Investigation into the circumstances surrounding the death of a prisoner at HM Prison Dovegate on 23 January 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2005

CONTENTS

Summary

Investigation methodology

The prisoner

HMP Dovegate

Events prior to the prisoner's death

Events after the prisoner's death

Findings and conclusions

Recommendations

This is the report of an investigation into the death of a prisoner at HM Prison Dovegate on 23 January 2005. The cause of death was cardiac failure.

One of my Investigators conducted this investigation. I also invited East Staffordshire Primary Care Trust (PCT) to undertake a clinical review into the care and treatment given to the prisoner. However, the PCT declined to undertake such a review, primarily because Dovegate does not commission its healthcare services from the National Health Service. The clinical review was therefore undertaken by an appropriately qualified independent clinician commissioned by my office.

I would like to extend my condolences to the prisoner's family for their loss. I would also like to thank the Director of HMP Dovegate, and his staff for their help and co-operation during this investigation.

I make no recommendations in this report, although the authorities at Dovegate will wish to check what offer was made in respect of funeral expenses in line with my comments in paragraph 45.

Apart from some very minor amendments, and removal of those involved the text of my report is as I submitted it in July 2005. I now refer to the prisoner as the 'man'.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2005**

Summary

On 27 September 2002, the prisoner was sentenced to 4 years imprisonment for a sexual offence. This was not his first period of imprisonment. On sentencing, the man was initially held in HMP Parc. In June 2004, he transferred to HMP Dovegate. He was a Category B prisoner until January 2005, when he achieved category C status. Following his re-categorisation, the prisoner hoped to be transferred back to HMP Parc prior to his release, in order to receive visits. He was due for release in March 2005. The prisoner did not have any identified serious health concerns when he came into custody.

On Sunday 23 January 2005, at 7.00pm, the prisoner died at Dovegate. He was 55 years old when he died. He had been taken to the Health Care Centre from his residential wing complaining of chest pains. Whilst in the Health Care Centre, the prisoner suffered a cardiac arrest and lost consciousness. Cardio-Pulminory Resuscitation (CPR) began immediately and it was noted that the prisoner was breathing, although he remained unconscious. The prisoner then suffered a further cardiac arrest and, despite the continuous efforts of prison nursing staff and paramedics, he was pronounced dead. The clinical review into his care and treatment whilst in custody concludes that he received a good level of medical care, comparable to that which is available in the wider community.

The Prison Service did not inform my office of his death until April 2005. Meanwhile, the inquest had been held on 7 March 2005 at which it was concluded that he had died of natural causes.

The investigation process

1. The investigation was opened at Dovegate on 13 April 2005 when Notices were sent to staff and prisoners notifying them that my office was conducting an investigation into the death of the man. The Director and his staff produced his core record, his Medical Record and a number of other documents for examination.

2. My investigator visited HMP Dovegate on 20 April, and spoke with representatives from the prison including staff and a fellow inmate who had known the prisoner at the time of his death.

3. One of my Family Liaison Officers contacted the prisoner's partner and offered the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that she would like explored and addressed. The family have no issues in respect of the care or treatment afforded to the prisoner whilst he was in custody, but would like to see a copy of the draft report.

4. My investigator contacted Her Majesty's Coroner to request a copy of the Post Mortem report.

5. HMP Dovegate is a contracted prison that provides its own healthcare. The East Staffordshire Primary Care Trust was given the opportunity to conduct a review into the prisoner's clinical care and management. However, as they are not the commissioning body they have declined to conduct a review. In light of this decision, my office independently commissioned a clinical review.

6. Although Dovegate told the Prison Service Headquarters of the prisoner's death promptly, my office was not notified until April 2005.

The prisoner

7. The man was born in 1950. He was one of 11 children and was brought up by his grandparents. He remained in contact with some of his siblings.

8. He left school with no qualifications. However, he later became a qualified bricklayer and had been employed as a painter and decorator. He had also undertaken some factory work as well as working as a Security Guard. At the time of his conviction, he was unemployed.

9. He had been married and has one grown-up son. However, the marriage broke down some time ago and there is no indication that contact was maintained between the prisoner, his ex-wife or his son.

