Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey McIntyre a prisoner at HMP Dartmoor on 14 July 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.

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 Jeffrey McIntyre was found dead in a cell in the segregation unit at HMP Dartmoor on 14 July 2015. He was 57 years old. I offer my condolences to Mr McIntyre's family and friends.

This is a perplexing case and the reasons for Mr McIntyre's death remain unascertained. Detailed medical investigations have discounted trauma from the earlier fight he was involved in, previous health conditions and substance abuse. Whatever the cause, it is likely that Mr McIntyre had been dead for some hours before he was found and I am concerned by the length of time it took officers, medical practitioners and other members of staff to establish that he had died.

It is particularly troubling that these opportunities for earlier intervention were missed while Mr McIntyre was housed in the segregation unit, a place of heightened risk and vulnerability for prisoners where additional safeguards and checks should exist. I note that the prison has already addressed these acknowledged failings

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 2017**

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Summary

Events

1. Mr McIntyre was a prisoner at HMP Dartmoor, serving a life sentence. On 13 July, officers took him to the segregation unit after a fight with another prisoner. A nurse examined him and concluded that there was no reason why he should not be segregated. Mr McIntyre raised no concerns with staff that day.

2. On the morning of 14 July, Mr McIntyre did not respond to the officers who unlocked him or to a number of other visitors, including a prison GP, a nurse, the duty governor, the chaplain and a member of the Independent Monitoring Board (IMB).

3. It was not until shortly before lunch, when officers became concerned about Mr McIntyre's wellbeing and asked a nurse to assess him. The nurse did not arrive at Mr McIntyre's cell until 2.15pm, when she discovered he was dead.

Findings

4. The post mortem report gave the cause of Mr McIntyre's death as unascertained: toxicology samples tested negative for alcohol and drugs, the injuries Mr McIntyre sustained in the fight on 13 July 2016 were minor and there was no evidence of traumatic injury to Mr McIntyre's brain or of natural disease. The clinical reviewer concluded that the healthcare Mr McIntyre received was generally equivalent to the care he would have received in the community. However, a prison GP and a nurse were not sufficiently prompt in responding to Mr McIntyre during their segregation round, and the clinical reviewer said that this was a missed opportunity to establish whether Mr McIntyre was unwell at an earlier stage.

5. Although the precise time of Mr McIntyre's death is unknown, it is likely he had been dead for several hours before he was found. A range of staff failed to check Mr McIntyre's wellbeing appropriately on the morning of 14 July despite having repeated opportunities to do so and despite his location in Dartmoor's segregation unit.

6. Segregation unit staff must manage challenging behaviours, but prisoners housed there may also be particularly vulnerable. It is, therefore, unacceptable that numerous members of staff, of different ranks and disciplines, did not sufficiently satisfy themselves of Mr McIntyre's wellbeing. Dartmoor has since addressed the failings we have identified by introducing new procedures, and they have reminded staff of their responsibilities when checking on a prisoner's welfare. On that basis, we do not make a recommendation.

Recommendations

- The Head of Healthcare should ensure that prison GPs and other healthcare staff understand the purpose and outcomes of healthcare segregation visits, and communicate with prisoners appropriately to ensure their welfare and wellbeing.

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 him.

8. The investigator visited Dartmoor on 22 July 2015. He obtained copies of relevant extracts from Mr McIntyre's prison and medical records.

9. We were unable to complete our report until we had received the post mortem and toxicological analysis, which established the cause of Mr McIntyre's death. We apologise for this delay.

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

11. The investigator interviewed ten members of staff in April 2016, and gave the clinical reviewer transcripts of his interviews with healthcare staff.

12. We informed HM Coroner for Exeter and Greater Devon District of the investigation. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr McIntyre's family to explain the investigation, and visited them with the investigator. Mr McIntyre's family was concerned that Mr McIntyre was not adequately checked in the segregation unit.

Background Information

HMP Dartmoor

14. HMP Dartmoor holds around 650 adult male prisoners. Dorset Healthcare Unit Foundation Trust provides the prison's healthcare.

HM Inspectorate of Prisons (HMIP)

15. The most recent inspection of HMP Dartmoor was in December 2013. Inspectors found that the environment in the segregation unit had improved since their last inspection. Inspectors reported that staff on the unit had a good knowledge of the prisoners in their care and that relationships between staff and prisoners were good, but noted that this was not always reflected in prisoner's history sheets.

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 commended the way the segregation unit was managed when there was a full complement of experienced trained staff on duty, but that some concerns had been raised during the summer when experienced members of staff were transferred to other duties.

