

**Investigation into the circumstances surrounding the death of
a male prisoner at HMP Dartmoor,
who died in July 2005**

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

May 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Dartmoor in July 2005. He had been suffering from ischaemic heart disease and died of a heart attack.

I extend my sincere condolences to his family and friends for their loss.

I would like to thank the Governor of HMP Dartmoor, and the members of her staff who assisted my investigator. I have found the prison's contact with the man's family to have been both sensitive and respectful.

I am also grateful to those who, on behalf of South Hams and West Devon Primary Care Trust, carried out a review of the man's medical care whilst he was at Dartmoor.

The man had a history of heart problems and was awaiting further tests at the time of his death. The review of his clinical care by South Hams and West Devon Primary Care Trust concludes that the treatment he received was appropriate in the circumstances.

I make four recommendations alongside some other suggestions as to good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2006

Contents

Summary

The Investigation Process

HMP Dartmoor

The events leading up to the man's death

Discussion of the issues

Findings and conclusions

List of recommendations

Summary

1. The man was 45 years old when he arrived at Dartmoor on 7 June 2005. He was serving a sentence of two years and six months for deception. He died on 24 July 2005 from a heart attack.
2. He had been at HMP Exeter since 9 May 2005. His health was initially assessed on arrival at Exeter and he then had a further assessment carried out by a doctor on 19 May. He was receiving drugs to relieve pain in his leg from a previous injury and also took medication for a heart condition. He was referred for an appointment at the local cardiology department.
3. On 7 June, the man was transferred to Dartmoor. A brief health screen was carried out for him but he did not see a doctor, signing a disclaimer to say he would make an appointment if he needed one.
4. Due to his leg injury, he could not stand for long periods of time and was located on the lowest landing of B wing. He spent much of his time in education.
5. On 14 June, he attended an induction session at the gym where, following his assessment, he was told that he needed to seek medical advice before using the gym. There is no evidence that the man did seek this advice but he did start attending sessions at the gym, attending mostly on Sunday mornings.
6. On Sunday 24 July, the man attended a gym session and was working on the mini-gym with a friend and fellow B wing prisoner. At 10:35am, shortly after starting to exercise, he collapsed. The Physical Education Officer (PEO), who was on duty in the gym, attended to him and an officer, who was also on duty, telephoned for healthcare to attend. Within a few minutes, a Healthcare Officer (HCO) arrived in the gym and requested emergency equipment to be brought from healthcare and for an ambulance to be called.
7. The HCO and Physical Education Officer began to carry out cardiopulmonary resuscitation (CPR) on the man and a second HCO then arrived with the emergency equipment. Resuscitation was attempted until the paramedics arrived at 11:00am and took over. Regrettably, the man did not respond to the resuscitation attempts and was pronounced dead at 11:10am.
8. A clinical review was carried out on behalf of South Hams and West Devon Primary Care Trust. The report concludes that the man's treatment was appropriate and the reaction to his collapse in line with

good practice. However, the report does also highlight some areas where improvements could be made.

9. The man's family were informed of his death within an hour, the news being broken to them in person by the Governor and a member of the Chaplaincy. The prison's liaison with the man's family has been well handled.
10. This report includes four recommendations and some other suggestions that the Governor of Dartmoor may wish to consider.

Investigation process

11. One of my investigators visited Dartmoor and met a member of the Independent Monitoring Board and a representative of the Prison Officers' Association (POA). She also visited the wing where the man had lived.
12. My investigator issued notices to staff and prisoners informing them of the investigation and inviting comment.
13. Access to the man's prison records, including his medical records, was provided to the investigator. The Coroner kindly provided a copy of the post mortem report. Devon and Cornwall Constabulary also shared with the investigator the statements taken at the time of the man's death.
14. The investigator conducted formal and informal interviews with several officers, members of healthcare staff and prisoners.
15. One of my Family Liaison Officers contacted the man's family to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have had. The family did not feel they had any particular concerns about his time in Dartmoor and did not wish to meet the Family Liaison Officer or investigator.
16. A draft of this report was sent to the family and to the Prison Service, and where they have made comments on the draft these have been reflected in the text.

