Investigation into the circumstances surrounding the death of the man on 7 October 2008 whilst a prisoner of HMP Shepton Mallet

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

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This is the report of an investigation into the death of the man, who died in a Hospital in Bath on 7 October 2008, whilst in the custody of HMP Shepton Mallet. The man had been taken to hospital on 4 October, after a fall in his cell. He was 54 years old.

One of my Family Liaison Officers contacted the man's sister to explain our role and the purpose of our investigation. I would like to offer my personal condolences to his family, and apologise for any additional distress caused by the delay in issuing my report.

The investigation was undertaken by one of my investigators. I would like to thank the Governor of Shepton Mallet, and his staff for their participation. Somerset Primary Care Trust (PCT) was commissioned to review the healthcare the man received in prison. I am grateful to the doctor who carried out this review.

When investigating a death from natural causes, the medical records are obviously of great significance. As such, the findings of the clinical review play a key role in the report. The review finds that the man received exemplary care whilst at Shepton Mallet.

I do not make any recommendations.

Jane Webb
Deputy Prisons and Probation Ombudsman **October 2009**

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SUMMARY

The man was 54 years old, and had spent 30 years in prison. He had been in Shepton Mallet previously but left to undertake offence-related courses in other establishments before returning in August 2006.

He suffered from some health problems, including asthma and obesity, and was in regular contact with healthcare. Also, he had had an operation on his knee in August 2008.

On 4 October, a friend went to see the man in his cell. He was lying on his bed, but he suffered a fall as he got up. An ambulance was called and, fearing that he might have broken a limb, it was agreed that he should go to hospital. Because the man was quite big, a second ambulance crew was required to lift him to the ambulance, but eventually he was transferred to hospital. Standard checks on his heart were made whilst on the way there, and no concerns were identified.

Following x-rays, staff were unable to tell what injuries the man had suffered. The hospital was not fully staffed as it was a weekend. They therefore arranged for him to remain in hospital until he could have a scan on the Monday.

Late on the Monday, hospital staff confirmed that the man had not broken any bones. He was due to have a check the following morning, before being discharged. However, during the night, he suffered a heart attack. Staff attempted to resuscitate him but were unable to do so. He was pronounced dead at 3.07am on 7 October 2008.

THE INVESTIGATION PROCESS

1. My investigator had access to all the man's prison records. He visited Shepton Mallet, and saw the healthcare centre, the wing where the man lived (C wing) and the location of his cell. He had the opportunity to see the inside of a cell identical to the man's. My investigator interviewed three members of staff in Shepton Mallet. The interviews were recorded and transcripts are appended to this report. Copies were sent to interviewees to sign and agree their accuracy. Two signed copies were returned. Notices were displayed at the prison to inform both staff and residents of the investigation, and inviting contributions if necessary. None were received.

2. One of my Family Liaison Officers contacted the man's sister and offered her the opportunity to raise any issues for me to address. There were no particular areas of concern, but the family said that they would like to see the report when it was published.

3. Somerset Primary Care Trust (PCT) was asked to carry out a review of the man's clinical care in prison. The investigator discussed the report with the PCT clinical reviewer, and I offer him my thanks for his review.

4. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation. He kindly provided a copy of the post mortem and toxicology reports on the man's death. Upon completion, a copy of the report will be sent to the Coroner to assist his investigation into the man's death.

BACKGROUND

HMP Shepton Mallet

5. A prison was first built on the site in 1610. Shepton Mallet became the Prison Service's first category C prison for life-sentence and other indeterminate-sentence prisoners in August 2001. With an operational capacity of 186, the regime includes full and part-time education, workshops, training courses and offending behaviour groups. The healthcare centre is staffed from 7.30am to 5.30pm Monday to Friday, and 7.30am to midday at weekends.

Previous deaths at Shepton Mallet

6. This is the fifth death at Shepton Mallet since I took responsibility for such investigations. Sadly, there has been one further death since the one which is the subject of this report. None of the circumstances of these deaths are similar to this.

Her Majesty's Chief Inspector of Prisons

7. The last report by Her Majesty's Inspectorate of Prisons followed an unannounced inspection in June 2008. There were no issues raised which are relevant to this report.

