Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Paget, a prisoner at HMP Swaleside, on 17 January 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Paul Paget died of a heart attack in his cell at HMP Swaleside, on 17 January 2023. He was 59 years old. I offer my condolences to Mr Paget's family and friends.

The clinical reviewer concluded that Mr Paget's clinical care was not equivalent to that which he could have expected to receive in the community. Notably, there was a lack of appropriate care planning for his chronic medical conditions and no action taken to address a persistent unwillingness to take medication.

The investigation also found that there was a significant delay in enabling the access of paramedics to the prison when Mr Paget was found unresponsive.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. Mr Paul Paget had been at HMP Swaleside since 24 January 2019, serving a sentence of 15 years and 9 months imprisonment for manslaughter and burglary.

2. Mr Paget had many long-term health conditions, including diabetes, heart disease, asthma, high blood pressure, lung disease and a history of heart attacks. He had a lot of contact with healthcare staff, but did not always cooperate with medical advice, attend appointments, or take his medication.

3. In August 2022, a GP at the prison made a referral to a vascular consultant, but Mr Paget died before he was able to attend an appointment.

4. At around 8.40am on 17 January 2023, a prison officer found Mr Paget unresponsive. Resuscitation attempts by prison staff and paramedics were unsuccessful and his death was confirmed at 9.25am.

Findings

5. The clinical reviewer concluded that Mr Paget's clinical care was not equivalent to that which he could have expected to receive in the community, as healthcare staff did not start monitoring Mr Paget's conditions promptly and no care plans were in place. Additionally, there was no evidence of any action in response to Mr Paget's reluctance to take medication and attempts to conceal medication.

6. Prison staff appeared unprepared for the arrival of the paramedics, so there was a significant delay in escorting them from the prison gate to Mr Paget's cell.

Recommendations

- The Head of Healthcare should ensure that newly arrived prisoners with long-term medical conditions are managed appropriately, including:
    - prompt referrals to the GP at the prison;
    - offering a further opportunity for a secondary health screen if a prisoner initially declines; and
    - creating and reviewing personalised care plans for all chronic illnesses.
- The Head of Healthcare should ensure that there are timely reviews when a patient refuses to take their medication.
- The Governor should ensure that there are no delays in ambulances entering and leaving the prison; and that in a medical emergency, access from the prison gate to the wing is coordinated to allow paramedics to reach an incident quickly.

The Investigation Process

7. HMPPS informed us of Mr Paget's death on 17 January. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Paget's prison and medical records. In response to information received about the circumstances surrounding Mr Paget's death, she had a meeting with the Detective Sergeant investigating on behalf of Kent Police and they later shared relevant information.

9. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Paget's clinical care at the prison. The investigator and the clinical reviewer jointly interviewed four healthcare staff and a prison officer. The interviews were conducted using Microsoft Teams video conferencing.

10. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Paget's sister, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not reply.

12. We shared the initial report with HM Prison and Probation Service. They found no factual inaccuracies and accepted our recommendations.

13. An inquest, held on 15 April 2024, concluded that Mr Paget died from natural causes.

Background Information

HMP Swaleside

14. HMP Swaleside, on the Isle of Sheppey, is part of the long-term high security estate. It holds up to 1,090 men, serving sentences of at least four years. Until April 2022, Integrated Care 24 (IC24) provided physical healthcare services at Swaleside and Oxleas NHS Foundation Trust provided mental healthcare services. Since April, Oxleas has provided both, including 24-hour nursing cover.

HM Inspectorate of Prisons

15. The last full inspection of HMP Swaleside was in October 2021. Inspectors found that service delivery was hindered by significant staff shortages. The primary care team relied heavily on agency staff due to longstanding vacancies and frequently operated below the set staffing level, with the Head of Healthcare often performing clinical duties to the detriment of the strategic elements of the role. Primary care staff received training, but supervision was inconsistent. Prisoners often missed healthcare and hospital appointments due to the shortage of staff to escort them.

16. Inspectors noted that learning from incidents was shared with staff, but oversight on the progress of healthcare recommendations from PPO investigations was variable.

