

**Investigation into the circumstances surrounding the
death of a prisoner at HM Prison Exeter on 13 February 2005**

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

May 2005

This is the report of an investigation into the death of a man on 13 February 2005. He was a prisoner at HM Prison Exeter. The cause of death was given as cardiac failure.

One of my Senior Investigators and one of my Investigators conducted this investigation. Torbay Primary Care Trust on behalf of the Exeter Primary Care Trust provided a clinical review into the prisoner's care and treatment.

I would like to extend my condolences to the prisoner's family for their loss. I would like to thank the Governor in charge of HMP Exeter, and his staff for their help and co-operation during this investigation.

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Prisons and Probation Ombudsman
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Summary

At approximately 1.43pm on Sunday 13 February 2005, prison staff were alerted by another prisoner to the fact that the prisoner was lying on the floor of his cell. He was unconscious and not breathing. Assistance from other staff was sought and efforts at resuscitation began immediately. Paramedics were also in attendance and cardio-pulmonary resuscitation continued for approximately one hour before the man was pronounced dead at a local hospital. He had a history of heart problems and the post mortem indicates that he died of a heart attack.

The clinical review indicates that the prisoner received appropriate care and treatment whilst at HMP Exeter. Shortly before his death the prisoner was a voluntary participant in a medical trial designed to reduce cholesterol. The prisoner's family have sought clarification as to whether stopping this treatment was a contributory factor in his death. I hope the clinical review reassures the family that this was not the case.

I have made four recommendations, which although not directly affecting the circumstances of the prisoner's death, could have a bearing on any future incidents.

The Investigation process

1. The investigation was opened at HM Prison Exeter on 21 February 2005. The Governor and his staff produced the prisoner's core record and a number of other documents for examination. Notices were issued to staff and prisoners telling them of the investigation. My investigators were able to speak to members of staff as well as prisoners who knew the deceased.
2. A Family Liaison Officer from my office contacted the prisoner's family on 28 February 2005. She offered them the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. Whilst the family had no general concerns about the level of health care afforded to the prisoner at Exeter, there was a concern that the decision to stop him from participating in an ongoing medical trial may have had a direct impact on his health.
3. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

The Prisoner

4. The prisoner was born in January 1937 in London. He was 68 years old when he died on 13 February 2005. He had been married for approximately 28 years and had two daughters from the marriage. The marriage ended a number of years ago.
5. The man had moved from London to Dorset with his immediate family a number of years ago. He had been employed in London for 14 years. In Dorset he worked in a number of factories. On retirement he moved to live in Cornwall.
6. The prisoner was convicted of rape of a minor at Truro Crown Court in October 2004. In December, he was sentenced to 8 years imprisonment. He strongly denied the offence and wanted to appeal against the conviction. He was subsequently denied leave to appeal and has been described as being angry at this decision, although it was his intention launch another appeal.
7. The prisoner had daughters. One of his daughters was his nominated next of kin. He also had two sisters. Regular contact with his daughters and sisters was maintained by telephone, letter and prison visits.
8. The prisoner's daughters are devastated at the death of their father. They have no particular concerns or questions about his death, acknowledging that he had a history of heart problems. Indeed, one sister said that the prison has been open and honest and that the prisoner received an appropriate level of health care. The only issue of note is that he was part of a medical trial to reduce cholesterol. His participation in this programme was stopped just before his death. The family would like to know if this was a contributory cause of their father's death. The Primary Care Trust were therefore asked to examine this point as part of their review.
9. The family are mindful and wary of the adverse publicity and impact that the Coroner's inquest might have on family members in the future.

HMP Exeter

10. Exeter is a Nineteenth Century prison that overlooks the city. It currently has four accommodation units with a healthcare facility in support. It accepts all adult and young offenders committed to prison by the courts from Cornwall, Devon and West Somerset.