Independent Monitoring Board (IMB)

8. Each prison in England and Wales has an Independent Monitoring Board (IMB). They are responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB for Shepton Mallet is the report for 2007-08. Nothing from the report is relevant to the circumstances of the man's death.

KEY FINDINGS

9. The man was sentenced to life imprisonment in 1978. He threatened to take his own life, and notes at the time refer to several previous attempts at suicide. He moved through the prison system and slowly he was noted to mature, learning to control his behaviour. After spending time in a number of different prisons, he arrived in Shepton Mallet for the first time in May 2003, before transferring to other establishments to undertake offence-related courses.

10. The Parole Board considered his case a number of times, and it was referred back to them early in 2004. They recommended that he undertake further work, and the case be reviewed again after one year.

11. On two occasions in late 2004, including over the Christmas period, the man was placed on special observations for prisoners thought to be at risk of self-harm. He had been taking the Sex Offender Treatment Programme, and it was thought that this may have raised some difficult feelings.

12. Reports submitted to the Parole Board in July 2005, showed him to be in a negative frame of mind. It was thought that he might be anxious about the possibility of moving to open conditions. He had been refused an escorted trip out of prison, known as escorted absence, after allegations that he had threatened a member of staff.

13. The man returned to Shepton Mallet on 17 August 2006. In January 2007, he was informed that the Healthy Sexual Functioning (HSF) course which he was due to take was not going ahead. In April, he moved jobs within the prison, at his own request. In June, he was informed that he would not be allowed escorted absence until further course work was completed. Reports indicate that he took this news well.

14. On 2 August, he complained of chest pain and was taken to hospital by ambulance. He was diagnosed as suffering from a chest infection. On 1 October, he suffered an asthma attack in his cell and was hyperventilating. Healthcare staff attended and treated him. However, he subsequently suffered further chest pain and shortness of breath, and the prison doctor decided that he should go to hospital. He was admitted, and once again was diagnosed with and treated for a chest infection.

15. A sentence planning and review board considered the man's case on 15 November. He did not represent a control problem and there were no adjudications against him or negative comments on his wing file. He mixed with a small group of prisoners, but only interacted with staff when he needed something. He had completed the Extended Sex Offender Treatment Programme and two core Sex Offender Treatment Programmes, as well as courses in stress management, enhanced thinking skills, anger management, relationships, and assertiveness. He had also participated in individual psychology work whilst in HMP Maidstone. He was again scheduled to take the HSF course.

16. The man had been suffering from ongoing pain in his knee. On 31 January 2008, in an effort to diagnose the problem, he was given an MRI scan (Magnetic Resonance Imaging, able to produce a picture of organs and tissues inside the body).

17. After a change in the course criteria, he was told on 21 March that he did not need to take the HSF course. He said that he would therefore apply for escorted absence. However, he still had not done so by late May, when he was given copies of his Parole Board papers. He finally submitted the applications in late June.

18. In May, he suffered a minor fall in his cell when his leg gave way underneath him. Healthcare staff attended. An occupational health assessment the following month confirmed that he had osteoarthritis in his knees, and he was prescribed painkillers and given a walking stick to aid his movement. He also saw medical staff in healthcare to address his obesity. He managed to lose some weight, but only a small proportion of what was needed.

19. Because of his poor health, the man had been unable to go to work in the prison workshops. He therefore chose to work in cell, and began to do so on 27 May.

20. Following the earlier investigations, it was decided that the man needed an operation to address the problems with his knee. He went to hospital on 1 August for a pre-operation assessment. The assessment showed that he was short of breath, even when sitting down, so the operation would have to be carried out under spinal anaesthetic to minimise risks such as deep vein thrombosis (DVT). The operation was carried out on 5 August, and he returned to Shepton Mallet that day.

21. Due to paperwork not being received in the prison, he missed a post-operation appointment on 18 September, and it was rearranged for 9 October. On 24 September he complained of having suffered a dizzy spell. He was given tests, but the results showed no irregularities.