Previous deaths at HMP Dartmoor

17. Mr McIntyre's death is at present unascertained. There is no similarity between his and other deaths at the prison.

Segregation

18. Segregation units are used to keep a prisoner apart from others. This might be because a prisoner:

- behaves in a way that staff think would put people in danger or be disruptive, difficult to manage or be unsafe to others;
- feels vulnerable or under threat from other prisoners;
- is serving a punishment of cellular confinement between an alleged offence and an initial hearing;
- is serving a punishment of cellular confinement after a disciplinary hearing.

19. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

Key Events

20. In 2006, Mr Jeffrey McIntyre was convicted and sentenced to life in prison for rape, false imprisonment, threats to kill and for intimidating a witness. On 5 May 2006, he was sentenced to life in prison. On 25 July 2014, Mr McIntyre was transferred to HMP Dartmoor.

21. Mr McIntyre had a history of knee pain, high blood pressure and headaches, and received medication for these. There is no evidence in the port mortem examination that these issues contributed to Mr McIntyre's death.

22. In the weeks leading to his death, Mr McIntyre made allegations about his treatment at Dartmoor. We have not investigated these matters further as the issues raised were not material to Mr McIntyre's death. We understand from the National Offender Management Service that they have investigated these allegations.

13 July 2015

23. On the morning of 13 July 2015, Mr McIntyre had a fight with another prisoner. Officers intervened and split the prisoners up. A nurse treated cuts to Mr McIntyre's face, gave him a tetanus injection and noted that he was coherent and orientated. (Mr McIntyre's post mortem examination concluded that the injuries sustained in the fight were minor and did not contribute to Mr McIntyre's death.)

24. At around 10.50am, officers took Mr McIntyre to the prison's segregation unit. He was not restrained. The deputy healthcare manager assessed Mr McIntyre and concluded that he was fit to be segregated. She said Mr McIntyre was polite, in good spirits and orientated to time and place.

25. Later that morning, Mr McIntyre spoke to a member of the Independent Monitoring Board and the duty governor. That day, officers noted that Mr McIntyre did not want his lunch, as it was not what he had ordered, but that he ate his evening meal. An officer charged Mr McIntyre with the disciplinary offence of fighting with another prisoner.

26. At 5.48pm, a chaplain talked to Mr McIntyre through the observation hatch in his cell door. She said Mr McIntyre was coherent and that they talked about the charities he might want to donate to during Ramadan. She said she told Mr McIntyre not to worry about getting out of bed and that he thanked her for her help, waved and raised his thumb. She said Mr McIntyre raised no concerns or issues, but appeared tired. (Her contact was the last verbal contact that Mr McIntyre had with a member of staff.)

27. At around 7.45pm, Officer A, the night officer, arrived on the segregation unit. He received a handover from his colleagues and no one raised any concerns about Mr McIntyre. At 8.05pm, je checked Mr McIntyre by looking briefly through the door observation panel. He noted that the cell was dark and that Mr McIntyre appeared asleep. CCTV shows that further brief checks were carried out at 9.13pm and 10.17pm.

14 July 2015

28. At 5.04am on 14 July, Officer A checked on Mr McIntyre's cell as part of his morning roll check. At 6.00am, the officer noted that Mr McIntyre had had a very quiet night and had slept the whole time. He said he had not spoken to Mr McIntyre during the night. Officer B, the early start day officer, checked Mr McIntyre's cell at 6.45am, and noted that Mr McIntyre appeared to be asleep.

29. At 8.07am, Officer B and Officer C opened Mr McIntyre's cell door. Officer B said he asked Mr McIntyre if he wanted a shower, to exercise and for his menu choice. Mr McIntyre did not respond and the officer told him that if he did not get out of bed, he would choose his meal for him. Officer C said Mr McIntyre was lying on his left-hand side, facing inwards, his left hand was tucked underneath his head in a sleeping position and his eyes and mouth were closed. As Mr McIntyre did not respond, Officer B closed his cell door. Officer C said he was not concerned about Mr McIntyre. Officer B later noted that Mr McIntyre had refused to get out of bed or acknowledge himself and Officer C.

30. At 8.08am, a prisoner and wing cleaner started his cleaning duties. Although CCTV footage showed that he stopped outside Mr McIntyre's cell and spoke in its direction, he told police that he did not speak to Mr McIntyre at any point or hear other prisoners speak to him.

31. At 8.48am, Officer B returned to Mr McIntyre's cell to ask him again if he wanted a shower or exercise and to ask for his menu choices. He looked through the door observation panel and saw Mr McIntyre was in the same position as earlier and said that he had no concerns.