10. He lived with his partner, who was his identified next of kin. She remained supportive of him throughout his sentence. Contact was maintained through frequent telephone calls and letters. However, due to the distance and expense involved, the prisoner did not receive any visits from his partner whilst at Dovegate.

11. He had a history of offending dating back to 1964. The offences were varied and included previous sexual offences. Consequently, he had experienced prison on a number of occasions. Throughout his custodial history, the prisoner did not participate in any programmes, for example the Sex Offender Treatment Programme (SOTP), to address his offending behaviour.

12. From September 2002 until 10 June 2004, he was held in HMP Parc. In June 2004, he was transferred to Dovegate.

13. In late November 2002, the prisoner complained of pain and discomfort in his groin and was admitted to the Health Care Centre at Parc for assessment. He was then referred to an outside hospital for tests, as there was a suspicion that he was suffering from kidney stones. The prisoner was advised to take regular analgesics for the pain and to drink plenty of fluids. However, a subsequent test on his urine sample detected the presence of abnormal cells for which he was referred for further investigations including a cystoscopy and biopsy.

14. From 3 to 5 June 2004, he was treated as an inpatient at hospital. The investigations undertaken did not detect anything sinister or untoward.

15. He was transferred to HMP Dovegate on 11 June 2004. On arrival at Dovegate, the Health Care staff reviewed him. The prisoner's reception screening indicates that he had suffered from a torn muscle in his left leg. He also stated that he had a hernia. The prisoner indicated that there was a family history of heart problems in that his mother had died of a massive heart attack, but denied that he had a heart condition.

16. On 29 June 2004, the prisoner made a formal complaint to the prison about the lack of treatment for his hernia, stating that whilst he was at Parc he had been advised that he would require an operation. He had been complaining for some months of a pain in his groin. The Health Care Centre advised him that a previous investigation had not detected anything untoward. However, on 13 September, the prison arranged for him to attend another hospital, as an outpatient. Investigations determined that there was no convincing evidence of a hernia and the prisoner was duly informed of this.

17. The only other contact the prisoner had with the Health Care Centre at Dovegate was on 5 August, when he, along with a number of other prisoners, was a victim of assault on 'G' wing. He received a cut above his right eye from a punch that required some sutures. The sutures were removed on 10 August. As a result of this incident, he and other prisoners made applications for compensation to the Criminal Injuries Compensation Board (CCCB). At the time of his death, the prisoner was still awaiting the outcome of his claim for compensation.

18. On 11 January 2005, the prisoner was told that he had been successful in achieving category C status. It was his intention to seek a transfer back to Parc, in order to receive visits from his partner prior to his release on 31 March 2005. According to his personal officer, the prisoner was a quiet man who did not present any problems to staff. He would spend a lot of his time watching television in his cell. He shared a cell and it was reported that he got on well with his cellmate. Whilst at Dovegate, the prisoner did not take part in any educational programmes and was not employed. He did not engage in any offending behaviour programmes.

19. There is no indication from speaking to the prisoner's personal officer or his cellmate that he was unduly worried about his health. There is nothing to indicate that, in the time preceding his death, the prisoner was suffering from any chest pains, although he had taken to wearing a pressure bandage on his left arm. The prisoner complained on occasion of indigestion and was in the habit of drinking milk in order to reduce the discomfort.

20. Before his sentence, the prisoner lived with his partner. Following his death, his ex- wife and someone representing his son telephoned the prison claiming to be the rightful next of kin. The prison, quite rightly, sought advice from the Coroner who advised that his current partner should be considered the next of kin.

.

21. Following the prisoner's death, a member of the prison chaplaincy acted as family liaison officer. This role has included arranging for his partner to view the body in the Chapel of Rest, as well as visiting Dovegate in order to meet staff and prisoners who knew him.

HMP Dovegate

22. Dovegate opened in July 2001 and is a male category B training prison. It is operated by Premier Custodial Services, now part of the SERCO Group. Dovegate consists of two prisons, the main prison and a Therapeutic Community (TC). The establishment has capacity for 1,060 prisoners of whom 600 can be housed in the main prison and 200 in the TC

23. The prison is not well served by public transport and is well away from the home areas of most prisoners. The prison offers a wide variety of education programmes as well as industrial work including light engineering, packing and other manual activity. There is a large gymnasium, with a well equipped weights room as well as a football pitch and running track.

