

**Investigation into the circumstances surrounding the death in custody
of a prisoner on 9 May 2005 at HMP Guys Marsh**

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

July 2005

This is a report of an investigation into the circumstances of the death of a prisoner on 9 May 2005 at HMP Guys Marsh.

All deaths of prisoners in custody are investigated, including those due to natural causes. The responsibility for carrying out these investigations traditionally fell to the Prison Service itself, but has now been passed to me to bring independence and greater consistency to the task.

One of my investigating officers conducted the investigation. A clinical reviewer carried out an independent clinical review on behalf of the South West Dorset Primary Care Trust.

My colleagues and I would like to extend our condolences to the prisoner's family and friends for their loss. I would like to thank the prison's liaison officer from Guys Marsh who ensured that all relevant information was made available to my investigator.

My report makes four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The prisoner died at the age of 32 at HMP Guys Marsh. He was serving a 12 month sentence for the possession of a class B drug with intent to supply. This was not the prisoner's first time in prison. The prison described him as polite and co-operative.

The prisoner was extremely overweight and, after consultation with the prison doctor, he was advised that he could use the treadmill in the gymnasium for light exercise, but he should stop if he felt any pain or shortness of breath. The prisoner collapsed and died while taking part in his exercise regime on the treadmill. He was discovered by the gymnasium orderlies who responded and tried – unsuccessfully – to save his life.

A clinical review was carried out on behalf of the South West Dorset Primary Care Trust.

The prisoner's death was not connected to the fact that he was in prison or to the level of care that he received there. He died of natural causes as a result of a serious heart condition causing a congestive cardiac failure and a dilated cardiomyopathy. However, the report identifies some flaws in the way the prisoner was dealt with after he collapsed. It makes four recommendations, and identifies an example of good practice.

Investigation methodology

All the initial indications were that this was a death from natural causes.

My investigator was given access to all the prisoner's prison records, including his medical records, and was given copies of everything that was required.

Notices to staff and prisoners were sent to the prison's liaison officer, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

One of my family liaison officers contacted the prisoner's partner, who raised a number of questions about the prisoner's care while at Guys Marsh.

Background

The prisoner

The prisoner was born in Birkenhead on 9 December 1972. He was 32 years when he died on 9 May 2005. He was serving 12 months at Guys Marsh for possessing a class B drug with intent to supply.

This was not the prisoner's first time in prison. Prison staff described him as a polite and co-operative man who behaved well in prison. However, he was a man who had a number of medical complaints.

The prisoner lived in Poole in Dorset with his partner. He had worked in car sales, window fitting and property development.

HMP Guys Marsh

After opening in 1960 as an open borstal, Guys Marsh later became a young offender institution. After completion of perimeter fencing in 1992, it became a closed establishment and started to accommodate adults.

It is now a category C prison and closed young offender institution, housing 300 young offenders and 570 adult prisoners. There are currently nine living units.

Events leading to the prisoner's death

Following sentencing on 10 March 2005, the prisoner was taken to HMP Dorchester. He was transferred to Guys Marsh on 21 March. During the reception health screening, he was assessed by medical staff to have multiple health problems that included cardiac problems. He had had two previous cardioversion operations and was awaiting another, as well as previous treatment for liver failure.

The healthcare worker who conducted the prisoner's physical health check described him as having a healthy appearance with good colour. He made good eye contact throughout the interview, and gave no indication of intention of self harm or any suicidal thoughts.

The prisoner's weight at the time of his death was 140kgs (approximately 22 stone). He was receiving treatment for a serious heart condition at Poole General Hospital.

Shortly after arriving at Guy's Marsh, the prisoner asked if he could use the treadmill in the gymnasium to help him lose weight. The medical officer at Guys Marsh agreed that he should attend rehabilitation classes in the gymnasium, seven sessions a week. This was to involve the prisoner using the treadmill for light walking exercise only. He was advised that he should stop if he felt any pain or discomfort.

The prisoner was offered an appointment on the 20 April with a cardiologist but declined, preferring to wait until June to see his own doctor.

There is little more of note until 9 May.

Events of 9 May 2005

On the afternoon of 9 May, at 3.45pm, the prisoner attended the gymnasium to take part in his rehabilitation class. At 3.55pm, a Physical Education (PE) Officer saw the prisoner walking on the treadmill as part of his exercise programme.

A prison gym orderly was subsequently walking past the cardio vascular exercise room (CV room), and saw that the prisoner had stopped walking. The orderly says it looked as if he was resting. Immediately after passing the door, he heard a thud and returned to CV room. He found the prisoner on the floor at the end of the treadmill. The orderly pressed the emergency stop button on the treadmill and knelt down to try to assist the prisoner.

