Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Albert Dorsey, a prisoner at HMP Wymott, on 7 June 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 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*

Summary

1. 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.

2. 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.

3. Mr Albert Dorsey died on 7 June 2020 from pneumonia while a prisoner at HMP Wymott. Mr Dorsey was 80 years old. I offer my condolences to Mr Dorsey's family and friends.

4. The clinical reviewer noted that Mr Dorsey had chronic obstructive pulmonary disease (COPD) and cachexia associated with his chronic long-term illness. She concluded that the health and social care that Mr Dorsey received at HMP Wymott was of a high standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.

5. We found two non-clinical issues of concern relating to the emergency response on 4 June 2020. We found that there was a delay in staff calling an ambulance once an emergency had been reported and the record keeping for the emergency response was poor. The clinical reviewer concluded that the delay in calling an ambulance did not contribute to Mr Dorsey's death.

Recommendations

- The Governor and the Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency, and the need for the control room to telephone an ambulance immediately.

- The Governor should ensure that record keeping relating to a medical emergency (including NOMIS, Wing records and Control Room logs) is accurate and sufficiently detailed, and records are completed in a timely manner.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Dorsey's clinical care at HMP Wymott.

7. A PPO investigator has investigated non-clinical issues, including Mr Dorsey's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. Our family liaison officer wrote to Mr Dorsey's next of kin, his cousin, to explain the investigation and to ask whether she had any matters she wanted to be considered during the investigation. She did not respond to our letter.

9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies. They asked that two additional points be added, and this report has been amended accordingly.

Previous deaths at HMP Wymott

10. Mr Dorsey's death was the eleventh death at HMP Wymott since June 2018. Of the previous deaths, nine were from natural causes and one was a drug related death. There are similarities between Mr Dorsey's death and a previous death at HMP Wymott in September 2018. In that case there was a delay in an ambulance being called after a medical emergency code was called.

Key Events

11. On 20 December 2016, Mr Albert Dorsey was sentenced to eight years in prison for sexual offences. He was sent to HMP Leeds. On 6 February 2019, Mr Dorsey transferred to HMP Wymott.

12. Mr Dorsey was diagnosed with chronic obstructive pulmonary disease (COPD) (a lung condition that causes breathing difficulties) prior to his imprisonment and cachexia (a wasting syndrome) in January 2017 while at Leeds.

13. A Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order had been put in place at HMP Leeds. Mr Dorsey agreed that should he suffer a cardiac arrest, he would not be resuscitated. Mr Dorsey and a prison GP reviewed this on 7 June 2019.

14. By early 2020, Mr Dorsey had become frailer, though his medical condition was stable. Mr Dorsey and a nurse discussed palliative care and Mr Dorsey agreed to be referred to a hospice. On 7 February, he was referred to St Catherine's Hospice near Preston and a palliative care specialist nurse later assessed him.

15. Mr Dorsey remained stable and settled at Wymott. On 19 May, it was agreed that he should be discharged from St Catherine's Hospice care as there were no specialist palliative care issues. Hospice staff remained available for advice and support.

16. On 20 May, Mr Dorsey had a high temperature and shortness of breath. A nurse reviewed him using the National Early Warning Score tool (NEWS-2 is a tool developed to measure clinical deterioration and is an important tool to improve patient outcomes). Mr Dorsey had a NEWS-2 score of 6. This required a GP to see Mr Dorsey.

17. A GP diagnosed a chest infection and prescribed Mr Dorsey antibiotics and steroids. Given his symptoms, as a Covid-19 precaution Mr Dorsey was put into isolation. Over the next few days he appeared to be slightly better and his temperature came down.

18. However, on 4 June, Mr Dorsey became acutely unwell with increased breathing difficulties. At 11.15am, a nurse was called and went to I Wing to assess Mr Dorsey. She arrived on the wing around 11.25am.

19. On assessment she found Mr Dorsey had a NEWS-2 score of 8 requiring an emergency response. A nurse then called the prison control room and told them that Mr Dorsey needed a 'blue light' (an emergency) ambulance. She waited with him until the ambulance crew arrived.

20. A control room operator recorded the phone call from a nurse on I Wing and called an ambulance.

21. The North West Ambulance Service (NWAS) logged the call at 11.49am. NWAS despatched an ambulance at 12.02pm which arrived at 12.22pm. Paramedics took Mr Dorsey to the Royal Preston Hospital.

22. Later that day, Mr Dorsey was transferred to the Chorley District Hospital. His health deteriorated further. On the morning of 7 June, it was confirmed that Mr Dorsey had died in hospital.

Post-mortem report

23. There was no post-mortem and the Coroner accepted the cause of death provided by a hospital doctor who found that Mr Dorsey died of community acquired pneumonia and chronic obstructive pulmonary disease.

Non-Clinical Findings

Emergency Response

24. The Prison Service Instruction (PSI) 03/2013 – Medical Emergency Response Codes requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The PSI makes it clear that there should be no delay in admitting and discharging an ambulance.

25. Our investigation found that there were delays in calling an ambulance. However, the accounts of the emergency response to treat Mr Dorsey on 4 June 2020 are conflicting and made precise assessment of the delay difficult.

26. The nurse said that she responded to a 'code blue' (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) radio call at 11.15am on 4 June. The control room operator, in her statement, made no mention of a code blue being called at 11.15am. There is no written record of the code blue call in the control room log or the I wing observation book on 4 June. The prison said that no code blue was called by healthcare staff.

27. The nurse said that she arrived to assess Mr Dorsey on I Wing at around 11.25am, and carried out a NEWS-2 assessment, (which usually takes less than five minutes). She then telephoned the control room to call an emergency ambulance. This would place her telephone call to the control room at around 11.30am.

28. The control room operator recorded in the control room log a telephone call from the nurse on I Wing at 10.43am but said that this was an error. In her statement she said she rang for an ambulance immediately and that the first call from healthcare staff on I Wing about Mr Dorsey was between 11.50am and 12.10pm. She also said in her statement that there could have been a seven-minute period between her receiving a call from healthcare staff and calling the ambulance and that she made the emergency call between 11.57am and 12.10pm. NWAS records show they were first called at 11.49am.

29. There is an estimated maximum time gap of 20 minutes. It has not been possible to satisfactorily account for this gap from the available information. If they did not call a code blue, Healthcare staff should have called one when Mr Dorsey was first discovered to be unwell. The control room staff should have called an ambulance immediately after receiving the call from healthcare staff, but the control room operator said that there could have been around a seven-minute delay between the call from healthcare and her 999 call. A delay of even a few minutes may make a critical difference in a medical emergency. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency, and the need for the control room to telephone an ambulance immediately.

Record Keeping

30. We are also concerned about the lack of accurate and timely record keeping for the emergency response when Mr Dorsey became unwell on 4 June. There were gaps in the control room log. The main entry relating to Mr Dorsey was out of chronology and did not include the action the control room took. There was no timing of the emergency call. There was also no record of the ambulance leaving the prison or mention of Mr Dorsey being taken ill and the emergency response in the I Wing observation book on 4 June. The only account of Mr Dorsey's ill health, assessment and hospitalisation was recorded in his medical records. More detailed records would have shown clearly the decision-making processes and action staff took to provide care for Mr Dorsey. We make the following recommendation:

The Governor should ensure that record keeping relating to a medical emergency (including NOMIS, Wing records and Control Room records) is accurate and sufficiently detailed, and records are completed in a timely manner.

Lisa Burrell

Assistant Ombudsman **February 2021**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T I 020 7633 4100
F I 020 7633 4141