PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man in August 2013

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 investigation report into the death of a man at HMP Dorchester in August 2013. He died from peritonitis, as a result of a perforated gastric ulcer. He was 58 years old. He had used over 20 aliases and after his death his original name was established. Efforts to locate his family have so far proved unsuccessful. I offer my condolences to those who knew him.

A clinical review was conducted of the man's clinical care at the prison. HMP Dorchester cooperated fully with the investigation.

The man had been at HMP Dorchester for only a little over a week by the time of his death and spent most of his time in the segregation unit. He appeared to be severely mentally unwell and was very challenging and difficult to manage. Staff at HMP Dorchester clearly worked hard to try to help him through his difficulties and get suitable professional treatment. Arrangements had been made for him to be assessed in a secure psychiatric unit but he died in the early hours of the day he was due to transfer.

The clinical reviewer noted that more frequent observations and checks during the evening and night he died might have helped identify when his condition became critical. However, the clinical reviewer recognised that the care of prisoners with acute undiagnosed illness is challenging, particularly when mental illness confounds the prisoner's behaviour and responses. As the man had previously been uncooperative, it is by no means certain that he would have allowed additional examinations, but it is regrettable that no further attempts to take his clinical observations were made the night he died. I am also concerned that there was a lack of clarity about the required level of checks by segregation unit staff. Nevertheless, I am satisfied that overall he received a generally high standard of clinical care at Dorchester. As the prison has now closed I make no recommendations for improvement.

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 **January 2014**

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SUMMARY

1. The man was remanded to HMP Dorchester on 23 July 2013. His behaviour immediately caused staff to question whether he was mentally unwell or suffering the effects of alcohol withdrawal. He was moved to the segregation unit the next day when he flooded his cell, spat at staff and behaved aggressively.

2. The man continued to behave unusually. He clutched his abdomen and vomited in his cell several times and also defecated on his cell floor. He resisted efforts to examine him or question him about his symptoms.

3. On 26 July, the man allowed healthcare staff to examine him and they gave a preliminary diagnosis of psychiatric illness with strong evidence of alcohol withdrawal. After seeking further advice, they sent him to hospital to treat his alcohol withdrawal but he was discharged the same day as it was concluded that he had a psychiatric illness. He was again taken to hospital as an emergency on the evening of 31 July, after staff saw him clutching his stomach and vomiting a dark brown substance. Blood tests gave a normal haemoglobin reading, indicating that he had not suffered significant internal bleeding. He refused all other examinations and was discharged back to prison.

4. On 1 August, arrangements were made to transfer the man to a local psychiatric assessment unit the next day. He allowed the prison doctor to take his pulse and temperature in the morning and these were both normal. The doctor noted that his pulse and, if possible, other clinical observations should be taken four times a day. A nurse twice attempted to take his clinical observations later that day but he refused both times. The last time a nurse visited him was at 6.45pm.

5. An officer checking cells in the segregation unit in the early hours saw the man lying on the cell floor. He, another officer and a nurse went into the cell. Efforts were made to try to resuscitate him but it was clear that he was already dead. A post-mortem examination found his cause of death was peritonitis secondary to a perforated gastric ulcer.

6. The man received a good level of care at Dorchester and there was evidence of efficient multi-disciplinary team working. However, we consider that there should have been at least one further attempt to take his clinical observations on the evening of his death which might have revealed a deterioration in his condition and there should have been more frequent segregation unit checks.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at HMP Dorchester informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one came forward in response.

8. The investigator visited HMP Dorchester on 6 August 2013 and met the Governor, the lead GP and a representative from the prison officer's trade union. He visited the segregation unit where the man had spent most of his time at Dorchester and obtained copies of his prison and health records. He subsequently interviewed eight members of prison staff, some jointly with the clinical reviewer.

9. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him. The Coroner unsuccessfully attempted to locate the man's family by placing adverts in local newspapers in the Lancaster area and making other enquiries.

10. NHS England, South Central Area Team appointed a clinical reviewer to review the clinical care the man received at Dorchester.

11. The man did not give details of any next-of-kin when he arrived at Dorchester. Enquiries after his death revealed his original name, but no family have been traced.

HMP DORCHESTER

12. HMP Dorchester, which closed on 29 November, was a small local prison serving the courts of Dorset and the surrounding area and held up to 291 male prisoners. Healthcare services were provided by NHS Dorset Healthcare University NHS Foundation Trust. There were daily GP services and an out-of-hours service. The healthcare unit had no inpatient beds. There was one nurse on duty overnight.

