

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Dovegate in September 2009**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, who was found dead in his cell at HMP Dovegate in September 2009. A post-mortem showed that he died from the effects of a combination of drugs. He was 38 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) undertook a review of the man's clinical care. Our investigation was suspended until the police completed their own investigation; this lasted three years. I am sorry for the consequent delay in the issue of this report.

The man had had problems with drugs for some time and had spent previous periods in prison. He was on remand at Dovegate and was undergoing a drug treatment programme. He acquired some illicit drugs and appears to have taken these some time during a night in late September 2009. When prisoners' cells were unlocked the next morning, his cellmate found him unresponsive and summoned staff. Attempts were made to resuscitate him but were unsuccessful. The clinical review concluded that he received appropriate healthcare during his time in prison, although it does note that he was not referred to the primary mental health team, despite a history of depression.

While we cannot be certain, it is possible that the man obtained illicit drugs from a newly arrived prisoner, which he then took in addition to his prescribed medication. Prison staff received some intelligence to this effect but no immediate action was taken. I recognise the pressures in a busy operational context, but consider that some discussion should have taken place that night about whether to conduct a search. However, I also recognise that this would have been unlikely to have been in time to prevent him taking the illicit drugs. I am pleased to note that both recommendations in the report have been accepted.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was remanded to custody in June 2009 and transferred to Dovegate in September. He had a history of problems with drugs and alcohol, and had previously spent time in prison. He agreed to accept treatment to try and overcome his drug problems, and began a treatment programme. At Dovegate he was located on a drug treatment wing.
2. In September 2009, a friend of the man's arrived on his wing and he went to see him in his cell. Another prisoner reported suspicions to staff that the new prisoner had brought drugs onto the wing.
3. The wing manager asked officers to watch the new arrival and his cell, but did not feel that the information he had received warranted a search at that stage. Shortly afterwards, prisoners were locked into their cells for the night.
4. Some time between 10.00pm and 11.00pm a nurse went to the man's cell to give him his night medication, when he said he was feeling fine. His cellmate said he heard him mumble in his sleep at about 1.00am.
5. When prisoners were unlocked later that morning, the man's cellmate was concerned that he was unresponsive. He called officers, who attempted to revive him. They were joined by prison nurses and subsequently by paramedics, but attempts to resuscitate him were unsuccessful. He was later found to have died of the effects of a mixture of prescribed and illicit drugs.
6. Staffordshire police conducted an extensive investigation into the circumstances around the man's death. Ultimately, the Crown Prosecution Service decided not to bring charges.
7. A clinical review of the man's care in prison concluded that he had received good care. He was helped to address his drug misuse problems, and when other health issues arose they were dealt with appropriately. The emergency response that morning was prompt.
8. Our investigation found that it is not possible to be certain how the man came by the illicit drugs that contributed to his death, and therefore whether his death could have reasonably been prevented. We make two recommendations, about mental health referrals for prisoners with a history of depression, and assessment of security information.

THE INVESTIGATION PROCESS

9. This office was informed of the man's death on 24 September 2009. The investigator issued notices to staff and prisoners at Dovegate informing them of the investigation and inviting anyone with relevant information to contact him. No one came forward.
10. Staffordshire Police conducted an investigation into the circumstances surrounding the man's death. In line with our agreement with the police, this office's investigation was suspended until October 2012, when the police completed their enquiries after the CPS decided that no charges would be brought. The investigator kept in close contact with the police throughout their investigation. For this investigation he had access to police materials, which included witness statements and summary documents.
11. Serco, the company that runs Dovegate, carried out their own investigation following the death of the man. Their report was not provided to our investigator, although we were given the statements made by staff and prisoners in the course of that investigation.
12. The investigator obtained the man's prison record, including his medical records. The local PCT carried out a clinical review of his medical care and treatment at Dovegate.
13. HM Coroner for South Staffordshire was informed of the investigation. The Coroner provided a copy of the post-mortem report. Throughout the course of the investigation, the investigator remained in contact with the Coroner's office. This report has been sent to the Coroner.
14. One of our family liaison officers contacted the man's mother to explain our investigation and offer her the opportunity to raise any matters for the investigation to consider. His family acknowledged that the police had conducted a very thorough investigation, but were concerned that the prison did not react more quickly to the intelligence about drugs. The family asked some questions in response to the draft report. We have replied to these in a separate letter.

