid this issue arising in the future.

THE INVESTIGATION PROCESS

7. The investigator was formally notified of the man's death in January 2011. Notices were subsequently issued to both staff and prisoners at HMP Dorchester to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. No responses were received. The investigator also studied all the relevant prison records relating to the man which included his main prison record and his medical records.
8. A clinical review was commissioned from Dorset Primary Care Trust into the care provided for him during his time in custody. The purpose of the review is to establish whether the care which he received in prison was equitable to that he would have been offered in the community and to identify any points of learning. The doctor was appointed to lead the clinical review. We are grateful for his review which was received on 30 June 2011 and is annexed to this report.
9. The 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 his enquiries into the man's death.
10. One of our family liaison officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The family raised the following matters:
 - The delay in the family being notified that he had been admitted to hospital.
 - The return of his belongings.

We have attempted to address these issues within the report. We hope that this helps the man's family to understand the events leading up to his death.

11. The investigator visited HMP Dorchester on 21 January and spoke to the Governor as well as other staff involved in the care of the man. The investigator also met the Vice Chair of the Independent Monitoring Board. The investigator returned on 10 February and interviewed more staff. He also interviewed the man's cell mate. Transcripts of these interviews are attached to this report.
12. After completing the interviews, the investigator discussed the emerging issues with the Governor, on 10 February, and later confirmed his findings in writing.

HMP DORCHESTER

13. HMP Dorchester is a small Victorian prison in the centre of Dorchester which holds up to 260 prisoners. Dorchester is a local prison, which means it receives adult men and young offenders who are remanded in custody or sentenced to imprisonment by the courts of Dorset and the South West. It holds approximately equal numbers of remand and convicted prisoners. In December 2010, Dorchester merged its command structure with the Young Offenders Institution at Portland.
14. The main prison buildings are compact. Prisoners are held in four wings, three of which radiate from a central hub. A and B wings hold remand and convicted prisoners, C wing operates mostly as a first-night centre, and D wing provides accommodation for those segregated for their own protection or for the good order of the prison.
15. Healthcare is provided by Dorset Primary Care Trust. Dorchester also provides 12 places for 24 hour in-patient care for prisoners at HMYOI Portland, HMP Guys Marsh and HMP The Verne. These are lower security prisons where those facilities do not exist. (These prisons are known as the Dorset prison cluster.)
16. The investigator reviewed the Ombudsman's reports into earlier two deaths at HMP Dorchester. He found no issues in common between the earlier deaths and that of the man.

Insiders and Listeners

17. Dorchester recruits experienced prisoners to operate as Insiders and Listeners. Insiders are experienced prisoners who welcome new prisoners, highlight any concerns and explain the processes they will encounter in the early days of custody.
18. Listeners support prisoners who may be at risk of suicide or self-harm. They are selected, trained and supported by the Samaritans to offer confidential emotional support 24 hours a day, to fellow prisoners in distress. The Listeners scheme is confidential and any prisoner can ask to speak to a Listener any time of the day or night.

Assessment, Care in Custody and Teamwork (ACCT)

19. The ACCT system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. Once placed on ACCT support, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from

Listeners, personal officers¹ and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. The arrangements are reviewed regularly by a multi disciplinary meeting, which should include the prisoner.

Cell sharing risk assessment

20. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody and is the basis for decision making when a prisoner's location is being decided. The Prison Service describes the purpose of it as:
- draw together and pool information about risk from operational and health care staff
 - make best use of documentary evidence
 - support staff judgements about allocation to cells
 - where cell sharing is unavoidable for a high risk prisoner , provide for senior managers to decide and record additional operational precautionary measures
 - provide a readily accessible record about risk of harm to others as a prisoner moves between wings/prisons
 - record decisions about managing and reviewing risk to enable early identification of racist, homophobic or violent prisoners to ensure that other prison service procedures to protect potential victims are followed.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB), appointed by the Secretary of State for Justice. The board is made up of voluntary, unpaid members of the local community. Their role is to satisfy themselves that the prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. The IMB report directly to the Secretary of State if they have any concerns. They also submit annual reports on how the prison has met the standards and requirements placed on it. Members of the IMB have access to every prisoner, every part of the prison and every prison record.
22. The most recent annual report published by the IMB at Dorchester covers the period from September 2009 to October 2010. The IMB drew attention to the good relationship between staff and prisoners which enabled the retention of a safe environment for prisoners, staff and visitors to Dorchester. The IMB also said:

“We note an increase in the level of illegal drugs introduced to the prison despite the considerable efforts of [the] Security [Department] to

¹ Each prisoner is allocated a personal officer, who is the first point of contact for them.

combat this. The root of the problem continues to be drugs brought in by visitors, newly arrived prisoners and the proximity of the perimeter walls the town centre. The increase has been accompanied by an inevitable increase in bullying and other discipline problems which the operational staff are increasingly ever vigilant.”

HM Chief Inspector of Prisons

23. The last inspection of HMP Dorchester by the HM Chief Inspector of Prisons was in April 2009. In her introduction to the report of the inspection, the former Chief Inspector said:

“Dorchester demonstrated that good management and excellent staff-prisoner relationships can mitigate some of the weaknesses inherent in a small, elderly and overcrowded local prison, which at the time of the inspection had also been turned into a building site. Like all local prisons, Dorchester receives a wide array of prisoners with an equally wide range of needs, yet they were generally kept safe, treated decently and had attention paid to their resettlement needs. There was still too little purposeful activity, but, overall, managers and staff deserve considerable credit for what they have achieved.”

HMP THE VERNE

24. HMP The Verne is a category C training prison for adult men on the Isle of Portland, Dorset. It holds up to 607 prisoners who are mainly life sentence prisoners or those who have received a determinate sentence (where the number of years imprisonment to be served is decided by the sentencing judge). Foreign national prisoners form a large part of the population.
25. The Verne has a strict allocation criteria which prisoners have to meet.
- Must be 25 years of age or over.
 - Must have at least nine months left to serve.
 - Must not have history of escape or attempt escape from prison custody in last 10 years.
 - Must not have history of racism.
 - Must not have history of prison drug trafficking or dealing in past five years.
 - If sex offender on present or previous sentences, must have completed Sex Offender Treatment Programme if required.
 - Must not require methadone detoxification.
 - Must not require intensive psychiatric intervention.
 - Must not be assessed as “high risk” on cell sharing risk assessment in last three months.
26. The most recent most recent annual report published by the IMB at The Verne covers the period from May 2010 to April 2011. The IMB drew attention to the “substantial increase” in the number of prisoners arriving at The Verne who were “out of criteria for this prison”.

27. The IMB also said:

“Such men are effectively being punished through no fault of their own and some were held for lengthy periods. This should not happen. The criteria are well established and it should not be possible for other prisons to send prisoners who it is known will not be able to stay at HMP The Verne. The length of time some prisoners are held in Segregation whilst transfers are being planned is inappropriate. Arrangements with other prisons have been made for regular transfers out but do not always work.”