HM Inspectorate of Prisons

13. HM Inspectorate of Prisons carried out an unannounced inspection of Dorchester in July 2012. The Inspectorate found the prison overcrowded, but considered that it was a safe prison with excellent staff-prisoner relationships. A new healthcare facility was being built at the time of the inspection, and inspectors felt that there had been significant improvement in services and the management of healthcare generally since the previous inspection in 2009.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure prisoners are treated fairly and decently. The last published annual report for Dorchester was for the year ending September 2011. The Board was concerned that some prisoners with serious mental health problems had been held in the segregation unit while awaiting transfer to NHS psychiatric units. They sought assurances that this would not become the norm given the loss of NHS psychiatric beds in the community in recent years.

Previous deaths

15. There were three deaths at Dorchester in the two years before the man's death. There were no direct similarities between any of those deaths and that of his.

KEY EVENTS

16. The man was born in March 1955 in Lancaster. His current name was one of over 20 aliases that he was known to use. He had lived in Poole, Dorset, for some years.

17. A housing and community support worker based in Poole told the investigator that the man had been a "rough sleeper" for over 30 years and he had coped quite well compared to many others. She said that he did not use hard drugs and, although he used alcohol, he would go for periods without drinking. He had been diagnosed with a stomach ulcer some years before. He had controlled his alcohol intake to relieve the symptoms and took his medication as prescribed. Around two years before, he had been given a flat and had settled in well enough for her to remove him from her caseload.

18. In the early hours of 2 July 2013, while he was living in the community, the man went to hospital as he had been vomiting blood. His haemoglobin (red blood cell) count was normal but he was prescribed lansoprazole, which is used to treat stomach ulcers and indigestion. He was advised to speak to his GP about the need for any further treatment.

19. On 11 July, the man was admitted to hospital with symptoms of slurred speech. Investigations into whether he might have had a stroke proved negative. The episode of slurred speech passed and he was discharged without the need for follow-up action.

20. The man was arrested on 22 July, charged with assault and he remained in police custody overnight. The next day, he was remanded from court into custody at HMP Dorchester. This was not his first time at the prison.

21. A nursing assistant attempted to carry out a healthcare reception interview with the man on 23 July, but noted:

> "Could not interview this man as he did not say one sentence that I could understand. He did not smell of drink but has done in the past. Got agitated at my questions and kept [standing] up. [I] feel that this man has mental health issues …"

22. The man was given a single cell in the first night centre. Staff there became concerned about his behaviour and asked a nurse to see him. A nurse noted that he had his fingers in his ears and would not answer questions. He picked up a chair and as if to smash the light fitting. She contacted the out-of-hours service and asked for a GP to visit.

23. The GP arrived at around 11.30pm and the nurse accompanied him to see the man. He allowed the nurse to check his pulse and blood pressure, which were normal, but he refused any further examinations. She noted that he had a history of alcohol abuse, but he refused an offer of chlordiazepoxide (a drug used to relieve the symptoms of alcohol detoxification). The GP prescribed chlordiazepoxide in case he changed his mind.

24. The prison doctor attempted to examine the man the next morning, 24 July, but he again refused. Officers told her that he had flooded his cell and had been spitting through the gap at the edge of the door. Her preliminary diagnosis was that he might be experiencing delirium tremens (visual or auditory hallucinations when an alcohol dependant person stops taking alcohol), so she wrote a further chlordiazepoxide prescription.

25. Two officers made similar entries in their records about the man spitting at and threatening staff and using abusive language. As a result, he was moved to the segregation unit. At around this time, he also threatened to start a dirty protest[1]. He continued to behave in an unusual way throughout the rest of the day.

26. The prison doctor saw the man again on the morning of 25 July. She noted that his conversation was rambling and confused and that he had started a dirty protest. She thought that he seemed mentally unwell and arranged for him to be reviewed the next day by the prison psychiatrist. He continued to soil himself and his cell for much of his remaining time at Dorchester although this seemed to be through mental health confusion rather than as a deliberate protest.

27. The man was moved to a different cell that afternoon so the soiled cell could be cleaned. It is noted that he walked to the new cell without any form of coercion, although he talked continuously in jumbled unconnected sentences during the move.

28. The prison psychiatrist visited Dorchester on 26 July, but he noted that when he tried to speak to the man he was "roaring unintelligibly [and] covered in faeces". The psychiatrist was concerned that he might need more intensive support than could be provided at a prison without a healthcare in-patient unit. Two prisons with in-patient units were contacted. One had no spare healthcare beds and the other would not admit a prisoner on a dirty protest to its healthcare unit due to the risk of spreading infection. The psychiatrist telephoned a colleague in psychiatric medicine for his opinion and also discussed the options with the prison doctor. They agreed that he should be sent to the emergency medical unit at hospital.