22. Like most prisons, Shepton Mallet runs a personal officer scheme. Each prisoner has a designated personal officer who maintains contact with them, and acts as their first port of call for any queries or problems the prisoner may have. The man's personal officer is referred to here as the officer. The officer told my investigator that he recalled seeing the man on the morning of 4 October, and the day seems to have been relatively uneventful until the early afternoon. The man had a single cell, and although the doors were unlocked, he had closed his door for some privacy. At approximately 1.40pm, he was lying on his bed when a friend came to see him. The friend looked through the window in the man's door and spoke to him. He began to get up, and the friend turned away. As he did so, he heard a thump coming from inside the cell. He looked back into the cell and saw the man lying on the floor.

23. The friend went to get some help. He went to the wing office and alerted two officers, who went to the man's cell. He was still on the floor. It was not clear what damage he might have suffered, so one of the officers decided not to try to

move him. The other officer returned to the office and contacted the Orderly Officer (who was responsible for the running of the prison), an Acting Principal Officer (PO). The PO made his way to the man's cell, arriving at approximately 1.45pm. The PO is a trained first-aider and, after assessing the situation, he contacted the gate lodge by radio and asked them to request an ambulance. The staff made the man as comfortable as possible where he lay, and covered him with a blanket.

24. The ambulance arrived at 1.50pm and paramedics were shown to the man's cell. They thought that he might have broken either his leg or his hip, and that he needed to go to hospital. However, due to his size, NHS regulations meant that the first ambulance crew were not allowed to lift him alone. A second ambulance was summoned, which arrived at 2.08pm. The paramedics treated him for his pain, then moved him onto a stretcher and, helped by prison staff, moved him out of his cell.

25. Because of the layout of the prison, the cells on the man's wing, C wing, are on the first floor above the healthcare centre. Access is therefore via stairs. The ambulance was parked in the space outside the healthcare centre, below the wing. In normal circumstances a prisoner on a stretcher would be taken to the ambulance via the fire exit at the end of the wing and down the emergency stairs to the waiting ambulance. However, on this day it was raining heavily. In view of the man's weight, it was not thought safe to try to take him down the metal stairway. Instead he was taken through the wing and down the indoor stairs.

26. The ambulance left the prison at 2.55pm. On the way to hospital the man was awake and sat up in the ambulance, talking. The paramedics gave him an electrocardiogram (ECG, an electrical recording of the heart used in the investigation of heart disease) which showed as normal.

27. The ambulance took the man to the Royal United Hospital in Bath, arriving at 3.33pm. He was admitted with a suspected broken femur (thigh bone), but it was not possible to confirm this by x-ray. It being a Saturday, the hospital was not fully operational. It was agreed that he would remain in hospital until the Monday, when a CT scan would be able to confirm what damage he had sustained. His family were not informed at this point that he was in hospital.

28. Whilst in hospital the man was wearing security restraints, and was accompanied by two prison officers (known as the bedwatch). The officer was one of the officers on one of the bedwatch shifts. He told my investigator that the man was comfortable in hospital, and not suffering other than pain from his leg.

29. The man had the scheduled CT scan on 6 October, which confirmed that there was no fracture. Another officer was on bedwatch at the time, and he telephoned the prison and told them that the man was to be assessed the following morning and then likely to be discharged.

30. However, at approximately 2.00am on 7 October, the man sat up in his bed, unable to breathe. He would not take oxygen, saying that he was too hot. He

got out of his bed into a chair, then collapsed as he moved to get back into bed. The presence of the bedwatch officers meant that medical staff were called immediately, and they attempted to resuscitate him. Sadly, he had suffered a heart attack, and they were unable to do so. He was pronounced dead at 3.07am.

31. The PO told my investigator that support was available to any staff who might have felt that they needed it. The officer did not recall being specifically offered support, but he also said that he would have known where to go if he had felt that he needed it.

Informing the man's family

32. The man's family were informed of his death by hospital staff. His next of kin was his sister. Her husband, the man's brother-in-law, received a telephone call at 2.00am on 7 October, from a hospital sister, informing him that the man had had a heart attack. Then, some 45 minutes later, a second call came through informing him that the man had died.

