PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

# Investigation into the circumstances surrounding the death of a man in July 2011 at HMP Dovegate

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

## February 2013

This is the report of an investigation into the death of a man in July 2011. He was found unresponsive in his cell on the inpatient unit at HMP Dovegate. The post mortem found that he died from heart disease, which caused fluid to build on his lungs. He was 52 years old. I extend my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received at Dovegate. Dovegate prison co-operated fully with the investigation. I apologise for the delay to this report.

The man was serving a life sentence and had been in prison since 2000. He had mental health problems and spent some 20 months in a secure hospital between 2008 and February 2010, after which he returned to Dovegate. On his return to prison, he apparently had no major physical health problems. However this investigation found that healthcare staff at Dovegate missed a number of opportunities to carry out appropriate tests and checks.

On 7 July 2011, his mental health began to deteriorate and, on 12 July, he was admitted to the prison inpatient unit for closer monitoring. It seems that his mental health conditions and the possibility that he had taken illicit substances might have masked the symptoms of physical illness. Healthcare staff considered that he might be physically unwell on 13 July and ordered tests, but these had not been carried out before his death.

In the absence of diagnostic tests which might have revealed his heart disease, it seems that the man did not show clear symptoms of a serious physical illness. While this report concludes that his mental health needs were being addressed by Dovegate, it also identifies concerns about other aspects of the clinical care he received. This care fell below the standard to which he was entitled and was not equivalent to that which he might have expected in the community.

The National Offender Management Service (NOMS) and the man's next of kin have both responded to the draft report. Their comments have been taken into account. I am pleased that NOMS have accepted the recommendations.

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** **February 2013**

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**SUMMARY**

1. In September 2000, the man was sentenced to life imprisonment after being found guilty of murder. He arrived at Dovegate in February 2008 but, in June of that year, transferred under the Mental Health Act to a secure hospital for treatment. While there, he was diagnosed with personality disorders and was prescribed anti-psychotic medication. In February 2010, he returned to Dovegate. His mental health issues were documented and hospital staff noted that he had no major physical health problems; however, he was obese and had slightly high blood pressure.

2. In October, the man reported blood in his urine and faeces and the psychiatrist reviewing him suggested that he undergo an annual health check and tests to ensure that he did not have cancer. Nothing was done as a result. A blood test carried out in December indicated an abnormality. Again, there is no evidence that this was followed up.

3. In February 2011, one of the prison doctors prescribed medication to help the man lose weight (which apparently had little effect). He was also prescribed pain relief medication and antidepressants.

4. Three months later, the man complained of hallucinations. The dose of his anti-psychotic medication was raised and he was also prescribed medication to treat anxiety. In May, he told his mental health case manager (a community psychiatric nurse) that he did not sleep well and often experienced palpitations in his stomach. The nurse referred him for a blood test and a test to measure the heart's electrical activity. Neither test was performed.

5. On several occasions, the man tested positive for drugs. Sometimes this was the result of his prescribed medication and he consistently denied having taken any illicit substances.

6. On 7 July, wing officers placed the man on suicide and self harm prevention measures because they were worried about him. Over the following days, he was regularly checked by staff and his mental health continued to cause concern. He began to sleep for long periods during the day, his speech sounded slurred and his movements were lethargic and slow. Staff thought that he was no longer taking proper care of himself. The prison doctor adjusted his prescribed medication because she thought he was over-sedated.

7. On 12 July, the man was admitted to the acute admissions unit (the prison inpatient unit) for closer monitoring of his mental and physical health. He underwent another drug test which indicated that he had taken cocaine (a stimulant). His medication was not given over the next few days because of his extremely sedated presentation.

8. The man was assessed by a psychiatrist on 13 July, who thought that he was suffering an underlying physical health problem. The psychiatrist and prison doctor agreed that he should undergo several tests. These had not been carried out by the time of his death.

9. The man slept for much of the day on 13 and 14 July. The next morning, a member of night staff checked him shortly after 4.30am and could not rouse him. The night manager attended and he and a nurse went into his cell. Staff and paramedics attempted to resuscitate him, but were unsuccessful. His death was pronounced at 5.02am. The post mortem showed that his death was the result of heart disease, which led to the build up of fluid on his lungs.

10. Although there were apparently no clear signs to suggest that the man was suffering with heart disease, we make ten recommendations as a result of the investigation. We conclude that the standard of clinical care offered to him at Dovegate was not of an equivalent standard to that he might have received in the community. In fact, the clinical reviewer finds that the care he received fell well below that he was entitled to.

## THE INVESTIGATION PROCESS

11. The Ombudsman's office was informed of the man's death on 15 July 2011. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No further information was received.

12. The investigator visited Dovegate on 19 July and met a number of people, including the Director, Head of Healthcare and staff who knew the man. He visited the man's cell on houseblock one and his room in the prison inpatient unit. Dovegate provided copies of his prison and medical record.

13. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received at Dovegate. The final copy of this review was received in June 2012 following further discussions with the PCT, which, along with workload pressures in our own office, delayed this report.

14. The investigator carried out interviews with prison and healthcare staff in January 2012. Some of the interviews were conducted jointly with the clinical reviewer. He provided verbal and written feedback to Dovegate following the interviews.

15. HM Coroner for the South Staffordshire district was informed of the investigation and provided the results of the post mortem investigation. The Coroner will be sent a copy of this report to assist with his enquiries.

16. One of the Ombudsman's family liaison officers contacted the man's next of kin, his former partner, outlining the purpose of the investigation and inviting her to raise any concerns. At a meeting with the family liaison officer and the investigator, the man's former partner asked:

    - Whether he had been diagnosed with a mental illness?
    - Why he had been admitted to the prison inpatient unit?
    - What assessments he received for his physical and mental health?
    - Whether his mental health symptoms might have masked his physical health problems?
    - Whether he was issued his medication in possession (meaning that he was responsible for taking the correct doses)?
    - Whether the medication that he was prescribed might have exacerbated an underlying heart condition?

17. The man's next of kin wrote to us in response to the draft report. While she was happy with the actions of uniformed staff and the art therapist, overall she was very dissatisfied with the level of healthcare in HMP Dovegate. She felt that Serco should be held accountable for their lack of training, poor record keeping, and for failing to put in place recommendations as a result of previous deaths at the prison. She also believed that if her former partner had had the diagnostic tests he should have had in July 2011, or been referred to a hospital sooner, his condition may have been diagnosed and his death prevented.

## HMP DOVEGATE

18. HMP Dovegate is a category B prison, privately run by Serco. The prison opened in 2001 and holds over 1,100 adult male prisoners either on remand or convicted.

