

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Anderson a prisoner at HMP Dovegate on 4 March 2018

A report by the Prisons and Probation Ombudsman

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.

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

Mr Paul Anderson died of inhaling the content of his stomach and sigmoid colon volvulus (twisting of the colon) on 4 March 2018 while a prisoner at HMP Dovegate. He was 39 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that healthcare staff could not have foreseen Mr Anderson's condition, and that they made strenuous attempts to preserve his life under very difficult circumstances.

When a prisoner rang for medical assistance for Mr Anderson on the day he died, he used a telephone hotline that prisoners were told that they could ring at any time. I am concerned that the number was not in use over the weekend, and therefore was not listened to until the day after Mr Anderson's 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.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. On 9 February 2018, Mr Paul Anderson was recalled to HMP Dovegate having breached his licence conditions.
2. During his initial healthcare induction, Mr Anderson told a nurse that he had been diagnosed with depression and asthma, and had a history of substance misuse. At this appointment, he tested positive for medication which had not been prescribed to him, and was referred to the substance misuse team. He was prescribed drugs to manage his conditions.
3. Mr Anderson was monitored closely by the Integrated Substance Misuse Team (ISMT) over the following month, and was given appropriate psychological care.
4. On Sunday 4 March, a prisoner who lived on the same wing as Mr Anderson contacted the ISMT helpline and asked for a member of the healthcare team to come to Mr Anderson's cell as he was vomiting and had diarrhoea.
5. At 12.25pm that day, a prison officer went to the medication hatch on the wing, and asked a nurse to visit Mr Anderson. A prison officer and a nurse went to Mr Anderson's cell, and found him unconscious on the floor, surrounded by vomit.
6. The nurse immediately called a medical emergency, and collected the emergency resuscitation bag. Officers and nursing staff responded and started cardiopulmonary resuscitation (CPR). Paramedics arrived at the prison and continued resuscitation efforts but he remained unresponsive throughout.
7. At 1.15pm, CPR was stopped, and paramedics confirmed that Mr Anderson had died.
8. The post-mortem report gave the cause of death as aspiration of gastric contents and sigmoid colon volvulus (twisting of the colon).

Findings

9. We are satisfied that healthcare staff could not have identified that Mr Anderson had sigmoid colon volvulus as it was a rare condition and he did not report any associated symptoms to wing or medical staff.
10. When Mr Anderson was found in his cell, healthcare and prison staff worked together under challenging circumstances to try to resuscitate him.
11. Staff told Mr Anderson that he could contact the ISMT telephone number at any time that he had concerns. A fellow prisoner used this number to alert healthcare staff when Mr Anderson became ill. However, the number was only for issues related to substance misuse, and was not picked up over the weekend, and was therefore not listened to until the day after his death.

Recommendation

- The Head of Healthcare should ensure that prisoners are aware how to seek medical assistance, regardless of the day or time of day.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Anderson's prison and medical records.
14. The investigator interviewed six members of staff at HMP Dovegate on 24 April 2018.
15. NHS England commissioned a clinical reviewer to review Mr Anderson's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator on 24 April 2018.
16. We informed HM Coroner for South Staffordshire of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Dovegate

18. HMP Dovegate is run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK, who took over from Serco Health in October 2014, provides healthcare services.

HM Inspectorate of Prisons

19. The most recent inspection of Dovegate was conducted in May and June 2017. Inspectors noted good interactions between healthcare staff and prisoners. They noted sound information governance and use of SystemOne (electronic case notes).

Independent Monitoring Board

20. 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 30 September 2017, the IMB reported that healthcare services were improving but retention of staff was a problem.

Previous deaths at HMP Dovegate

21. There have been nine previous deaths at HMP Dovegate since January 2015, three of which have been from natural causes. There are no similarities between these cases and that of Mr Anderson's.

Key Events

22. On 5 January 2018, Mr Paul Anderson was released from HMP Oakwood on licence. He breached his licence conditions and was recalled to HMP Dovegate on 9 February 2018.
23. On his arrival, a nurse completed his initial health screen. She noted that he had a history of depression and asthma. She also noted that he had a history of drug misuse and that he had tested positive for opiates, cannabinoids, benzodiazepines and cocaine. She referred him to the Integrated Substance Misuse Team (ISMT). He was prescribed drugs to manage his conditions.
24. Later that day, a nurse substance misuse practitioner noted that he was not able to see Mr Anderson that evening as there were no available spaces. However, he reviewed his reception notes and prescribed medication to manage nausea (a symptom of withdrawal) and for pain relief.
25. On 10 February, a nurse and the ISMT assessed him and noted that he was in withdrawal. Mr Anderson was prescribed 30mls of methadone to be taken once a day for five days, and it was recorded that in line with the ISMT pathway, his blood pressure and pulse should be taken twice a day.
26. On 13 February, a nurse completed a five day ISMT review. As Mr Anderson was experiencing cravings, his methadone dosage was increased to 40mls. His blood pressure and pulse remained within the normal range.
27. After he saw an ISMT psychosocial support worker, on 28 February 2018, Mr Anderson was noted to be settled on his methadone dose, and had not been using any illicit drugs. She noted that she would review him within three weeks. At this appointment, Mr Anderson requested a distraction pack (containing activities, writing material and information about support).
28. She recorded in his medical records that as she approached Mr Anderson's cell, she saw him come out of a neighbouring cell, looking confused, and noted that he stumbled against the railings. She stated that when she asked Mr Anderson if he was okay, he responded aggressively. She told the investigator that she reported her interaction with Mr Anderson to the wing officers. There is no evidence that any further action was taken.
29. On 4 March, a prisoner left a message on the ISMT telephone to say that Mr Anderson was in bed with diarrhoea and sickness. He asked for a member of the healthcare team to attend. The time of this call cannot be ascertained.
30. At approximately 12.25pm that day, an officer attended the medication hatch on Mr Anderson's wing. He asked if a nurse could attend to Mr Anderson as a prisoner had seen him vomiting in his cell. A nurse said that she looked at his medical records, and then attended his cell promptly with the officer.
31. The nurse told the investigator that when she arrived at Mr Anderson's cell, she found him on the floor, unresponsive. She said that she left the officer at the cell and went to the medication room on the wing to get the emergency bag. She immediately radioed a medical emergency code blue (which indicates breathing