24. Dovegate runs a 24 hour primary healthcare facility, which has a full time medical officer. There are regular clinics by a dentist, chiropodist, optician and psychiatrist. The prison contracts staff working within the Health Care Centre although agency staff are used to meet shortfalls in staffing levels.

25. In the past, Dovegate has suffered from a high turnover of staff that has led to the dilution of experience within the prison. According to a member of the Independent Monitoring Board (IMB) to whom my investigator spoke, staff retention rates are now becoming more stable.

Events leading to the prisoner's death

26. On Sunday 23 January, at approximately 5.30pm, the evening meal was being served on 'G' wing. The prisoner had been served his main meal, although he was unable to eat it. However, he did take some ice cream in order to aid his digestion. According to staff who had seen him that day, he did not complain of any pain or discomfort.

27. At 5.30pm, the prisoner approached two members of prison staff, one of whom was his personal officer who were working on the servery and asked if he could speak to one of them. He complained of pains in his right arm and his chest and was holding his hands across his chest. The prisoner felt that he had indigestion. He looked pale.

28. The prisoner was told to lie down in his cell, although he commented that this made the pain worse. He was therefore advised to sit down instead. Because of his pain he was accompanied by an officer, whilst another officer contacted healthcare by telephone, detailing his symptoms.

29. Initially, staff from healthcare stated that they would attend 'G' wing to assess the prisoner. However, it was quickly decided that because of his symptoms, the prisoner should be taken immediately to the Health Care Centre. There he could be assessed and monitored more effectively with the specialised equipment that was to hand. Staff in healthcare strongly advised the custody officers that the prisoner should be transported from 'G' wing to the Healthcare Centre, a distance of some 200 yards, by wheelchair. A wheelchair was available for use on the wing.

30. When staff returned to the prisoner's cell with a wheelchair, he appeared to be a little more relaxed sitting on a chair. He continued to complain of pains in his chest as well as a horrible taste in his throat.

31. At first, the prisoner was reluctant to leave the wing in a wheelchair and walked with the aid of two officers to the wing exit. He then agreed to be pushed to the Health Care Centre. On leaving his cell he asked his cellmate to look after his possessions as he was going to hospital. Whilst he was being conveyed to the Health Care Centre by the two custody officers, the prisoner was quite chatty, talking about his home and his family.

32. At 5.45pm, the prisoner arrived with his escorts at the Health Care Centre. He was taken to the triage room where he was asked to sit on a bed. He was attached to a heart-monitoring machine. Whilst this procedure was being carried out, he was asked by the nurse if there was any family history of heart problems. The prisoner confirmed that his mother had died of heart failure and joked that he had some time to go yet. His pulse and blood pressure were taken. The pulse was weak and his blood

pressure slightly elevated. The ECG test confirmed that some myocardial damage had occurred that indicated a problem with his heart.

33. In view of the ECG reading, the prisoner was immediately given 300mg of aspirin that he swallowed in the nurse's presence. The nurse had also ensured that an ambulance was called and the Duty Operations Manager informed. An oxygen cylinder and mask was prepared for his immediate use.

34. On returning to the triage room, the prisoner was informed by a nurse that he was being taken to hospital. Whilst sitting on the bed, it was noted that his complexion paled and his eyes rolled to the back of his head. He became unconscious and slumped on the bed. The time was approximately 6.00pm.

35. In response to his collapse, another member of the nursing staff was summoned to the triage room and cardio–pulmonary resuscitation (CPR) began. After approximately two minutes of CPR, it was noted that he could breathe unaided. However, his pulse was faint and he remained unconscious.

36. Healthcare staff had been advised to contact the paramedic team if the prisoner's condition deteriorated. Whilst a member of the nursing staff was speaking to the paramedic team, he suffered another cardiac arrest. The time was 6.05pm. The information was relayed to the paramedics by one of the custody officers who had escorted the prisoner to the Health Care Centre, thus allowing the nurse to attend the triage room and assist her colleagues with CPR.

