Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Symes a prisoner at HMP Dovegate on 22 September 2018

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 Christopher Symes died of heart failure on 22 September 2018, at HMP Dovegate. He was 42 years old. I offer my condolences to Mr Symes' family and friends.

Overall, Mr Symes received a good standard of healthcare, equivalent to that which he could have expected to receive in the community.

The investigation found there were issues with Mr Symes medication. The pharmacy at Dovegate being did not dispense Mr Symes' prescription medication for six days.

It also found deficiencies in the use of emergency radio codes on the day Mr Symes died.

I am satisfied, however, that neither issue affected the outcome for Mr Symes.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 21 August 2018, Mr Christopher Symes was sentenced to 18 weeks imprisonment for breaching a restraining order. He was sent to HMP Dovegate.

2. Mr Symes arrived at Dovegate having been previously diagnosed with heart, liver and kidney failure. He also had Type 2 diabetes. His poor health was further complicated by a long history of substance misuse.

3. During a review on 22 August, a prison GP noted that Mr Symes appeared to have jaundice, a build-up of fluid in the abdomen and swelling to his legs. He identified that Mr Symes might be suffering from liver failure and referred him to hospital for further review. Hospital staff confirmed the diagnosis of liver failure and Mr Symes stayed in hospital until 29 August.

4. Following his discharge from hospital, Mr Symes was moved to the inpatient unit at the prison. Healthcare staff reviewed Mr Symes regularly and appropriately sought advice from secondary care providers.

5. On 10 September, during a routine review, a prison GP noted that Mr Symes' blood pressure was low and the swelling in his legs had increased. He sought advice from secondary care providers. A cardiologist who had been involved in Mr Symes' care prior to his imprisonment advised the GP that Mr Symes had previously been considered for a heart transplant but due to his long history of substance misuse this was not possible, and the only option open to him would be to treat the symptoms. He also concluded that Mr Symes' prognosis was not a positive one. Mr Symes' condition continued to deteriorate.

6. At 6.44am on 22 September, a nurse reviewed Mr Symes. He told the nurse that he had felt short of breath during the previous night. She rearranged his pillows so that he could sit up to ease his breathing.

7. At 8.45am, two Prison Custody Officers working on the inpatient unit told a nurse that Mr Symes had died. An emergency ambulance was called at 9.00am. At 9.22am, paramedics confirmed that Mr Symes had died.

8. The post-mortem report gave the cause of death as terminal heart failure and a failure of the left chamber the heart.

Findings

9. The clinical reviewer concluded that Mr Symes received a standard of clinical care equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately assessed his clinical needs and sought advice from secondary care providers.

10. However, we are concerned that between 31 August and 5 September, the pharmacy department at Dovegate did not dispense Mr Symes' prescription medications. Although this did not affect the outcome for Mr Symes, it could be critical in future cases.

11. We are also concerned that the officers who discovered Mr Symes unresponsive on 22 September, did not call an emergency medical code as they decided he was already dead. This is not a judgement that officers are qualified to make and they should always call for emergency medical assistance.

Recommendations

- The Head of Healthcare should review the system for the ordering and dispensing of prisoners' prescribed medications to ensure that:
    - medications are dispensed consistently and without delay; and
    - a mechanism is in place to identify those medications considered to be of an urgent nature.
- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, so that there is no delay in calling a medical emergency code or calling an ambulance.

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 him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Symes' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Symes' clinical care at the prison.

15. We informed HM Coroner for South Staffordshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The investigator wrote to Mr Symes' mother to explain the investigation and to ask if she had any matters she wished the investigation to consider. She did not respond to our letter.

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, provides healthcare services at Dovegate and there is an inpatient healthcare unit with 24-hour nursing care.

HM Inspectorate of Prisons

19. The most recent inspection at Dovegate was conducted in May and June 2017. Inspectors noted good interactions between healthcare staff and prisoners. They also noted sound information governance and use of SystmOne (the electronic medical 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. Mr Symes was the 11th man to die while a prisoner at HMP Dovegate since September 2015. All the deaths were from natural causes. There has been one self-inflicted death since. There are no similarities with those cases.

Key Events

22. On 21 August 2018, Mr Christopher Symes was sentenced to 18 weeks in prison for breaching a restraining order. He was sent to HMP Dovegate.

23. Mr Symes arrived at Dovegate with many pre-existing medical conditions, including congestive heart failure (a condition in which the heart does not function efficiently), Type 2 diabetes, acute kidney failure and liver failure. Mr Symes had recently been discharged from hospital, where he had received treatment for a chest infection and water retention.

24. During his reception health screen, Mr Symes said that he had a long history of drug and alcohol misuse, including smoking cannabis, injecting psychoactive substances (PS) and heroin. Healthcare staff contacted Mr Symes' community GP to obtain a copy of his current prescription medications. They noted his medications included a daily dose of 30mg of methadone (used as part of a treatment program for drug detoxification) and diazepam (used to treat the symptoms of alcohol withdrawal).

