Investigation into the circumstances surrounding the death of a man at HMP Dorchester in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

The man died in prison. After alerting a prison officer that he was feeling unwell he collapsed in his cell. Despite receiving prompt medical attention from a doctor and nursing staff, he did not regain consciousness. The investigator and the Family Liaison Officer join me in offering our sincere condolences to his family and friends for their sad loss.

In the course of the investigation, we asked for a clinical review to be carried out into the medical care and treatment the man received in custody. A doctor was appointed by Dorset Primary Care Trust to undertake a clinical review on my behalf. I am grateful for his assistance and report.

The investigation found that the man's serious medical condition was identified quickly on reception into prison and appropriate treatment provided. The clinical reviewer notes one area where medical care – unrelated to his death - might have been enhanced, and a recommendation is made accordingly but, overall, his treatment was at least as good as he would have received in the community. In addition, the prison ensured a decent and compassionate level of care for him.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

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SUMMARY

1. The man was sentenced to 18 months imprisonment. This was the second occasion he had been imprisoned, with the first custodial sentence being in 1969.

2. When he was sentenced, he was not a well man and was suffering with severe chronic obstructive pulmonary disease (COPD) which he had had for a number of years. (This is a term used for a number of conditions, including chronic bronchitis and emphysema, COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.) He had mobility problems and found it difficult to carry out basic exercise such as walking.

3. On reception into prison, his medical condition was quickly identified and that he was given rapid access to specialist medical examination the following day. In addition, he was deemed to be vulnerable and at risk of harming himself and as a precaution he was monitored under the Prison Service suicide and self harm procedures. That monitoring was in place for a few days, after which his risk was such that the monitoring was no longer necessary and he settled down.

4. Throughout his stay at the prison, his medical care was good and in some ways better than that which would normally be expected in the community. Although his condition did not improve, prison staff ensured his life was as comfortable as possible and would deliver his meals to his cell and arranged for him to live in a cell on the ground floor, to prevent him having to climb stairs.

5. It is clear from this report that, whilst at prison, he was cared for well by medical and prison staff. However, the clinical reviewer notes that that he had a urine infection or possibly prostate problems which were not fully investigated. Accordingly, we make one recommendation for the Primary Care Trust relating to this aspect of his medical care.

THE INVESTIGATION PROCESS

6. When this office was notified of his death, the investigation was allocated to one of our investigators and he contacted the prison to obtain details of what had occurred. Later that month the investigation was transferred to another investigator for him to complete. Additionally, a Primary Care Trust was asked to appoint someone to undertake a clinical review. A doctor was appointed to undertake the review on our behalf.

7. The investigator visited the prison to begin the investigation and was met by one of the prison’s senior managers. The prison’s senior manager introduced the investigator to the Governor, Deputy Governor, Chair of the local Independent Monitoring Board (IMB) and Chair of the local Prison Officers Association. The purpose of these meetings was to explain how the investigation would proceed and discuss any concerns they might have.

8. That same day the investigator contacted the doctor to ensure he had the man’s medical records. The doctor confirmed he had received the records and was in a position to proceed with the clinical review.

9. In order to gain an insight into the man’s brief connection with the prison, the investigator met a prison officer who knew the man reasonably well. That officer was able to describe how prison staff had been aware of his medical condition and the arrangements that had been put in place to make his life as comfortable as possible.

10. We received the clinical review report from the doctor. His conclusion of the man’s care was that it was of a high standard, appropriate and equal to that which might be expected from general practice in the community. He makes one recommendation for the Primary Care Trust.

11. One of our Family Liaison Officers contacted the man’s son and explained our role in investigating deaths in custody. She later followed that telephone call up in writing. As part of the consultation period, the man's son received the draft report, we are grateful for his consideration of this. The man’s son was content with the findings.

HMP DORCHESTER

12. The prison is situated close to the city of Dorchester. Originally built around 1880 the prison holds a maximum of 260 male prisoners and occasionally foreign national prisoners awaiting transfer to immigration centres awaiting deportation.

13. The design of the prison is a traditional Victorian radial establishment, with four wings radiating out from a central point. In addition there is a small healthcare centre with a four bed in-patient facility. The healthcare centre has 24 hour nursing cover with a trained nurse being on duty during the night.

Her Majesty's Chief Inspector of Prisons

14. Her Majesty's Inspectorate of Prisons for England and Wales (HMI Prisons) is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration detention facilities. The role of Her Majesty's Inspectorate of Prisons is to provide independent scrutiny of the conditions for and treatment of prisoners and other detainees, promoting the concept of 'healthy prisons' in which staff work effectively to support prisoners and detainees to reduce reoffending or achieve other agreed outcomes.