HMP Dartmoor

17. Dartmoor is a category C training prison. The prison was last inspected by HM Chief Inspector of Prisons in February 2003. A relatively high percentage of prisoners reported that they had never felt unsafe (63%). However, the inspection team considered that there was little evidence of positive engagement between staff and prisoners, with only 9% of prisoners reporting that staff had checked on their well being in the last week.
18. Dartmoor works collaboratively with HMP Channings Wood and Exeter as part of the Devon Prisons Health Partnership. The prison's healthcare has been the commissioning responsibility of South Hams and West Devon Primary Care Trust (PCT) since April 2003. The healthcare department has a doctor available every weekday. Overnight and weekend cover is provided by Devon Doc, an out of hours service commissioned by South Hams and West Devon PCT.
19. One other prisoner has died at Dartmoor since I became responsible for the investigations into all deaths in prison custody in April 2004. That death was self inflicted and occurred in August 2004.

Events leading up to the man's death

20. The man underwent reception screening on first reception at HMP Exeter on 9 May 2005. This indicated that he had a history of pain in his right leg following an injury sustained as a child in a road traffic accident.
21. He was seen again by healthcare staff on 19 May, when he was given a thorough health assessment at the request of Plymouth Crown Court. His health assessment revealed a number of issues. He was found to be overweight and suffering from high blood pressure. It was also noted that he was registered disabled, was a smoker and was showing signs of mild heart failure, possibly related to a leaking heart valve. It was recorded that he was prescribed the following medication:
 - a. Gabapentin capsules 300mg, 4 capsules once daily for right lower leg pain
 - b. Co-codomol, 2 tablets daily for pain relief
 - c. Lansoprazole 15 mg daily for prevention of stomach irritation
 - d. Naproxen 250mg
22. Following examination, 2.5mg daily of Bendroflumethiazide was added to his prescription. It was noted that he was to be referred to the cardiology department at the Royal Devon and Exeter Hospital for further investigation. Notes were also made regarding the injuries to his right leg. It was recorded that he had chronic pain, walked with altered gait and suffered from immobility in his right ankle.
23. On 26 May, the man was seen by a doctor in his cell and was prescribed Enalapril 2.5mg daily. He was to see the doctor again in 14 days. Also on 26 May, a letter of referral was sent to the Royal Devon and Exeter cardiology department.
24. On 7 June, he was transferred to Dartmoor. A reception proforma was completed for him, indicating his weight, height and that he received medication. It was also recorded on the proforma that he had a history of hypertension and physical disability, and had previously misused drugs. The member of staff who completed the form placed a question mark next to the question that asked about coronary heart disease. The proforma also indicated that he should be located on a low landing and should avoid standing for long periods. The member of staff who completed the proforma with him did not fill in their own details on the form.
25. The same day, the man completed a healthcare disclaimer, signing to agree that he was happy not to see a doctor in reception and that he was aware of the procedures to follow if he did want to see a doctor in future. This disclaimer was endorsed by a Healthcare Officer (HCO). A note was made by the HCO on his medical record that he had been seen on reception and had stated that he was well.

26. On 14 June, the man attended an induction session at the gym. When a prisoner is inducted to the gym, they are required to complete a physical readiness questionnaire and to sign an agreement confirming that they will follow gym rules. The Physical Education Officer (PEO) who conducted the man's induction session advised the investigator that approximately 10-15 prisoners are inducted to the gym each week. On the questionnaire it was indicated that the man had a heart condition and had been advised not to do physical exercise unless recommended by a doctor. The PEO noted on the questionnaire that the man had a heart murmur referral and was awaiting the results of tests. Responses to the questions indicated that he should speak to a doctor in person before starting to become more physically active. The man signed the questionnaire and completed a compact agreeing to comply with the gym rules. Following a conversation with this man, the PEO noted the following information on his physical education record, under 'medical restrictions':

"Cardio problems. To see doctor before using the gym. Right leg short- must use raised personal footwear."