19. Primary healthcare at Dovegate is provided by Serco Health, including an 11 bed inpatient unit. South Staffordshire and Shropshire NHS provide the mental health in-reach service, for prisoners diagnosed with a severe and enduring mental illness. Prisoners with less severe mental health problems, such as depression and anxiety, are treated by the prison doctors and Serco Health employed mental health nurses. In March 2011, Dovegate moved from handwritten paper based medical records to a computerised medical record system, SystmOne. Before that date, healthcare staff maintained paper records.

### HM Inspectorate of Prisons (HMIP)

20. The most recent published report on Dovegate by HMIP followed an unannounced short follow up inspection in October 2011. The report found that the prison had made good progress addressing the healthcare related recommendations made following the previous inspection in 2008. HMIP highlighted good partnership working between prison and healthcare staff. The inpatient regime had improved as had mental health services, which were now well regarded.

21. At the 2008 inspection, HMIP recommended that the number and skill mix of staff in the healthcare department should be reviewed. By the time of the 2011 inspection this had been achieved. In 2008, HMIP also recommended that the prison develop healthcare policies for the management of older prisoners (considered to be those aged over 50). In 2011, the Inspectorate reported that Serco used the national service framework for older adults to guide provision and there was a lead nurse for the care of older adults. In 2008, HMIP made ten pharmacy related recommendations, all of which had been partially or fully achieved by the time of the follow up inspection. Since the last inspection, a senior nurse and a healthcare assistant were based on the inpatient unit throughout the day. Interactions between staff and inpatients were good.

### Independent Monitoring Board (IMB)

22. Each prison is monitored by an Independent Monitoring Board of unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained. The most recent IMB annual report for Dovegate covers the period 1 October 2010 to 30 September 2011.

23. The Board praised the significant improvements in the management of healthcare provision. They noted that the inpatient unit was generally very busy with many inpatients suffering mental health problems and monitored under suicide prevention measures, increasing the workload of staff in the unit.

Although the number of healthcare related complaints by prisoners was still high, the Board wrote that provision was improving.

### Previous deaths at HMP Dovegate

24. The man was the 15th prisoner to die at Dovegate since the Ombudsman began investigating all deaths in prisons in 2004. It is most disappointing to find that some of the recommendations we make in this report have been made several times in earlier investigations. In particular, we have raised concerns about the standard of record keeping, the failure to undertake and record interventions and the management of medicines.

### Personality disorder

25. A personality disorder is a mental health condition, which affects how the individual thinks and feels. There are many different types of personality disorders, each with different symptoms. However, some of the more common symptoms include anxiety, depression, being emotionally "disconnected" and having difficulty maintaining close relationships.

26. Personality disorders are usually treated with long term psychological therapies (normally based around talking therapies). There is no licensed medication to treat personality disorders although some patients find medication such as antidepressants helpful in managing some of their symptoms.

### Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.

## KEY EVENTS

28. On 26 September 2000, the man was convicted of murder and sentenced to life imprisonment. He spent the first eight years of his sentence at HMP Long Lartin, before moving to Dovegate on 12 February 2008.

29. The man had a history of mental health problems and had misused alcohol for many years. In 1997, while on remand, a psychiatrist concluded that he did not have a mental illness but did have "significant personality difficulties strongly suggestive of a sociopathic personality disorder". (Some mental health specialists do not consider people with personality disorders to be mentally ill, regarding the behaviours present as manipulative and within the individual's control.)

30. However, in June 2008, the man transferred to hospital for psychiatric evaluation and treatment under the provisions of sections 47/49 of the Mental Health Act 1983. In 2009, hospital staff found that he showed signs of having paranoid, schizotypal and antisocial personality disorders. (Individuals with paranoid and schizotypal personality disorders often prefer social isolation and find maintaining relationships difficult. They may have strange or eccentric beliefs. Antisocial personality disorders result in a disregard for the rights of others.) While at the hospital, he was also assessed for sleep apnoea (interrupted breathing during sleep) but it seems that no formal diagnosis was made.

31. In November 2009, hospital staff concluded that the man did not have a treatable mental illness and could be returned to prison, preferably to a prison able to manage his personality disorders. His return to Dovegate, the prison from which he had transferred to hospital, was arranged.

32. On 3 February 2010, the hhospital compiled a discharge summary in advance of the man's return to Dovegate on 8 February. Hospital staff recorded that he was prescribed olanzapine 10 milligram (mg) tablets and aspirin 75mg. The records do not show why he was taking aspirin. (Olanzapine is approved for the treatment of schizophrenia and bipolar disorder and is sometimes used to treat anxiety disorders.) The discharge summary recorded that he had mental and behavioural disorders due to his history of alcohol misuse and he sometimes complained of hearing voices. However, they recorded that he had no major physical health problems. His blood pressure was 132/86 (which is slightly higher than normal) and his weight was 147.2 kilograms (kg).

33. On arrival at Dovegate on 8 February, the man's blood pressure was recorded as 150/86, which was, again, higher than normal. On 10 February, his olanzapine prescription was confirmed and continued. He did not hold any of his medications in possession but was required to collect them from the wing treatment hatch according to the dose. On 19 February, he complained that he had not received any medication since arriving at Dovegate. Staff investigated and confirmed this was the case, noting that he had not collected his medication. (Prisoners are normally expected to collect their prescribed medication from the healthcare centre or a wing treatment room at set times of

the day.) The matter was resolved and he began taking olanzapine the following day.

34. The man made an application to the healthcare centre on 1 March. He wrote that he had not seen anyone from the mental health in-reach team (MHIT) since arriving at the prison. He said that he was “cooped up” in his cell 23 hours a day with no one to talk to and that he was “going off his head”. He said that he was having problems with voices in his head. It is not clear from the medical records copied to our investigator when he was first seen by the MHIT, but a mental health nurse signed the record application form on 5 April, noting that he was on the MHIT caseload.

35. On 21 May, the man complained of feeling unwell and lacking energy. He was seen by a member of the MHIT who requested that he undergo a routine annual health check. There is no record to confirm whether the health check took place.

36. The man was subject to a drug test on 4 June, which indicated that he had used drugs which were believed to be illicit. However, healthcare staff confirmed that he was prescribed medication, which was the likely cause of the positive test.

37. The man’s blood was tested on 17 June and the results showed he had a raised cholesterol level. High cholesterol levels can lead to the narrowing and hardening of the arteries. It seems that no action was taken as a result of the test.

38. On 8 September, the man’s olanzapine was increased to 15mg a day. The reason for the raised dose is not recorded. He was seen in a nurse-led clinic on 21 September, when he complained of pain in his hips over the past three months. He was prescribed tramadol (used to treat moderate to moderately severe pain).

39. A Consultant Forensic Psychiatrist reviewed the man on 26 October. He said that for the last two weeks, he had passed dark coloured urine and had fresh blood in his stools. She recommended that he have an annual health check and that various specific tests were carried out because he was at high risk of developing bowel cancer. There is nothing in his medical record to indicate that any further action was taken in response to the psychiatrist’s recommendation.