37. CPR continued by three members of the health care nursing staff without interruption. A spinal board was placed under the mattress of the bed to reduce the bounce effect and to allow for more effective treatment. However, there was no evidence of a pulse or respiratory effort from the prisoner. Nursing staff attempted to insert a geudal airway in order to assist with his breathing, but they were unable to do this as his jaw had locked in a closed position. An ambubag was connected to the oxygen mask already on his face. There was still no cardiac output.

38. At 6.30pm, the ambulance arrived and the paramedics were promptly escorted to the triage room. The paramedics attached their own cardiac monitor to the prisoner's chest and continued with CPR. Electric shocks were also delivered via the defibrillator, but there was still no response.

39. After approximately five minutes of CPR in the triage room, the paramedics decided to move the prisoner to the ambulance by stretcher. An intubation tube was inserted into his throat to oxygenate his lungs. An intravenous canula was inserted into the forearm so that advanced life support medication could be administered. Heart massage and shock treatment continued for a further 30 minutes. Throughout this procedure there was no response from the prisoner.

40. At 7.00pm, the prisoner was pronounced dead by the paramedics. He was moved back to the triage room in the Health Care centre to await the arrival of the police and the Coroner's officer. Police arrived at Dovegate at 7.40pm to begin their investigation. They have confirmed that they do not suspect any foul play. The Assistant Director of Healthcare was also notified of the death. The prison contingency plan in the event of a death in custody was implemented and followed correctly.

Events after the prisoner's death

41. After the prisoner was pronounced dead, his cell was sealed until the arrival of police. The prisoner's cellmate was informed of his death and was moved to another cell until the police had completed their enquiries. Other inmates on the wing were confined to their cells for the rest of Sunday evening.

42. A senior member from the prison contacted the Police station near to where the prisoner's partner resides. Police visited her and conveyed news of his death. In other circumstances, the Director or a prison representative would normally have visited in order to break the news, but in view of the distance involved this was not possible.

43. On Monday 24 January, a member of the prison chaplaincy staff made contact with the prisoner's partner by telephone. Arrangements were made for her to travel from her home to view the body in the Chapel of Rest and to visit Dovegate. She was also given the opportunities to meet staff and prisoners who knew her partner, and express their condolences.

44. Prisoners were formally informed of their fellow inmate's death on 24 January. The prisoner was a popular man and prisoners, as well as staff who knew him, were shocked and saddened at the news. A memorial service was held on 'G' wing shortly after the prisoner's death and was well attended.

45. On 3 February, the funeral of the prisoner took place. The prison contributed to the funeral costs by paying for a member of the family who lived a long way away. The prisoner's partner and other members of his family attended. A representative from Dovegate also attended the funeral. Although I make no formal recommendation, the prison will wish to check that it offered to meet all reasonable funeral expenses. If it did not do so, a renewed offer should now be made.

46. The Inquest into the prisoner's death was held on 7 March 2005. The inquest concluded that he died of natural causes.

47. The clinical review concludes that the prisoner received timely, efficient, and appropriate treatment whilst in custody. The review also concludes that in the time leading to his death, he received prompt attention from prison and healthcare staff.

48. The review confirms that the treatment afforded to the prisoner was at least comparable to that found in the wider community.

Findings and conclusions

49. The prisoner had no known previous history of heart problems, and to all intents and purposes, was considered to be a fit and healthy man up until his death. He had relatively few dealings with healthcare whilst in prison, and did not appear to have any significant issues that would affect his health. The prisoner's family have raised no issues in respect of the care or treatment he received whilst he was at Dovegate.

50. The clinical review confirms that the prisoner enjoyed reasonably good health and that he received timely and appropriate medical and nursing treatment. This treatment was equivalent to that found in the wider community.

51. The action taken by the custody officers and nursing staff on 23 January appears to have been appropriate and timely. The prisoner suffered spontaneous cardiac arrests and, despite the continuous efforts by health care staff and paramedics, they were unable to save him.

Recommendations

52. I make no recommendations in respect of the prisoner's death but attention is drawn to my comments in paragraph 45.