

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Dovegate, in August 2008 at
Queens Hospital, Burton on Trent**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2009

This is a report into the circumstances surrounding the death of a life sentence prisoner at HMP Dovegate, on 16 August 2008. The man was 70 years old and died from natural causes at Queens Hospital, Burton on Trent. I offer my sincere condolences to the man's family for their loss.

The investigation was led by my one of my investigators. I must thank South Staffordshire Primary Care Trust (PCT) for the appointment of the clinical reviewer. I am also grateful to the Director and staff of HMP Dovegate, especially the Deputy Director whose assistance was a great boon to my investigator.

The findings of the clinical review have strongly influenced this report. I judge that the man received good quality care whilst at Dovegate. However, I am critical of the use of restraints on the man at the point when it was known he was critically ill. I also make recommendations regarding coordinated care plans and recording senior managers' decisions.

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SUMMARY

At the time of his death, the man was 70 years old. He had been serving a life sentence since 1981. The man had served his sentence in a variety of prisons. He was transferred to HMP Dovegate from HMP Kingston on 17 September 2003.

The man had an initial assessment when he arrived at Dovegate and was accepted onto the Therapeutic Community programme. He was allocated to the Therapeutic Community A Wing (TCA) on 10 October 2003. The man was taken off the therapy programme on 7 October 2004, but stayed in the unit as Dovegate senior managers decided that that it was the best location due to his age and health needs.

The man was admitted to Queens Hospital, Burton on Trent, on 9 June 2008 after complaining of chest pains. He discharged himself and returned to the prison before any tests could be undertaken. On 4 August, the man was treated for a chest infection, and it was noted that he was losing weight. He transferred to the prison's healthcare centre for observation.

Two days later, the man's condition had deteriorated and he was again admitted to Queens Hospital. He was given intravenous antibiotics, and was awaiting further tests and scans. Whilst at the hospital the man was escorted by two officers, and was restrained using the long escort chain.

The healthcare manager visited the man on 11 August. The healthcare manager was told by hospital staff that the man had terminal cancer but his likely life expectancy could not be given at that point. Efforts were made to find the man a place in a hospice.

Two days later, the man was visited by a second healthcare manager, and the security manager. He was sitting in a chair, receiving oxygen and looking poorly and weak.

The next morning, the second healthcare manager received a telephone call from the MacMillan Nurse at the hospital to say that the man's condition had deteriorated greatly since the previous day. The Director of Dovegate gave the order to remove the man's restraints and reduce the escort to a single officer. This was eventually complied with at 8.00pm. At 5.32am on 16 August 2008, the man died.

I address a number of issues arising out of this investigation. I conclude that Dovegate should have considered assessing of the use of restraint and the level of escort when there was a significant change in the man's circumstances. In addition, prisoners with multiple and complex health problems should have co-ordinated care plans, and senior managers' decisions to allow prisoners to remain in the Therapeutic Community need to be formally documented.

THE INVESTIGATION PROCESS

1. My investigator visited Dovegate and spoke to staff who knew the man. Notices were posted to staff and prisoners about the investigation, inviting contributions. No prisoners came forward wishing to be interviewed, but my investigator interviewed five members of staff. In addition, my investigator studied all the relevant prison records relating to the man, including his main prison record, medical records, statements made by staff. He also visited the man's cell.
2. South Staffordshire Primary Care Trust asked the clinical reviewer to carry out a review of the man's clinical care. I am grateful to the clinical reviewer. My investigator discussed aspects of the man's treatment with healthcare staff at Dovegate and with the clinical reviewer.
3. My investigator contacted Her Majesty's Coroner for South Staffordshire to inform him of the nature and scope of my investigation and request a copy of the Post Mortem report.
4. One of my family liaison officers maintained contact with the man's brother, during the investigation. The man's brother did not have any specific issues he wished to be considered by my investigator.