15. In the introduction to the most recent report on the prison, following an announced inspection, the then Chief Inspector said in her introduction that despite major refurbishment work being carried out, the prison was commendably safe. She adds that there was excellent staff-prisoner relationships and sound focus on resettlement.

16. In her final paragraph, the Chief Inspector said:

> "In many ways, the Prison demonstrated that good management and excellent staff-prisoner relationships can mitigate some of the weaknesses inherent in a small, elderly and overcrowded local prison. The Prison receives a wide array of prisoners with an equally wide range of need, yet they were generally kept safe, treated decently and had attention paid to their resettlement needs. …overall managers and staff deserve considerable credit for what they have achieved".

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) made up of unpaid members of the public appointed by the Secretary of State for Justice. Their role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members are able to visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who requests to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chairperson of the Board produces an annual report to the Secretary of State for Justice.

18. In the latest report, covering the period from 1 October 2010 – 30 September 2011 the Board said the overall view of the prison was very positive. They add that there is evidence of remarkable change being made and supported by staff meeting the challenges with commitment from them all. In conclusion the Board said:

> "In spite of the huge changes taking place generally within the Prison Service and the impact upon the Prison, the staff and prisoner survey responses are that it is still considered a safe and well run establishment".

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT plan should be available to all staff where the prisoner is located. Within 24 hours of the plan being opened, the at-risk prisoner will be interviewed by a trained ACCT assessor. The ACCT assessment section has eight questions which are used as a reminder to the assessor of areas to be covered. The assessor's role is to consider the questions and if necessary expand the questioning, recording their comments in the ACCT plan. Following the assessment a case review meeting is held, which is a multi disciplinary meeting and meant to involve sufficient numbers of staff to make an informed decision. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT plan and attend case reviews. Regular case reviews are held until it is felt the prisoner is no longer at risk and that the ACCT plan can be finally closed. In the meantime, prisoners are monitored. Monitoring can be anything from constant observation to intermittent.

Multi Agency Public Protection Arrangements (MAPPA)

20. The Criminal Justice Act 2003 requires local agencies working in partnership to make arrangements to asses and manage the risk posed by sexual and violent offenders in their area. These arrangements are known as MAPPA.

21. There are three level to MAPPA:

    Level one is normally managed by a single agency and is the lowest monitoring procedure available under the MAPPA system.

    Level two means that anyone identified as falling into that category would be managed by more than one agency, very often Probation and Police with more if necessary.

    Level three is used for anyone considered to be high risk and is where more than one agency will take responsibility for the management of the person concerned.

Code red and code blue

22. In the event of urgent medical assistance being required, prisons usually have a radio code system to alert the medical staff to the emergency situation. Code red informs the medical staff that the patient is bleeding. Code blue alerts them that the patient is in breathing difficulty. The system ensures that the medical staff take the correct emergency equipment with them and helps provide the appropriate medical care as quickly as possible.

KEY EVENTS

23. The man appeared at Weymouth and Dorchester Crown Court where he was sentenced to five concurrent 18 month prison sentences for serious offences. He was then taken to prison. When he arrived at the prison he went through the normal reception procedure and was interviewed by prison and medical staff. During that process he indicated that he had thoughts of ending his life by overdosing or hanging and said he did not know how he would cope with a prison sentence at his age.

24. In response to that interview, the nurse dealing with him opened an Assessment Care in Custody and Teamwork (ACCT) plan. The nursing Assistant noted what he had said and passed the plan to a manager for an immediate action plan to be put in place to keep him safe. In addition and due in part to his medical condition, he was located in a cell in the prison healthcare department for observation. The following day a further assessment was carried out and the assessor noted that he was feeling more hopeful about his future than he had the previous day.

25. From then on he was monitored under the ACCT process until when his risk was assessed as being in a position where the plan could be closed. A post closure interview was held and confirmed the ACCT plan could be closed. That was the last occasion when he was monitored under the ACCT procedure.

26. In his clinical review, the doctor said the man was a smoker and had suffered with chronic obstructive pulmonary disease (COPD). He adds that medical tests carried out before he was imprisoned had shown severe obstruction. He went on to say that during the reception screening process he told Nursing Assistant that he smoked 15 cigarettes a day and was taking medication for a heart condition.

27. Following the reception screening, he was seen that same day by the prison doctor. The doctor wanted further tests to be carried out and so asked healthcare staff to arrange an Electro Cardiograph (ECG) appointment at the local hospital.

28. The next day he was taken to the Hospital where an ECG was carried out plus an x-ray. The doctor said he was given a range of potent medicines as well as oxygen to help relieve his symptoms. The doctor went on to say that the medical records show that he had been short of breath even when making his bed.