32. At 8.50am, a GP and Nurse A arrived at the segregation unit to carry out a welfare check of the prisoners. Officer C briefed them about the prisoners. The GP said he was told about Mr McIntyre's fight the previous day, that he had received treatment for a cut to his head and that he had had a tetanus injection. He said he was told Mr McIntyre had not complained of any medical issues.

33. At 8.52am, Officer C, Nurse A and the GP went to Mr McIntyre's cell. Officer C opened the cell door and the GP and the nurse stood behind the officer in the corridor outside. No one went into the cell. Officer C said he told the GP and nurse that if they were happy with Mr McIntyre from a medical point of view, he would deal with Mr McIntyre for the rest of the day. The GP said he did not speak to Mr McIntyre, but left with the impression that he was breathing as he could see movement on his chest. The nurse said she did not see or talk to Mr McIntyre. She noted on behalf of the doctor that he had seen Mr McIntyre breathing, but that he "would not engage with GP". The officer locked the cell door about twenty seconds later. He said he did not see Mr McIntyre breathing, but felt reassured that the nurse and GP had and that this confirmed his own belief there were no concerns about Mr McIntyre. (The GP, contrary to information from other members of staff, said Mr McIntyre was lying on his right-hand side, facing the wall.)

34. At 9.33am, a prisoner and wing cleaner told police he had a conversation with Mr McIntyre while mopping the floor outside Mr McIntyre's cell. He said Mr McIntyre called out his name and asked for some tobacco, saying he had a headache and

the tobacco would help him. He told Mr McIntyre he did not have any tobacco and that he should ask the nurse for a tablet. He said that he spoke to Mr McIntyre for about five minutes. He said he did not look towards Mr McIntyre's cell when he had the conversation, as he carried on cleaning the floor. (He told police that it was some weeks before he told staff about this conversation.)

35. At around 10.00am, the duty governor and Head of Security and Operations arrived on the unit. The officers briefed him before he started his daily round. He said he was told that Mr McIntyre was being difficult and was not speaking to staff. At 10.12am, Officer B unlocked Mr McIntyre's cell for the governor to speak to him. Both men stood outside the cell for about six seconds before the officer re-locked it. The governor told the investigator that Mr McIntyre was lying on his side with his eyes closed. He said he introduced himself and asked if Mr McIntyre had any problems, but got no response. He said he had no concerns about Mr McIntyre's welfare.

36. Just before 10.30am, the duty governor told Officer C to ask Mr McIntyre to attend his disciplinary hearing. The officer went into Mr McIntyre's cell and asked him if he wanted to attend the hearing. He said he talked to Mr McIntyre and said it would be in his best interest to attend the hearing. As Mr McIntyre did not respond, he left the cell twenty seconds later. He told the governor that Mr McIntyre did not want to attend, and the governor noted in the disciplinary hearing record that Mr McIntyre had refused to engage and that the hearing had been adjourned.

37. At about 11.30am, the Supervising Officer (SO), the duty manager, visited the segregation unit. The officers briefed him but raised no concerns about Mr McIntyre. At 11.52am, Officer B opened Mr McIntyre's cell door to ask if he wanted his lunch. The officer noted that Mr McIntyre was in his bed in the same position that he had been in earlier that morning and he still had not responded. He looked into the cell again about a minute or so later.

38. At 11.58am, Officer B unlocked Mr McIntyre's cell for a chaplain. Neither entered the cell and the officer locked the cell about twelve seconds later. The chaplain said she told Mr McIntyre that she would process his Ramadan charity choice and asked if there was anything else she could help him with. She said the officer had told her that Mr McIntyre had not responded to staff all morning. She noted that Mr McIntyre remained under his bed covers, with only his head showing, and although she noted that breathing was visible, he did not respond to her. (When the investigator interviewed her, she questioned her recollection of whether she had in fact seen Mr McIntyre breathing, but confirmed that he appeared to be lying in the same position as the previous night.)

39. Officer B said he became concerned by Mr McIntyre's lack of engagement and, after the chaplain visited, he discussed with Officer C how they might deal with Mr McIntyre's unresponsiveness. He told police that he discussed with Officer C how he could not see Mr McIntyre breathing, although others had said they had. He said that they had discussed going into the cell to shake Mr McIntyre, as he had been in the same position for several hours, but Officer C suggested they ask a member of healthcare to assess Mr McIntyre first, thinking that Mr McIntyre

might have some mental health issues. He said he agreed with Officer C, who he said was a more experienced member of staff.