HMP DOVEGATE

5. Opened in 2001, Dovegate is a category B prison for adult male prisoners sentenced to over four years. It is managed by Serco under contract to the National Offender Management Service (NOMS). It currently holds up to 860 prisoners. This is made up of 660 in the main prison and 200 in the Therapeutic Community (TC). Healthcare services in Dovegate are provided by Serco Health.
6. The therapeutic environment in the Dovegate TC is based on group work. It takes serious offenders, who have often been disruptive elsewhere, and places them in a community for a two year period. The community focuses on group therapy, led by a prisoner chosen from within the group, and supervised by prison staff. Group members are challenged over their attitudes to offending to make them aware of the suffering experienced by victims, and helped to work towards changing their behaviour and attitudes.
7. The last inspection of Dovegate by HM Chief Inspector of Prisons, Dame Anne Owers, before the man's death was in December 2006. It was an unannounced follow up inspection of the TC. The Chief Inspector found that:

“Dovegate TC had established itself as an important and effective contributor to the management of serious, long-term and challenging prisoners in England and Wales.”

8. In particular, her report said:

“We first inspected the unit in 2004 and commended its innovative contribution to working with serious, long-term and often very difficult prisoners, although we were concerned that some beds were being filled by inappropriate prisoners for commercial rather than therapeutic reasons. This short follow up inspection reaffirmed the value of the therapeutic community model at Dovegate, but once again found too many inappropriate prisoners being held on the unit. This disrupted therapy, blocked beds and provided little benefit to those who did not wish to be there.”

9. The Chief Inspector went on to say:

“Dovegate TC remained a largely safe and well controlled place with the impressive levels of peer support and self-management that distinguish successful TCs. Accommodation was of good quality and the range of services, including healthcare, were now reasonable.”

10. The Dovegate Independent Monitoring Board (IMB) published their last report in January 2008. The IMB commented on the TC as follows:

“The communities, run on a democratic model, develop their own characteristics, and during the past year the Board has observed communities becoming unsettled when the number of residents out of therapy rises. In theory, a resident who opts out of the therapeutic regime, or is deselected, returns to his sending establishment. In practice, this does not

happen, in part because of the difficulty of moving lifers who make up a large proportion of the TC.”

11. Regarding healthcare at Dovegate, the IMB reported:

“The inpatient facility has 12 beds but for the majority of time the need is for single rooms which reduce the area to six beds.”

“Sometimes a prisoner can be in the hospital for a long time. They usually come from the most vulnerable prisoners who find living on the wings is more than they can cope with.”

“The IMB do receive complaints about the healthcare centre. They generally are around missed appointments and the time it takes to get an appointment with a specialist. The missed appointments are sometimes due to transport and escort problems. The time to get an appointment with a specialist is about the same time as it takes a member of the public to get an appointment.”

12. The man was the sixth prisoner to have died at Dovegate since 2004 when I took responsibility for investigating all deaths in prison custody. None of the circumstances of the previous deaths is similar in nature, although two were of prisoners located in the TC.

KEY FINDINGS

13. Born in London in September 1937, the man had been married and had a daughter and a son. He became estranged from his family following his arrest and subsequent conviction. However, the man had contacted his brother in the weeks before he went into hospital and had asked him to be his nominated next of kin.
14. The man was first remanded into custody to HMP Brixton on 29 August 1980. He was convicted and given a life sentence on 14 August 1981, and then transferred to HMP Wormwood Scrubs. Over the next 20 years, the man moved to different prison establishments until he was transferred HMP Dovegate on 17 September 2003.
15. Over the period of time that the man was in custody he had suffered from different health problems. These included emphysema (lung disease), pulmonary embolism (blockage of the pulmonary artery or one of its branches), prostratism (enlarged prostate gland), and arthritis. The man's regular medication included Diclofenac (anti-inflammatory and analgesic for arthritis), suppositories (laxative/haemorrhoid drug), aspirin, Omeprazole (treatment of stomach conditions), and Tamsulosin (treatment of enlarged prostate gland). In addition, he took Warfarin (anticoagulant medication to thin the blood).
16. The man was located on the Therapeutic Community (TC), and allocated a ground floor single cell on A wing (TCA). After 18 months in the TC, he decided that he no longer wished to engage in group therapy. When a prisoner makes this choice they are expected to transfer to a normal houseblock or be returned to the prison from which they had transferred to Dovegate. However, the prison's senior managers decided that, due to his age and health, he should remain in the TC because ground floor accommodation and the TC regime were beneficial to him. The man stayed in the TCA until shortly before he was taken to hospital.
17. The clinical reviewer has highlighted that the number of the man's medical conditions resulted in hospital appointments with five specialities at Queens Hospital, in addition to treatment within the Emergency Department. A number of cancellations and changes were made to his outpatient appointments, the majority made by the hospital. For example, the prison doctor made an urgent referral to the orthopaedic service in December 2007 and an initial appointment was for 18 January 2008. The hospital made three changes to the appointment and the man was eventually seen on 15 July.
18. On 9 June 2008, the man complained he was having chest pains and was taken to the Emergency Department at Queens Hospital. He was due to have various tests completed but discharged himself and returned to the prison the next day.
19. Several weeks later on 4 August, healthcare staff noticed that the man was losing weight and he was treated for a chest infection. He was moved to healthcare for a period of observation. He was advised to sit up as much as possible and encouraged to use his inhalers.

