Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Subodh Nath Dhoomun a prisoner at HMP The Mount on 17 August 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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*

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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 Subodh Nath Dhoomun was found hanged in his cell at HMP The Mount on 16 August 2015 and died in hospital the next day. He was 50 years old. I offer my condolences to Mr Dhoomun's family and friends.

The investigation found that Mr Dhoomun had never given any indication of suicidal thoughts throughout the ten years he had served of a life sentence. I am satisfied that staff at The Mount could not have predicted Mr Dhoomun's actions, which were sudden and unexpected. However, I am concerned that it took too long to respond effectively after another prisoner raised concerns about Mr Dhoomun, although we cannot know if a quicker response could have saved him.

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

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

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Summary

Events

1. On 17 February 2005, Mr Subodh Nath Dhoomun was convicted and sentenced to life imprisonment, with a minimum period to serve of 16 years before he could be considered for release. Mr Dhoomun had been at HMP The Mount since February 2013.

2. Mr Dhoomun had never harmed himself in prison and no one had ever considered he was at risk of suicide. He had settled well at The Mount, had a job as cleaner, was a volunteer carer on his wing, was the wing equality representative and was on the enhanced regime level. Mr Dhoomun had no significant health problems until June 2015, when he began to have seizures. Epilepsy was suspected.

3. At 6.39am, on 16 August 2015, the prisoner in the cell next to Mr Dhoomun told a night patrol officer that he had heard a banging noise from Mr Dhoomun's cell and was concerned that he might have had an epileptic fit. The patrol officer could not see or get a response from Mr Dhoomun and sought help, but officers did not go into the cell until 7.05am, when they found Mr Dhoomun had hanged himself in the separate toilet area. The staff called an emergency and began cardiopulmonary resuscitation until paramedics arrived. The paramedics took over emergency treatment and took Mr Dhoomun to hospital where he was placed on life support. On 17 August, doctors withdrew life support and Mr Dhoomun died that evening. He had left a suicide note in which he expressed remorse for his offence and said that he was not sure how he would cope when he did not know what illness he had and he had no one to look after him.

Findings

4. Mr Dhoomun had given no indication to staff or other prisoners that he had thoughts of suicide. No one had identified that Mr Dhoomun was very anxious about having epilepsy and we do not consider that prison staff could have predicted or prevented his actions.

5. We are concerned about the emergency response. After the prisoner in the next cell raised the alarm and staff could not see or get a response from Mr Dhoomun, it took 26 minutes before officers went into his cell. We cannot know whether a quicker response would have saved Mr Dhoomun but we are concerned that there was such a delay in checking his wellbeing. There was also a delay in getting a defibrillator to Mr Dhoomun's cell and in paramedics reaching his cell after they arrived at the prison. After the emergency incident and Mr Dhoomun's death, there was no hot debrief and staff were not asked to complete incident statements, both of which are mandatory Prison Service requirements.

Recommendations

- The Governor should ensure that all prison staff are aware of and understand their responsibilities during medical emergencies, including that:
    - Staff enter cells quickly when there are serious concerns about the health of a prisoner.
    - Staff can access and bring appropriate equipment, including defibrillators, immediately to a medical emergency.
    - There is no avoidable delay in ambulance staff reaching prisoners.

- The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner’s death.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact him.

7. The investigator visited The Mount on 21 August. He obtained copies of relevant extracts from Mr Dhoomun's prison and medical records.

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

9. The investigator interviewed 11 members of staff and one prisoner at The Mount in September and October, eight jointly with the clinical reviewer.

10. We informed HM Coroner for Hertfordshire 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 Dhoomun's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Dhoomun's family asked us if he had used drugs or alcohol in prison before he died. Mr Dhoomun's family received a copy of the initial report. They did not make any comments.

Background Information

HMP The Mount

12. HMP The Mount is a medium security prison, which holds up to 1,032 convicted adult men.

13. Hertfordshire Community NHS Trust provides primary healthcare services and GP services are commissioned from the Pathfinder Practice, South West Hertfordshire Health Centre. There are daily GP sessions Monday to Friday, with out of hours provision at other times. There are no healthcare staff on duty between 8.00pm and 8am.

HM Inspectorate of Prisons

14. The most recent inspection of HMP The Mount was in April 2015. Inspectors found that The Mount was clean and well maintained. Care for men at risk of suicide and self-harm was adequate, although some lessons from previous investigations into deaths at the prison had not been fully embedded. Most prisoners said that staff treated them respectfully but were very busy. Equality and diversity arrangements were satisfactory. Health services were reasonably good overall but medicines management was poor.

Independent Monitoring Board

15. 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 most recently published report for the year to February 2015, the IMB commented that The Mount was a well run prison where staff endeavoured to provide a fair and decent service in a challenging environment.

Previous deaths at HMP The Mount

16. Mr Dhoomun's death was the third at The Mount since January 2014. One of the previous deaths was from natural causes and the other was self-inflicted. Six weeks after Mr Dhoomun's death, there was a further self-inflicted death. There were no significant similarities with the circumstances of the other deaths, but we have previously made a recommendation about delays with ambulances leaving the prison after a medical emergency. In this investigation we found there was a delay in ambulance staff reaching the prisoner.