KEY EVENTS

28. The man was born in 1967. He was unemployed before coming into custody. He was released from custody on licence in August 2010. Just over four weeks later, in October, the man was given a formal warning as he breached his licence having committed an offence of being drunk and disorderly.
29. In November, he was charged with assault which he had carried out in October. He was subsequently recalled to custody following the second breach of his licence conditions.
30. Following his recall he remained at large until November when he was apprehended by the police. He also failed to attend an appointment with his probation officer in November. The man's family received a copy of my draft report and commented on it. They said that he had given himself up when recalled to custody.
31. The man arrived at HMP Dorchester in November. At his first reception health screen interview, it was recorded that he was alcohol dependent, had previously used drugs, had been previously diagnosed with Hepatitis C and had a heart attack in 2005. He was also a smoker who did not want assistance to stop. (Initial health screen interviews highlight any immediate mental or physical health problems requiring referral to the doctor or other specialist service.)
32. The Cell Sharing Risk Assessment (CSRA), completed by a prison officer when Mr Green arrived at Dorchester recorded that he said he "might flip out and stab somebody". As there was a risk of harm to another prisoner it was decided that his level of risk should be "high".
33. On the following day in November, he was seen by the prison doctor who was also the man's General Practitioner in the community. The prison doctor prescribed diazepam (for anxiety and insomnia) and also recorded that he required a single cell as "he is dangerous, with a proven record of assault."
34. In December, the man was seen again by the prison doctor. The man informed the doctor that he no longer wished to be considered as a "High Risk prisoner". The prison doctor recorded that he was "happy to overrule his previous categorisation for this". He made this decision based on his knowledge of the man over a number of years having dealt with him in the community.
35. On the following day in December, the man transferred to HMP The Verne. His CSRA risk, completed by another prison officer on the same day, was now recorded as "low". The prison officer made the following comments on the form: "Low on CSRA, located in single [cell] , no problems at present".
36. Inside the secure perimeter walls of The Verne, there is minimal physical security and prisoners are able to move freely around the prison. For this reason, only those prisoners who meet the strict reception criteria are accepted. The final criteria which prisoners have to meet is:

- Must not be assessed as “high risk” on cell sharing risk assessment in last three months.

As the man did not meet this final criterion for being accepted at The Verne he was moved to the segregation unit pending his return to Dorchester in December.

37. In early January 2011, wing staff contacted the healthcare centre as the man had informed them that he had made a number of applications to see the prison doctor. The senior nurse checked the healthcare centre’s records which showed that there had only been one request and action had been taken on it. Nevertheless she arranged for him to be seen the following day by the Nurse Manager who found him to have an itchy scratched rash on his forefinger. She prescribed a steroid cream and arranged for him to be seen by the prison doctor the following week. Four days later, in January, the prison doctor diagnosed dermatitis of the hands and increased the strength of the cream.
38. At around 9.15pm on 15 January, an officer responded to the bell for the cell where the man was located with his cell mate. The man informed the responding officer that he was not feeling very well and asked to see a member of the healthcare team. The responding officer asked him to describe what was wrong with him so that he could pass this information onto the nurse
39. In his statement to the Governor, the responding officer confirmed that the man told him he was experiencing palpitations and had vomited. After the man then vomited into the toilet bowl the responding officer went directly to the healthcare centre and described the man’s symptoms to the nurse.
40. The responding officer, the nurse, a second officer and the Night Orderly Officer² all then went to the man’s cell. The nurse found the man was very unwell, with palpitations, severe headache and abdominal pains. His skin was grey, he had vomited and he had raised blood pressure. Fearing that he might have overdosed on an opiate (which he would have obtained illicitly) and that he was in danger of cardiac and/or respiratory arrest the nurse gave him an injection of naloxone, an antidote to opiates. This had little effect and, as he was clearly very ill, the nurse asked the senior officer to call for an ambulance.
41. A rapid response paramedic arrived at the gate around 9.25pm and was escorted to the wing by an Operation Support Grade (OSG)³. The man’s cell mate said that the man had illicitly obtained and taken subutex (an opiate like substance widely used in prison as maintenance and for detoxification for opiate addiction) at 10.00am that day. The man himself also later confirmed this. An ambulance arrived at the prison at around 9.43pm.

² The Night Orderly Officer is the person in charge of the prison at night time.

³ An Operational Support Grade (OSG) is a basic grade member of staff who will not have received the same level of training as a prison officer and he/she will have much less interaction with prisoners.