40. At 12.25pm, Officer C contacted the prison's healthcare centre and spoke to Nurse A. He asked for a nurse to assess Mr McIntyre as he refused to interact with staff. He said he acknowledged that Mr McIntyre had already been seen by the healthcare team that morning, but felt he would be happier if a nurse could check on Mr McIntyre. He said that the nurse told him that she would ask Nurse B to check on Mr McIntyre, as she had a good rapport with him. She did not say when this would be. (Nurse A said she told the officer that when Nurse B returned from lunch, she would ask her to come and see Mr McIntyre.) The officer said he did not consider the situation to be urgent as the doctor had earlier reported having seen Mr McIntyre breathing.

41. Officer C was due to go to lunch at 12.30pm but remained on the unit for an extra 10 minutes to wait for Nurse B, believing she was on her way. She did not arrive, and he went to lunch.

42. At 1.39pm, Officer B unlocked Mr McIntyre's cell for a member of the IMB to complete his routine daily check of prisoners in the segregation unit. Officer C, who had now returned from lunch, was also present. None of the men entered Mr McIntyre's cell, but remained in the doorway. Officer B relocked the cell forty seconds later. The IMB member said that Mr McIntyre was lying on his right side, covered by a blanket and did not speak. He said he told officers he was concerned about Mr McIntyre's welfare.

43. Officer C telephoned Nurse A a second time and asked if Nurse B had been told to visit Mr McIntyre. He said she responded, "oh", followed by a pause, and said she would send her immediately. The IMB member said he decided to wait, but as no one from healthcare had arrived he left the segregation unit to get someone.

44. The member of the IMB returned to the segregation unit, followed by Nurse B just before 2.15pm. Nurse B said it was only then that she was asked to see Mr McIntyre. She said that Nurse A had forgotten to ask her. Nurse B explained to the member of the IMB and the officers that she felt Mr McIntyre would be more likely to engage with her if they waited out of sight of him in the corridor.

45. At 2.15pm, Officer B unlocked Mr McIntyre's cell. He said he was happy for the nurse to go into the cell on her own as he had assessed that there was no risk to her given her status as a member of healthcare staff. Nurse B called our Mr McIntyre's name, but got no response. She told the investigator that Mr McIntyre looked as if he was asleep, lying on his left side. She said she touched Mr McIntyre. She said she realised that Mr McIntyre was dead immediately as he was cold and rigor mortis was present, so no one tried to resuscitate Mr McIntyre.

46. The nurse immediately called for help from both officers who were standing outside the cell. Officer C called a medical emergency code blue, asked for the emergency response nurse to attend and said that an ambulance was required. The ambulance was later stood down when the prison GP confirmed at 2.20pm that Mr McIntyre had died.

Contact with Mr McIntyre's family

47. Mr McIntyre had named his sister as his next of kin. On the evening of 14 July, the police broke the news of Mr McIntyre's death to the family. The next day the Head of Residence Services and family liaison officer, spoke with the family. He later visited the family and several family members visited Dartmoor. The prison contributed to the cost of Mr McIntyre's funeral in line with national policy.

Support for prisoners and staff

48. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr McIntyre's death, and offered support.

Post mortem report

49. The post mortem examination concluded that Mr McIntyre's death could not be ascertained. The pathologist reported that Mr McIntyre's brain showed that no traumatic injury or disease contributed to his sudden death. Medical opinion indicated that Mr McIntyre's death could be classified as sudden cardiac death with morphologically normal heart (sudden arrhythmic death syndrome).

Toxicology tests showed that Mr McIntyre had therapeutic levels of paracetamol and amlodipine, which he had been prescribed for his high blood pressure. Mr McIntyre tested negative for alcohol and any other substances, including new psychoactive substances.

Findings

Unlock procedures

50. The Prison Officer Entry Level Training (POELT) manual says that before unlocking a cell, staff should physically check the presence of the occupants. It says that staff must ensure that they receive a positive response from them by knocking on the door and waiting for a sign of acknowledgment. The manual says that if staff do not get a response, they may need to open the cell to check that the prisoner has not escaped, is not ill or dead. This did not happen: staff failed to establish Mr McIntyre's welfare when they unlocked his cell at 8.00am.

51. Prison Service Order (PSO) 1700 on segregation, says that officers should engage in purposeful dialogue with prisoners and that managers, during their visits, should ensure that prisoners are being treated fairly, safely and with dignity.

