

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Dunwoody a prisoner at HMP Featherstone on 4 July 2018

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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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Samuel Dunwoody died at HMP Featherstone on 4 July 2018 due to the toxic effects of an antidepressant combined with early liver and pancreatic disease. Mr Dunwoody was 57 years old. I offer my condolences to Mr Dunwoody's family and friends.

Mr Dunwoody had a number of health conditions. He was supported for the symptoms of post-traumatic stress disorder and prescribed an antidepressant to help with these. The clinical reviewer is satisfied that the management of the conditions that contributed to Mr Dunwoody's death was equivalent to what he could have expected to receive in the community.

I am satisfied that prison staff followed appropriate emergency response procedures when Mr Dunwoody was found unresponsive in his cell.

Following his death, an inhaler found in his cell tested positive for psychoactive substances (PS). Although not a feature or cause of his death, I am concerned about the availability of PS at Featherstone, a concern I have recently raised with the prison.

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

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. In June 2013, Mr Samuel Dunwoody received a life sentence for murder. He arrived at HMP Featherstone in December 2016 with a number of health problems including two heart attacks in the last year, asthma and injuries to his leg and back requiring the use of a walking stick. He was also taking antidepressants for post-traumatic stress disorder (PTSD). He reported a history of cirrhosis of the liver and pancreatitis some years earlier. He was prescribed medication for his conditions.
2. Mr Dunwoody was supported by the mental health team during early 2017 for his PTSD symptoms and self-reported fleeting thoughts of suicide. He was discharged from the team's services in April 2017, when his key worker felt he no longer needed help.
3. Mr Dunwoody had an ultrasound on his liver in May 2017 due to an abnormal finding in his blood tests. The ultrasound was reported as normal and no further action was taken.
4. On 18 June 2017, Mr Dunwoody was found collapsed in another prisoner's cell. When a nurse responded she found him sitting up and claiming to have fallen over. He denied any use of illicit substances.
5. Mr Dunwoody's antidepressant medication was increased in November 2017 as he said he was experiencing PTSD symptoms. He was referred to a trauma group and attended one session before deciding that he did not like a group work setting.
6. On 4 July, Mr Dunwoody was found slumped on his bed by an officer completing routine checks on cells. The officer made an appropriate emergency call at 7.02pm and officers responded immediately and began cardiopulmonary resuscitation. Paramedics arrived and continued resuscitation which was unsuccessful and Mr Dunwoody was pronounced dead at 7.47pm.
7. During a cell search following Mr Dunwoody's death, an inhaler was discovered that tested positive for psychoactive substances (PS).

Findings

8. Mr Dunwoody arrived at Featherstone with a number of health conditions which were managed appropriately. He died due to the combined effects of a high level of antidepressants with the early stages of liver and pancreatic disease. The clinical reviewer considers that it is not possible to say if this was accidental or if Mr Dunwoody deliberately took an overdose of his medication.
9. The clinical reviewer is satisfied that it was reasonable for prison doctors to take no further action when the ultrasound of Mr Dunwoody's liver found nothing abnormal. She considers that the management of the conditions that contributed to Mr Dunwoody's death was equivalent to what he could have expected to receive in the community.

10. The clinical reviewer makes one recommendation about chronic disease management that the Head of Healthcare will want to consider.
11. Although it appears that PS did not contribute to Mr Dunwoody's death, I am concerned about the availability of PS at Featherstone. This is an issue I have raised in the two most recent investigations at the prison.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Featherstone informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr Dunwoody's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Dunwoody's clinical care at the prison.
15. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. The investigator contacted Mr Dunwoody's sister to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not raise any concerns.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Featherstone

18. HMP Featherstone is a medium security, Category C prison, holding around 650 convicted men. Healthcare services are provided by Care UK.

HM Inspectorate of Prisons

19. The most recent inspection of Featherstone was conducted in October 2018. The key message from the inspection was one of improvement, and they found that the prison had come a long way since their last inspection in 2016. They found that energy and initiative were evidenced throughout the prison which resulted in benefits for prisoners. Availability of illicit drugs was still considered to be a challenge for the prison but there was an impressive range of measures in place to try and tackle the problem.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to October 2018, the IMB were pleased to report that concerns from the previous reporting period had been addressed and felt that the prison was a much safer and decent prison for both staff and prisoners. They felt that more could still be done to improve the poor state of some of the buildings. Cancellations of hospital appointments were too high due to a lack of escort staff.