42. The paramedic and ambulance staff took over the man's care and decided to take him to hospital. They left the prison at around 10.20pm and he was taken to the Accident and Emergency (A&E) at a local hospital. At 2.00am the next morning, the nurse was telephoned by staff at hospital to say the man had a chest infection.
43. An initial risk assessment determined that, whilst in hospital, restraints (an escort chain which is a set of handcuffs linked by a chain) were to be applied to the man and two officers should remain on duty at his bedside (this is known as a bedwatch).
44. Around 8.50am, on 16 January, the man asked that his family be informed of his whereabouts. The staff on bedwatch informed the prison of his request and his family were contacted and arrangements were made for them to visit him in hospital. Following an assessment by a hospital doctor at around 9.00am it was decided that as his oxygen levels were low he would be sedated and assisted with his breathing.
45. The risk assessment was subsequently revised at 9.20am, by the Head of Prisoner Health, and the restraints were removed and not re-applied. A log of activities was maintained by the officers on bedwatch duty, which was checked on a regular basis by a visiting duty governor. The man stopped breathing at around 4.00pm and hospital staff commenced cardiopulmonary resuscitation (a combination of chest compressions and mouth to mouth breathes). The efforts to revive the man continued for 45 minutes until the hospital staff were able to find a pulse.
46. Two officers were on bedwatch duty on the morning in January. When interviewed as part of the investigation, the first officer confirmed that during his bedwatch the man was on a ventilator and did not regain consciousness. He said he "just looked like he was fast asleep".
47. At around 6.25am, hospital staff went to the man's bedside. The bedwatch staff were notified by a hospital doctor, that the man was pronounced dead at 6.30am.
48. After he died, the prison activated its death in custody contingency plan. The police visited both the hospital and the prison and interviewed staff. They found no suspicious circumstances.
49. Prisoners were informed of his death during one morning in January. They were also asked whether they required any support or wanted to speak to a Listener. All the prisoners being monitored for suicide or self-harm were reviewed.
50. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. A hot debrief was held in January. There

were no areas of concern raised at that time but the staff who had been on bedwatch duty were offered support from the prison's care team.

51. After the man died, Dorchester appointed a prison family liaison officer. She maintained contact with the family and assisted with the funeral arrangements. Dorchester also offered financial assistance with the costs of the man's funeral. His funeral took place in January 2011. The prison family liaison officer also made arrangements for all of his belongings to be returned and this happened after his funeral.
52. The post mortem report records the man's death as being due to natural causes, as a consequence of pulmonary oedema (fluid on the lungs) and pneumonia caused by emphysema. He had admitted taking subutex and the toxicology tests carried out after his death showed traces of norbuprenorphine, a metabolite of subutex (meaning that it is one of the chemicals which is made when subutex is digested by the body) which he admitted taking in the morning of the day he was taken ill. There was also traces of naloxone. However, the toxicologist suggested that the medication found in his blood stream was not directly responsible for his death as the amounts found were too low to be hazardous.

ISSUES

Contact with the man's family

53. As mentioned earlier in the report, the man's family were contacted by, the Ombudsman's family liaison officer. The family were initially concerned about the return of his belongings, however these were returned after his funeral. The family were also concerned about not being immediately contacted and informed that he was in hospital.
54. The man's mother told Ombudsman's family liaison officer that she had spoken to her son during the morning of 15 January. She said that her son was trying to sort himself out but felt there was never enough support outside of prison. His mother was told that he was in hospital at around 8.50am one day in January. She was told that he had been calling for her before she got there and feels she should have been contacted sooner. The man's family received a copy of my draft report and commented on it. They said they travelled to the hospital straight away after being informed of his admittance to hospital and arrived after he had been sedated. The man's family also said they would have liked to have been contacted when he was admitted to intensive care. As mentioned in paragraph 44, it was recorded in the bedwatch log that he made his request for his mother to be informed that he was in hospital at 8.50am. The prison clearly acted quite quickly to grant this request. We would expect a prison to inform the next of kin as soon as practicable after a prisoner had been admitted to hospital. It does not seem unreasonable for Dorchester to have waited until the following morning before contacting the family as the seriousness of his condition was not clear at that stage.

