Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Dean a prisoner at HMP Hatfield on 24 August 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 Michael Dean died of a chest infection and lung disease at HMP Hatfield, on 24 August 2015. He was 66 years old. I offer my condolences to Mr Dean's family and friends.

Mr Dean's lung condition was controlled by medication and well managed by prison healthcare staff. There was no indication that he was acutely unwell and his death was sudden and unexpected. When he was found collapsed in his cell, staff responded quickly, but it was evident that he had died. I am satisfied that Mr Dean received a good standard of healthcare at Hatfield, equivalent to that he could have expected to receive in the community, and that prison staff could not have been foreseen or prevented his death.

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

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

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Summary

Events

1. In December 2000, Mr Michael Dean was sentenced to life imprisonment for murder. He had been at HMP Hatfield since September 2013.

2. Mr Dean suffered from a number of chronic health problems, including heart disease, high blood pressure and chronic obstructive pulmonary disease (COPD - the name for a collection of long-term progressive lung diseases, including chronic bronchitis and emphysema). Healthcare staff monitored Mr Dean and prescribed relevant medication. They also conducted an annual review of his COPD.

3. Just after 8.00am on 24 August 2015, another prisoner found Mr Dean collapsed in his cell and alerted staff. Nurses and paramedics examined him and it was evident that he had died.

Findings

4. The clinical reviewer concluded that the standard of care Mr Dean received at the prison was equivalent to that he might have expected to receive in the community. We are satisfied that Mr Dean received good care at Hatfield and staff could not have foreseen or prevented his sudden and unexpected death.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Hatfield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Dean's prison and medical records. She interviewed two members of staff and one prisoner by telephone in October 2015.

7. NHS England commissioned a clinical reviewer to review Mr Dean's clinical care at the prison. The clinical reviewer spoke to two nurses by telephone.

8. We informed HM Coroner for South Yorkshire East of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted Mr Dean's family, to explain the investigation. They had no specific matters for the investigation to consider.

10. Mr Dean's family received a copy of the initial report. They did not raise any issues or comments on the factual accuracy of this report.

11. The prison considered our initial report and did not identify any factual inaccuracies.

Background Information

HM Prison Hatfield

12. HMP Hatfield is a low security resettlement prison near Doncaster, holding over 300 men. Nottinghamshire Healthcare NHS Trust provides daily health services at the prison.

HM Inspectorate of Prisons

13. The report of the most recent inspection of HMP Hatfield has not yet been published. At the time of the previous inspection in October 2012, inspectors noted that a range of clinics was available, including nurse-led clinics for asthma and smoking cessation. Access to the GP was limited, particularly for prisoners who were out at work during the day.

Independent Monitoring Board

14. 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 February 2015, the IMB reported that there were low staffing levels in healthcare due to recruitment problems.

Previous deaths at HMP Hatfield

15. Mr Dean was the second prisoner to die from natural causes at HMP Hatfield, since the start of 2013. There were no significant similarities with the circumstances of the other death.

Key Events

16. On 8 December 2000, Mr Michael Dean was sentenced to life imprisonment, for murder and arrived at HMP Leeds that day. He progressed through his sentence and moved to HMP Hatfield on 4 September 2013.

17. Mr Dean had high blood pressure, heart disease and chronic obstructive pulmonary disease (COPD – the name for a collection of long-term progressive lung diseases including chronic bronchitis and emphysema) for many years. He was prescribed medication and healthcare staff reviewed his condition annually. Mr Dean had been a long-term smoker, but stopped in July 2014.

18. On 5 September 2013, a prison GP, Dr A, noted Mr Dean's COPD diagnosis. She saw him several times that month and prescribed three inhalers – salbutomol (to widen the airways), ipatropium bromide (a long lasting inhaler) and clenil modulite (a steroid to improve breathing). He was also prescribed prednisolone (a steroid tablet) and uniphylin continus (to help breathing). Mr Dean had frequent contact with healthcare staff to collect medication.

19. On 8 June 2015, Dr A noted that Mr Dean's chest was settling after the use of steroids and antibiotics. She said his breathing and walking had improved.

20. On 18 August 2015, a modern matron, Nurse A, completed Mr Dean's annual COPD review. She took various measurements, such as his oxygen saturation levels and respiration rate. All were within normal range and she did not indentify any acute illness. She noted he took his medication as prescribed and regularly used his inhalers. The nurse was unable to do a spirometry assessment (to check his lung capacity and function) as Mr Dean was recovering from a chest infection at the time. She planned to conduct the test, once he had finished his course of antibiotics.