40. A prison doctor assessed the man on 18 November, after a mental health nurse referred him to her. In interview, she said that she knew that he had mental health problems and that, on this occasion, he seemed distressed. She prescribed lorazepam (for the short term treatment of anxiety) for five days because he seemed agitated.

41. On 22 November, the man’s olanzapine prescription was stopped and then restarted by a doctor on 6 December. There is no entry in his medical record to explain this.

42. The man's blood was tested again on 14 December and showed a raised glucose level (which can be a sign of diabetes). There are no further entries about this until 7 March 2011, when a mental health nurse noted that no action had been taken in response to the test results. The nurse requested a further blood test, but there is no evidence that this was acted upon.

43. The man was prescribed citalopram (an antidepressant) on 22 February 2011. There is no further information to explain the reason for the prescription.

44. On 24 March, Dovegate began using SystmOne, a computerised medical record system, although some staff continued to make handwritten entries in his record until 27 April.

45. The man saw the doctor again on 30 March. He said that his mood was low because he had no contact with his family and faced years of imprisonment. She advised him to continue to take his medication. She recorded that his body mass index (a measure used to assess whether the patient is a healthy weight for their height) was well above the recommended level and prescribed orlistat (weight loss tablets) for three months. Orlistat can also help to reduce blood pressure and prevent the onset of diabetes. He was given advice about reducing his food portion size to help lose weight.

46. On 21 April, the man said that he was seeing spiders, but denied taking any illicit substances. His daily dose of olanzapine was increased to 20mg, which is generally the maximum daily dose prescribed. Olanzapine has many possible side effects including a dry mouth, dizziness, irritability, sedation, insomnia, constipation, weight gain and increased appetite. He was also prescribed 1mg of lorazepam for 14 days (ending on 5 May). Lorazepam has strong sedative effects.

47. A Healthcare Assistant (HCA) conducted the man's well man check on 3 May. She recorded that his blood pressure was 98/88 (slightly outside normal limits), his pulse was 84 (within the normal range) and his blood oxygen level was 96 percent (to the lower end of normal). His weight was 147.42kg but his ideal weight was 94.68kg. It seems that no action was taken in response to the slightly abnormal test results.

48. A multi agency safety and health (MASH) meeting was held on 4 May. (Dovegate devised the MASH programme to manage more challenging prisoners.) During the meeting, the man's art psychotherapist (he was attending art sessions as part of his mental health treatment), said that he had seemed drowsy during a recent session. He had been taking lorazepam and the increased olanzapine dose for two weeks. Staff agreed that he should only be receiving the lorazepam as required and not necessarily every day. A mental health nurse made a note on his file that medication should only be given to him if there was a clinical need. She also passed this information to the Community Psychiatric Nurse (CPN), his mental health care co-ordinator (who is responsible for monitoring and arranging the patient's mental health care).

49. At 4.20pm that afternoon, the man saw a doctor, who recorded that, while he was still depressed, his mood seemed better than at their last appointment. She concluded that he should continue to take citalopram. She noted that he was still taking orlistat but was also using the gym and trying to eat smaller portions. He was still complaining of chronic pain in his hips, which she concluded was probably being made worse by his weight. She prescribed paracetamol in addition to tramadol, to help relieve the pain.

50. The CPN was due to see the man on 11 May but had to cancel the appointment. She saw him on A wing, where he lived, and told him that he had an appointment with a prison doctor the following morning. There is no record of a consultation with the doctor in his medical notes, but according to his prescription charts, the doctor prescribed him lorazepam for ten days. (The prescription was written on a chart dating from August 2010.)

51. On 19 May, the man had an appointment with the CPN. He told her that he was still seeing spiders every day (including during the appointment). He said that the spiders did not hurt him but that he was fed up with them. He said that he frequently experienced palpitations or "butterflies" in his stomach and that his hands were unsteady. He said that his sleep was erratic. She ordered blood tests and an electrocardiogram (ECG, a test to show whether the heart is functioning normally).

52. On 27 May, a nurse recorded that she had been unable to obtain a blood sample, it is not clear why. The man was weighed and had lost about a kilogram since 3 May. He was told to come to the clinic the following week for his blood test. There are no entries suggesting that an ECG was carried out.

53. The CPN visited the man on the wing on 1 June. She noted that he looked well kempt, did not appear anxious or uneasy and seemed more positive. The nurse recorded that he had recently tested positive for subutex (a heroin substitute medication), which he denied having taken. He said that he was no longer seeing spiders and she concluded that he did not need to be prescribed lorazepam any longer. She reminded him to attend appointments with the nurse to check his physical health.

54. The man failed to attend an appointment for his blood test on 7 June. The following day, he told a nurse that he was hearing voices, which he described as demons. Officers told the nurse that he seemed anxious and had been pacing around the wing.

55. On 14 June, the man missed another appointment for his blood test. The CPN saw him again on 15 June. She noted that he knew he had missed his blood test appointments. Otherwise, he appeared well kempt and seemed settled. She noted that officers on his wing were supportive. She reviewed his medication charts and noted that he had been taking most of his medication as prescribed but that he sometimes missed his paracetamol doses. She recorded that the nurse dispensing medication on his wing was also supportive and had agreed to contact the MHIT if there were any concerns.

56. The man's next appointment with the CPN was on 22 June. She recorded that he seemed calm and relaxed but that he was seeing spiders all over his body, which he found irritating. He said that he had tested positive for opiate drugs in a recent drug test, but that this was the result of his prescribed medication not illicit drug use. He said that he sometimes thought about drinking 'hooch' (illicitly brewed alcohol) to help him cope and she warned him about the dangers of this. He said he generally felt anxious and asked to be prescribed lorazepam again. She asked the nurse in the wing treatment room to arrange this. She reminded him that it was important he attended his physical health appointments. On 24 June, he was prescribed 0.5mg of lorazepam twice a day for 12 days.

57. The CPN saw the man again a week later, on 29 June. He continued to see spiders from time to time and said that the prescribed lorazepam was not helping. She gave him some written material to help him manage his anxiety. By the end of the appointment, he seemed in good spirits.

58. On the morning of 5 July, a doctor saw the man at the wing treatment hatch. She described him as "twitching with lorazepam". (One of the side effects of lorazepam can be ataxia – a lack of coordination of muscle movements). He said that he was still seeing spiders and felt as if they were crawling over his body. The doctor noted that he had not experienced any muscle twitching when he had previously been prescribed lorazepam but suggested that he try diazepam (prescribed to ease anxiety) instead. He agreed and she prescribed 10mg of diazepam to be taken three times a day.