Clinical care

55. As noted, a review of the man's medical care was undertaken by a clinical reviewer on behalf of Dorset Primary Care Trust. During his previous sentence in Dorchester which ended in August 2010 he had been weaned from heroin. This appears to have been successful as his urine screen, when he returned to custody in November 2011, was negative for opiates. Although the screen was positive for benzodiazepines the class of drugs to which diazepam belongs. There was no record of his weight when he returned to custody. In July 2010, he weighed 11 stone and 1 pound, the ideal body weight from someone of his height was recorded as 12 stone and 8 pounds. He had previously weighed 13 stone and 3 pounds in February 2007. There is no record of what caused the weight loss and it is surprising that he was not weighed on his return to custody. We recommend that the Head of Healthcare confirms the effectiveness of healthcare screening on reception for new prisoners.

The Head of Healthcare at HMP Dorchester should confirm the effectiveness of the healthcare screening procedures when prisoners are received at the prison.

56. From the medical records, it was clear that he was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical

reviewer was initially concerned about the time it took for the man to go the short distance from the prison to hospital. After further investigation he was able to resolve this issue. The clinical reviewer writes:

“By the time the substantive ambulance arrived the paramedic had had ten minutes to assess and no doubt start preparing him for transfer. Nevertheless the ambulance did not leave the prison until 48 minutes after the paramedic arrived and even then it took nine minutes to make the mile and a half journey to A&E in the late evening on a Saturday night in January. However, given that the overriding concern of the prison authorities is security and that Dorchester is a Victorian prison without lifts it is difficult to see how evacuating this seriously ill patient could have been achieved more expeditiously.”

Emergency Response

57. The clinical reviewer draws attention to the time it took for the man to move from his cell at Dorchester to the hospital. However, it should be noted that paramedics continued to treat and assess him following their arrival in the prison, and whilst they moved him, and this continued until his arrival at hospital. We also agree that the process of safely transporting the prisoner to the hospital was handled in a timely manner within the restrictions imposed by the prison environment and the circumstances of his condition.

Use of the segregation unit at HMP The Verne

58. The man transferred from Dorchester to The Verne in December but after the former Governor of HMP The Verne, discovered that he did not meet the criteria for acceptance at The Verne he was placed in the segregation unit. In her statement to the PPO investigator, she confirmed that, although staff at Dorchester had said he was not high risk on his CSRA, she had discovered after examining his records that had not been the case when he first arrived at Dorchester. She wrote:

“I contacted the Governor at Dorchester, personally, advising him that I was not able to keep the man at The Verne as he did not meet the allocation criteria. The man was therefore returned to Dorchester.”

59. In his written response to the investigator, the former Governor of HMP Dorchester, confirmed that he was contacted by the Deputy Governor at The Verne during the afternoon in December. The Deputy Governor of Dorchester was concerned that the man had been highlighted as a high risk on his CSRA and this “rendered him outside of The Verne's criteria”. The former governor of Dorchester told the deputy governor of Dorchester that if the man had appeared to have been made high risk on the CSRA at any time at Dorchester “it was, at worst, an administrative error”. After his first night in custody he had successfully shared a cell at Dorchester and the former Governor of Dorchester gave a personal undertaking to accept responsibility if he should prove to be anything other than “low risk”.