29. In addition to the doctors clinical review report, the Prison doctor has submitted a note of the man’s medical condition. In his report, the Prison doctor said the man had severe emphysema (another name for COPD) which meant he was extremely short of breath with minimal exertion the Prison doctor said his condition had been stabilised with regular nebulisation and in cell oxygen therapy. Additionally, he had been given systemic steroids, however his report does not make it clear whether they were administered by

mouth or injection. He was also given anti-biotics to treat infection, as he had shown signs of respiratory tract infection. As well as that treatment, he was given aspirin and simvastatin which is used to help reduce cholesterol, as he had signs of coronary heart disease. He went on to say that the chest x-ray had confirmed the respiratory diagnosis but there was no acute evidence of ischaemia, which can be described as an inadequate flow of blood. Due to his medical condition, the prison doctor arranged for the man to remain in the prison healthcare under observation.

30. In the meantime and due to the nature of his offence, the Ministry of Justice National Offender Management Service wrote to the Offender Manager Unit at the prison to inform them that he would be monitored under the Multi Agency Public Protection Agency procedure, level one. Further arrangements would have been made to continue MAPPA by the National Probation Service about six months prior to his release. However, those arrangements had not been decided at the time of his death.

31. The man was discharged from the healthcare centre and moved to a cell within the main prison accommodation area. Due to his health problems he was given a cell on the ground floor so that he did not have to climb stairs.

32. Five days later, he had what is described in his medical record as a severe coughing bout and shortness of breath shortly after collecting his medication from healthcare. The doctor said the problem was quickly and effectively dealt with by nursing staff using nebulisers and oxygen.

33. He mentioned for the first time to medical staff that he had urinary problems. A test of his urine showed that he had positive signs of leucocytes and nitrates which indicate an infection in his urine but no evidence of protein or glucose. The doctor said that urine is normally sterile and should not have leucocytes, nitrites, protein or sugar in it. The presence of leucocytes and nitrates suggest a urinary infection and would need a laboratory test to confirm or exclude this. The doctor said that as far as he can tell from the clinical records there was nothing more done about those results. In his opinion the symptoms suggest he had an enlarged prostate (a gland in the male reproductive system) and a urine infection, something which he adds merited further tests.

34. The man used his in cell emergency alarm to call for assistance. An Officer responded to the alarm. In a written statement, the officer said he found him sitting in a chair using his nebulizer and that he had told the officer he was having trouble breathing. The officer said his skin colour appeared good and so he went to healthcare, which is about ten metres from his cell and asked a Nurse for assistance.

35. Having returned to the cell along with the Nurse, they found the man on the floor of his cell using his nebuliser. In her statement, the Nurse said that whilst examining him, he collapsed, stopped breathing and had no pulse. She and the officer laid him onto the cell floor and began cardio pulmonary resuscitation (CPR) chest compressions. (CPR is a combination of rescue

breaths and chest compressions which aim to keep blood and oxygen flowing around the body.) In his report, the Officer said his condition had worsened rapidly and that he had lost colour in his skin, plus his lips were blue.

36. The officer used his prison radio to request additional medical assistance by using the emergency code, “code blue”, which indicated breathing problems. Once that message had been announced by the prison radio communications officer, several prison and medical staff went to his cell, including two other nurses and the Prison doctor. Additionally at about the same time the radio operator telephoned the emergency services to request an ambulance.

37. In her statement, one of the two nurses who went to the man’s cell for additional medical assistance said that when she heard the code blue message she collected an emergency grab bag from healthcare and that the bag contained an automated defibrillator. [A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.] When she arrived at the cell she attached the defibrillator to him and it instructed manual CPR to continue, which means chest compressions were to continue. The other nurse who also went to the man’s cell for additional medical assistance said in her report that she had assisted with the chest compressions.

38. The Prison doctor said in his report that he had overseen the rescue attempts and that he had remained unresponsive throughout. The doctor said paramedics arrived at the cell at 9.50am. After discussing the man’s medical condition with them, CPR was discontinued at 9.56am and he was pronounced dead. The doctor that carried out the clinical review said that once he had collapsed he became asystolic which means there was no sign of any electrical activity in the heart.

Following the man’s death

39. Once it had been confirmed that the man had died the Governor appointed a Senior Officer as the prison Family Liaison Officer (FLO). She and one of the prison managers went to the man’s son, his nominated next of kin that same day to break the news. The prison record shows that the prison FLO kept in contact with the man’s family and that the prison contributed towards the cost of the funeral.

40. As well as the prison appointing an FLO, we also appointed a member of our staff to carry out a similar role. On this occasion the FLO from our office contacted the man’s family shortly after his death. The FLO from our office explained the investigation process and gave the family the opportunity to raise any concerns or questions they wished to be addressed as part of the investigation. This report will be made available to his family. The FLO from our office said the man’s family did not raise any issues or concerns about his care.