59. At 2.00pm on 7 July, the man approached a Prison Custody Officer (PCO) and said that he was missing a fellow prisoner who had recently been transferred to another prison. He then wandered around the wing, staring at the walls and stairs. A PCO told the nurse in the treatment room that the man did not seem well. Later that day, the PCO asked him if he was okay. He said that he felt a nuisance and would be better off taking his life. The PCO promptly opened an ACCT plan. The unit manager directed that, until the ACCT assessment interview had taken place, staff check him once an hour and try to engage him in conversation. This was not the first time that he had been monitored on an ACCT plan.

60. An officer conducted the ACCT assessment interview at 8.00am the following day. The man told her that he was fed up of living and that voices in his head were telling him to kill himself. He said that spiders were crawling over his body and the walls were moving. While he had not harmed himself yet, she recorded that he had definite thoughts of killing himself. He said that he would never see or have contact with his children and that he had nothing to live for and could not go on.

61. At 10.15am, the unit manager, wing officer, a PCO, and a member of the psychology department and the man met for the first ACCT case review. The group reviewed what he had said to the wing officer and concluded that he posed a low risk to himself. Staff were instructed to check him twice an hour and engage him in conversation when possible.

62. The Caremap section of the ACCT plan was also completed during the meeting. (The Caremap identifies the prisoner's most urgent and pressing issues, sets achievable goals to help resolve the issues and identifies who is responsible for resolving each goal.) Two issues were recorded on the man's Caremap. The first was that he was upset at having lost contact with his family and he was encouraged to submit an application to the prison family liaison officer to discuss this. He was also worried that he would be labelled a "grass" by other prisoners if they saw him talking to staff. The unit manager recorded that wing staff should continue to encourage him to talk to them if he needed to. The next case review was due to take place on 15 July.

63. That afternoon, the man was moved to a different cell on the wing. In interview, the unit manager said that this was because of a problem between him and the prisoner in the cell next door. The PCO said he was moved to a cell closer to the office so that wing staff could keep a better eye on him. Another PCO noted in the ACCT ongoing record (which records details of staff observations and interactions with the prisoner) that the new cell was larger and did not involve climbing stairs and he was happy about the move.

64. At 7.20am on 9 July, a Security Officer (SO) (who works night shifts at the prison) recorded that the man had pains and cramps in his legs but 20 minutes later, he had gone back to sleep. He was out of his cell in the morning, but slept between 1.40pm and 3.45pm and again from 5.40pm to 7.35pm. He used the telephone in the evening and watched television, before falling asleep again at about 9.00pm. At 11.10pm, he woke and told the SO that he had more pains in his legs. The SO contacted the control room and, shortly before midnight, a nurse came to see him in his cell and gave him paracetamol for the pain. The SO recorded that his knees looked swollen. The nurse did not make an entry in his medical record. After receiving the medication, he appeared to sleep well until about 8.00am.

65. The man collected his medication at about 8.40am on 10 July and, when asked by an officer, said that his legs were feeling better. At 9.20am, he (who was employed as one of the wing cleaners) cleaned the wing. He told a PCO that his legs were still hurting. At 10.30am, he returned to his cell and slept until he was woken for lunch at 12.15pm. He slept again for an hour after lunch. At 3.10pm, he told a nurse that he had fallen out of bed. She said that she would try and arrange for him to see the doctor. (The nurse did not make an entry in his medical record, instead making one in the ACCT plan, and it seems he did not see a doctor that day.)

66. The man telephoned a friend shortly after 9.20pm that evening. (All telephone calls made by prisoners are recorded. Prison staff can monitor calls either on a random basis or if there is any information suggesting monitoring is necessary. As part of the investigation, the investigator was provided with transcripts of the calls he made in the days before his death. There is nothing to indicate that prison staff monitored his telephone calls.) During the call, his friend commented that he sounded sleepy and was slurring his words. He said that he thought he should see the doctor and that he might be on the wrong

medication. After the call, he returned to his cell and fell asleep at about 10.30pm.

67. On 11 July, a HCA saw the man when he came to the wing treatment hatch. He said that he was still seeing spiders, the walls were shaking and he was hearing voices. He said he wanted to kill himself. The HCA spoke to a doctor, who said that she would review his medication.

68. That morning, the man told a PCO that he had been feeling out of breath recently and that was why he had moved cell. He described hearing voices and said that he felt anxious. At 10.00am, a PCO recorded that someone from the mental health team had come to see him and spent about half an hour with him. There is no corresponding entry in his medical record.

69. The man slept in his cell between 1.00pm and 2.00pm, then carried out his wing cleaning tasks and talked to other prisoners. At 2.40pm, a PCO noted that his mood seemed low, that his movement was very laboured and his speech was slow and slurred. At 2.59pm, a PCO wrote that he had called the MHIT because he was concerned about him. He described him as seeming vacant, aggressive and extremely paranoid. The PCO wrote that his cell and clothes smelt of urine. It seems that he did not see anyone from the MHIT that day.

**Events leading up to the incident**

70. A PCO noted that the man was awake and making a telephone call at 7.45am on 12 July. A few minutes later, another PCO spoke to him, who appeared to be in a very low mood. He said that the voices were telling him he was worthless. The PCO wrote that his cell was very dirty. Another officer noted that he had not eaten his dinner from the night before.

71. At 9.20am, the man went to the treatment hatch on the wing and saw a doctor. She noted that he seemed to be over-sedated. A PCO described his speech as very slurred and lethargic. He told the doctor that he was still seeing spiders, but she considered that he seemed less anxious and had no apparent side effects from the diazepam. However, she decided to reduce his daily dose of diazepam to 5mg tablets, taken three times a day and review him again in a week.

72. The man had an appointment with a mental health nurse at about 10.20am in the healthcare centre, following officers concerns the previous day. She wrote that he was extremely unkempt and that his clothes were dirty. He said that his mental health had deteriorated over the last three days, but he did not know why. He said that he could feel spiders running over his body. The nurse wrote that he struggled to stay awake during the appointment and fell asleep several times. He said that he was sleeping well at night but could not tell the nurse if he was eating or not. She carried out a urine test, which tested positive for blood (which can be a sign of infection or other health problems). He also said that he had blood in his stools. She carried out a drug test, which was positive for benzodiazepines (because he was prescribed diazepam) and

cocaine (and the information was submitted to the security department later that day). His blood pressure was 146/76 (slightly higher than normal)

73. The nurse decided that the man should be admitted to the prison inpatient unit for further observations of his physical and mental health. In interview, she said that he was so drowsy during their appointment that she thought he might have an underlying physical health problem. She thought that he would benefit from increased nursing care in the inpatient unit. He was admitted to the unit straightaway.