29. The man was sent to hospital that afternoon and he returned to the prison later that night. A discharge letter from the hospital stated:

> "There is no strong evidence of alcohol withdrawal. We await full confusion screen results … The impression is of psychiatric illness …"

30. On 27 July, one of the segregation officers noted in the man's prison record that his "demeanour and attitude" was much improved that day. He had taken a shower, gone to the exercise yard and had remained clean. Late that

[1] A dirty protest is when a prisoner smears their cell and sometimes their body with faeces. This is usually when the prisoner is in dispute over some aspect of their imprisonment or treatment.

afternoon, a nurse checked him and noted that he was alert, talking constantly in a loud voice, but was not making any sense. There was evidence that he had vomited but the nurse noted there was no sign of blood.

31. The man's records show that he declined medication three times on 28 July. Officers noted that he had been shouting out and swearing randomly and had flooded his cell. He accepted medication in the morning on 29 July, but refused it in the afternoon. He spoke incoherently most of the day and threw both his midday and evening meals around his cell.

32. The man remained in a confused state on 30 July and was noted to have been shouting and rambling incoherently. There is no record of whether he accepted or rejected his medication.

33. The man had been referred to the mental health in-reach team and a nurse had planned to see him 1 August. When she came into the prison on the afternoon of 31 July to see another prisoner, the segregation unit staff asked her to see him as well, as they were worried about him. A nurse went to his cell and introduced herself. He was agitated and pacing the cell. He said he was unwell and asked her to walk him up to hospital, which she told him she could not do. He then began to ramble and, picking up on her name, spoke about Radio Caroline and said that his daughter was called Caroline. He then told her that she was a "plastic nurse" and began to use offensive language.

34. The nurse telephoned the psychiatrist and they agreed to refer him to Ravenswood House, a secure psychiatric assessment unit. They arranged to transfer him to Ravenswood House on 2 August.

35. That evening, officers asked a nurse[2] to see the man as he had vomited in his cell. When she looked into the cell, she noticed that the floor was covered in a dark brown fluid that she thought could be blood or vomit. He was sitting on his bed, bent over and clutching his stomach. She spoke to one of the GPs at the out-of-hours service who advised that he should be taken to hospital by emergency ambulance.

36. One of two officers who escorted the man to hospital that evening said that before going to hospital the man was helped to wash and given clean clothing. When they reached the hospital, he was taken to a cubicle in the emergency admissions unit. While there, he continued to shout out and refused all attempts by the hospital clinicians to examine him, although he allowed them to take a blood sample for testing. This showed a haemoglobin count score within normal range. The officer said he gave little sign that he was in pain, apart from a slight wince from time to time. After attempting to examine him for around an hour, hospital staff discharged him and he returned to the prison segregation unit at around midnight.

37. A nurse telephoned the hospital for information and was told that the man had been discharged as he would not agree to be examined but he had appeared

[2] The nurse's entries in the clinical records appear under her previous surname.

alert. He went to see him but each time he switched on the cell light to look into the cell, he switched it off from inside and he poured a cup of water over his head. He told the staff that he would monitor him through the night and arrange for the doctor to see him in the morning.

38. Just after midnight, the nurse noted that the man had been retching. He said that he had been sick between the wall and his bed but he became aggressive when the nurse asked him questions about his symptoms and tried to examine the vomit with his torch or by switching on the cell light. The nurse noted that while the man was not fully rational, he was alert. He asked officers to continue to check him every hour.

39. The nurse saw the man again at around 4.30am. He switched on the cell light and noted that he was lying on his bed. He had defecated on the cell floor, but there was no indication that he had vomited again. He asked him how he was and he replied that he would be fine if the nurse would switch off the light and leave him alone.

40. On 1 August, the Governor expressed concern about the man's condition during the night. A prison doctor went to his cell at around 10.00am and noticed black material or fluid on the floor which she thought might have been "coffee ground vomit"[3], but could not be certain as it had dried. He allowed her to take his temperature, pulse and blood oxygen saturation, which were all within the normal range. He had been holding his upper abdomen when she first went into the cell but when she tried to examine his abdomen or question him about symptoms; he became increasingly agitated so she ended the consultation.

41. The doctor telephoned the psychiatrist. They agreed that the psychiatrist would arrange for the man to be transferred to a mental health unit. The doctor spoke to two nurses and noted in his records that his pulse and, if possible, other clinical examinations, should be carried out at least four times per day and that if he were to vomit blood he should be transferred to hospital. She prescribed lansoprazole to combat stomach acid.