41. In order to gain some insight into his life in prison, the investigator met another Officer who had known him quite well. The Officer said the man was a frail man with poor mobility and that it took a lot of effort for him to move. He said that due to the nature of the man's medical condition he was allocated to a cell on the ground floor so as to prevent him having to climb stairs. The officer added that prison staff routinely collected his meals for him and took them to his cell. He said that apart from the medical problems the man did not come to the attention of prison staff. The Officer said he very rarely left his cell, preferring instead to remain in the room.

ISSUES

Clinical care

42. In his clinical review the doctor said that overall it seemed that the man was well cared for in the prison. He said he was given a chest x-ray soon after arriving at the prison and that this was something he feels would not have been available so quickly to a general practitioner in the community. The doctor went on to say that the man's physical problems were assessed quickly and that he was well cared for in the prison healthcare centre. He remained there for about one month, after which he had little contact with healthcare staff other than collecting his normal medication.

43. Overall the doctor believes the care that the man received in the prison was of a "high standard, appropriate and commensurate with what might be expected from general practice" in the community. However, he said he would have liked to have seen evidence that the results of the urine test taken had been acted upon. In the doctor's opinion the symptoms suggested he had an enlarged prostate and that he had a urine infection. He said the man should have been referred to a doctor for further examination of the prostate and laboratory tests carried out to establish whether or not he had a urine infection. The doctor adds that he does not believe that a different approach would have in any way altered the outcome, but some of his urinary symptoms might have been alleviated.

    The PCT should ensure that staff are aware of what they should do, if the results of testing an elder man's urine suggest it may be infected

44. Once it was clear that the man was not well, medical care was obtained very quickly. The code blue message was effective and prompted the correct response from medical staff and a speedy request for an emergency ambulance. Rescue attempts carried on for over twenty minutes and were overseen by the prison doctor, but sadly he died. We are satisfied that the medical care and interventions were appropriate, professional and that the proper emergency equipment was taken to the cell in response to the code blue message.

Prison Officers

45. Once the man had been deemed suitable to move into a normal prison cell, his care continued to be of a high standard. The man's case is a good example of the extent some officers will go to look after those in their care. Knowing that he had difficulty in moving around, prison staff ensured that his meals were collected and would take them to his cell. His care by all concerned was dignified and proper.

Support for staff and prisoners

46. Once the man's death had been confirmed and as part of the normal prison routine the local Independent Monitoring Board (IMB) was informed. In a report written by a member of the local IMB she said that following the man's death the prison chaplain had helped support and that ongoing support would be continuing for prison staff and prisoners affected by the death. Additionally, in a report written by the Chair of the local IMB she said members of the IMB had spoken to prisoners and prison staff. She adds that in her opinion all staff worked professionally and that there was "great respect and sensitivity…"

Review of open ACCT plans

47. Whenever there is a death in a prison anyone being monitored at the time should have their ACCT plan reviewed. This is to ensure they are safe and have not been adversely affected by the death. We understand from the Safer Custody Manager that all open ACCT plans were reviewed.

Hot De-Brief

48. Following any serious incident in a prison there is normally a hot de-brief carried out. The purpose of that meeting, which is usually chaired by a senior prison manager, is to identify any issues surrounding the incident and to learn what went well and what could have been done better. It allows those involved to give their account of what has occurred and discuss what happened.

49. A hot de-brief meeting took place, chaired by Senior Manager. The minute of the de-brief shows the chronology of what had occurred. It also shows the local care team were informed and asked to support those involved or affected by the man's death. In addition and as support for prisoners, the local Samaritans were informed and attended the prison that evening.

CONCLUSIONS

50. Clearly when the man arrived into prison custody he was not a well man and struggled to cope with any sort of exertion. His medical condition was identified quickly on his reception into prison and treatment began that same day. It is evident that he was placed into an area where not only his medical condition could be monitored, but also his initial thoughts of ending his life.

51. Having been identified as someone who may wish to harm himself the correct monitoring systems were put in place. Although his death was not an act of self harm, we are satisfied that the correct and appropriate measures were put in place to support him at what is regarded as a highly vulnerable time and that his medical condition was managed appropriately.

52. This investigation has shown that his medical condition was identified quickly and appropriate action taken to find the extent of the problems affecting his breathing. We are satisfied that he received prompt and proper medical care.

53. Additionally we are pleased to learn of the help and support offered to him by prison officers. Their actions ensured he was able to receive regular meals without the need for him to leave his cell to collect them. This was a decent and compassionate level of care by all concerned. The Governor may wish to share these comments with his staff.

RECOMMENDATIONS

1. The PCT should ensure that staff are aware of what they should do, if the results of testing an elder man's urine suggest it may be infected

   The Ministry of Justice National Offender Management Service wrote to me confirming that the PCT had accepted the recommendation and introduced a system to ensure the doctor reviews all test results.