27. The PEO told the investigator that, following this induction session, the man's records would have been filed in the gym. He also said that he would have mentioned to other members of gym staff that he had carried out an induction session for a prisoner with medical problems. The PEO felt that, as a close-knit team with only six members of staff, information was easily shared in this way.

28. A further note was made on the man's medical records on 17 June to confirm that he was fit for education. As part of the review of his medical care, the clinical reviewer established that he was seen by a doctor that day, and that he sought advice on his fitness to attend education but not about his fitness to attend the gym.

29. There are two further entries in the man's medical record on 20 June. The first of these confirms his appointment with the cardiology department at the Royal Devon and Exeter Hospital. The second entry refers to a conversation between healthcare staff and wing staff regarding moving him to a higher landing on the wing. The note states that he was only able to walk up one flight of stairs at the most, was awaiting a cardiology appointment and was to remain on the lower landing.

30. A fellow B wing prisoner, who was a friend of the man's, told the investigator that he and the man attended the gym together on several occasions. The gym attendance records indicate that the man attended on Sundays 3, 10 and 17 July. His friend said that he was aware that the man had not been to the gym for some years as he had problems with his leg. He knew that he had been keen to get fit and he had never seen him struggling on any of the other occasions they had been to the gym together.

24 July

31. At 10:15am on 24 July, the duty PEO arrived at B wing to collect 20 prisoners to attend a session at the gym. The PEO made a list of the names of the prisoners and, together with a second officer, escorted the group to the gym. The man and his friend were amongst the group of prisoners. They arrived at the gym and each prisoner was ticked off the list, admitted to the gym and went to get changed. The gym session started at about 10:25am.
32. The man and his friend began using the multigym with the man pulling weights, whilst his friend counted the repetitions for him. The man had been exercising for only a few minutes when he appeared to give a loud sigh and fall towards the floor. The friend guided him on to the floor. The PEO was standing a few metres away from where the man had collapsed and immediately went over to assist. This PEO ensured that the man's airway was clear and asked the second officer to contact healthcare. The officer made a call to healthcare, informing a Healthcare Officer (HCO) that a prisoner had collapsed and they needed assistance. The PEO put a call out over the radio to say that there was a medical emergency. The incident log records that this happened at 10:40am.
33. The officer that had made the call told the investigator that, when he got through to healthcare, he was asked for the name and number of the prisoner who had collapsed and what was wrong with him. The prisoner's friend told the investigator that he was confused by the request as he felt that it was irrelevant and delayed the response of assistance from healthcare.
34. The gym is approximately 200 metres from the healthcare centre. The HCO arrived just before 10:40am and immediately carried out a quick assessment of the man's condition. He then asked for the emergency bag, oxygen and a defibrillator to be brought from healthcare, and for an ambulance to be requested. It is not clear whether he telephoned through to healthcare himself or whether this was done by the PEO or officer. The internal telephone log showed that a call was made from the gym to healthcare at 10:39:19 and a call was then made to the emergency number "222" at 10:39:45. The second officer remembers making this call to the emergency number to ask for an ambulance. The incident log notes that it was received at 10:42am.
35. The HCO and the PEO started to carry out cardiopulmonary resuscitation on the man, with the PEO carrying out compressions and the HCO performing mouth to mouth resuscitation. The second officer asked other prisoners to move towards the back of the gym, away from the area where the man was being attended to.