difficulties), and the control room called an ambulance. West Midlands Ambulance Service noted that they received the call at 12.30pm.

32. After hearing the code blue, two officers went to Mr Anderson's cell.
33. The nurse told us that she returned to Mr Anderson's cell less than two minutes after she had left to get the resuscitation equipment. She said that the two officers were just starting cardiopulmonary resuscitation (CPR) as she arrived.
34. An officer started chest compressions, while the other officer maintained Mr Anderson's airways. An officer was advised to leave, and the nurse inserted an airway tube, and attached a defibrillator. This showed no shockable rhythm, and was repeated every two minutes. During this time, a further three officers arrived at Mr Anderson's cell, and at the direction of the nurse, assisted with CPR.
35. The ambulance arrived at the prison at 12.41pm, and at Mr Anderson's cell at 12.44pm. Paramedics continued resuscitation efforts but Mr Anderson remained unresponsive. At 1.15pm, they pronounced that Mr Anderson had died.

Contact with Mr Anderson's family

36. On 4 March 2018, an officer was appointed as the family liaison officer (FLO). Mr Anderson had nominated his mother as his next of kin. The FLO and the acting industries manager visited Mr Anderson's mother at 5.40pm on 4 March and broke the news of Mr Anderson's death to his family. They offered their condolences and gave the family some information about Mr Anderson's death. They visited again the next day.
37. Mr Anderson's funeral took place on 4 April, and the prison contributed towards Mr Anderson's funeral expenses in line with national instructions.

Support for prisoners and staff

38. After Mr Anderson's death, the assistant director of residential and segregation, debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. Prison staff who were interviewed as part of the investigation told the investigator that they felt supported after Mr Anderson's death.
39. The prison posted notices informing other prisoners of Mr Anderson's death, and offering support.

Post-mortem report

40. The post-mortem report gave the cause of death as aspiration of gastric contents and sigmoid colon volvulus (twisting of the colon).

Findings

Clinical care

41. The clinical reviewer noted that sigmoid colon volvulus is a surgical emergency and once suspected, requires urgent hospital admission. It can occur when a person has chronic constipation but Mr Anderson's medical records did not indicate that he had constipation or a history of it. While the clinical reviewer noted that all of Mr Anderson's prescribed medication listed constipation as a side effect, healthcare staff could not reasonably have foreseen the presence of sigmoid colon volvulus.
42. She noted that individuals with sigmoid colon volvulus are likely to present with a sudden onset of lower abdominal pain, abdominal distension and failure to pass wind or faeces. However, she noted that it can also present gradually with vague symptoms. We cannot say whether Mr Anderson was in pain when he stumbled into the railings on 29 February but he did not present to healthcare or prison staff with any symptoms associated with sigmoid colon volvulus until he was found vomiting in his cell on the day he died.
43. The clinical reviewer noted that the resuscitation procedure for Mr Anderson would have been challenging for healthcare staff in any clinical setting and she stated that prison and healthcare staff made every effort to reduce the vomit inhaled by Mr Anderson, and to preserve his life.

ISMT telephone hotline

44. On Monday 5 March 2018, an ISMT manager recorded in Mr Anderson's clinical notes that a prisoner had contacted the ISMT telephone hotline on Sunday 4 March 2018, and said that Mr Anderson was in bed with diarrhoea and sickness. He asked for a member of the healthcare team to attend as soon as possible.
45. Although we could not establish the exact time of the call, it was likely made before midday, as a prisoner then approached an officer who went to the medication hatch at approximately 12.25pm. This resulted in a nurse going to Mr Anderson's cell.
46. The investigator was not able to interview the prisoner but there is evidence in Mr Anderson's medical records that an ISMT practitioner told him that he could ring the number at any time if he had any concerns. During interview, the Head of Healthcare and a nurse told the investigator that the ISMT telephone line was manned from Monday to Friday only and was not for acute or primary care needs.
47. While the outcome for Mr Anderson would not have changed if a member of the team had picked up the ISMT telephone on 4 March, in other circumstances this may not be the case. We make the following recommendation:

The Head of Healthcare should ensure that prisoners are aware how to seek medical assistance, regardless of the day or time of day.

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