74. The man came out of his cell for lunch at 11.50am, but fell asleep at the table and so was returned to his cell. At 3.02pm, a HCA wrote that he had wet himself twice since arriving on the unit and so she had been unable to take a sample of urine for testing. She noted that he was being checked once an hour. She wrote that she had asked a doctor to assess him, but was told that the doctor had already seen him that day and that nursing staff would need to carry out an assessment of his clinical needs if they wanted her to assess him again. She took his blood pressure reading again and it was 146/79.

75. A doctor came to see the man at 4.51pm. She wrote that his speech was almost unintelligible and that he appeared to be extremely sedated. She added that it was hard to establish whether he felt unwell because he was so sedated. She noted that his main issue seemed to be panic attacks, linked to the spiders he thought he could see and feel. The doctor said that she would assess him again the following day.

76. Entries in the man's ACCT plan detail that, having slept through most of the afternoon. He was unlocked for his evening meal at 5.30pm, however he said that he was not hungry, and went back to sleep for the rest of the evening. Because he seemed so sedated and had tested positive for cocaine, he was not given his 6.00pm medication. He woke at 11.00pm, having a panic attack. The night nurse gave him some paracetamol, which calmed him, and he went back to sleep. This is recorded on the ACCT but not recorded in his medical record. He apparently slept soundly the rest of the night.

77. The next morning, 13 July, the MHIT leader saw the man just after 10.20am. She recorded that he still appeared very sedated and unsteady on his feet and so he was not given his morning medication. He denied taking any illicit substances.

78. A doctor saw the man at midday and noted that he was more coherent than the previous day. He said that he had seen blood in his urine and stools for the past three weeks but he was reluctant to be examined. She wrote that he would need to be examined if he was still passing blood the following week. She ordered a urine test and directed that he remain an inpatient.

79. The man saw the MHIT psychiatrist and the CPN a short time later. He told them he had thought about hanging himself the previous day and about cutting his arms with a razor. He said that he still had thoughts of harming himself. The CPN recorded that, following discussions between the psychiatrist, doctor

and herself, a full physical health check, bloods and an ECG had been requested. She did not record whether the checks were considered to be urgent or who should carry them out. The psychiatrist faxed a letter to the prison doctors summarising his findings and the treatment plan agreed with the doctor, but this arrived after his death.

80. At 4.10pm on 13 July, the man made a telephone call to a friend. He said that his food or drink had been spiked with cocaine, which had resulted in the positive drugs test.

81. A HCA saw the man again just before 5.00pm. He still seemed over-sedated and so, following discussion with the doctor, he was not given his medication. An entry in the ACCT at 6.00pm noted that he had eaten his lunch and dinner that day. The HCA wrote that he would be assessed the following day, with a view to receiving his medication as normal. (His medication had now been withheld for 24 hours.)

82. The following morning, a PCO noted that the man had wet his bedding but otherwise seemed alright. Shortly after, he saw a nurse, who collected urine and stool samples. She recorded that the urine tested positive for blood and protein (indicating that the kidneys might not be functioning properly). He was prescribed loperamide (to treat diarrhoea) because he was passing faecal fluid and was advised not to eat for 24 hours and to drink plain boiled water. He was not given his morning dose of diazepam but did take his prescribed dihydrocodeine (which was prescribed for hip pain), aspirin and citalopram. He showered and then slept from 11.00am until 4.00pm. At 4.25pm, he was given his medication and a drink of water but went straight back to sleep.

83. At 4.47pm, a doctor noted that the man was due a blood test and that all of the necessary paperwork had been completed. However, there is no record of any bloods being taken. No mention was made of the full physical check or ECG agreed the previous day.

84. A PCO woke the man up at 6.00pm, in order to give him some more water to drink. He woke briefly at 7.00pm, but was asleep again by 7.30pm. SO A was on duty overnight in the inpatient unit and received the handover from the PCO. She told the SO that he had been on fluids that day and that he was passing blood in his urine and stools. She said that he had been given incontinence pads to wear overnight. In interview, the SO said that he was not made aware of a fluid chart (which monitors how much fluid a patient has drunk over a set period).

85. In interview the duty manager in charge of Dovegate on the night of 14 July explained that his duty involved visiting all areas of the prison, checking ACCT plans and dealing with any incidents that arose. He explained that security officers each carry a sealed pouch with a cell key in it, which they can use to enter a cell in an emergency (which is standard practice and means that entering cells at night is easily monitored).

86. Only one nurse is on duty overnight. Her shift started at 8.00pm but she was initially based in the reception area. She said that, as far as she knew, she was not expected to carry out medical observations (for example, blood pressure or pulse readings) on the man overnight and had not received any information about him in the shift handover. In interview, the nurse said that it was difficult to carry out medical observations at night because unlocking a cell, except in an emergency, required the night manager and another member of staff to be present. The nurse arrived on the inpatient unit sometime after 11.00pm, and he was asleep.

87. SO B was also on duty that night and he and SO A shared the duties, including checking prisoners on ACCT plans, between them. According to entries in the man's ACCT plan, he was checked roughly every half an hour, except between 12.35am and 1.20am. In interview, SO B explained that, in his view, the purpose of the ACCT observation was to check for any signs of self harm. He said that, if the prisoner seemed to be asleep, he checked for signs that they were breathing. He said that he could normally hear whether the prisoner was breathing because the unit was generally quiet at night. However, he said that if he had any concerns, he would wake the prisoner. He said that the man sometimes snored loudly.

88. SO B checked the man at 4.00am and recorded no concerns. SO A then took over his ACCT checks. At 4.34am, SO A looked into the man's cell and could not see any movement or signs that he was breathing. His left hand was visible and the SO thought it looked unnaturally pale. He could not see his face, which was turned towards the wall. He tried to rouse him but got no response. He called to the nurse, who joined him at the cell door. The nurse could not rouse him either and so, at 4.36am, she used her radio to call for the night manager.

89. The nurse collected the emergency medical bag, defibrillator (which can help to restart the heart by delivering an electric shock) and oxygen from a room close by. The duty manager was a few minutes away from the inpatient unit when he heard the radio call. He and a PCO arrived at the cell at 4.40am and they and the nurse went in. The nurse tried to wake the man but he did not respond and so she asked the officers to move him to the floor so that she could commence cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to move oxygen around the body). At 4.45am, the duty manager used his radio to request that an emergency ambulance be called.

90. The nurse attached the defibrillator pads to the man's chest, but the machine instructed that no shock be given and that staff attempt CPR. The PCO delivered chest compressions while the nurse gave him oxygen. The nurse said that he felt warm to the touch and so she was hopeful that he could be resuscitated.

91. The first response paramedic vehicle arrived at Dovegate at 4.50am and the paramedics reached the cell about four minutes later. An ambulance arrived at 4.58am. The paramedics carried out a number of tests but, at 5.02am, they concluded that he had died.