36. One of Dartmoor's governors told the investigator that she was duty governor on 24 July and, at 10:40am, heard a call over the radio that there had "been a collapse" in the gym. She made her way to the gym and, on arriving, saw the HCO and the PEO carrying out CPR on the man. She and the PEO began to move the prisoners out of the gym, escorting them from the entrance furthest from where the man had collapsed.
37. A second HCO arrived from healthcare with the additional equipment. He attached the defibrillator to the man whilst the first HCO inserted an airway. CPR was stopped twice to enable the defibrillator to be used. Neither of these attempts to start the man's heart was successful and CPR continued until the paramedics arrived to take over the resuscitation.
38. The prison control room was originally told that an air ambulance had been dispatched and the police were informed that a helicopter would be landing in the grounds of the prison. However, at approximately 10.50am, an ambulance vehicle arrived at the gate and was escorted to the gym, arriving at 11:00am. The paramedics took over resuscitating the man but were unable to get any response. He was pronounced dead at 11:10am.
39. The incident log shows that the police were called at 11:10am. They arrived at the prison at 12:15pm.
40. The governor who had been duty governor on the day, told the investigator that she and the prison's Roman Catholic priest went to break the news of the prisoner's death to his family. The man's records contained addresses for two next of kin, one for his mother and one for his son. The decision was made to visit his mother's address as his son's age was not known. The Governor and the Roman Catholic priest left the prison at 11:40am. The man's family were advised that the prison would help towards the cost of the funeral and were offered the opportunity to visit the prison if they wanted to.
41. A hot debrief was held for staff on the day following the man's death. This was chaired by the deputy governor.
42. The Governor wrote a letter of condolence to the man's mother on 26 July, reiterating the prison's willingness to help with the funeral costs. Appropriate arrangements were made to return his possessions and personal cash to his family.
43. The man's funeral was held on 8 October. While several prisoners expressed a wish to attend the funeral, this was something which the prison was unable to authorise. Prisoners were, however, given the opportunity to contribute towards a wreath for the funeral.

Discussion of the issues

The appropriateness of the man's medical care

44. The clinical review by the PCT concludes that the man's family history and lifestyle resulted in a high risk of coronary heart disease. The results of the post mortem showed that he suffered from severe heart disease that was very advanced for someone of his age. The assessment made by the doctor at Exeter included a detailed medical history, but did not make reference to the man's family history of heart disease.
45. The clinical review considers that aggressive management of the man's condition with drugs and cardiological intervention might have reduced the likelihood of an acute event. However, the combination of genetic and environmental factors made it impossible to say whether his death could have been prevented.
46. The clinical review notes that, while the man's assessment at HMP Exeter was thorough, no blood tests were requested.
47. When he arrived at Dartmoor on 7 June, the man was not seen by a doctor and so his planned 14 day follow up after his appointment in Exeter on 26 May was not taken forward. It appears that this would have been a good opportunity to review his treatment. It is noted, however, that the man was given the opportunity to make an appointment with the doctor and signed a disclaimer to say that he did not wish to do so.
48. I make recommendations concerning medical reviews of prisoners with pre-existing medical conditions, and also regarding the appropriateness of medical disclaimers for these prisoners. In addition, the clinical reviewer raised some housekeeping points in terms of record keeping.

The man's use of the gym

49. The clinical review of the man's care considers that exercise in the gym could have precipitated his collapse, but that he was at a high risk of such an event at any time.
50. Discussions with gym staff revealed different approaches to managing prisoners wishing to use the gym who should seek medical advice first. The man does not appear to have sought advice between the gym induction on 14 June and the first session on 3 July, and there was no system in place to prevent him using the gym. The gym staff may wish to consider, in conjunction with healthcare staff, ways to introduce remedial or graded exercise for prisoners with known pre-existing medical problems.