60. In his written response to the investigator, staff at Dorchester confirmed that they had been contacted by the former Governor of the Verne during the morning of the next day. She informed them that the man was being held in the segregation unit as he did not meet the criteria to be accepted at The Verne (as he had been high risk on the CSRA in the previous three months). It was explained that that the Deputy Governor at The Verne had accepted the explanation of why the man had been high risk on the CSRA.
61. They wrote:
- “The former Governor of the Verne unfortunately maintained the view that there was no room for compromise and said that she would be held personally accountable if there was to be another escape from The Verne. I was a little puzzled by how this related to the man but she was adamant that she wasn't allowed to deviate in any way from the published criteria. I admit to being exasperated by this lack of flexibility and there was a heated exchange of words which I now regret.”
62. They decided that it would be unfair to the man for him to be segregated over the weekend through no fault of his own and he decided to make arrangements for his transfer back to Dorchester. However, before he could put this into motion they were informed that the man had already been returned to Dorchester by staff from The Verne. They also wrote: “Although the man settled well on his return it did seem to me unnecessary and unfair that he should be deprived of finishing his sentence in Category C conditions.”
63. Following a previous self-inflicted death at HMP The Verne it was recommended that the Governor, with support from National Offender Management Service (NOMS) headquarters, should conduct a thorough review of the use of segregation at the prison and ensure that it is compatible with national policies. The Ombudsman's office was subsequently informed that the recommendation was been accepted and received the following response from NOMS:
- “Initial talks between the Area Manager and Governor have taken place. Arrangements to move any prisoners who are ‘out of criteria’ have been made with HMP Dorchester to reduce the numbers of segregated prisoners and the time they spend in the unit. A detailed review should now be conducted by the Segregation Manager to identify further issues which need to be addressed or improved.”
64. With regard to the circumstances surrounding the man's return from The Verne it would appear that he did not meet the criteria to be accepted at the prison. Although assurances were given, by the Governor of Dorchester, about his conduct whilst in custody he was still placed into the segregation unit pending his transfer. It is important that the new Governor of The Verne ensures that they work in partnership with Dorchester to ensure that this problem does not arise again in the future.

Use of restraints

65. As previously mentioned, whilst the man was in hospital the initial risk assessment determined that restraints were to be used and that two officers should remain with him. It was in line with standard procedures that Mr Green was handcuffed in the first instance. At the time the handcuffs were first applied, he was conscious and could reasonably have been judged to pose a security risk. The assessment was subsequently revised and the restraints were removed and not re-applied. The investigator has looked at this and found that the action taken by Dorchester was appropriate.
66. The investigator found that the bedwatch notes were concise with legible and appropriate entries. At interview, prison staff spoke perceptively and compassionately about their relationship with the man. This speaks well of the care offered to him during his time in custody and is a credit to the staff at Dorchester. The Governor may wish to share this assessment with his managers and staff.

CONCLUSION

67. The man arrived at HMP Dorchester in November 2010. He transferred to HMP The Verne in December but returned two days later. During one evening in January 2011, staff attended his cell after his cell mate asked for assistance. The man was subsequently taken to a local hospital and was later admitted. However two days later, he passed away.
68. From the bedwatch log, it was clear to the investigator that the staff involved with the man's care behaved with compassion and sensitivity. The security arrangements at the hospital were also in line with current policy and expectations.
69. The Prison and Probation Ombudsman has previously raised the issue of the use of segregation for prisoners who do not meet the criteria to be accepted at The Verne. We hope that this practice will now be reviewed by the new Governor of the prison.
70. In his review, the clinical reviewer concludes:

“I believe that the care he received in both HMPs Dorchester and The Verne was both of a high standard and appropriate and commensurate with General Practice outside prison. All in all I think he had good care. In my experience of writing these reports he is unique in having the same GP in and outside prison, which must have been to his benefit.”
71. In light of the findings of this investigation and the clinical review, we conclude that the healthcare provided to the man was equitable to that he would have received in the community.
72. I make one recommendation concerning health screen procedures for new prisoners when they arrive at Dorchester.

RECOMMENDATION

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Head of Healthcare at HMP Dorchester should confirm the effectiveness of the healthcare screening procedures when prisoners are received at the prison.

Accepted - First night reception screen process will include a mental health assessment, substance misuse assessment and general health observations. A second reception screen will be carried out the next morning. This will include a more in-depth general health assessment, such as recording the weight of the individual, blood pressure, family history etc. Systems will be put in place to ensure that second reception screens are carried out and abnormal findings are followed up immediately.