## Contact with the man's family

92. Following the man's death, a prison's family liaison officer (FLO) was appointed. The man had apparently not had contact with any family since 2008 and during a review of next of kin contact details in 2011, he had declined to provide up to date information. The FLO contacted the man's solicitor and then a victim liaison officer for details of any listed next of kin. Neither could provide contact details for any of his family and so the local police were asked to assist. Later in the afternoon of 15 July, the victim liaison officer confirmed that he had broken the news of his death to the grandmother of the man's son, who had, in turn, informed her daughter (the man's former partner and the mother of his son).

93. The FLO spoke to the man's former partner (who became the sole point of contact with the prison) on 15 July. In line with national guidelines, the prison offered a financial contribution towards the cost of the funeral. Initially, the FLO offered to attend the funeral and return his property to the family in person. However, on 28 July, she tried to contact the man's former partner to let her know that she would not be able to come to the funeral because it was being held in Cornwall (approximately 300 miles from Dovegate). She was apparently unable to speak to her directly, but left a telephone message for her, saying that the prison would send flowers.

94. Over the following few days, the FLO and the man's former partner both tried to contact each other on several occasions, but were unable to speak until 6 August. The FLO said that she would arrange for the man's property to be delivered by courier at his former partner's address. During the telephone conversation, the man's former partner said that she had complained about her to other prison staff she had spoken to over the preceding days. According to the family liaison log, she apologised and said that the FLO had been supportive and helpful.

95. The man's belongings were delivered on 11 August. In a telephone conversation that day, his former partner said that she was unhappy with the courier who had delivered them, but did not want to discuss it further. On 18 August, the FLO wrote that she had explained she would continue to offer support to her, but that, over time, the level of contact would decrease. She wrote that she understood this.

96. In September 2011, the man's former partner expressed some concerns about her liaison with the prison. She told our family liaison officer that the FLO asked to attend the funeral to represent the prison and offered to return the man's property to his family on the day of the funeral. She described being touched and pleased that someone from the prison would be at the funeral. She was, therefore, disappointed to learn subsequently from the funeral directors that no one from the prison would attend. The property was returned to her by courier. She said that, despite what she had been told by the FLO, the property had not been sorted before being sent to her.

97. The prison said that following a discussion between the FLO and the man's former partner, the former partner was clear that she did not want to receive her former partner's clothing, but was keen to have his personal possessions and all his paperwork. The items were listed and packed and sent by courier. Money that had been credited to his account was also accounted for and sent under separate cover by recorded delivery.

98. The man's former partner also described finding it increasingly difficult to contact the FLO, despite initial assurances from her that she would offer support for as long as it was needed. She said that on several occasions she telephoned and left messages for her, which were not returned. On one occasion, she raised her frustrations with the FLO's supervisor and received an apology. She described being increasingly reluctant to contact the prison because she felt she was becoming an inconvenience.

99. The prison said that the FLO's supervisor had not been made aware of these concerns. The FLO was on leave for a period in August 2011 but alternative arrangements were put in place for the man's former partner to contact the prison in her absence.

**Support for staff and prisoners**

100. In line with national guidance, all of the staff involved in the incident were invited to a debrief meeting on the morning of 15 July. The prison care team offered further support to staff.

101. The man was particularly friendly with three prisoners at Dovegate and they were personally told of his death. All three were peer support workers (who have been trained to offer support to other prisoners) and were aware of the support available to them.

102. Notices were posted around the prison to inform other prisoners of the man's death and an announcement was made at a meeting attended by prisoner representatives who were asked to share the news with prisoners on their wings. All prisoners who were on ACCT plans had their arrangements reviewed that day. A service was held at the prison for those prisoners who knew him.

**Post mortem and toxicology**

103. A post mortem was carried out on 19 July and found that the man's death was due to:

    1a pulmonary congestion and oedema
    1b ischaemic heart disease
    1c coronary artery atherosclerosis

104. The man died from an accumulation of fluid in his lungs, which was due to a reduced blood supply to the heart because of blockages in the arteries.

105. The toxicology examination found no trace of cocaine or other illicit substances in the man’s body. The only substances identified were those prescribed to him.

## ISSUES

106. The local PCT commissioned a clinical reviewer to review the clinical care the man received at Dovegate. Her review is detailed and lengthy. In her review, she makes a number of recommendations. In the ensuing discussion, we have reflected many of her concerns but have not repeated all of the recommendations she makes.

### Clinical care

*Assessing and treating the man's physical health needs*

107. The man returned to Dovegate from hospital in February 2010. The discharge summary completed by the hospital noted that there were identified mental health problems but no major physical health problems, although his blood pressure was slightly higher than normal and he was obese.

108. Over the following 17 months, there were a number of indications that the man had physical health problems, but it seems that they were not acted upon or fully investigated.

109. On 21 May 2010, healthcare staff noted that the man might benefit from a routine annual health check; it seems that this was not followed up. The doctor who assessed him on 26 October the same year repeated that he should be undergoing an annual health check. Annual health checks can include a variety of tests which monitor, for example, blood pressure, blood sugar levels and indications of some of the more common cancers and chronic illnesses. He did not undergo such a check while at Dovegate. During the investigation, the healthcare manager acknowledged that Dovegate was not currently offering annual health checks and that this area needed further investment. Although annual health checks were not available at the prison, we see no reason why he could not have undergone relevant and appropriate tests as required.

110. In June 2010, the man was found to have high cholesterol; in October, he described passing dark coloured urine and having blood in his stools; in December, tests revealed he had high glucose levels; in May 2011, tests showed he had slightly high blood pressure and slightly low blood oxygen levels. In interview, one doctor acknowledged that he was at risk of heart problems because he was prescribed olanzapine (which can affect the heart) and he was overweight. Despite the known risks, there is no evidence to suggest that any of these findings led to further investigations or that his physical health was being closely monitored and managed. It is extremely disappointing to find that we have raised such issues in past investigations at Dovegate and that we find ourselves repeating such recommendations here.

111. Dovegate's failure to respond to the man's apparently deteriorating physical health is most apparent in the weeks leading to his death. On 19 May, he told the CPN that he was experiencing palpitations or the feeling of butterflies in his stomach, had unsteady hands and was sleeping erratically. The nurse referred him for an ECG which was not carried out. The healthcare unit at Dovegate is

equipped with an ECG machine meaning that the test can be carried out on site by healthcare staff and we were told that most nurses have been trained to carry out the procedure. He was twice referred for an ECG in the days leading to his death, but did not undergo one. Interviews with staff revealed no good reason for this. Given that he died of heart related problems, such a test may very well have identified problems and any treatment may have commenced earlier. The failure to carry out the ECG is a serious omission.