42. A nurse told the investigator and clinical reviewer that she had attempted to examine the man and take his clinical observations at around midday and again at just before 5.00pm. He refused to be examined both times, although he accepted his medication. At 6.45pm, a nurse visited the segregation unit and noted only that he still appeared to be confused.

43. Officer A was on duty on the night of the incident. When interviewed, he said that his colleague had given the man a cigarette at about 8.45pm and, in return, he had promised not to ring his cell bell that night. (He had rung his cell bell frequently for no apparent reason.) He had then been quiet until about 10.15pm, when he rang his cell bell and asked Officer A to re-light his cigarette. He rang his cell bell once more at 10.45pm. When Officer A went to see him, he was walking around his cell shouting that everybody, including the prisoner in the next cell, was trying to poison him.

[3] A term used by medics to describe vomit containing coagulated blood.

44. The man did not ring his cell bell again after that. Although a nurse had asked the segregation unit officers the day before to continue to check him hourly, there was no further check until 2.45am when Officer A went to check on him when he thought that he had been unusually quiet. He shone his torch into the cell and saw him lying face down on the floor. He called to him but got no response. He was uncertain whether he had just fallen asleep on the floor or whether there might be a problem, but as he had been volatile and it was not an obvious emergency, he first went to the healthcare unit to ask the nurse for his opinion.

45. The nurse went back to the cell with Officer A, turned on the cell light and kicked the door a few times but still got no response. He then asked to go into the cell. As it was unclear whether it was a life-threatening situation, the officer went to collect another officer while the nurse went to get the emergency bag. Officer A then broke his sealed pouch which contains a cell key for use in an emergency at night, and unlocked the door.

46. The nurse examined the man and found that he was not breathing, he had no pulse and there were signs that rigor mortis had begun to set in. Nevertheless, the nurse started chest compressions, assisted by an officer and an Operational Support Grade (OSG). Officer A radioed for an ambulance. The nurse attached a defibrillator[4] to him, which did not indicate that a shock should be given. The resuscitation attempts continued until paramedics arrived and pronounced him dead at 3.09am.

47. A debrief was held on 2 August for staff to speak about their involvement in the emergency they were told of the support available through the prison's care team.

48. The other prisoners in the segregation unit were told about the man's death and checks were made on all those subject to suicide and self-harm monitoring in case they had been adversely affected.

49. The man had not given any details about his next-of-kin and, there was doubt about his true identity because of the number of different aliases he had used. After his death, the prison discovered that he had received support in the community from the housing team at Poole Borough Council. Enquiries with them revealed his original name. They believed that he had two brothers but that he had had no contact with them for many years. To date, no further information about his family has been found.

50. A post-mortem examination found that the man's cause of death was acute peritonitis, arising from a perforated peptic gastric ulcer. The pathologist explained that he had had ulceration of the stomach for a considerable time to the point where the ulcer had burst, allowing contaminated stomach contents to

[4] An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient including whether or not an electrical shock should be given to re-establish an effective heart rhythm.

flow into the abdominal cavity leading to an overwhelming inflammation of the cavity lining. Examination of his brain revealed nothing of significance.

ISSUES

Clinical care

51. The clinical reviewer considers that, overall, the man received good care at Dorchester and a lot of resource and effort went into managing him and his illness. He was appropriately sent to hospital for investigation twice, when prison staff found it difficult to assess him and there was uncertainty about a diagnosis. She found that there was good cross-discipline work and communication between prison managers and staff, prison healthcare staff and the in-reach psychiatric services. She suggests one area of improvement, discussed below, but concluded that his care was equivalent to that he could have expected to receive in the community.

The decision to move the man to the segregation unit

52. The man had behaved strangely from the time he arrived at Dorchester on 23 July. Staff suspected that he had mental health problems, but he was uncooperative when they tried to question him and he became disruptive: he flooded his cell; spat through the gap between his door and the door frame; was abusive to staff; and threatened to start a dirty protest. In view of this, he was moved to the segregation unit during the afternoon of 24 July. While this was not ideal, we recognise that the prison has no inpatient unit and they were unable to transfer him to other prisons with such a facility. We are therefore satisfied that, in spite of his health conditions, this was a reasonable decision to try to manage a disruptive prisoner.

53. The man remained in the segregation unit for the rest of his time at the prison. Although he continued to defecate in his cell, it seems likely that his actions were due to mental confusion rather than a protest about his conditions.