33. The man's brother-in-law was subsequently in contact with a governor from Shepton Mallet. The man's sister and brother-in-law were invited to attend a memorial service at the prison, and took the opportunity to collect his belongings. The prison assisted with the costs of the funeral.

Informing the man's friends

34. The man had two friends at Shepton Mallet to whom he was particularly close. They were taken aside by staff at 7.50am and told that he had died. They were advised to speak to staff if they felt that they needed support. Notices were posted around the prison informing other prisoners and staff.

Post mortem and cause of death

35. A post mortem examination was carried out on 12 January 2009. The examination found severe coronary artery disease, and a large embolism blocking both main arteries. The toxicology report showed opiates in the blood, which is likely to have been a result of the codeine the man had been prescribed.

36. The post mortem report gives the cause of death as:

    1(a) – pulmonary embolism
    1(b) – deep vein thrombosis
    1(c) – immobility; obesity; coronary artery disease

ISSUES

37. The clinical reviewer writes that the healthcare that the man received in Shepton Mallet was exemplary. He goes on to say that the ambulance and hospital staff also acted to the highest standard. Prison staff responded quickly, an appropriate assessment was made, and the ambulance service were exceptionally quick to attend.

38. The man was overweight and was not in the best of health. Healthcare staff tried to help him lose weight, but he had only limited success. The clinical review notes that, in the light of his occupational health assessment in June 2008, he was diagnosed as having osteoarthritis in his knees and given painkillers and a walking stick. However, to go to healthcare to collect his daily medication, he had to go over uneven walkways, stairs, and through heavy doors. Although this did not contribute to his death, the Head of Healthcare may wish to consider how medication is dispensed to prisoners with mobility problems.

39. On the day that he collapsed, when the first ambulance arrived to take him to hospital they were unable to do so as NHS regulations preclude a single ambulance crew from carrying someone of his size on a stretcher. This caused a delay while a second ambulance was summoned. This delay did not cause any particular difficulties either, as the man was not in a life-threatening situation. In another situation, however, such a delay could make a difference. I am pleased to note that in the light of these events, the prison have left a list of prisoners' BMIs (body mass indexes: a number calculated from a person's weight and height) with the gate. When an ambulance is required, if the prisoner's BMI is over 30 (an indication of obesity) the gate will give the Ambulance Service the information when requesting the ambulance so they know if a second crew will be required. I commend the prison for taking the initiative, and draw it to the attention of the Safer Custody Offender Policy Group. The Governor may also wish to consider whether it is sensible to locate obese and immobile prisoners above the ground floor.

40. In order to get the man into the ambulance, staff decided not to take him down the metal staircase at the end of C wing in the rain. Instead he was taken through the wing and down the indoor stairs. In my view this was a sensible decision. He was not in a life threatening situation, and this was a good decision made on the grounds of safety.

41. The man's family were not informed that he had gone to hospital on the day he had fallen. He was not in imminent danger, and there was at that stage no confirmation that he had suffered any serious injury. It was subsequently confirmed that he had not broken any bones, and but for his heart attack would have returned to prison. In these circumstances I regard it as reasonable that his family were not informed at that time.

42. When the man unexpectedly suffered a heart attack, he was already in hospital. Bedwatch staff immediately alerted medical staff, who did their best to

resuscitate him. I do not believe that any more could have been done to prevent his death.

CONCLUSION

43. The man had been in prison for a number of years and was not in the best of health. He was in frequent contact with healthcare, and I find that he was well looked after in Shepton Mallet. On 4 October 2008, he suffered a fall in his cell and was taken to hospital. Whilst there, he suffered a heart attack. Staff were unable to revive him.

44. The man's death could not have reasonably been anticipated. He was given tests on his heart on the way to hospital, and no problems were detected. No blame can be attached. The pathologist told the clinical reviewer that had the man not died when he did, the state of the arteries to his heart were such that it was certain that it was only a matter of time before he suffered a fatal heart attack. The clinical reviewer says that the care given to the man during his time in Shepton Mallet was exemplary, according with the best standards of general practice. I am pleased to endorse the reviewer's commendation.