21. Mr Dean had a single room. Mr A, the prisoner who lived in the room next to him, told the investigator that Mr Dean had complained of a chesty cough for a few weeks, but he had used breathing machines and inhalers to help. He said that on the evening of 23 August, they had spoken and had a hot drink together. Mr Dean washed their cups and returned them to him at around 10.15pm. He then went back to his own room.

22. At approximately 6.55am, on Monday 24 August, Mr A went to work in the prison kitchens. He noticed that Mr Dean's door was closed. He said this was unusual as they were both early risers and Mr Dean would usually go to his room for a chat before he went to work. He thought Mr Dean had decided to have a lie in.

23. Between 7.05am and 7.15am, Officer A completed a visual check of prisoners on the unit who were not at work. He counted the prisoners, but was not required to obtain a response from them. The officer looked through the observation panel of Mr Dean's door and saw his outline, and thought he was reaching out for something. He said that Mr Dean was always up at that time so he did not think it was unusual that he was not in bed. He continued to check other prisoners. The officer told the investigator that he thought he had seen Mr Dean, but in retrospect should have realised that it was unusual for Mr Dean not to have the main cell light on.

24. Mr A said he returned from working in the kitchens between 8.10am and 8.15am, and looked through the observation panel in Mr Dean's door. Mr Dean was not on the bed or the chair, so he went to look in the showers and kitchen area. As he still could not find him, he went back, looked through the panel again, and saw Mr Dean on the floor. He pushed the door open and called his name, but got no response. He went to the wing office and told Officer B, who followed Mr A to the cell. Mr A checked, but could not find a pulse.

25. At 8.12am, Officer B radioed for urgent assistance, but did not use an emergency medical code. Nurse B went to the cell straight away with an emergency bag. She assessed Mr Dean and realised he had died. He was cold with no pulse, his pupils were fixed and dilated and rigor mortis was apparent. Nurse A arrived and asked for an ambulance to be called. The nurses agreed it would not be appropriate or dignified to try to resuscitate him.

26. The control room staff called an ambulance at 8.23am, which arrived at 8.36am. The paramedics confirmed that Mr Dean had died.

Contact with Mr Dean's family

27. Later that morning, the prison appointed prison manager, A, as the prison's family liaison officer. At 11.45am, prison manager A, and Mr Dean's offender supervisor and prison manager, B left the prison to break the news to Mr Dean's next of kin. Prison manager, A, offered advice and support. She remained in contact with Mr Dean's family until after his funeral, which was held on 18 September 2015. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

28. After Mr Dean's death, prison manager, C, debriefed the staff involved in the emergency response and offered support. The staff care team also offered support.

29. The prison posted notices informing other prisoners of Mr Dean'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 Dean's death. Prisoner, A, said that officers had arranged for a close friend to sit with him after he found Mr Dean collapsed, He said he got good support from his friend and did not need additional support after Mr Dean's death but was aware of the help available.

Post-mortem report

30. The coroner gave the cause of death as a chest infection and chronic obstructive pulmonary disease (COPD). The pathologist noted sepsis of the lung, (a whole body response to an infection). Sepsis can lead to sudden death and cannot be predicted.

Findings

31. Mr Dean had suffered from COPD for many years. He took his medication regularly, used his inhalers and was active in the prison.

32. The clinical reviewer noted that prison healthcare staff monitored Mr Dean's COPD appropriately. He had annual reviews and the most recent was on 18 August 2015, six days before his death. The clinical reviewer was satisfied that Mr Dean's care was equivalent to that he would have received in the community. We agree that the prison's healthcare team gave him commendable and well-coordinated care. Mr Dean's death was sudden and unexpected. There was nothing staff at the prison could have done to prevent it.

Emergency response

33. Officer A, who did the roll check at about 7.15am, saw that Mr Dean was in his room, but did not realise that anything was wrong. While roll checks are principally for security reasons, to check that prisoners are present, staff should also satisfy themselves by a visual check, that the prisoner is alive and breathing. However, Officer A believed he saw Mr Dean move, so did not try to get a verbal response. It is apparent that Mr Dean was dead at the time, but we accept that Officer A did not recognise there was any problem.

34. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, requires governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. Hatfield issued a notice to staff about medical emergency codes on 9 February 2013.

35. Officer B did not use a medical emergency code. When interviewed, we were satisfied he was fully aware of the emergency response procedures. However, he said that he was in shock when he radioed for urgent assistance, as he thought it was clear that Mr Dean was dead. Although the officer did not use an emergency code, nurses and other staff arrived very quickly. Staff did not call an ambulance immediately, but this did not affect the outcome for Mr Dean, as he had been dead for some time. We are satisfied that the staff made an appropriate decision not to attempt resuscitation, which would have been futile in the circumstances.