**The Healthcare Manager should ensure that prisoners are referred for appropriate tests when a medical need has been identified, the tests are promptly carried out and the results recorded in the medical record.**

112. From 9 July, the man began to sleep for much of the day. Officers described him as slow moving and slurring his words. A doctor and other healthcare staff described him as seeming over-sedated. His medication, some of which had sedative effects, was reduced and then withheld for 24 hours. Urine tests carried out on 12 and 14 July showed the presence of blood and protein (sometimes indicating kidney problems). However, there is little evidence to indicate that healthcare staff properly considered whether there might be a more serious underlying physical condition causing these symptoms. We asked the doctor whether his mental health problems might have masked the symptoms of physical ill health. She explained that she had assumed that his over-sedated presentation was the result of illicit drug use. We are concerned that healthcare staff failed to consider other causes for his presentation; we are also concerned that there was no proper assessment of his over-sedation. We make the following recommendations:

**The Healthcare Manager should ensure that all healthcare staff properly investigate the symptoms of physical ill health, even when the prisoner has mental health problems or has tested positive for substances (or illicit substance use is suspected).**

**The Healthcare Manager should remind all healthcare staff that a diagnosis of over-sedation must be supported by an appropriate assessment of the prisoner.**

113. The clinical reviewer asked the Staffordshire cluster of PCT's deputy medical director whether healthcare staff at Dovegate should have detected the man's underlying heart disease. He concludes that, from the evidence in the medical record, there were no clear signs to indicate that he had heart disease, although his obesity put him at higher risk of this.

114. The PCT cluster medical prison health lead was asked whether the man's prescribed medications might have contributed to his death. He concludes that the undiagnosed heart and lung problems might have been aggravated by both his prescribed medication and any illicit substances he might have taken.

*Care in the inpatient unit*

115. On 12 July, as a result of his various unexplained symptoms, the mental health nurse decided that the man should be admitted to the inpatient unit for closer monitoring by nurses. However, the clinical reviewer identifies failings in the care he received in the inpatient unit and a lack of clarity about the role of the inpatient unit. She notes that the majority of entries made in his record while he was an inpatient were made by healthcare assistants. There was little evidence of nursing input despite his mental and physical health symptoms.

116. The nurse was on duty the night of 13 July and was apparently the only general nurse to have any contact with the man following his admittance to the unit. She said that she was not given any information about him at her shift handover and was not required to carry out any observations or checks on him overnight.

117. Dovegate's lead nurse told the clinical reviewer that, since the man's death, admissions criteria had been developed. The clinical reviewer was also told that any prisoner requiring nursing care during the night is transferred to outside hospital or to another prison that is able to offer those facilities. However, there remains a lack of clarity about the function of the inpatient unit at Dovegate. The clinical reviewer writes that continued ambiguity about the services delivered and the role of the inpatient unit at Dovegate would pose a very real threat to prisoners who are housed there. We make the following recommendation:

**Serco Health should review the inpatient unit at Dovegate at the earliest opportunity to:**

- **Identify and agree a service specification;**
- **Identify and install the required staff skill mix; and**
- **Produce a set of policies and procedures that support the provision of available treatment.**

118. Once admitted to the unit, no care plan was devised for the man setting out the reason for his admission, identifying his physical and mental health problems and the observations and treatment required while an inpatient. In fact, there is no record of his blood pressure, pulse, temperature or blood oxygen readings being taken after 12 July. We make the following recommendation:

**The Healthcare Manager should ensure that a detailed care plan, including physical and mental health problems, the frequency of observations and any required tests, is drawn up for every prisoner on their admittance to the inpatient unit and shared with all relevant healthcare staff.**

119. On the morning of 12 July, an officer noted in the ACCT plan that the man had not eaten the previous evening's meal. That day, he apparently did not eat either his lunch or dinner. On the evening of 13 July, he was advised not to eat for 24 hours. There are also entries in the ACCT plan relating to his fluid

consumption. On 14 July, while on a fluid only diet, he was woken by officers to ensure that he drank water. There is no evidence that healthcare staff were monitoring either his food or fluid intake.

**The Healthcare Manager should ensure that inpatients' fluid and food intake is properly monitored and recorded.**

120. The clinical reviewer also notes that officers recorded in the ACCT plan that the man had wet the bed several times since his admission to the unit and had been given continence pads. However, there is no evidence that a continence assessment had been carried out to rule out underlying causes or any care plan devised to manage possible side effects or the disposal of clinical waste. As a result, we make the following recommendation:

**The Healthcare Manager should ensure that prisoners undergo a full continence assessment if there is any evidence of continence problems and that a care plan is devised.**

*Medicines management and record keeping*

121. On a number of occasions, the prescribing, administration and recording of the man's medication fell below an acceptable standard, as did the maintenance of his medical record. He was prescribed olanzapine at hospital and on his arrival at Dovegate, in February 2010, the prescription was continued. However, he did not receive any medication until he had been at the prison for 12 days and had complained. In response, healthcare staff reported that he had not collected his medication. There is no evidence to suggest that staff were aware that he was not collecting medication prescribed for a mental health problem, or that they took any steps to investigate the reason.

122. On 22 November 2010, the olanzapine prescription was stopped and not restarted until 6 December, without explanation. The British National Formulary recommends a gradual withdrawal when discontinuing anti-psychotic treatment to avoid acute withdrawal syndrome or rapid relapse. In the absence of a clinical reason, it seems that the prescription was stopped in error and, therefore, without any support or supervision mechanisms in place to monitor the man's health.

123. The clinical reviewer highlights a number of errors and omissions in the completion of the man's medication charts, which made it difficult to be certain that he received his medication as prescribed. The charts did not always include the month of administration; the clinical reviewer notes that medication was apparently dispensed before it had been prescribed; and that multiple medication charts were being completed simultaneously. It seems that the generally poor completion of the charts meant that, on occasions, he was administered his medication twice, because healthcare staff were not clear that he had already received it.

124. We have raised concerns about the management of medicines at Dovegate previously. On this occasion, the issues were discussed during the

investigation with the Healthcare Manager and lead nurse at Dovegate who agreed that some key actions would be implemented with immediate effect. However we make the following recommendation:

**The Healthcare Manager should review the prescribing policy at Dovegate to ensure that it clearly states expectations in relation to medicines management and the completion of prescription charts.**

125. It seems that Dovegate worked hard to address the man's mental health needs. He had regular contact with mental health staff, his prescriptions were altered as necessary and staff responded quickly to concerns about his apparently worsening mental health. However, overall, we agree with the clinical reviewer's conclusion that the standard of clinical care he received at Dovegate fell well below what he was entitled to and what he might have received in the community.

**The emergency response**

126. When SO A looked into the man's cell he thought that something was wrong and that he was not breathing. He summoned help by calling the nurse over. When he could not be roused, they used a radio to ask that the duty manager attend. He was close to the healthcare centre and arrived within about four minutes of the radio call. SO A and the nurse did not unlock and enter the cell preferring to wait until the duty manager arrived.