The speed of response by healthcare staff

51. The man's friend told the investigator that he felt frustrated that healthcare staff had not arrived quicker, and he felt time was wasted asking questions such as the prisoner's name and prison number.
52. Unfortunately, it has not been possible to interview the HCO who arrived first to attend to the man and so it remains unclear whether he did ask for the information and, if so, what his reasons were. However, both the second officer and the PEO told the investigator that their initial reaction to the man's collapse was that he was having some sort of seizure. If this information was relayed to the first HCO then he may, quite rightly, have been trying to establish what medication might be needed to treat the prisoner or to pass the details on to another healthcare officer to look at the prisoner's records whilst he went to give assistance. The clinical reviewer told the investigator that he believed this to be entirely appropriate in the circumstances. Routinely asking for a prisoner's name and number if they have collapsed should not be necessary, and certainly not if urgent assistance is being requested. However, given the information that the first HCO may have received, his questions were entirely reasonable.
53. In his incident report, the first HCO estimated that he arrived at the gym some five minutes after receiving the call from the other officer. The internal telephone log shows that two calls were made from the gym to healthcare in very quick succession, one at 10:35:21 and one at 10:35:30. It would appear that one of the calls requested assistance from healthcare, although it has not been possible to establish why two calls were made. The internal telephone log also shows a call being made from healthcare to the gym at 10:38:28. It has not been possible to establish who made this call. However, at 10:39:19 a call was made from the gym to healthcare, and 26 seconds later a call was made to the control room. It seems very likely that the last two calls were the result of the first HCO's assessment of the man. It therefore seems likely that the first HCO was already en route to the gym when the call was made from someone there at 10:38:28.
54. The officer and the PEO both told the investigator that the first HCO arrived quickly and made an immediate assessment of the prisoner's condition. An ambulance was requested immediately and efforts were made to resuscitate the man. Both the PEO and the first HCO had up to date CPR training, and the review carried out by the PCT concludes that their efforts to revive the man were in keeping with best practice.

The use of 'codes' when an emergency call is put out

55. At the time of the man's death, there was no system in place to alert healthcare staff to the type of emergency. The clinical reviewer explained to the investigator that the prison would now be implementing a radio procedure where the nature of the emergency would be conveyed. This would enable staff to take appropriate equipment with them.

Use of emergency services

56. The clinical reviewer also told the investigator that consideration had been given by West Country Ambulance Service to send an air ambulance. The road ambulance arrived in good time and so the air ambulance did not prove necessary. However, the experience highlighted that there was no prior agreement in the prison about where a helicopter would land if necessary. The clinical review recommends that a protocol is established to deal with similar events in future.

Delivering the news of the man's death to his family

57. The duty governor on the day told the investigator that she decided that she needed to act very quickly to inform the man's family of his death. The man was well known in the local area, his collapse had been witnessed by many prisoners and a call had already been received at the prison from someone enquiring whether it was true that he had died. The prison's death in custody contingency plans include a note that advice from probation and police may be valuable in deciding on the best way to inform a family of a prisoner's death. The Governor believed that she needed to make a decision based on individual circumstances, and her swift action probably prevented the man's family from hearing the news from another source. The governor explained that she asked the Roman Catholic priest to attend with her for two reasons. First, she knew from the man's records that he was a Roman Catholic. Secondly, she had not undertaken family liaison training herself and therefore was appreciative of the priest's experience.

58. Prison Service Order (PSO) 2710, which came into force in January 2006, provides comprehensive advice about important considerations when delivering the news of a prisoner's death. The PSO advises that as much information as possible should be sought about a prisoner's family before making the initial visit to break the news of a death. As far as is possible, staff should endeavour to gather as much information as they need to be sure that they are not entering an unsafe environment. The governor had not undertaken FLO training, nor was PSO 2710 in existence at the time of the man's death. Whilst steps should be taken to ensure the safety of staff whenever possible, the governor's quick action and consideration for the family is

commendable. I judge her actions in dealing with the man's family to have been prompt, sensitive and well handled.

Attendance of prisoners at the man's funeral

59. The man was a popular prisoner and a number of prisoners wanted to attend his funeral. The duty governor on the day of the man's death told the investigator that the decision was taken by senior management that this would not be possible for security reasons. This information was not relayed back to those prisoners who had asked to attend the funeral, leaving them feeling frustrated. The governor explained that in future the prison would be aware of the need to keep prisoners informed whether they were allowed to attend the funeral of a friend and that, in the event they were not, the reasons would be clearly explained. The investigator was told that prisoners who knew the man had made a collection for his family. The governor explained that the prison planned to hold a memorial service on 16 October. The investigator was subsequently told that this had not gone ahead as only three or four prisoners expressed an interest in attending.