HMP DOVEGATE

15. HMP Dovegate is a category B prison for up to 1060 adult male prisoners sentenced to over four years imprisonment and local remand prisoners. The prison is managed by Serco. Healthcare services are provided by Serco Health. M wing was opened in September 2009 and is an Integrated Drug Treatment System (IDTS)¹ wing, specifically for remand prisoners who have a drug dependency. Prisoners are supported by the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team, and many are on medication to stabilise or assist their withdrawal from illegal drugs. Prisoners usually stay on the wing for a maximum of 28 days.

Her Majesty's Inspectorate of Prisons (HMIP)

16. The most recent published report on Dovegate by HMIP followed an inspection in October 2011, two years after the man's death. The previous inspection, in 2008, had found drugs to be a problem in the prison, relatively easy for prisoners to acquire and a major security concern. The follow up report found that, since the previous inspection, the integrated drug treatment system (IDTS) had been fully introduced and there was an appropriate range of clinical interventions for prisoners with drug problems. Inspectors found that the supply reduction strategy was well integrated with the drug and alcohol strategy.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board, of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The last report published by the IMB for Dovegate was for the year 2010-2011. In relation to drugs, the report noted that the monthly harm reduction meetings seemed to be effective, but that the monthly supply reduction meetings were rarely held. In their report for 2009- 2010, the IMB noted that the quantity of drugs being brought in by remand prisoners was a challenge with which the prison was coping.

Previous deaths at Dovegate

18. The man was the tenth prisoner to die in HMP Dovegate since this office took over responsibility for investigating deaths in prison custody in 2004. There have since been a further seven deaths. In a previous report, this office made recommendations about managing prisoners who suffer or have suffered from depression and this report contains one further such recommendation.

¹ The Integrated Drug Treatment system aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on early custody; improved integration between clinical and CARAT services; and reinforcing continuity of care between prison and the community.

KEY EVENTS

19. The man was born in 1971 and was brought up in the Stoke-on-Trent area. He had a history of drug and alcohol problems and had used heroin for 10 years. He had a number of previous convictions and had spent time in prison before. He suffered from back pain since being involved in a road accident when he was 26 years old and had also been treated for depression.
20. Very shortly after his release from a previous sentence in June 2009, the man was arrested on suspicion of burglary. When taken into police custody, he had with him a prescription for methadone (a heroin substitute). He told the police doctor that he was also prescribed diazepam (an anxiety relieving medication) and medication for depression. On 10 June 2009, he was charged with burglary and remanded into custody at HMP Shrewsbury.
21. At a routine reception health screen it was noted that the man was receiving treatment for depression. He was referred for counselling. He began an alcohol detoxification programme. He also agreed to undergo treatment for withdrawal from drugs and signed a consent form to begin a course of Subutex (used to treat opioid addiction). He saw a psychotherapist at Shrewsbury. He was noted to be very positive and motivated to make changes for the future.
22. The man transferred to HMP Dovegate on 8 September 2009. He was located on M wing, which is an Integrated Drug Treatment System (IDTS) wing for remand prisoners. He was allocated a double cell that he shared with a cellmate. He had the lower bunk.
23. A Prison Custody Officer (PCO) was the man's assigned drug worker on the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team. This included being responsible for drawing up a care plan in relation to his drug treatment. She saw him on 9 September, when he admitted that he had illicitly been taking Subutex in prison.
24. The man had been prescribed Subutex as part of his drug treatment but, at a case conference on 14 September, at his request this was changed to methadone. He was also prescribed anti-inflammatory medication for back pain.
25. The man told his drug worker that he had no intention of using heroin again and therefore did not intend to complete the heroin module of his drug programme. They discussed the risks involved in heroin and how these could be reduced. On 18 September, he told her that he felt more stable taking methadone.
26. On 21 September, the man had a review meeting with a member of the CARAT team. She noted that he looked unwell, and was sweating, but as this was consistent with withdrawal symptoms, she had no concerns about him. Later that day, he attended a clinical review, at which his drug worker, and a doctor and prison nurse, were present. He was sweating and looked pale. He said that he felt unwell, and the doctor agreed that his methadone prescription would be gradually increased from 20mgs to 50mgs.
27. At 2.00pm on 22 September the man again said that he felt unwell. A nurse went to M wing and assessed him. His blood pressure, pulse and temperature

were all within normal limits, and the nurse gave him some paracetamol. At 10.00pm a nurse woke he to give him his prescribed medication and asked him how he felt. He said that he felt better and declined further paracetamol.