52. Prison Service Instruction (PSI) 75/2011, Residential Services, says that staff have a key role in spotting signs of distress. It refers to previous examples we identified of staff failing when they unlocked prisoners' cells in the morning to identify prisoners who had died overnight. The PSI says that staff must engage positively with prisoners and where prisoners are not expected to leave their cell, staff should check their wellbeing by, for example, obtaining a response from them when they unlock their cells.

53. Dartmoor's local segregation unit policy dated January 2015 (and current at the time of Mr McIntyre's death), says that prisoners should be dressed and out of bed by 8.00am, and should stand to greet visitors so staff can be assured of their wellbeing.

54. The national instructions and local policy are clear that staff should ensure a prisoner's wellbeing. Between 8.00am and midday on 14 July 2016, a significant number of staff from a range of disciplines visited Mr McIntyre on eight occasions. Yet when he did not respond to them, they did nothing further to check his wellbeing. He remained in his bed, under his blanket, apparently asleep, lying in the same position.

55. While we recognise that initially staff might not have wanted to wake Mr McIntyre if he was asleep, they had a professional responsibility and a duty of care to check on his wellbeing. It is unacceptable that they repeatedly did not do so. It was not until lunch time, when officers became concerned about Mr McIntyre's wellbeing that they asked a nurse to review him. Despite this, the nurse did not arrive on the unit until 2.15pm. When she went into Mr McIntyre's cell, she found that he had died.

56. We are extremely concerned that it took over six hours and eight separate visits for staff to become aware that Mr McIntyre had died. The fact that this unacceptable sequence of events took place in the segregation unit, where prisoners may well be at heightened levels of vulnerability and risk and where staff responsibility for their welfare is particularly acute, magnifies these failings.

57. In light of Mr McIntyre's death and our investigation, Dartmoor updated their local segregation policy in April 2016. The policy now says that if a prisoner is not out

of bed by 8.00am, staff should satisfy themselves as to the prisoner's welfare by getting a response. The policy says that if staff are concerned about a prisoner not responding, they should assess the risk before going into the cell to check on the prisoner's welfare and they should call an emergency response code if there are any concerns. Since Mr McIntyre's death, Dartmoor has introduced new procedures. Staff are now required to check all prisoners in the segregation unit hourly for their first 24 hours on the unit. The Governor of Dartmoor also issued an order on 13 August 2015, which reminded staff of their responsibilities when they unlock prisoners. We are satisfied that Dartmoor addressed our concerns with the action they have taken and we therefore make no recommendation.

Segregation unit healthcare assessment

58. PSO 1700 on segregation says that healthcare staff must assess the physical, emotional and mental wellbeing of prisoners and whether there are any clinical reasons to advise against continuing segregation. Dartmoor's local segregation policy dated January 2015, required doctors and nurses to assess prisoners' physical, emotional and mental well being during visits.

59. Before the prison GP carried out his segregation round, staff told him that Mr McIntyre had been involved in a fight the previous day, that he received treatment for a cut to his head and had been given a tetanus injection. Given this information, and the fact that Mr McIntyre failed to respond to the officer who unlocked him that morning, we are troubled that the doctor did not adequately assess Mr McIntyre's welfare, for example, by trying to speak to Mr McIntyre. (His cell door was open for 20 seconds and CCTV showed the doctor and nurse standing behind the officer at the door of the cell.)

60. In his clinical review, the clinical reviewer said there were no significant concerns about the healthcare Mr McIntyre received that contributed to his death. He said that the care Mr McIntyre received was equivalent to that he would have received in the community. Despite this, he reported that the prison GP and Nurse A did not sufficiently prompt Mr McIntyre to respond during their visit. He said that had they done so, there might have been an opportunity to establish whether Mr McIntyre was impaired or unwell at an earlier stage.

61. The clinical reviewer noted that doctors and nurses provided an important independent function to officers and other prison staff. He said that the segregation checks by healthcare staff needed to be sufficient to give reassurance that prisoners had appropriate mental and physical capacity to remain in segregation. He said that a prisoner's suitability for segregation was ongoing and a prisoner's health could change over time.

62. The clinical reviewer concluded that although there was no current specific guidance about the structure and content of welfare checks, the clinicians undertaking them owed vulnerable prisoners in the segregation unit an important duty of care. He said that, healthcare professionals should be directed by their clinical knowledge to confirm that a prisoner's location in segregation was appropriate. He said that where there was doubt, they should take further action or seek further advice. We share his conclusions and make the following recommendation:

The Head of Healthcare should ensure that prison GPs and other healthcare staff understand the purpose and outcomes of healthcare segregation visits and communicate with prisoners appropriately to ensure their welfare and wellbeing.

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