At 4.05pm, the orderly ran to the office to alert staff that the prisoner had collapsed and to get their help. He then returned to the CV room closely followed by PE Officers.

One of the PE Officers and some gym orderlies moved the gym equipment, to make more room around the prisoner to better assist him. He was placed in the recovery position, while the PE Officer returned to the office to call for healthcare and an ambulance to attend.

A Healthcare officer received the call for emergency medical assistance over his prison radio and, not knowing what type of emergency he was attending, he ran to the gym. He arrived at 4.12pm and started checking the prisoner's vital signs. After ensuring that an ambulance had already been called, he started Cardio Pulmonary Resuscitation (CPR), assisted by a gym orderly who was another prisoner who had first aid experience from his time with the Fire Brigade.

At this time, the PE Officer ran to the Healthcare centre to collect oxygen, while another officer collected the defibrillating equipment. Upon his return, he and the Healthcare officer, assisted by the gym orderly, commenced two cycles of defibrillation and CPR.

At 4.30pm, the paramedics arrived at the prison and they continued for a total of 50 minutes with CPR and seven cycles of defibrillation before accepting that the prisoner could not be resuscitated. They ceased all activity at 4.45pm. At 4.51pm, the prison car was sent to collect the on call medical officer, from the Royal Chase Hospital in Shaftesbury. The doctor attended at 5.30pm and formally pronounced the death of the prisoner.

At 7.10pm, the Governor and a Senior Officer arrived at the home of the prisoner's partner, to inform her that he had died.

Police officers arrived at 7.32pm, and confirmed that the prisoner's body could be removed from the establishment. A local funeral director subsequently took the prisoner's body to Dorchester County Hospital.

Following a Post Mortem, the cause of death was determined as follows:

- ❖ 1 A Congestive Cardio Failure.
- ❖ 1 B Dilated Cardiomyopathy.

Level of Compliance

Prison Service Order 2710 sets out what action must be taken following a death in custody. Guys Marsh fully complied with this order.

All necessary information was collated for the purposes of this investigation, including an incident checklist. This checklist was an aid to ensure that all relevant information was collected, as well as a comprehensive record of events.

I also commend the Governor for personally visiting the home of the prisoner's partner to deliver the sad news.

Clinical Review

A clinical review was carried out into the care of the prisoner at Guys Marsh. During the course of the review, a number of prison staff were interviewed. The report concludes that the advice that the medical officer gave to the prisoner, that he should take gentle exercise, was right. However, the reviewer raises two concerns about the care that the prisoner received from the prison.

First, he says that valuable minutes might have been saved if CPR had been started by prison officers, who he understands had been appropriately trained, rather than waiting for healthcare staff. However, he says that CPR is rarely successful outside hospital.

Second, he concludes that the radio message to healthcare should have been clearer about the nature of the emergency, so that healthcare staff could have initially brought the appropriate equipment.

Findings and Conclusions

The prisoner received appropriate treatment from medical and prison staff for a number of medical conditions. He died of natural causes as a result of a Congestive Cardio Failure and a Cardiomyopathy. The clinical review leaves no doubt as to the poor state of the prisoner's health.

The prison doctor was fully aware of the prisoner's medical condition. He permitted him to attend the gymnasium for seven sessions a week in a rehabilitation class, to assist with his weight loss. The prisoner had declined the opportunity to see a cardiologist on 20 April, as he preferred to see his own doctor at an appointment already booked for June.

I commend the actions that staff took on 9 May in attempting to save the prisoner's life, and particularly the actions of healthcare staff and the gym orderly in attempting to resuscitate him. However, I agree with the findings of the clinical review that there were two flaws in the process – the failure of prison staff to start CPR sooner, and the poor quality of the radio message about the emergency.

Recommendations

I endorse the recommendations of the clinical review.

- ◆ All staff should be instructed that if they are trained in the use of First Aid and CPR they should start CPR as soon as possible. The sooner CPR is commenced the more successful the outcome might be.
- ◆ The prison should ensure that there is a system of relaying radio messages to warn healthcare and other staff to what type of emergency they are required to attend, and that staff are trained to follow it.

The clinical review includes some other points that the Governor may wish to consider.

I also recommend that the Governor should consider the placing of a portable defibrillation machine located in the gymnasium area and PE Officers should be trained in its use. This could make response times considerably quicker.

Finally, I recommend that the Governor convey to the gym orderly and the Healthcare staff my particular commendations for their attempts to resuscitate the prisoner.

Good Practice

The use of a liaison officer checklist when dealing with fatal incidents ensures a comprehensive record of events, and that all necessary action is completed. Guys Marsh had a very good example of this checklist.

