

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Inayat, a prisoner at HMP Dovegate, on 4 February 2021

**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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## 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Inayat died of a heart attack caused by heart disease on 4 February 2021, while a prisoner at HMP Dovegate. He was 64 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that, overall, the clinical care that Mr Inayat received at HMP Dovegate was equivalent to that which he could have expected to receive in the community. However, she identified that healthcare staff missed opportunities to escalate Mr Inayat's care in the two months before he died.
5. We did not identify any non-clinical issues of concern.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendations

- The Head of Healthcare should ensure that prisoners with hypertension are managed in line with National Institute for Health Care and Excellence guidelines.

## The Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Inayat's clinical care at HMP Dovegate.
8. The PPO investigator has investigated the non-clinical issues in Mr Inayat's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. The investigation included a paper review of prison incident logs, records, staff statements and a full review of the medical care received by Mr Inayat since his arrival at HMP Dovegate.
9. The PPO family liaison officer wrote to Mr Inayat's family to explain the investigation. Mr Inayat's family asked several questions about Mr Inayat's clinical care, the decline in his health and the investigation process, which are addressed in this report and the clinical review.
10. Following any death in custody, the PPO asks prisoners if they have any information they wish to share in confidence or if they require any support. No one came forward with any concerns or information.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

12. Mr Inayat's family received a copy of the draft report. They did not make any comments.

### **Previous deaths at HMP Dovegate**

13. There were four deaths from natural causes, two self-inflicted deaths and one drug-related death at Dovegate in the two years before Mr Inayat's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

14. On 30 October 2013, Mr Inayat was convicted of murder and sentenced to a minimum term of 22 years in prison. On 19 August 2014, he was transferred to HMP Dovegate.
15. In 2015, healthcare staff found that Mr Inayat had angina (chest pains caused by reduced blood flow to the heart) and heart disease.
16. On 24 November 2020, the clinical administrator recorded that Mr Inayat had high blood pressure. On 22 December 2020, 7 and 28 January 2021 healthcare staff checked Mr Inayat's blood pressure which remained high. There is no record that healthcare staff took any action to address his high blood pressure.
17. At 10.26pm on 3 February, Mr Inayat told two officers that he had chest pains and was struggling to breathe. At 10.29pm, a Custodial Operations Manager (COM) radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing and triggers the control room to call an ambulance immediately). The control room called an ambulance immediately. A nurse responded to the code blue and arrived at Mr Inayat's cell at 10.35pm to examine him and support staff.
18. At 10.50pm Mr Inayat stopped breathing. The nurse started CPR (lifesaving first aid procedure) and attached pads for the defibrillator (a machine that can help to restore a normal heartbeat). Two officers supported the nurse by giving Mr Inayat chest compressions. He started breathing after a few compressions.
19. The ambulance arrived and paramedics were in Mr Inayat's cell by 11.07pm. At 11.20pm, Mr Inayat stopped breathing again. Paramedics continued to give chest compressions for 40 minutes and at midnight, they confirmed that he had died.
20. The post-mortem examination found that Mr Inayat died from a heart attack caused by heart disease.

## Clinical Findings

21. The clinical reviewer concluded that overall, the clinical care that Mr Inayat received at HMP Dovegate was equivalent to that which could have expected to receive in the community. The clinical reviewer said that his long-term physical health was appropriately managed.
22. The clinical reviewer found that healthcare staff missed opportunities to monitor Mr Inayat's high blood pressure and escalate his care between 25 November 2020 and 28 January 2021. The clinical reviewer had no concerns about the emergency response.

**Karen Johnson**  
**Assistant Ombudsman**

**November 2021**



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