Findings and Conclusions

60. The man had a history of heart problems, was on medication and was awaiting an appointment with a specialist. His heart condition was severe and an acute episode might have occurred at any time.
61. The clinical review of the man's care considers that, while his assessment and care appear to have been appropriate, his arrival at Dartmoor was an opportunity which was missed for his care plan to be reviewed. Therefore, based upon the view of the clinical reviewers:

I recommend that all patients with a current healthcare management plan for a medical condition should be reviewed by a doctor within five days of arrival at Dartmoor.

This recommendation has been accepted by the Prison Service. The service gave the following response:
"The existing protocol is to be modified to include medical conditions."

62. On his arrival at Dartmoor, the man completed a reception disclaimer form indicating that he was happy not to see a doctor. He was taking medication and was awaiting an appointment at a cardiac department. I consider that an individual presenting with the man's condition should have been seen and assessed by a doctor without being given the option to sign a disclaimer. Therefore, in addition to the above recommendation:

I recommend that the practice of prisoners signing reception disclaimers is reviewed. Prisoners who are prescribed medication and present with medical problems should not be given the option to complete such a disclaimer and should be seen by a doctor within five days of arrival at Dartmoor.

The Prison Service has partially accepted this recommendation and has issued the following response:
"Doctors are only available at Dartmoor four days per week. The doctor will see all such prisoners within seven days from the date of arrival."

63. The man was advised to seek medical advice before attending the gym, but appears not to have done so. He attended the gym on several occasions and did not experience any difficulties. It is not possible to know whether his collapse was caused by sudden exercise.
64. The man was able to use the gym, unchallenged, despite his induction session revealing that he needed to seek medical advice. There appears to be no system for monitoring what happens to the information that is recorded when a prisoner is inducted to the gym.

I recommend that a system is put in place to minimise the risk of a prisoner using the gym unless he can demonstrate that he has sought appropriate advice. Consideration should be given to introducing remedial or graded exercise for prisoners with known medical problems.

The Prison Service has accepted this recommendation and made the following comment:

“PERQ (Physical Education Readiness Questionnaire) are filled in for each prisoner and any issues are referred to Healthcare Centre immediately for examination and a report is done with recommendations, which are acted upon.”

65. The response to the man’s collapse was swift and appropriately handled. Both the PEO and the first HCO had up to date CPR training and their care of the man is described as in keeping with best practice. The clinical reviewer told the investigator that a system was being put in place to ensure that “codes” were used to alert healthcare staff to the type of emergency they were being called to. Systems such as this are common practice across much of the prison estate.

I recommend that the Governor ensures that staff are aware of, and are adhering to, the use of emergency “codes”. All staff should be advised of the meaning of the codes and in what circumstances to use them.

The Prison Service gave the following response to this recommendation:

“In the event of a medical emergency, the first on scene will summon help via the control room to alert Healthcare Centre response staff. The first on scene will also use code ‘RED’ for blood and ‘BLUE’ for oxygen.”

66. The governor who was duty governor on the day of the man’s death had not attended FLO training and worked closely with the Roman Catholic priest to deliver the news of the man’s death to his family. Her liaison with the family has been compassionate and timely.

List of Recommendations

- 1. I recommend that all patients with a current healthcare management plan for a medical condition should be reviewed by a doctor within five days of arrival at Dartmoor.**
- 2. I recommend that the practice of prisoners signing reception disclaimers is reviewed. Prisoners who are on medication and presenting with medical problems should not be given the option to complete such a disclaimer and should be seen by a doctor within five days of arrival at Dartmoor.**
- 3. I recommend that a system is put in place to minimise the risk of a prisoner using the gym unless he can demonstrate that he has sought the appropriate advice. Consideration should be given to introducing remedial or graded exercise for prisoners with known medical problems.**
- 4. I recommend that the Governor ensures that staff are aware of, and are adhering to, the use of emergency “codes”. All staff should be advised of the meaning of the codes and in what circumstances to use them.**