Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Vine, a prisoner at HMP Dartmoor, on 3 July 2021

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. 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 Paul Vine died in hospital on 3 July 2021, of severe chronic obstructive pulmonary disease while a prisoner at HMP Dartmoor. Mr Vine was 67 years old. I offer my condolences to Mr Vine's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Vine received at HMP Dartmoor was equivalent to that which he could have expected to receive in the community. He made no recommendations.

5. We found that the emergency response on 4 May 2021, did not follow prison policy and there was a delay in calling an ambulance. We make one recommendation.

Recommendation

- **The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance immediately.**

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Vine's clinical care at HMP Dartmoor.

7. The PPO investigator has investigated non-clinical issues, including Mr Vine's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered. In November 2021, the case was re-allocated to another investigator, who wrote up the report based on the previous investigator's investigation.

8. The PPO family liaison officer wrote to Mr Vine's next of kin, his daughter, to explain the investigation. She did not respond to our letter.

9. The initial report was shared with the Prison Service. The Prison Service pointed out a factual inaccuracy and this report has been amended accordingly.

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

Previous deaths at HMP Dartmoor

11. Mr Vine was the eighth prisoner to die at HMP Dartmoor since July 2019. Of the previous deaths, six were from natural causes and one was self-inflicted.

12. There are no similarities between our findings in the investigation into Mr Vine's death and our investigation findings for the previous deaths.

Key Events

13. On 1 May 2014, Mr Paul Vine was remanded to HMP Exeter. On 2 May, he was sentenced at Truro Crown Court to 18 years imprisonment for sexual offences.

14. When Mr Vine arrived at Exeter, healthcare staff completed an initial health assessment and identified that Mr Vine had COPD (Chronic Obstructive Pulmonary Disorder, a serious lung condition), which was controlled with inhalers and nebulisers. Throughout Mr Vine's time in prison, his COPD was reviewed regularly by clinical staff.

15. In July 2016, Mr Vine transferred to HMP Dartmoor.

16. In June 2017, a prison GP saw Mr Vine to review his COPD. During the appointment the GP talked about a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order, which meant that if his heart or breathing stopped he would not be resuscitated. Mr Vine said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. This decision was discussed with Mr Vine's sister and daughter.

17. In October, Mr Vine was referred for oxygen provision to relieve breathlessness associated with his COPD. He was given a supply of portable oxygen cylinders which helped him manage his condition.

18. In May 2019, Mr Vine was transferred to HMP Whatton.

19. In June, a prison GP saw Mr Vine. She reviewed his COPD and his DNACPR order. The GP noted that Mr Vine's use of his nebuliser and inhaler had increased. She referred him to the local hospital's respiratory team. Mr Vine later refused to attend the arranged hospital appointment.

2020

20. On 7 February 2020, Mr Vine transferred back to HMP Dartmoor.

21. In March, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, a national lockdown came into force across the country. In prisons, regimes were severely curtailed, a COVID-19 management strategy was implemented, and a range of services including drug and health services were reduced in scope. Face-to-face appointments were reduced, and some non-urgent appointments were cancelled.

22. On 1 April, Mr Vine was identified as vulnerable to infection and complications from COVID-19 and was given a shielding letter by prison healthcare staff. On 3 April, he moved onto the prison's shielding unit.

23. In August, Mr Vine was admitted to Derriford Hospital, Plymouth with an exacerbation of his COPD on two occasions and was reviewed by the respiratory team. His oxygen supply was altered to continuous low flow provision. Due to his deteriorating health, the prison appointed a family liaison officer (FLO) to support and inform Mr Vine's family. He spoke to Mr Vine's daughter about his health.

2021

24. Mr Vine's clinical condition gradually worsened throughout his time in custody. At a GP review on 12 April 2021, Mr Vine's COPD was assessed as being "end stage".