25. On 22 August, a nurse reviewed Mr Symes. She discussed his history of substance misuse with him. She created a five-day care plan to monitor his withdrawal from drugs and alcohol. As part of that care plan, Mr Symes was regularly reviewed and supported by the prison's mental health in-reach team (MHIRT).

26. Later the same day a prison GP reviewed Mr Symes. He concluded that Mr Symes presented as being extremely unwell. He appeared to have jaundice (a yellowing of the skin which can be an indicator of liver problems), ascites (a build-up of fluid in the abdomen) and swelling to his legs. He thought that he might have liver failure. He sent Mr Symes to hospital by emergency ambulance for review.

27. Hospital staff reviewed Mr Symes and confirmed that he had liver failure. They also diagnosed him with pleural effusion (a build-up of fluid between the lungs and chest cavity) and identified that he needed his chest drained to reduce the amount of fluid in the chest cavity.

28. Mr Symes stayed in hospital as an inpatient until 29 August. He was discharged back to prison and was transferred to the prison's healthcare inpatient unit. Hospital staff told a prison GP that Mr Symes had severe left ventricular dysfunction (an early stage indicator of heart failure) and had developed dilated cardiomyopathy. They decided that Mr Symes should be referred to the cardiologist who had previously reviewed him at the hospital. Mr Symes' treatment plans were updated in line with advice from hospital staff, and a referral was made to the cardiology team at the hospital the same day.

29. On 3 September, a prison GP reviewed Mr Symes. He noted that Mr Symes had not had received the furosemide and spironolactone (both used to treat water retention) or ramipril (used to treat high blood pressure in patients with heart conditions) medications he had previously been prescribed as part of his treatment plan. Healthcare staff repeatedly enquired about Mr Symes'

medications in the days that followed. Mr Symes received his medications on 5 September.

30. A prison GP reviewed Mr Symes again on 10 September. He recorded Mr Symes' blood pressure as low. He also noted an increase in the swelling to Mr Symes' legs.

31. The following day, a prison GP contacted the consultant cardiologist at the hospital for advice. The cardiologist diagnosed Mr Symes with dilated cardiomyopathy. He told the prison GP that Mr Symes had previously been considered for a heart transplant. However, his long history of substance misuse meant it was not possible for him to undergo such a procedure. He also told the prison GP that Mr Symes would only be offered treatment to treat his symptoms and he said that Mr Symes' prognosis was not a positive one.

32. The cardiologist told the prison GP to adjust Mr Symes' diuretic medication (used to increase urine production, which in turn reduces water retention, a side effect of the heart not pumping blood around the body effectively) and said that if the adjustment to his medication was not producing the required results, he could be admitted to hospital to undergo intravenous diuretic treatment. He told the prison GP that he would send him a letter confirming his prognosis for the prison records.

33. On 12 September, a prison GP met with Mr Symes. He told Mr Symes about the discussion he had had with the consultant cardiologist about his condition, and his poor prognosis. He noted that Mr Symes had understood what he had been told and that Mr Symes said that he wanted to have the treatment offered to him. The prison GP reviewed and adjusted Mr Symes' medication in line with advice from hospital staff and updated his treatment plans.

34. Mr Symes continued to mobilise and was able to collect his medication from the medication hatch, although he was increasingly short of breath.

35. On 21 September, a nurse reviewed Mr Symes. Mr Symes told her that he had slept in his chair because he experienced shortness of breath if he slept in his bed. The nurse arranged for Mr Symes to have extra pillows to try to make him more comfortable.

36. Later the same day, a prison GP reviewed Mr Symes. He noted that Mr Symes was short of breath and had a crackling in his lungs when he inhaled. He also noted that despite Mr Symes not reporting any chest pains, the swelling in his legs had increased and he appeared jaundiced.

37. At 6.44am, on 22 September, a nurse reviewed Mr Symes. He told her that he had felt short of breath during the night. The nurse rearranged his pillows to make him more comfortable and to try to ease his breathing. He told her he felt better and had no further issues.

38. At 8.45am, two officers told a nurse that Mr Symes had died. The nurse asked the officers if they had called a code blue (an emergency medical code indicating that a prisoner is not breathing). The officers said that there was no need for a code blue call because they had both checked Mr Symes and confirmed that he had died.

39. The nurse told the officers that, regardless of whether they thought Mr Symes had died, an emergency medical code should have been called. The nurse immediately radioed for the first responder in healthcare to assist him and she immediately made her way to Mr Symes' cell. The first responder told the nurse to check Mr Symes' condition and to call an emergency code blue.

40. The nurse collected an emergency grab bag, containing the emergency response equipment, from a nearby office and made his way back to Mr Symes' cell. He entered the cell at 8.48am and noted that Mr Symes was lying on his back on the bed, with a television remote control in his hand. His pupils were fixed and dilated. The nurse checked for a pulse, but did not find one.

41. At 8.52am, a nurse attached a defibrillator to Mr Symes' chest. It indicated there was no shockable rhythm. The first responder arrived shortly afterwards and noted that Mr Symes was cold to the touch and appeared cyanosed (a condition where the skin appears blue caused by low oxygen saturation levels). She also noted the early onset of rigor mortis (a rigidity of the body that begins to set in around two hours after death). The nurse made a code blue emergency call at 9.00am.