20. By the morning of 6 August, the man's condition had deteriorated considerably. At 8.30am, he was taken by ambulance to the Emergency Department at Queens Hospital. A risk assessment for the man's escort was authorised by the duty director. The order was for a two officer escort, with a long chain single restraint. It was not known at the time how long the man would be at the hospital and consideration was given to public safety because of the seriousness of his convictions.
21. Following initial assessment in the Emergency Department, the man was moved to a ward. At 1.00pm, prison healthcare staff made a follow up call to the hospital to check on the man's condition. The hospital staff said that he was receiving intravenous antibiotics and was due to have tests and scans.
22. The healthcare manager visited the man on 11 August. The healthcare manager was told by the hospital staff that a diagnosis of terminal lung cancer had been made. The hospital had made a referral to the MacMillan Services for cancer support. In addition, a hospice place was urgently being explored by hospital staff. The bedwatch and restraints remained in place.
23. Three days afterwards, the man was visited by the second healthcare manager and security manager for Dovegate. The second healthcare manager found the man sitting out of bed and receiving continuous oxygen. She observed that he looked very poorly. Hospital staff told her that the man had been visited by members of his family. No changes were made to the arrangements for the bedwatch or restraints.
24. During the morning of 15 August, the MacMillan Nurse contacted the second healthcare manager to say that the man's condition had deteriorated greatly since the previous day and that it would only be a short time before he passed away. The second healthcare manager spoke to the Director of Dovegate to ask for the restraints to be removed. The Director asked for written confirmation from the hospital of the man's condition before he would make any decision to alter the escort arrangements. The hospital provided the information by fax later that afternoon. A new risk assessment was completed which reduced the escort to one officer, with no restraint required. The order was given at 6.00pm and the restraint was removed at 8.00pm with a single officer in place as escort. The officer on duty at the time was a Prison Custody Officer (PCO).
25. Later that evening the first PCO handed over escort duty to a second PCO. The second PCO was present when the man died at 5.32am on 16 August. His death was confirmed by the doctor of Queens Hospital at 5.45am. The prison chaplain contacted the man's family to inform them later that morning. Notices were issued to both staff and prisoners to let them know of the man's death.
26. In the days following the man's death, the deputy director was in regular contact with his family. In addition, the deputy director made arrangements with the funeral directors, with the costs offered in full by the prison.

ISSUES

Remaining in the Therapeutic Community

27. In her report of December 2006, HM Chief Inspector of Prisons raised concerns about prisoners remaining in the TC once they had come out of therapy. Whilst I have every respect for the Chief Inspector's recommendation, I accept that in the man's case the decision to keep him in TCA was intended to promote his welfare and wellbeing. Having visited the TCA and seen the man's cell, my investigator believes that the location was well suited to meet his needs. However, such decisions should be formally documented so that there is a clearly recorded rationale for the actions taken.

The Director should ensure that the reasons for deciding that prisoners may remain in the Therapeutic Community when therapy has ended are fully documented.

Use of restraint

28. When there are any changes to a prisoner's circumstances, a new risk assessment for the bedwatch requirements should be undertaken. The prison healthcare contract manager knew that the man was terminally ill on 11 August but did not review the use of escorts and restraints. Another healthcare manager and security manager visited three days later and described the man as very weak, but again there was no review of the risk assessment.