25. At around 1.10pm, on 4 May, an officer found Mr Vine in his cell struggling to breathe. She pressed the emergency alarm and healthcare staff were asked to attend. A nurse responded to the alarm and reached Mr Vine a few minutes later. He found Mr Vine struggling to catch his breath and his oxygen levels were low. He called a 'code blue' (a medical emergency code indicating when a prisoner is unconscious or having breathing difficulties) and gave him oxygen treatment.

26. At 1.18pm, the prison control room made a 999 call to South West Ambulance Service. An emergency ambulance arrived at the prison at 1.34pm. Paramedics treated Mr Vine before taking him to Derriford Hospital. Mr Vine was escorted by two prison officers but was not restrained in line with his assessed level of risk and health condition. During his transfer to hospital, Mr Vine's health deteriorated, and paramedics administered adrenaline medication.

27. On 5 May, the FLO rang Mr Vine's daughter to tell her that Mr Vine was in hospital. A visit was arranged for her to see her father for 6 May.

28. On 10 May, a prison nurse spoke with hospital staff. Hospital staff told him that Mr Vine was likely to be moved onto palliative care. The prison sent the Early Release on Compassionate Grounds (ERCG) paperwork to the hospital consultant to complete the medical assessment.

29. On 11 May, the hospital assessed that Mr Vine was ready for discharge, but his oxygen needs could not be met in prison. Mr Vine remained in hospital. Healthcare staff and hospital staff explored hospice and community hospital places for Mr Vine.

30. On 9 June, the results of a CT scan showed that Mr Vine had an aggressive type of lung cancer. He was assessed as not suitable for treatment due to his current health condition. On 10 June, hospital doctors gave Mr Vine's prognosis as 8-12 weeks.

31. On 25 June, following input from probation staff, the Governor endorsed the ERCG application. The application was submitted to the Ministry of Justice for their consideration and decision. Mr Vine died before a decision was made.

32. In the evening of 1 July, Mr Vine's health deteriorated significantly. Hospital staff were concerned that he was close to death and informed prison staff. At 9.45pm, the FLO rang Mr Vine's daughter and arranged an emergency visit for her.

33. On 3 July, at around 1.15am, the two prison officers on Mr Vine's bedwatch were concerned that Mr Vine had stopped breathing. They immediately alerted a nurse, who came and confirmed that Mr Vine had died. A hospital doctor later pronounced Mr Vine dead at 2.20am.

34. At 2.10am, the Duty Governor rang Mr Vine's daughter to tell her that Mr Vine had died. In line with policy, the prison contributed to the cost of Mr Vine's funeral.

Cause of death

35. The cause of death was provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Vine's cause of death as severe chronic obstructive pulmonary disease caused by lung cancer.

Non-Clinical Findings

Emergency Response

36. PSI 03/2013, *Medical Emergency Response Codes*, requires prisons to have a medical emergency response code protocol which should trigger healthcare staff to attend immediately (if they are on duty) and control room staff to call an ambulance immediately. It says that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. It makes it clear that there should be no delay in calling an ambulance (for example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called). The PSI also says, "It is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required".

37. On 4 May 2021, at around 1.10pm, an officer found Mr Vine in his cell struggling to breathe. She pressed the emergency alarm and healthcare staff were asked to attend.

38. The officer did not call a 'code blue' as she should have done, which is not in line with PSI 03/2013. She told us that she did not call a code blue because there were healthcare staff in the prison. However, the purpose of using an emergency code is not only to summon healthcare support but also to alert the prison control room to call an ambulance.

39. The time gap between the officer finding Mr Vine struggling to breathe and an ambulance being called was around eight minutes. In this case, the clinical reviewer considered that the delay did not contribute to Mr Vine's death. However, in other cases, a delay of even a few minutes might make a critical difference in a medical emergency.

40. We make the following recommendation:

    The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies in line with Prison Service Instruction (PSI) 03/2013. In particular, where there are serious concerns about the health of a prisoner, staff should use an emergency code immediately to alert control room staff to call an ambulance immediately.

Sue McAllister, CB
Prisons and Probation Ombudsman **March 2022**

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