17. The inspectorate carried out an Independent Review of Progress in July 2022. Inspectors reported that the shortage of officers had become worse. No meaningful progress had been made in addressing shortfalls, which meant staffing was at crisis point and impacting on all aspects of the regime.

Independent Monitoring Board

18. 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 April 2022, the IMB reported that a change in healthcare management had resulted in an improvement to healthcare services. However, at times, there had been significant shortages of healthcare staff, which had led to greater use of agency staff and a backlog of appointments.

Previous deaths at HMP Swaleside

19. Mr Paget was the twenty-second prisoner at Swaleside to die since January 2020. Of the previous deaths, eleven were due to natural causes, eight were self-inflicted and two were related to substance misuse. There have since been two deaths, one self-inflicted and the other due to natural causes.

20. We have previously raised the need for care plans, action on non-compliance with medication and delays in escorting ambulances. To address this, the prison said that healthcare staff would have yearly updates and there would be clinical audits of records. An urgent review would be booked if a prisoner declined medication and gate staff were reminded to prioritise processing ambulance staff.

Key Events

21. Mr Paul Paget was remanded to prison on 20 January 2018. He was later convicted of manslaughter and burglary and sentenced to 15 years 9 months imprisonment. After moving between several prisons, Mr Paget transferred to HMP Swaleside on 24 January 2019.

22. Mr Paget had several chronic medical conditions, including type 2 diabetes, ischaemic heart disease, asthma, chronic obstructive pulmonary disease (COPD), hypertension, rheumatoid arthritis, osteoarthritis, angina, depression and a history of heart attacks. He sometimes refused to take his medication, eat, or drink.

23. Due to persistently refusing medication and food, Mr Paget temporarily transferred to the healthcare inpatient unit at HMP Elmley between 11 and 21 February 2022. On his return to Swaleside, he had a reception health screen but declined a secondary screen (which explores medical conditions in greater depth). No care plans were created for his long-term conditions, and he was not referred to the GP at the prison.

24. On three occasions in March, Mr Paget refused to take his insulin. In June, he tried to conceal other medication (dihydrocodeine and mirtazapine). No action was recorded in response to these incidents.

25. On 25 August, Mr Paget's left foot was swollen, painful and discoloured. A nurse made an urgent appointment for him to see the GP, suggesting that he might need a vascular review. Another nurse reviewed Mr Paget the next day and found that he was retaining fluid. She discussed with the GP the possibility of a referral to the vascular clinic and made an appointment for a GP review.

26. In the early hours of 27 August, Mr Paget reported that he had chest pain and his GTN spray had not helped to relieve it. A nurse sent him to hospital. He was discharged later that day, as it was thought to be muscular pain.

27. On 30 August, a GP at the prison reviewed Mr Paget and referred him to a vascular consultant.

28. Over the following months, healthcare staff treated Mr Paget for several health issues, referring him to secondary and emergency care when necessary. At times, he failed to attend medical appointments.

29. On 22 October, Mr Paget refused to attend the triage clinic for an electrocardiogram (ECG – to check the heart's rhythm and electrical activity) and signed a disclaimer. He agreed to an ECG on 30 October.

30. On 8 December, Mr Paget missed the appointment with the vascular consultant, as no prison officers were available to escort him to the hospital. (It was rearranged, but Mr Paget died before the date of the new appointment.)

Events of 17 January 2023

31. Between 7.10 and 7.15am on 17 January 2023, Officer A carried out a welfare check and count of prisoners. When checking Mr Paget's cell, he opened the observation panel, but did not turn on the cell light. The officer thought he heard Mr Paget grunt in response to him.

32. At around 8.40pm, an officer unlocked Mr Paget's cell for the medication round and saw him lying on the floor. She knew him well and that he was a heavy sleeper. However, he did not respond when she shouted his name and there appeared to be no 'rise and fall' of his chest. As Mr Paget was undressed, she asked a male officer to help her to check him. Mr Paget remained unresponsive, so they called a code blue medical emergency at 8.45am and Officer B began cardiopulmonary resuscitation (CPR).