Previous deaths at HMP Featherstone

21. Mr Dunwoody was the eleventh prisoner to die at Featherstone since 2015 and the sixth to die of natural causes. The presence of psychoactive substances was an issue in the two most recent investigations we have completed at Featherstone.

Psychoactive Substances (PS)

22. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
23. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

24. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

25. On 18 June 2013, Mr Dunwoody received a life sentence, with a tariff of 19 years for a murder that he had committed in 1988. This was not his first time in prison. In 2009, Mr Dunwoody received treatment at HMP Liverpool for alcohol withdrawal and told nurses that he had a previous history of cirrhosis of the liver and pancreatitis.
26. On 20 December 2016, Mr Dunwoody transferred to HMP Featherstone from HMP Birmingham. A nurse completed his reception assessment and noted he had had two heart attacks in the last year, asthma, injuries to his leg and back requiring the use of a walking stick and was taking anti-depressants for post-traumatic stress disorder (PTSD). Mr Dunwoody was prescribed medication for these conditions.
27. On 21 December, healthcare staff received a call from mental health services at HMP Birmingham to let them know that Mr Dunwoody was known to their service. On 21 February 2017, Prison Service suicide and self-harm prevention procedures (known as ACCT) were opened for Mr Dunwoody as he said his mental health was declining and he had fleeting thoughts of suicide. A mental health nurse became Mr Dunwoody's key worker on 22 February and provided weekly support for his PTSD symptoms. His ACCT was closed on 3 March. On 5 April, Mr Dunwoody's key worker discharged him from the mental health services case load as she felt that he did not require their help.
28. On 22 February 2017, a prison GP reviewed Mr Dunwoody after routine blood test results taken soon after his arrival at Featherstone, revealed some minor abnormalities with his liver function. The tests were repeated and revealed a high alkaline phosphatase level. This could be caused by an obstruction to the liver or inflammation of bones or joints.
29. On 23 May, a prison GP reviewed Mr Dunwoody due to his abnormal liver function result in recent blood tests. He referred him for an ultrasound of his liver, gallbladder and pancreas. These were reported as normal and no further action was taken.
30. On 26 May, Mr Dunwoody met with a prison health trainer. His blood pressure was recorded as normal but he had gained weight and had a body mass index (BMI) of 31.7 (Normal range is 23-25.) Mr Dunwoody started a smoking cessation course which he completed in August.
31. On 18 June, a code blue emergency was called as Mr Dunwoody was found collapsed in another prisoner's cell. (This indicates that a prisoner is unconscious, not breathing or is having breathing difficulties.) When a nurse arrived at the scene, Mr Dunwoody was able to sit up and told her that he had fallen over. He denied any use of psychoactive substances (PS).
32. On 15 November, a prison GP reviewed Mr Dunwoody's sertraline (antidepressant) medication. Mr Dunwoody said that he was experiencing PTSD symptoms and the GP increased his prescription from 50mgs to 100mgs daily. The GP referred Mr Dunwoody to a prison psychologist for further support.

33. On 30 November, a prison psychologist assessed Mr Dunwoody and said that he would require focused therapy aimed at treating his bad dreams and flashbacks. Mr Dunwoody agreed to attend a trauma group but after the first session on 2 February 2018, said that he did not want to return as he found it difficult to work as part of a group.
34. During the early evening of 4 July 2018, Mr Dunwoody's wing was unlocked for association. An officer was completing routine checks on cells and, after entering Mr Dunwoody's cell to check the cell windows, he saw Mr Dunwoody slumped on his bed. He said that his skin looked purple and he was unresponsive when he called his name. He immediately radioed a code blue emergency at 7.02pm.
35. The officer got the attention of a Supervising Officer (SO) who was working further down the landing. He attended the cell immediately along with another officer and they lifted Mr Dunwoody onto the floor. The SO began cardiopulmonary resuscitation (CPR). An officer went to collect the emergency response kit while another collected the defibrillator. The SO continued with CPR and used the defibrillator when it arrived. Paramedics arrived at 7.06pm and continued with CPR. At 7.47pm they pronounced Mr Dunwoody dead.
36. When Mr Dunwoody's cell was searched after his death, an inhaler was found with foil around the mouthpiece. The inhaler was tested and showed a positive result for PS.