Events prior to the prisoner's death

11. When the prisoner was convicted in October 2004, he was identified as at risk of self-harm. However, he quickly settled into the routine at Exeter and has been described by staff as a model prisoner with a mature outlook on life, who did not present any management problems. He was a popular man with other prisoners on the wing.
12. On reception at Exeter, the Health Care staff interviewed the prisoner to establish his past medical history and current health status. It was noted that in 1987 he had suffered a heart attack and that in 1989 he underwent a triple bi-pass operation. In 1997 he again suffered a heart attack and in 1998 was admitted to hospital suffering with severe breathing difficulties. The prisoner also suffered from unstable angina. As a result of his heart condition his blood pressure was monitored regularly and he was prescribed the necessary medication.
13. The prisoner had also been taking SEARCH tablets, as part of the research into their effectiveness in the reduction of cholesterol homosistine, conducted by the British Heart Foundation. This was an approved clinical trial. The prisoner was scheduled to finish his course of SEARCH tablets in February 2005.
14. Upon receiving a sentence of 8 years from Crown Court, in December 2004, the prisoner apparently adjusted quickly to his new circumstances, although he continued to assert his innocence. When his request for leave for an appeal was rejected, it was his intention to launch another appeal.
15. In late December 2004 he was placed on the enhanced privileges regime. On 17 January 2005, he was moved to D3 landing where he occupied a single cell.
16. While at Exeter, the prisoner participated in education classes for numeracy and literacy and was also attending offending behaviour programmes. He had also previously taken part in the Thames Valley Sex Offender Intervention Programme and was reported to have had a strong commitment to this programme.
17. From the log of telephone calls made by the prisoner prior to his death, it is evident that he was adapting to life at Exeter. He did not share or report any issues or significant concerns in respect of his health or well being. However, the prisoner did admit to having a slight cough to his sister. On the morning of his death the prisoner telephoned one of his daughters, as well as his sister. There was nothing in their conversation to indicate that he was feeling unwell or out of sorts.
18. At 1.43pm on Sunday 13 February, an officer was alerted by a prisoner on 'D' wing that the man had been found collapsed in his cell and was not breathing. A fellow prisoner on the wing had walked past his cell door that

had been left ajar and alerted an officer to the fact that he was lying on the floor. The officer radioed for assistance stating that a prisoner had stopped breathing. The prisoner's cell bell was also activated, although it is not known who activated the alarm.

19. At 1.45pm an ambulance was called. The prison doctor was also requested to attend the wing. At the same time a request was made for the Orderly Officer and the Duty Governor to attend the scene.
20. The Wing Officer was the first member of staff to reach the prisoner's cell. He ordered prisoners on the wing back into their cells, and this was duly complied with. He then began Cardio Pulmonary Resuscitation (CPR) on the prisoner. A Senior Officer assisted him. Both officers are trained in first aid. The Orderly Officer and the Duty Governor quickly arrived at the scene and they then took over resuscitation from the officers.
21. The Staff Nurse was in the Health Care Centre and also received a request by radio to attend 'D' wing to attend a prisoner who had stopped breathing. Before he could attend, arrangements had to be made for another member of prison staff to relieve him. The Staff Nurse was the only member of staff on duty at that time in the Health Care Centre. Local policy requires that the Health Care Centre must be supervised at all times. Fortunately, a member of staff was found immediately to supervise the Health Care Centre.
22. Once the Staff Nurse was released from his supervisory duties, he made his way to the prisoner's cell. It should be noted that the Staff Nurse had been informed that a prisoner was not breathing and so took the decision to attend with only his personal resuscitation kit.
23. The defibrillator was not taken to the scene. It is, however, highly unlikely that the use of such equipment would have affected the outcome in this prisoner's case. However, it did become apparent during the investigation that the only defibrillator is located securely in the Health Care Centre and can only be retrieved by a member of the nursing staff. The locally available defibrillator has been described as 'heavy and awkward to carry', depending on the individual's physical ability. This could waste valuable time in the effective deployment of the defibrillator elsewhere in the prison.
24. On entering the prisoner's cell, the Staff Nurse took over the lung inflation from one of the officers. However, the prisoner was not responding to resuscitation and signs of cyanosis were detected on his lips.
25. At 1.55pm, the ambulance arrived and resuscitation attempts continued. However, the ECG monitor showed no output. At 2.07pm, the Doctor arrived. He advised that the ECG reading was ambivalent and that the prisoner should be transferred immediately to hospital.