33. Several other operational and healthcare staff arrived, including the Governor, the Head of Healthcare, a GP at the prison and a paramedic employed at the prison.

34. An ambulance crew arrived at the prison at 8.54am. They reached the cell around 20 minutes later and continued CPR. At 9.25am, they stopped the resuscitation attempts and Mr Paget's death was confirmed.

Contact with Mr Paget's family

35. The prison's family liaison officer made several attempts to contact Mr Paget's sister. She was on holiday, so he was unable to inform her of Mr Paget's death until 2 February. The prison arranged Mr Paget's funeral, in consultation with his sister and met the funeral expenses.

Support for prisoners and staff

36. A prison 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 care team attended. The Head of Healthcare also conducted a debrief with healthcare staff to reflect on the clinical actions.

37. The prison posted notices informing other staff and prisoners of Mr Paget's death and offering support.

Post-mortem report

38. The post-mortem report concluded that the cause of Mr Paget's death was 1a) acute myocardial infarction, 1b) critical coronary artery atherosclerosis and 1c) chronic ischaemic heart disease (a heart attack due to underlying heart disease).

Findings

Clinical findings

39. The clinical reviewer concluded that although many of Mr Paget's clinical concerns were handled appropriately, his clinical care was not equivalent to that which he could have expected to receive in the community, due to the lack of care planning.

40. We reflect the clinical issues related to Mr Paget's cause of death. However, the Head of Healthcare will need to address the wider findings and recommendations set out in the clinical review report.

Management of Mr Paget's long-term conditions

41. National Institute for Health and Care Excellence (NICE) Guideline 57 covers the management of the physical health of people in prison. It states that, for continuity of care, every prisoner should receive a second-stage health assessment within seven days of their arrival. The guidance also says that older people and those with chronic conditions who are serving longer prison sentences should be monitored regularly.

42. Mr Paget had many chronic health conditions. Healthcare staff should have referred him to the GP when he returned to Swaleside in February 2022 and should also have offered a further opportunity for a secondary health screen, after he initially declined. Although relevant medication was prescribed, there were no care plans in place and staff did not begin regular assessment and monitoring until 25 August 2022, when he reported a swollen leg.

43. There was no evidence that healthcare staff discussed with Mr Paget his repeated refusal to take his insulin or assessed his mental capacity to take decisions about his health. There was no plan to address his general unwillingness to take medication and no action was recorded in response to his attempt to conceal some of it.

44. In view of the omissions identified, the clinical reviewer concluded that Mr Paget's care was not in line with NICE guidance. We recommend:

The Head of Healthcare should ensure that newly arrived prisoners with long-term medical conditions are managed appropriately, including:

- **prompt referrals to the GP at the prison;**
- **offering a further opportunity for a secondary health screen if a prisoner initially declines; and**
- **creating and reviewing personalised care plans for all chronic illnesses.**

The Head of Healthcare should ensure that there are timely reviews when a patient refuses to take their medication.

Emergency response

45. Prison Service Instruction (PSI) 3/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency to ensure a timely, appropriate and effective response. This includes a mandatory requirement that prisons must, "…prevent any unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison (with or without the patient) …"

46. Swaleside's protocol for admitting and discharging ambulances is embedded in the prison's local security strategy. It says that gate and control room staff should give priority clearance to emergency vehicles entering or leaving the prison and movement should be as timely as possible. It also gives detailed instructions on how to facilitate this.

47. The paramedics recorded that there had been a delay of around 20 minutes between their arrival at the prison and reaching Mr Paget's cell. They said this was largely because the officer escorting them did not know where to take them; and no one answered the radio when she tried to check. This included a five-minute wait at a gate with a sign, 'do not use gate'. Eventually, a staff member passing by told them they should go through it.

48. As ambulances are requested and therefore expected, staff should prepare for their arrival and ensure there are minimal delays in granting paramedics access to the prison. We recommend:

    The Governor should ensure that there are no delays in ambulances entering and leaving the prison; and that in a medical emergency, access from the prison gate to the wing is coordinated to allow paramedics to reach an incident quickly.

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