127. The duty manager explained that, under normal circumstances, night staff were expected to wait until the night manager had arrived before unlocking a cell. However, he said that, in an emergency, staff could use the key they carry in a sealed pouch, normally after using their radio to ask for permission to enter the cell. The SO said that despite believing this was an emergency situation, he knew the duty manager was close by and so preferred to wait until he arrived.

128. Clearly, a prompt emergency response and commencement of resuscitation maximise the prisoner's chance of survival. It is probably a measure of staff lack of confidence that they chose to wait for the duty manager rather than go into the cell. Prison Service guidance states that the first person on the scene must enter the cell as soon as possible, following the local strategy for safely doing so. The guidance states that they may do so alone but in the event of concerns for personal safety they must inform the orderly officer, amongst other things, before proceeding. In this instance SO Padley was quickly joined by Nurse Mtombeni and we can see no reason why they did not enter the cell immediately to appropriately assess the man.

**The Director and Head of Healthcare should review the local strategy and ensure staff are aware of their responsibilities upon finding a prisoner in any state of collapse.**

## Contact with the man's next of kin

129. The man's former partner had some concerns about the quality of the liaison she received from Dovegate. She was disappointed that no one from the prison attended the funeral, despite being told that they would. She was also upset that his unsorted belongings were returned to her by courier rather than face to face. In addition she found it increasingly difficult to contact the FLO and, as a result, felt that she was a nuisance.

130. As detailed in the Key Events section of this report, the man's former partner raised some of her concerns with prison staff. According to the FLO's family liaison log, the former partner later apologised to her, who she said had been helpful. According to the log, she described feeling supported by the prison.

131. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer custody), which came into force in April 2012, contains guidance about the role of the family liaison officer including attending the funeral, returning belongings to the next of kin and managing ongoing contact with the family. It notes that, if the next of kin wish, a member of prison staff should attend the funeral. It also guides that the next of kin should be consulted about how they would like to receive the prisoner's property.

132. It is a shame that the FLO apparently did not discuss her reasons for not attending the funeral or returning the man's property in person with his former partner. We make the following recommendation:

**The Director should ensure that all family liaison officers are aware of and follow the guidance contained in PSI 64/2011 when dealing with a bereaved family.**

## CONCLUSION

133. The man was given a life sentence in 2000. He transferred to a secure psychiatric hospital in 2008, where he received treatment until his return to Dovegate in February 2010. On his return to prison, his mental health was well documented and he apparently had no major physical health problems. However, he was obese and had slightly high blood pressure.

134. In July 2011 he was found unresponsive in his cell in the inpatient unit and could not be resuscitated. The post mortem found that he died of fluid building on his lungs as a result of heart disease.

135. The man apparently displayed no clear symptoms of heart disease, and therefore we find that his death from the disease was not predictable. However it is clear that his physical health was deteriorating and we are concerned that staff failed to properly assess, record or treat him. His mental health needs were being addressed and met, but we are concerned that the concentration of staff on his mental health may have overshadowed his deteriorating physical health. We agree with the clinical reviewer's conclusion that the standard of clinical care he received at Dovegate fell well below what he was entitled to and what he might have received in the community.

## RECOMMENDATIONS

1. The Healthcare Manager should ensure that prisoners are referred for appropriate tests when a medical need has been identified, the tests are promptly carried out and the results recorded in the medical record.

   NOMS accepted this recommendation. They commented:

   > "System 1 is now utilised to allocate tasks across the primary care team. These are then allocated to the appropriate clinic for completion. A record of completion is maintained on the patient record and proof of attendance at the appropriate clinic recorded on there as well."

2. The Healthcare Manager should ensure that all healthcare staff properly investigate the symptoms of physical ill health, even when the prisoner has mental health problems or has tested positive for substances (or illicit substance use is suspected).

   NOMS accepted this recommendation. They commented:

   > "The Healthcare Manager has already facilitated training for all full time R.G.N's in the care of:-
   >
   > - Minor injuries
   > - Autonomous practice
   >
   > The Healthcare Manager cannot be held accountable for individual professional judgement made by a General Practitioner."

3. The Healthcare Manager should remind all healthcare staff that a diagnosis of over-sedation must be supported by an appropriate assessment of the prisoner.

   NOMS accepted this recommendation. They commented:

   > "The Healthcare Manager will remind all healthcare staff of this in team briefings over the course of a month.
   >
   > In addition to this, the Healthcare Manager will advise staff of the appropriate assessment tool that should be used to assess over-sedation where this symptom is present."

4. Serco Health should review the inpatient unit at Dovegate at the earliest opportunity to:

   - Identify and agree a service specification;
   - Identify and install the required staff skill mix; and
   - Produce a set of policies and procedures that support the provision of available treatment.

NOMS accepted this recommendation. They commented:

> "Serco Health and the Prison Director will review the use of the inpatient facility and make recommendations on its use, specification and appropriate skill mix. This will be handed over to the Director to install the required skill mix in accordance with the recommendation."

5. The Healthcare Manager should ensure that a detailed care plan, including physical and mental health problems, the frequency of observations and any required tests is drawn up for every prisoner on their admittance to the inpatient unit and shared with all relevant healthcare staff.

   NOMS accepted this recommendation. They commented:

   > "The Healthcare Manager will ensure that the mental health in-reach team are compliant with their service level agreement.
   >
   > Primary care patients will have a standardised assessment plan created upon entry to the unit."

6. The Healthcare Manager should ensure that inpatients' fluid and food intake is properly monitored and recorded.

   NOMS accepted this recommendation. They commented:

   > "The healthcare manager will liaise with the Director to identify suitable training for staff to carry out this activity."

7. The Healthcare Manager should ensure that prisoners undergo a full continence assessment if there is any evidence of continence problems and that a care plan is devised.

   NOMS accepted this recommendation. They commented:

   > "A continence assessment tool will be made available to the appropriate healthcare staff."

8. The Healthcare Manager should review the prescribing policy at Dovegate to ensure that it clearly states expectations in relation to medicines management and the completion of prescription charts.

   NOMS accepted this recommendation. They commented:

   > "The Healthcare Manager will ensure that staff are compliant with Serco Health Policy."

9. The Director and Head of Healthcare should review the local strategy and ensure staff are aware of their responsibilities upon finding a prisoner in any state of collapse.

NOMS accepted this recommendation. They commented:

> "The Healthcare Manager and Director will review the local strategy to ensure that staff are aware of their responsibilities."

10. The Director should ensure that all family liaison officers are aware of and follow the guidance contained in PSI 64/2011 when dealing with a bereaved family.

    NOMS accepted this recommendation. They commented:

    > "The Director will ensure that all Family Liaison Officers are aware of the guidance contained in PSI 64/2011."