28. On 23 September, the man told a member of the CARAT team that he was concerned about a cancelled Drug Intervention Programme meeting with his community drug worker. She spoke to his drug worker, who said that she was aware of the cancellation and had made arrangements to rearrange it. He was pleased it was being sorted out.
29. During the evening of 23 September, four new prisoners arrived on M wing. One of whom, Prisoner A, already knew a number of prisoners on the wing, including the man. Several prisoners went to this prisoner's cell to greet him and officers noted that there was a good deal of activity around him.
30. Some time between 6.00pm and 6.30pm, Prisoner B went to take menu cards to the cells on M wing. As he approached Prisoner A's cell he said he heard him say "Give us a chance, I've only just got it out of my arse". When he went into the cell, Prisoner A, the man and another prisoner were there and he saw a package of brown powder on the desk, when Prisoner A stepped in front of it, blocking his view. He said Prisoner A then handed the man a small wrap of paper, which he took to be drugs. The man put it into his pocket, and Prisoner B left the cell. When police questioned Prisoner A, he denied that any drugs were involved, and suggested that what he passed to the man was a roll-up cigarette.
31. Between five and ten minutes later Prisoner B told the Unit Manager that he had seen something that suggested that Prisoner A had some drugs. He also said that there was a lot of activity around his cell. It does not appear that Prisoner B mentioned that he had seen the man in the cell. Prisoner B later told police that he told the Unit Manager that he thought drugs were involved. The Unit Manager said Prisoner B did not specifically mention drugs, but it was implicit that they both assumed that to be the case.
32. The Unit Manager told Prisoner B that he would report what he had told him. He told police that he had been unable to deal with the information straight away as he was dealing with another incident. He filled out a Security Information Report (SIR), which he submitted the next morning and asked two PCOs to monitor Prisoner A and maintain a visible presence around him and his cell. He did not mention to either of the officers that this prisoner might have passed something to the man. When interviewed, neither PCOs could recall whether the Unit Manager specifically mentioned drugs but, as M wing was a drug treatment wing, they both assumed that any illegal activity would have been likely to involve drugs. Both said they made a point of watching Prisoner A and his cell. One PCO noted various prisoners, including the man, around Prisoner A's cell on at least two occasions. Staff dispersed the groups.
33. Later that evening, approximately an hour after he had gone into Prisoner A's cell, Prisoner B saw Prisoner A on the wing, apparently under the influence of drugs. He also saw the man on the wing that evening but said he appeared to be acting normally.

34. At approximately 7.45pm, a PCO gave the man his IDTS drugs pack² for the night. Prisoners were then locked into their cells until the morning.
35. Between 10.00pm and 11.00pm PCO A escorted a nurse dispensing night medication to prisoners on the wing, including the man. When they reached his cell, he came to the door and took his medication. The nurse stated he said he was fine when she asked.
36. The man's cellmate later told Serco's investigation team that the man took "something" that night. He told the police that he heard him mumbling in his sleep at about 1.00am.
37. Between 5.15am and 5.30am, PCO A conducted a roll count of the wing to check all prisoners were present. When interviewed by the police, she said that she did not notice anything untoward about the man's cell. When the shifts changed and day staff came on duty, a further check was made at around 6.55am. She and another PCO said that he was lying on his bed, slightly propped up and noted nothing unusual about his appearance.
38. PCO B was working at the medication dispensing hatch on M wing when, between 7.30am and 7.50am, he heard shouting and saw a number of prisoners around the man's cell. He ran to the cell to see what the problem was, thinking some prisoners might be fighting. As he got near, the man's cellmate came out and said that the man was not breathing. When he went into the cell, he saw him lying on his bed. He was on his back and his left arm was hanging over the edge of the bed. He could see that his lips were blue and there were traces of vomit around his mouth. He could see no movement. He pressed the emergency alarm to get help then moved his head and cleared his airway.
39. The Unit Manager was working on the lower landing of the wing when he became aware that something was wrong and went to the cell. When he arrived, he saw PCO B clearing the man's airway and he radioed to request an emergency ambulance. Between them they moved him onto the floor and the PCO began to try to revive him by giving him rescue breaths (often referred to as mouth-to-mouth resuscitation).
40. Two nurses arrived just as the officers moved the man onto the cell floor. The nurses applied an oxygen mask to him and performed cardiopulmonary resuscitation (CPR – which is a mixture of rescue breaths and chest compressions to keep blood and oxygen circulating around the body).
41. Another PCO heard the alarm and went to M wing. As he arrived, there was a group of prisoners around the cell. The Unit Manager and PCO B were inside. The Unit Manager asked for the prisoners to be locked back in their cells and the PCO assisted other staff in doing this. He then returned to the cell and assisted with the resuscitation attempts. At 8.24am, the ambulance crew arrived at the cell and the paramedics, with the nurses, continued to try to revive the man. By 9.10am, he still had no heartbeat, was not breathing, and was not responding to treatment. Paramedics advised that no more treatment

² Many drug users have had a poor diet, and these packs contain energy-giving foods such as chocolate and energy bars to help prisoners who might be suffering withdrawal symptoms.

should be given, and attempts to resuscitate him stopped. At 10.00am a locum doctor working in the prison, officially certified his death.

