Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Weston a prisoner at HMP Dartmoor on 10 November 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Weston died on 10 November 2015, of congestive heart failure caused by ischaemic heart disease, at HMP Dartmoor. He was 80 years old. I offer my condolences to Mr Weston's family and friends.

Mr Weston had been sentenced to prison in July 2015 and had diabetes and heart disease. His conditions were well monitored and managed at Dartmoor. I am satisfied Mr Weston received appropriate care from healthcare staff at Dartmoor and they could not have prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2016**

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Summary

Events

1. In July 2015, Mr John Weston was sentenced to three years in prison and had been at HMP Dartmoor since 19 August 2015.

2. Mr Weston had diabetes and heart disease, for which he took medication. Mr Weston was 80, his chronic conditions were well controlled and he did not have much significant interaction with prison GPs or nurses during his time at Dartmoor.

3. Between 11 October and 20 October, Mr Weston was admitted to hospital after reporting shortness of breath and chest pain. Hospital doctors diagnosed fluid on the lungs and an irregular heartbeat for which they prescribed medication. Mr Weston did not complain of any further chest pain or shortness of breath after he returned to the prison.

4. On Sunday 8 November Mr Weston said he had coughed up blood and had vomited. A nurse monitored him during the day and noted his blood pressure, pulse and temperature were all normal, and he was not acutely unwell. Nurses continued to monitor Mr Weston over the next two days.

5. At about 5.45am on Tuesday 10 November, a night patrol officer saw Mr Weston sitting slumped on his bed. He looked pale and was not moving. The night patrol officer called for help. A nearby officer joined him immediately and they went into Mr Weston's cell. The officer could not find any signs of life and his body was cold. He believed it was clear that Mr Weston had died. He and the night manager agreed not to attempt resuscitation. The communications room called an ambulance. At 6.10am, paramedics arrived and confirmed Mr Weston's death.

Findings

6. Prison healthcare staff reviewed and monitored Mr Weston's long term conditions of diabetes and ischaemic heart disease appropriately and the clinical reviewer was satisfied that this care was equivalent to that he would have received in the community. When he became ill on 8 November, nurses monitored his condition. The clinical reviewer considered the scope of the monitoring and a plan of action could have been better recorded, but recognised that his symptoms did not point

towards congestive heart failure and this would not have prevented his death. The staff who found Mr Weston cold and unresponsive correctly decided not to attempt resuscitation. We consider Mr Weston received appropriate care at the prison.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. One prisoner wrote to the investigator with information, which she considered in the investigation.

8. The investigator obtained copies of relevant extracts from Mr Weston's prison and medical records. She interviewed two members of staff by telephone on 28 January and 4 February. An investigation manager, interviewed a member of staff by video link on 3 February.

9. NHS England commissioned a clinical reviewer to review Mr Weston's clinical care at the prison.

10. We informed HM Coroner for Exeter and Greater Devon District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Weston's neighbour and his solicitor, as he had listed them both as his next of kin. She explained the investigation and asked if they had any matters they wanted the investigation to consider. Neither had any specific questions or concerns.

12. Mr Weston's neighbour and solicitor received a copy of the initial report. They made no comments that have led to changes within the report.

13. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Dartmoor

14. HMP Dartmoor holds up to 642 adult male prisoners. The prison comprises six residential wings. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare. Healthcare staff are on duty between 7.45am and 5.30pm on weekdays and between 8.15am and 5.15pm at weekends.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors found the delivery of health services had improved with a small but well qualified team of healthcare staff delivering a wide range of clinics. Seven GP clinics were delivered each week.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to September 2015, the IMB reported that the healthcare provider at Dartmoor had changed, though the new provider still suffered with a shortage of nursing staff. This meant that doctors had to complete tasks that should have been done by nurses. The IMB noted that the ageing prison population's more complex and often chronic health conditions resulted in an increased attendance at a range of outpatient appointments and increased age related checks.

Previous deaths at HMP Dartmoor

17. Mr Weston was the fourth prisoner to die from natural causes at HMP Dartmoor since January 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

18. On 17 July 2015, Mr John Weston was sentenced to three years in prison for sexual offences and sent to HMP Bristol. On 19 August, he was transferred to HMP Dartmoor.

19. Mr Weston's was 80 years old and had diabetes (which was appropriately controlled with medication) and heart disease. He took medications to treat angina symptoms, high blood pressure and high cholesterol.

20. There were no significant entries in Mr Weston's medical record from August to October 2015.

21. On 10 October, when he was collecting his medication, Mr Weston told Nurse A that he had felt short of breath for about two weeks and produced a lot of green catarrh, especially at night. He was not sleeping well and had not eaten since the day before. The nurse noted that he looked pale and unwell. She recorded that his blood pressure, pulse and temperature were normal. The nurse advised Mr Weston to try to eat and said she would review him later.

22. Nurse A saw Mr Weston again later that afternoon. He had eaten, but his symptoms remained. She consulted another nurse and the healthcare manager and they advised that Mr Weston should rest that night and they would review him the next day.

23. On 11 October, Mr Weston continued to feel unwell and complained of chest pain during the night. Staff called an ambulance and paramedics attended and took an electrocardiogram (ECG – a test that records the electrical activity of the heart), which was inconclusive. At 5.00am, the paramedics took Mr Weston to Derriford Hospital, Plymouth, for investigative tests.

24. Mr Weston remained in hospital for nine days and had tests. Hospital doctors diagnosed pulmonary oedema (fluid on the lungs) and atrial fibrillation (an irregular heartbeat) for which they prescribed medication. Mr Weston returned to Dartmoor on 20 October. (The clinical reviewer noted that the hospital did not provide a discharge summary about his treatment and ongoing care and in his review recommended that the prison healthcare staff discuss this with the hospital to prevent it happening again.)