26. In the meantime the Deputy Governor tried to contact the prisoner's daughter to advise her of her father's condition. A message was left on her answer phone asking that she ring Exeter.
27. At 2.30pm, the prisoner was taken to hospital with two escorts as well as the Staff Nurse in attendance. Mechanical restraints were not used on him and the resuscitation attempts continued on the way to the hospital. Despite continuing attempts at resuscitation, at 2.44pm a Doctor at the hospital pronounced the prisoner dead. A hospital chaplain administered the appropriate last rites to him.
28. Once the prisoner had been pronounced dead, his cell was sealed and all contingency plans were activated and correctly followed. All relevant documentation was provided to the investigators by the prison. This was completed to a high standard, enabling the investigation team to establish a clear picture of the events of that afternoon.

Events after the prisoner's death

29. When the prisoner had been pronounced dead, the Duty Governor sought help from the Duty Governor at HM Prison Weare to visit the prisoner's daughter's home address in Dorset and tell her of the death of her father. While these arrangements were being made, the prisoner's daughter telephoned Exeter in response to the message left on her answer phone. The Duty Governor relayed the sad news of her father's death.
30. At approximately 3.05pm, a 'Hot Debrief' was carried out with all staff who were involved in the incident. Staff informed prisoners on the wing of the death of their fellow inmate. Appropriate support and counselling was offered to the prisoners.
31. The prisoner's daughter contacted Exeter again on the morning of 14 February and spoke to the Acting Deputy Governor. Following this telephone call, the Governor sent a letter offering condolences. The letter also mentioned that arrangements could be made for the family to visit Exeter and that assistance could be given with funeral expenses if they wished. On 16 February, staff from Exeter visited the prisoner's daughter at home. She was told that the Prisons and Probation Ombudsman would undertake a full investigation of the circumstances surrounding the prisoner's death, and that the Exeter Coroner would be conducting out an inquest.
32. On 24 February, the prisoner's funeral took place. His family were determined that this should be a quiet affair.
33. On 28 February, the prisoner's daughter was contacted by one of our family liaison officers. She had no general concerns in respect of the care and treatment of her father whilst he had been at Exeter.

Clinical Review

34. The clinical review undertaken on behalf of the Exeter Primary Care Trust confirms that the prisoner's death was not related to the quality of care that he received whilst in prison but was from apparent natural causes.
35. In respect of the decision to stop the prisoner's participation in the SEARCH programme, shortly before his death, the review concludes that the programme was designed to reduce cholesterol over a long period of time and that withdrawal from medication would not have been a contributory factor in his death.

Post Mortem report

36. The post mortem report indicates that the prisoner died from cardiac failure. The toxicology report also indicates that there were no illicit substances detected in the blood. The pathologist also identified that there were no suspicious findings.

Findings and conclusions

37. Up until shortly before his death, the prisoner was taking part in an approved medical trial sponsored by the British Heart Foundation called SEARCH. The trial is designed to reduce cholesterol in people who have suffered with a heart condition. The prisoner's family expressed concern that taking him off this programme shortly before his death might have contributed to his death. The clinical review on the prisoner concludes authoritatively that this could not have been the case.
38. It became apparent during this investigation that there could have been a delay in medical staff attending to the prisoner in that, at the time assistance was required from the Health Care Centre, there was only one member of staff on duty. The Health Care Centre needs to be supervised at all times and an appropriate member of prison staff would need to be found to undertake supervisory duties. In this particular case, cover was found immediately. However, without adequate local arrangements there might be occasions when appropriate cover cannot be found so quickly, delaying medical staff from attending an emergency situation.
39. The location of defibrillators was also noted to be an issue, although the use of this equipment did not have a bearing on the outcome in this prisoner's case. Currently, the only defibrillator is located securely within

the Health Care Centre and can only be retrieved by a member of the Health Care team who has the necessary keys. The equipment has been described as 'bulky and awkward' and has to be taken by a member of staff to where it is required. It may be more prudent to locate and secure such equipment in other parts of the establishment.

Recommendations

Establishment

The Governor of Exeter should satisfy himself that adequate arrangements are in place to provide prompt cover to the Health Care Centre when staff are required to attend an emergency in the prison.

The Governor should consider the introduction of a coded radio call system to ensure that Health Care staff attending an emergency are able to take the necessary equipment to the incident and to manage it effectively.

Primary Care Trust

The Primary Care Trust should give consideration to placing appropriate portable Automated External Defibrillators strategically in other parts of the prison with easy access in the event of an emergency.

The Primary Care Trust should give consideration to the introduction and use of emergency bags that can easily be moved from health care to the scene of an incident and contain the necessary equipment to manage incidents until the arrival of paramedic support.