Informing the man's family

42. The prison appointed a family liaison officer. The family liaison officer, the prison chaplain and one of the prison's senior managers visited the man's mother, who was his nominated next of kin, at 10.40am that morning and informed her of her son's death.

Debrief

43. A debrief for staff who had been involved in the emergency response was held on the morning of 25 September, to ensure they had the opportunity to discuss any issues arising and to remind them of the support available. Notices were posted to inform other staff of the man's death.

Informing prisoners

44. Prisoners were formally informed of the man's death by notices from the Director. His cellmate was offered individual counselling and support.

Post-mortem report

45. The post-mortem report indicated that the man's death was due to:
- 1(a) pulmonary congestion and oedema
 - 1(b) recent intake of heroin together with methadone, diazepam and chlordiazepam.
46. This means that the man died from a build-up of fluid in his lungs when his system became depressed because of a combination of drugs. This included therapeutic doses of those prescribed to him as part of the detoxification programme plus an additional recent intake of heroin.

Funeral

47. The funeral was held on 7 October 2009. The prison was represented by the family liaison officer and the chaplain. In line with national guidance, the prison contributed to the costs.

Police investigation

48. Staffordshire police conducted an investigation into the circumstances in which the man died. Prisoner A denied supplying any drugs to him, who he described as a friend. He said that he knew many prisoners on the wing, a number of whom came to see him when he arrived, which was why staff might have noticed that his cell was busy. No charges were brought in relation to the death.

ISSUES

Healthcare

49. On reception at Shrewsbury, the man received a routine health screen. This appropriately identified his drug and alcohol problems, the medication he was taking, his history of depression, and his ongoing back pain. He was given treatment for withdrawal from alcohol and drugs and referred for counselling. Staff contacted his doctor to confirm his prescriptions. When he transferred to Dovegate he was located on the drug treatment wing and referred to the CARATs team. His prescription was changed from Subutex to methadone when he said that Subutex was not working well for him. The dosage was increased when he was observed to be suffering from symptoms of drug withdrawal. He was given medication for depression and received pain relief for his back problems.
50. The clinical review concluded that the care given to the man during his time in prison was appropriate and responsive to his needs. His death was not related to any failure in the care that he received. However, the clinical review notes that although he had a history of depression his records do not indicate that he was referred to the primary mental health team at Dovegate.

The Healthcare Manager should ensure that prisoners with a history of depression are referred to the primary mental health team for assessment.

Assessment of intelligence

51. The National Offender Management Service (NOMS) has a National Security Framework (NSF) which includes guidance on the management of intelligence and completing security information reports (SIR) whenever information is received about a prisoner. The intelligence is evaluated by the prison's security department for reliability and the potential impact on the prison's security. The author should indicate whether in their view the information needs to be assessed immediately, within 24 hours, or within 72 hours. Both the NSF and Dovegate's local security strategy say that, on receiving intelligence, staff should submit an SIR. There is no guidance on any action beyond this.
52. Prisons evaluate a high level of intelligence information. Between 2009 and 2010, there were over 8000 SIRs submitted in Dovegate. Almost a quarter of these involved information about drugs.
53. Prison staff often need to make quick decisions in response to situations. There is no central guidance for prison officers on how to classify information as requiring immediate action; this is a matter for individual judgement. The Unit Manager told the police that on average he received reports like the one from Prisoner B between three and six times a day. In this instance, it was a single piece of intelligence and he said that he did not know how reliable a source the prisoner was. He was therefore unable to assess the likely accuracy of the information. However, even if the information was true, the immediate threat to the security of the wing or the prison was low.
54. The Unit Manager received the information from Prisoner B at approximately 6.30pm. He filled out an SIR, but did not submit it at that time. In his statement

to the police, he said that there is no obligation on staff to submit SIRs immediately and he was aware that the prison's intelligence unit is only staffed between 8.00am and 5.00pm. Had he submitted the report when he received the information, the SIR would not have been acted upon by the intelligence unit until the following morning. We are therefore satisfied that he acted appropriately in submitting the SIR report at 7.00am the next morning.