Key Events

17. On 10 July 2004, Mr Dhoomun was extradited back to the UK from Mauritius and remanded to prison, charged with murder. On 17 February 2005, he was convicted and sentenced to life imprisonment, with a minimum period to serve of 16 years before he could be considered for release on licence. On 25 February 2013, Mr Dhoomun was transferred to HMP The Mount.

18. Throughout Mr Dhoomun's time in prison he did not harm himself and no one ever assessed him as being at risk of suicide or self-harm. At The Mount, Mr Dhoomun lived on Narey Wing, which is for prisoners aged 50 and above. He was on the enhanced level of the Incentives and Earned Privileges Scheme, which rewards good behaviour with additional privileges. He was employed as a wing cleaner, was a volunteer carer and the wing equality representative. Officers described Mr Dhoomun as a model prisoner. Mr Dhoomun kept in contact with his family and records show that his last phone call to his family was on 10 August 2015. His family told the prison that he said nothing to concern them about his state of mind in this call.

19. Mr Dhoomun’s medical records show that while he was in prison he had been treated for insomnia, back pain and dry skin. He had no recorded mental health problems and there was no information to indicate that he used drugs or alcohol. On 9 December 2014, a prison GP referred Mr Dhoomun to a specialist after he had some seizures. On 15 June 2015, a consultant neurologist examined Mr Dhoomun and thought it likely that he had epilepsy, although there was no firm diagnosis. The neurologist prescribed incremental doses of lamotrigine, an anticonvulsant medication, and made a follow-up appointment for four months later. Mr Dhoomun took the medication as prescribed.

20. On 28 July, officers called an emergency when they found Mr Dhoomun apparently having an epileptic fit. A nurse responded and recorded that he was confused, agitated and kept going in and out of consciousness. Paramedics arrived, assessed Mr Dhoomun and took him to hospital for further treatment.

21. At 1.10pm on 29 July, Mr Dhoomun returned to The Mount. Mr Dhoomun told a nurse that a hospital doctor had increased the dose of lamotrigine and would arrange a brain scan. He said he still had headaches. She recorded that Mr Dhoomun appeared fit and well, and she advised him to continue to take his medication and to drink plenty of water. She made an appointment for him to see a doctor a week later.

22. On 5 August, Mr Dhoomun had a brain scan at hospital. On 6 August, a prison GP reviewed Mr Dhoomun, who said that he had not had any more seizures in the last week and had experienced no side effects from taking his medication. The doctor noted that the result of the brain scan had been sent to a consultant neurologist.

23. At 6.39am on 16 August, the prisoner in the cell next to Mr Dhoomun pressed his cell bell. An operational support grade (OSG 1), the night patrol officer, answered the cell bell within 30 seconds. The prisoner told the OSG that he had heard banging coming from Mr Dhoomun’s cell and he was concerned that Mr Dhoomun had suffered an epileptic fit.

24. CCTV footage shows that the OSG looked into Mr Dhoomun's cell at 6.39am. He said he looked into the cell but could not see Mr Dhoomun, so he shouted his name and kicked the door. He got no response. The toilet door was open and he thought that Mr Dhoomun was using the toilet. CCTV shows that he used his radio and walked away from Mr Dhoomun's cell at 6.42am.

25. OSG 2, who was on duty in the control room, told the investigator that OSG 1 had radioed to say that he could not see Mr Dhoomun. He said he told OSG 1 to go back to the cell and try and get a response. A custodial manager had just come on duty as the orderly officer (in charge of the day to day running of the prison) and was in the communication room at the time. He heard OSG 2 speak to OSG 1, and told OSG 2 to ask other officers to go to assist OSG 1.

26. An officer said that he had arrived early at the prison for a day shift. He had collected his radio and was on his way to his wing when he received the radio message to go to Narey Wing.

27. CCTV footage shows that OSG 1 went back to Mr Dhoomun's cell at 6.51am. He then walked up and down the landing and sometimes stopped at the cell door. At 6.58am, the officer arrived and joined the OSG outside Mr Dhoomun's cell. The officer told us that he radioed for additional assistance but, after several minutes, the custodial manager told him to go into the cell.

28. At 7.05am, the officer and OSG 1 went into Mr Dhoomun's cell and found that Mr Dhoomun had hanged himself behind the toilet door, using bedding as a ligature. The officer radioed a code blue emergency, cut the ligature from around Mr Dhoomun's neck and started cardiopulmonary resuscitation.

29. Other staff responded to the emergency, including an acting supervising officer (SO) and the custodial manager. The SO told the investigator that there are automated external defibrillators (life-saving devices that give the heart an electric shock in some cases of cardiac arrest) placed around the prison, but he could not find one on Narey Wing. He had to go to another wing to get a defibrillator and he arrived back with one at 7.14am. The custodial manager and SO attached the defibrillator to Mr Dhoomun but it found no shockable heart rhythm.