25. On 21 October, Nurse B reviewed Mr Weston, who said he was tired and felt a little unwell. She advised him to drink plenty of fluids.

26. At about 9.00am on Sunday 8 November, Mr Weston told Nurse A that he had been coughing up blood and had felt blood trickling down the back of his throat. He said he was constipated and had vomited that morning. The nurse could not see any sign of blood or vomit in his mouth or in his cell. She took his clinical observations, which were normal. Mr Weston said he had not yet taken his morning medication and the nurse encouraged him to take it. Mr Weston said he did not want to go to hospital. Nurse B discussed Mr Weston with Nurse C and they decided to monitor him over the weekend, as he had a GP appointment booked for two days later on Tuesday 10 November.

27. At 4.30pm on 8 November, Nurse A went to see Mr Weston again. His symptoms were the same and his observations were still normal. He had still not taken his medication. The nurse told Mr Weston that if he felt worse in the night he should alert wing staff. She wrote an entry in the wing observation book that Mr Weston was not feeling well so that staff would be aware and informed Supervising Officer A.

28. At about 9.00am on 9 November, Nurse A went to see Mr Weston in his cell. He said he had not slept well and felt nauseous. He said he had drunk some milk and eaten some biscuits earlier that morning. His observations were normal, but he still refused to take his medication, despite the nurse's advice. Shortly after, Nurse D examined Mr Weston. She found his abdomen was soft and she could hear bowel sounds. Nurse A considered he was slightly better than the day before and had not been sick. The nurses agreed to continue monitoring Mr Weston until his GP appointment and reiterated that he should let wing staff know if he felt worse.

29. Nurse A went back to see Mr Weston at about 4.45pm. He remained the same and she told him to let wing staff know if he felt worse.

30. Officer A, who was on the night shift, knew that Mr Weston had not been feeling well and that Nurse A had been to see him earlier in the day. At about 11.15pm, The officer checked Mr Weston who was asleep in bed, facing the wall, but clearly breathing. Mr Weston did not press his cell bell to call staff during the night.

31. At about 5.45am on 10 November, an operational support grade, A, carried out a roll check to establish that all prisoners were safe in their cells. When he checked Mr Weston he was sitting slumped on his bed with his back against the wall. He looked pale and was not moving. The OSG called for help from Officer A, who was nearby. For security reasons, night staff do not carry standard prison keys but have a cell key in a sealed pouch for us in an emergency. The officer radioed the night manager who agreed they should use the emergency key to go into Mr Weston's cell.

32. When they went into the cell, Officer A called to Mr Weston, but he did not respond. He checked Mr Weston and could not see any signs of breathing or find a pulse. Mr Weston was cold to the touch and it was evident to the officer that he had died. The night manager arrived quickly afterwards and they decided it would not be appropriate to attempt resuscitation. At 5.48pm, the officer radioed the communications room to request an ambulance. The ambulance arrived at 6.10am and paramedics confirmed that Mr Weston had died.

Contact with Weston's next of kin

33. Mr Weston had listed two people as his next of kin, his neighbour in the community, and his solicitor. The deputy governor telephoned Mr Weston's neighbour at 8.15am and explained that Mr Weston had died that morning. He said that the prison's family liaison officer would contact them later that day. The deputy governor contacted Mr Weston's solicitor at 12.20pm.

34. The prison's family liaison officer spoke to Mr Weston's neighbour at 1.45pm and offered condolences and explained her role. The prison's family liaison officer kept in contact with Mr Weston's neighbour and solicitor.

35. Mr Weston's funeral was on 2 February 2016. The prison paid for this in line with national policy.

Support for prisoners and staff

36. After Mr Weston's death, the prison's family liaison officer debriefed the staff involved in the emergency response and offered support and that of the staff care team.

37. The prison posted notices informing staff and prisoners of Mr Weston's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Weston's death.

Post-mortem report

38. The post-mortem found that Mr Weston had died of congestive cardiac failure due to ischaemic heart disease. A contributory factor was diabetes mellitus.

Findings

Clinical care

39. Mr Weston was elderly man and suffered from heart disease and diabetes. He took a variety of prescribed medications and both his heart disease and diabetes were well managed, with care equivalent to that he would have expected to receive in the community. He did not have a great deal of interaction with healthcare staff during the months he was at Dartmoor. He had a brief hospital admission in October 2015 for fluid on the lungs and an irregular heartbeat, but did not give any serious cause for concern after this. When Mr Weston complained of feeling unwell on 8 and 9 November, nurses examined and monitored him. He said he did not want to go to hospital, and nurses considered he was not acutely unwell.

40. The clinical reviewer considered that the scope of the monitoring and a plan of action could have been better recorded, but recognised that his symptoms did not point towards congestive heart failure and this would not have prevented his death. (The clinical reviewer has made a recommendation about this in his review, which the Head of Healthcare will need to address.) The clinical reviewer considered that the constipation Mr Weston complained of was probably related to the medication he was taking. The symptom of coughing up blood should have indicated the need for a medical assessment, Nurses noted that Mr Weston had a GP appointment arranged for 10 November and tried to bring this forward by a day, but no doctor was available. As Mr Weston's symptoms did not suggest heart failure, the clinical reviewer was satisfied that this would not have affected the outcome.

41. The emergency response was swift and we consider that the decision not to attempt resuscitation was entirely appropriate.

42. Overall, we consider that Mr Weston received an appropriate standard of care at Dartmoor.

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