55. The Unit Manager also mentioned the risk involved if staff had made a direct intervention at that time. Prisoner B passed the information to him while prisoners on the wing were unlocked for association³. The number of officers on the wing in relation to the number of prisoners was low. Many of the prisoners on the wing were withdrawing from drugs, which sometimes made them volatile. He said that if staff tried to search a prisoner and met resistance, they risked a dangerous confrontation.
56. Once prisoners had been locked in their cells, the situation was different. Staff would have been able to conduct a cell search. The Unit Manager had received information that suggested a new prisoner had brought drugs on the wing that evening. At Dovegate, if a member of staff judges that some intelligence needs to be acted on urgently while the intelligence unit is staffed (during office hours), they can contact them directly. Outside those hours they can contact the duty manager, but this was not done. It is important to note that while Prisoner B's and his respective accounts of the conversation between them differ a little, it does not appear that the prisoner told him that he saw the man take anything from Prisoner B, so it is unlikely that his cell would have been identified for a search. However, a newly arrived prisoner who attracted the attention Prisoner A appeared to have done that evening ought to have raised suspicion. Combined with the intelligence received, we consider that the Unit Manager should have at least discussed with the duty manager that evening whether to take any further action.

The Director should ensure that when intelligence is received that a newly arrived prisoner is in possession of drugs, managers consider and document whether to take immediate action.

57. Although there is some circumstantial evidence that the man might have obtained drugs from Prisoner A on that particular evening, it is not possible to know for certain how or when he obtained the drugs that contributed to his death. He had admitted to his drug worker on 9 September to taking illicitly obtained Subutex. As well as his prescribed methadone, the post-mortem report showed the presence of diazepam and chlorodiazepoxide (neither of which had been prescribed) and heroin. During his time at Dovegate he was not subject to any cell searches and he did not take any drug tests. It is therefore possible that he might have taken illicit drugs on more than one occasion.

Observation through the night

58. When prisoners begin drug treatment programmes that involve medication prescribed as a substitute for illicit drug use, they are subject to observations once an hour, usually for the first day, to ensure their wellbeing and then

³ When prisoners are out of their cells and can socialise together.

frequent monitoring for the first 72 hours. The man had been on a drug treatment programme since before he arrived in Dovegate and would no longer have been subject to frequent checks.

59. Prisoners are not routinely observed during the night unless there are specific security concerns, or if they are on special monitoring arrangements such as if they have just begun drug treatment or are thought to be at risk of harming themselves. This did not apply to the man. The last time he had any interaction with staff was when the nurse gave him his medication between 10.00 and 11.00pm. His cellmate said he heard him mumbling in his sleep at approximately 1.00am. During the roll check shortly before 5.30am there was apparently nothing untoward about him, and staff did not notice anything when they made a visual check shortly before 7.00am. These checks are principally for security reasons to ensure that prisoners are present and not to check on their wellbeing and it is possible that he was not alive at those times.

Emergency response

60. When the man was found by his cellmate to be unresponsive, staff reacted swiftly. An emergency call was put out, an ambulance was requested without waiting for healthcare staff to arrive, and uniformed staff moved him from his bed and started attempts to resuscitate him. Resuscitation attempts were carried out by nurses, prison officers, and paramedics.
61. The clinical review considered the emergency response. It notes that the ambulance was called and arrived in a timely fashion. The review goes on to say that there were no difficulties in the ambulance crew accessing the prison. We are satisfied that the response was appropriate.

RECOMMENDATIONS

1. The Healthcare Manager should ensure that prisoners with a history of depression are referred to the primary mental health team.

This recommendation was accepted. NOMS commented:

“HMP Dovegate follow evidence based guidelines by National Institute of Clinical Excellence (NICE) Depression in Adults (2009). Guidelines state that patients with depression are reviewed every 6 months. The man was at H.M.P Dovegate for approx. 2.5 weeks. The care of patients with depression can be managed by a professional which may be an R.M.N from Primary Mental Health Team or a G.P.

I can confirm that patients at HMP Dovegate are managed by either the G.P or Primary Mental Health Team which consists of 3 R.M.Ns and a Lead Nurse.”

2. The Director should ensure that when intelligence is received that a newly arrived prisoner is in possession of drugs, managers consider and document whether to take immediate action.

This recommendation was also accepted. NOMS commented:

“The Security Management within the prison will send a briefing note with what to do if Intelligence is received in this action point circumstance. This briefing note will go to Dovegate All Managers, Dovegate Duty Directors, and Dovegate SMT.”