30. Ambulance service records show that the 999 call was made at 7.07am. Paramedics arrived at the prison at 7.16am and reached Mr Dhoomun's cell at 7.26am. The paramedics took over resuscitation and managed to establish a pulse. At 7.41am, an air ambulance arrived with a doctor. At 8.11am, paramedics took Mr Dhoomun to hospital, where he was admitted to the intensive care unit and placed on life support.

31. At 8.35am, a prison chaplain contacted Mr Dhoomun's brother and told him that Mr Dhoomun had been taken to hospital and was in a serious condition. At 10.15am, the chaplain and a prison family liaison officer met Mr Dhoomun's family at the hospital.

32. On 17 August, doctors withdrew life support and at 8.30pm, recorded that Mr Dhoomun had died. The chaplain and family liaison officer continued to support Mr Dhoomun's family in the days after his death. In line with Prison Service

instructions, the prison contributed to the costs of the funeral. The medical certificate of death stated that the cause of death was hypoxic brain damage as a result of hanging. No post-mortem examination was held.

33. Mr Dhoomun had left a suicide note in his cell. He said that he was sorry for the hurt and distress he had caused his victim, her family and his family. He said he did not know how to cope when he did not know what illness he had and had no one to look after him.

Support for prisoners and staff

34. There was no debrief for the staff who had been involved in the emergency response after Mr Dhoomun was found hanging or after his death, and they were not asked to complete incident report forms, as Prison Service instructions require. The staff were offered the support of the prison's care team.

35. The prison posted notices informing other prisoners of Mr Dhoomun's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Dhoomun's death. The prisoner who had raised the alarm said staff and Listeners (prisoners trained by the Samaritans) supported him.

Findings

Clinical Care and Assessment of Risk of Suicide

36. The clinical reviewer considered that the standard of healthcare Mr Dhoomun received at The Mount was appropriate and generally equivalent to that he could have expected in the community. Mr Dhoomun was promptly treated in July 2015, when he had a seizure and was appropriately admitted to hospital.

37. Mr Dhoomun had no history of self-harm or attempted suicide. He had given no indication to anyone that he had any suicidal thoughts or that he was extremely anxious about the cause of his seizures. We agree with the clinical reviewer that staff at The Mount could not have foreseen Mr Dhoomun's actions, although he noted that a small number of people who have been treated with lamotrigine (Mr Dhoomun's epilepsy medication) have had suicidal thoughts.

38. In his review, the clinical reviewer identified some healthcare matters, not related to the circumstances of Mr Dhoomun's death, which the healthcare manager will need to address.

Emergency Response

39. We are concerned about the length of time it took to go into Mr Dhoomun's cell after the prisoner raised concerns about him. When OSG 1 could not see Mr Dhoomun in his cell or get a response, he radioed to seek assistance. It was 16 minutes before an officer joined him on the wing, and a further seven minutes before they went into the cell.

40. Prison officers have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there appears to be a clear risk to life, the local night patrol procedures state that officers can unlock and enter a cell on their own, without the authority of the orderly officer if they alert the control room.

41. OSG 1 and, later, the officer could not see that Mr Dhoomun had hanged himself and we accept that it was not immediately clear by looking in the cell that this was a life-threatening situation. However, the prisoner had said that he thought that Mr Dhoomun might have had an epileptic fit. When they could not get a response from Mr Dhoomun, the staff should have been concerned and acted with more urgency. There was a delay of 26 minutes between the time that the OSG first looked into the cell and could not see Mr Dhoomun or get a response from him and the staff going into the cell. This was an unacceptable delay. We cannot know whether earlier intervention might have saved Mr Dhoomun.

42. Once the emergency code blue was called, the control room called an ambulance immediately and officers started cardiopulmonary resuscitation. However, the defibrillator that was usually on Narey Wing had been moved, and it took the SO five minutes to collect one from another wing. It is important that staff can access emergency equipment quickly in an emergency.

43. According to ambulance service records, the ambulance arrived at The Mount at 7.16am. However, it took another ten minutes for paramedics to reach Mr

Dhoomun's cell. We consider this is too long. In 2014, we made a recommendation to The Mount that ambulances should be able to exit the prison quickly. In that case, it took the ambulance ten minutes to leave the prison. It is clearly as important, if not more so, that paramedics reach prisoners quickly in emergencies. We make the following recommendation:

The Governor should ensure that all prison staff are aware of and understand their responsibilities during medical emergencies, including that:

- **Staff enter cells quickly when there are serious concerns about the health of a prisoner.**
- **Staff can access and bring appropriate equipment, including defibrillators, immediately to a medical emergency.**
- **There is no avoidable delay in ambulance staff reaching prisoners.**

Actions following a death in custody

44. PSI 64/2011 sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that staff directly involved, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable. No members of staff were asked to complete the forms after the initial emergency incident of after Mr Dhoomun died.

45. PSI 64/2011 also has a mandatory action that, in line with PSI 8/2010 (Post Incident Care), the prison should hold a 'Hot Debrief' to support staff, but one was not held. While Mr Dhoomun did not die until the next day, we consider that finding and responding to Mr Dhoomun hanging was a potentially traumatic incident within the terms of Prison Service instructions. We make the following recommendation:

    The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

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