42. An external first responder arrived at 9.11am (first responders can administer emergency pre-hospital care). He attached an electrocardiogram (ECG used to check the electrical output of the heart) but could find no evidence of a heartbeat. The emergency ambulance arrived at 9.14am.

43. At 9.22am, paramedics confirmed that Mr Symes had died.

Post-mortem report

44. The post-mortem report gave the cause of death as terminal heart failure caused by acute left ventricular failure (failure of the left chamber of the heart which pumps oxygenated blood to the organs of the body) and dilated cardiomyopathy (decreased ability to pump blood due to damage to the left ventricle).

Contact with Mr Symes' family

45. On 22 September 2018, the prison appointed an officer to act as family liaison officer (FLO).

46. At 11:35am, the FLO accompanied by another officer, visited Mr Symes' mother, his nominated next of kin, to inform her of Mr Symes' death. They continued to offer the family support.

47. Mr Symes' funeral was held on 12 October. The prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

48. The staff who found Mr Symes were offered the support of the Staff Care and Welfare Team at the prison to ensure they had the opportunity to discuss any issues arising, and to offer support.

49. The prison posted notices informing other prisoners of Mr Symes' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by his death.

Findings

Clinical care

50. Mr Symes arrived at Dovegate with a number of pre-existing medical conditions for which he was prescribed appropriate medications. He had been diagnosed with Type 2 diabetes, heart, kidney and liver failure, complicated by a long history of substance misuse leading to reduced treatment options, which impacted greatly on his wellbeing.

51. The clinical reviewer found that healthcare staff regularly reviewed Mr Symes appropriately and referred him to secondary care for review. They also made good efforts to seek specialist advice in order to adjust his treatment when necessary.

52. The clinical reviewer concluded that the clinical care Mr Symes received at Dovegate was equivalent to that which he could have expected to receive in the community.

Mr Symes' medication

53. On 30 August 2018, a prison GP reviewed and adjusted Mr Symes' medication in line with advice from secondary care providers.

54. However, during a review on 3 September, he noted Mr Symes' prescription for furosemide, spironolactone and ramipril had not been dispensed. It was not until 5 September that the pharmacy department at Dovegate dispensed all the medications that Mr Symes needed.

55. When asked why the pharmacists at the prison were unable to dispense Mr Symes' full prescription, the lead pharmacist at Dovegate said that the delays were caused by a change in the system of ordering and dispensing medication from external providers to an in-house service provided by pharmacy staff at Dovegate. The lead pharmacist said that those changes to the system had led to a delay in the processing of Mr Symes' prescription.

56. He also said that further delays were caused because Mr Symes' prescription for ramipril had been written up as a tablet, when it should have been in capsule form. The prescription had to be re-written to reflect that change and his spironolactone medication was not in stock and had to be ordered, causing further delay.

57. The lead pharmacist said that once all the drugs were correctly prescribed and in stock, Mr Symes received his prescription on 5 September 2018. However, this meant that Mr Symes had been without his medication for 6 days.

58. Although the clinical reviewer considers the delay in prescribing the prescription medications did not make a difference to the outcome for Mr Symes, that might not be the case in future cases. The clinical reviewer also noted that Mr Symes would probably have felt more comfortable if he had received the medication. We make the following recommendation:

The Head of Healthcare should review the system for the ordering and dispensing of prisoners' prescribed medications to ensure that:

- **medications are dispensed consistently and without delay; and**
- **an alert mechanism is developed for those medications considered to be of an urgent nature.**

Restraints, security and escorts

59. When prisoners must travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this must be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk considering factors such as the prisoner's health and mobility.

60. On the occasion Mr Symes' was taken to hospital, staff carried out a thorough risk assessment and, appropriately, they did not restrain him.

Emergency response

61. On 22 September two officers told a nurse at 8.45am that Mr Symes had died. They did not call a code blue or contact the prison's healthcare first responder because they thought Mr Symes' was dead. The nurse called a code blue at 9.00am.

62. Prison Service Instruction (PSI) 03/2013, which covers medical emergency response codes, clearly states that a code blue should be called if a prisoner is unconscious or unresponsive, so that an ambulance may be called immediately.

63. In addition to PSI 03/2013, a local notice 005/2017, issued on 8 March 2017, by the Head of Custody noted concern that staff were not using emergency medical radio codes correctly. A pocket-sized emergency medical response code card was produced and issued to staff. The guidance in the notice to staff and on the code card says that if the incident does not warrant an emergency response, assistance should be sought from Hotel 1. However, in Mr Symes case, neither of those actions were carried out by the staff involved. Although they may have thought that Mr Symes had died, this is not a judgement that prison officers are qualified to make and they should, therefore, always use an emergency code to call for healthcare assistance.

64. When asked, a Custodial Operations Manager said that a code blue should have been called by the officers who found Mr Symes. While the delay in calling an emergency did not affect the outcome for Mr Symes, that might not be the case in the future. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, so that there is no delay in calling a medical emergency code or calling an ambulance.

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