Post-mortem report

37. The post mortem report found that Mr Dunwoody died of: 1a) fatty liver and early pancreatitis and 1b) sertraline toxicity. The level of sertraline found was below the lethal level, but the pathologist considered that Mr Dunwoody's liver and pancreatic disease may have affected the metabolism of sertraline and so enhanced its impact within the body.
38. PS was not detected in the toxicology tests completed after Mr Dunwoody's death.

Contact with Mr Dunwoody's family

39. On 6 July, the Governor telephoned Mr Dunwoody's brother to break the news of his death. He explained to him that he had tried to give the news in person and had travelled, unsuccessfully, to his last known address. Mr Dunwoody's brother said that he had moved to Northern Ireland some time ago. He thanked the Governor for his efforts to locate him.
40. An officer was appointed as family liaison officer after Mr Dunwoody died and liaised with Mr Dunwoody's sister in law about the funeral arrangements. The funeral took place on 26 July and the prison contributed to the funeral costs in line with national guidance.

Support for prisoners and staff

41. After Mr Dunwoody's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing other prisoners of Mr Dunwoody's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dunwoody's death.

Findings

Clinical care

Mental health

43. Mr Dunwoody was known to mental health services at Featherstone and was prescribed sertraline (an antidepressant) for his symptoms of PTSD. He held the sertraline in possession. The post-mortem found the cause of death to be a combination of a high level of sertraline with early liver and pancreatic disease. The clinical reviewer states that it is difficult to know whether Mr Dunwoody took a planned overdose or whether the findings were accidental. (He had reported taking an overdose of sertraline at HMP Birmingham in 2015, so might have been aware of its impact.)
44. The clinical reviewer explained that sertraline in patients with normal liver function is a relatively safe medication in overdose and the levels in Mr Dunwoody's blood were not enough to be fatal in normal circumstances. She also noted that levels of sertraline can be five times higher at post-mortem than an individual would show when alive. The high post-mortem levels cannot, therefore, indicate the number of tablets taken by the patient.
45. The clinical reviewer concludes that Mr Dunwoody was seen regularly enough by healthcare staff that they would have had the opportunity to observe any changes in his mood. We agree with the clinical reviewer that the care Mr Dunwoody received for his mental health was equivalent to what he could have expected to receive in the community.

Liver disease

46. The post-mortem revealed that Mr Dunwoody had an enlarged, fatty liver and pancreas. The clinical reviewer considers that this finding is consistent with Mr Dunwoody's self-reported history of high alcohol use and his obesity.
47. The clinical reviewer states that abnormal liver function can cause a build-up of sertraline in the body. The pathologist considers this build up, combined with liver disease was the cause of Mr Dunwoody's death.
48. Routine blood tests taken in early 2017 showed Mr Dunwoody had a high alkaline phosphate level. This could be caused by either an obstruction to the liver or by inflammation of bones or joints. Mr Dunwoody was known to have bone damage and arthritis from previous injuries. He was referred for an ultrasound of his liver which was reported as normal. No further action was taken.
49. The abnormal blood test results could have been attributable to Mr Dunwoody's arthritis and bone injury. The clinical reviewer, therefore, considers that, although an ultrasound is not an accurate investigation for the liver condition that Mr Dunwoody had, it was understandable that the prison doctors were reassured by the ultrasound result and took no further action.

50. The clinical reviewer is satisfied that the care Mr Dunwoody received in relation to his liver disease was equivalent to what he could have expected to receive in the community.

Chronic disease management

51. Mr Dunwoody said during his reception assessment that he had experienced two previous heart attacks. He was taking medication that was appropriate for the prevention of heart disease. The clinical reviewer found that Mr Dunwoody had no structured review of his heart disease of the kind that would normally take place in the community. Nor was he followed up after abnormal results were disclosed during routine tests of his asthma.
52. The clinical reviewer concluded that the care that Mr Dunwoody received in respect of chronic diseases at Featherstone was not equivalent to what he could have expected to receive in the community. Although not related to his death, the clinical reviewer makes a recommendation that the Head of Healthcare will want to consider.

Emergency response

53. When Mr Dunwoody was found unresponsive in his cell there were no medical staff working in the prison due to the time of day. The appropriate emergency procedures were followed and we agree with the clinical reviewer that the resuscitation attempt was conducted promptly and efficiently.

Psychoactive substances

54. Although the toxicology report did not show any PS in Mr Dunwoody's system, it is concerning that an inhaler found in his cell after his death tested positive for PS. Mr Dunwoody had one previous suspected incident of using PS in June 2017. There were no entries in his security record to suggest that he was suspected of using PS.

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