29. The next morning, after a telephone call from the hospital about the man's worsening condition, the healthcare manager asked the prison's Director to remove the restraints. A new risk assessment (which Dovegate was unable to provide for my investigator) was only completed following written confirmation being faxed from Queens Hospital. The restraints and one escort officer were eventually removed at 6.00pm that day, only 11 hours before the man died. The single bedwatch officer remained until the man passed away.

30. At interview, the duty director, confirmed that all bedwatch risk assessments should be reviewed daily by the visiting manager. The Local Security Strategy concerning managers' visits to prisoners in hospital states:

"The bedwatch will be visited daily by a manager who will check to ensure it is being conducted properly, including the maintenance of records and who will replace the mobile phone battery if supplied. The manager will complete the Management Bedwatch Checklist."

31. The checklist is a tick list to confirm that the escort officers have followed and completed the required procedures. It does not provide confirmation that the existing risk assessment has been reviewed or what changes, if any, are required.

32. In April 2008, all Governing Governors and Heads of Groups were sent a written communication from the Head of Security, National Offender Management

Service. It provided a summary of two judicial reviews concerning the risk assessment procedures for hospital escorts and bedwatches, with particular emphasis on the use and application of restraints. Specifically the summary states that:

“The Judgement ...

- Makes the distinction between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and those risks posed by the same prisoner when suffering from a serious medical condition. Medical opinion regarding the prisoner’s ability to escape must therefore be considered as part of the assessment process.
- Deems the restraining by handcuffs of a prisoner receiving chemotherapy (and, by implication, other life saving treatment) degrading. Such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
- Requires that each decision is properly considered taking account of all relevant information and be proportionate to the risks involved.
- Requires a fresh risk assessment to be conducted each time it is reviewed in order to establish: the level of restraints to be used during transportation to and from the hospital and the level of restraints to be used during the prisoner’s stay in hospital.”

33. In light of the advice offered to all prisons in April 2008, consideration should therefore have been given to the man’s bedwatch arrangements from 11 August onwards. At this point there was a significant change to the man’s circumstances as he had been diagnosed with terminal cancer. By 14 August, the man’s condition had deteriorated as witnessed by the healthcare manager. The risk assessment should have been reviewed and the man’s privacy and dignity should have been considered. Instead, no reviews appear to have taken place until a few hours before the man’s death.

The Director should amend the Local Security Strategy to incorporate the guidance from the National Offender Management Service regarding the risk assessment procedures for hospital escorts and bedwatches.

Clinical care

34. The clinical review highlights the number of appointments that the man had with different hospital specialists. The review recognises that, in the man’s case, the majority of cancellations and changes were by the Queens Hospital. However, there appeared to be limited liaison between the treating clinicians to link any findings and/or investigations. There were also delays before Dovegate received feedback from consultations, and in one instance the report was not forwarded for three months.

The Healthcare Manager should consider a mechanism to ensure that prisoners who have complex health problems, which require referrals to different hospital specialists, have a coordinated single case management plan.

RECOMMENDATIONS

1. The Director should ensure that the reasons for deciding that prisoners may remain in the Therapeutic Community when therapy has ended are fully documented.

This recommendation reflects the working practice at the time. However, residents no longer remain on the Therapeutic Community after they have completed therapy. They are now relocated to a specific Resettlement Unit for transfer from the Therapeutic Community. Therefore this requirement is not now necessary.

2. The Director should amend the Local Security Strategy to incorporate the guidance from the National Offender Management Service regarding the risk assessment procedures for hospital escorts and bedwatches.

This has been accepted. Assistant Director of Security and Operations is to review the Local Security Strategy (LSS) for compliance by 31 March 2009.

3. The Healthcare Manager should consider a mechanism to ensure that prisoners who have complex health problems, which require referrals to different hospital specialists, have a coordinated single case management plan.

This has been accepted. The Healthcare Manager is to review current protocols and co-ordinate mechanisms to improved case management to ensure continuity of care across different hospital specialists by 31 July 2009..