54. The clinical reviewer noted that it is unusual for psychosis to occur for the first time in a man of his age. Therefore, it was appropriate first to exclude other potential causes of his behaviour, such as atypical alcohol withdrawal. He remained non-compliant and, after a review and discussion between the nurse and psychiatrist, arrangements were made to transfer him to Ravenswood House on 2 August. The clinical reviewer states that, even in the case of a person with acute psychosis, it is not unusual for transfer to a suitable bed to take weeks rather than days. The arrangements for his transfer were prompt and a bed was available within two days of the referral.

55. Although we accept that there were grounds to hold the man in the segregation unit we are concerned about his level of observations by segregation unit staff when he was there. Guidance in Prison Service Order (PS0) 1700 requires that "All prisoners located in the segregation unit must be observed by an officer at a frequency which is relevant to the individuals' circumstances and will be based upon a case management approach. The observation level should be decided by the person authorising segregation. There are some prisoners that are familiar with segregation and may be at ease with it whilst a prisoner that is not

familiar with it may need to be observed on a more regular basis which ideally would be at least hourly".

56. We were not given the original segregation authorisation form and have been unable to discover whether any frequency of observations was set at that time. However, the front of the man's segregation unit history sheet did not include the required frequency of observations as it is supposed to do, but for most of his time in segregation, hourly checks were made. It is apparent that the nurse considered that observations were hourly as he asked officers to continue to check him hourly the night of the incident. In the absence of any written expectation we would have expected segregation unit officers to have checked him at least hourly, particularly taking into account his poor state of physical and mental health. Had this been done it is possible that his collapse would have been noticed in time to get medical help, although we cannot know whether this would have altered the outcome.

The failure to diagnose the man's condition

57. The man's displayed mental confusion throughout his time at Dorchester, although the pathologist who conducted the post-mortem examination discovered no obvious physical cause or explanation. Unfortunately, his mental health problems and resistance to attempts to examine him made it extremely difficult for staff at HMP Dorchester and those at the hospital to investigate his symptoms. He permitted blood samples to be taken but these gave normal haemoglobin readings which indicated that he had not suffered significant blood loss.

58. The clinical reviewer noted that the man's temperature and pulse were both normal in the morning. This also suggests that a perforation was most unlikely at that time and instead, most probably occurred some time during the evening or night. The clinical reviewer explained that when an ulcer perforates, the stomach contents leak into the abdominal cavity causing an immediate onset of such severe pain that the person would be unwilling or unable to move or be able to shout for help.

59. On the morning of 1 August, the prison doctor had asked for clinical observations of pulse and other measures to be taken, if possible, four times per day (that is, at around six hour intervals). A nurse attempted the observations at around midday and again at 5.00pm, but the man refused to be examined. Another nurse visited the segregation unit at 6.45pm and noted that he still appeared confused. That was the last time he was seen by a nurse before his death.

60. The clinical reviewer suggests that more frequent medical observations of the man during his time in the segregation unit and, specifically, during the evening/night before his death when his perforation probably occurred, might possibly have helped prevent his death. Although he might well have continued to be uncooperative, we consider that as there was a nurse on duty overnight, further checks should at least have been attempted as advised by the doctor.

The emergency response

61. When Officer B checked the man at about 2.45am, he was lying on his side, unresponsive, on the floor of the cell. The officer was unsure whether it was an emergency so he asked a nurse to check him. The nurse asked to go into the cell but due to the man's volatile behaviour the officer thought it better to call his colleague before entering the cell.

62. Dorchester's contingency plans on the action to be taken in the case of an apparent death in custody state that:

> "… a lone member of staff, even at night, may need to enter [a] cell if … [an] apparent injury demands an immediate response to save life [for example] hanging prisoner, severe bleeding."

63. Although Officer B would have been expected to enter the cell in an obvious emergency, he said it was not clear whether the man was asleep or unconscious. In light of this and his previous volatile and unpredictable behaviour, we consider that the officer's actions were understandable. Although we would have expected the officer to have opened the cell when the nurse requested, we accept that the situation was unknown at the time and there was no undue delay.

64. Dorchester's contingency plans on an apparent death state that staff should:

> "Check for signs of life [and] administer first aid … unless rigor mortis (a stiffening of the body after death) has set in."

65. The nurse found no signs of life when he examined the man: he was not breathing, he had no pulse and there was evidence of rigor mortis. Even so, he attempted resuscitation and efforts continued until ambulance paramedics arrived and declared that he was dead. The investigator was unable to interview the nurse to clarify his rationale for attempting resuscitation as he had been on long term sick leave for some time. As rigor mortis was present we would not have expected a resuscitation attempt.