

**Investigation into the circumstances surrounding
the death of a man at HMP Featherstone in February 2012**

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

October 2012

This is the report of the investigation into the death of a man at HMP Featherstone in February 2012. He was 45 years old and was found dead in bed at about 8.20am. The post mortem showed that he died of a heart attack, due to a build up of fatty deposits in his arteries. I offer my condolences to his family and friends.

The man's death was investigated by an investigator. A review of the clinical care he received at Featherstone was conducted by a clinical reviewer, at the request of the local Primary Care Trust (PCT) cluster. Staff and prisoners at Featherstone co-operated fully with the investigation.

The man had suffered a serious heart attack in 2001 and had surgery to widen his arteries. He was also diagnosed with angina (chest pain related to heart disease). He was prescribed a number of medications to try to prevent further heart problems, which he continued to be prescribed once in prison.

He had been at Featherstone since January 2012, after receiving a four year prison sentence in 2009. While in prison, his heart condition was monitored and he received treatment in line with national guidelines for the long term care of patients who have suffered heart attacks. The evidence suggests that he was well informed about his diagnoses and aware of the importance of diet, exercise and stopping smoking.

In the days leading to his death, the man was seen by healthcare staff and his blood pressure, pulse, temperature and blood oxygen levels were measured and caused no concern. He did not complain of any chest pain. This investigation has not found any evidence to suggest that healthcare staff missed any opportunities to predict his heart attack in the days preceding his death. The clinical reviewer concludes that the clinical care he received in prison was equivalent to what he might have received in the community.

The investigation identified only a small number of areas for improvement. These related to arrangements for prescribing sleeping tablets and the preservation of evidence after a death. Overall, I am satisfied that the man was well cared for and that there was nothing more the prison could have done to predict or prevent his death.

Following the consultation period, this final version of the report includes the responses of both the man's family and the National Offender Management Service (NOMS).

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

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October 2012

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SUMMARY

1. The man was remanded into the custody of HMP Hewell in June 2009. He had suffered a serious heart attack in 2001, was diagnosed with angina and was prescribed a range of medication. He also had a history of illegal drug misuse and, once in prison, underwent a detoxification programme until he was no longer dependent on substances.
2. Prison doctors ensured that he was prescribed the necessary medication and his heart condition was monitored. He was given advice on exercise, diet and giving up smoking.
3. The man suffered two angina attacks in July and September 2009. In August 2010, a blood test showed that his cholesterol levels were high and he tried to reduce them by adopting a low fat diet. However, in November the dose of one of his medications was raised in an effort to reduce the cholesterol levels.
4. He was released on licence in December 2010 but he broke the conditions of his licence and was recalled to Hewell in July 2011. He continued to be prescribed appropriate medication. On 5 January 2012, he transferred to HMP Featherstone. On his arrival, healthcare staff discussed diet and exercise with him and advised him to give up smoking.
5. On 30 January, the man's blood was tested and his cholesterol levels were still high. On 9 February, he underwent a test to assess how well his heart was functioning. The test showed no immediate causes for concern.
6. The man began complaining of a headache and flu-like symptoms on 18 February. The following day, he saw a nurse who gave him paracetamol. He was still feeling unwell the next day and was assessed in his cell at lunchtime. Two healthcare assistants took his pulse, blood pressure, blood oxygen levels and temperature. His pulse rate was slightly fast, but all of the other measures were normal. He did not complain of any chest pain. That evening, he collected his dinner as normal, had a shower and seemed a little better. He did not ask to see healthcare staff again that day.
7. At about 8.20am the next day, an officer unlocked all of the cells on the man's house unit. The man's cell mate got out of bed and found that the man was unresponsive, blue in colour and cold to the touch, so he raised the alarm. Officers and healthcare staff responded and concluded that he had been dead for some time and so they did not attempt to resuscitate him. At 8.40am, the prison doctor confirmed that he had died.
8. This investigation has found that the man's known heart conditions were treated in line with national guidance and that he received a standard of care equivalent to that he might have received in the community. We make two recommendations, one concerning prescribing sleeping tablets and the other about the preservation of evidence after a death in prison. However, neither would have prevented his death.

THE INVESTIGATION PROCESS

9. The Ombudsman's office was notified of the man's death on 21 February 2012. An investigator visited Featherstone on 28 February to open the investigation. During the opening visit, she met the Governor and other members of the management team, a member of healthcare staff and the prison family liaison officer. She also spoke to a member of the Independent Monitoring Board and prison staff who knew the man. She was provided with copies of his prison and medical records.
10. Notices were issued to staff and prisoners at Featherstone informing them of the investigation and inviting them to contact the investigator should they wish to talk to her. There was no response to the notices.
11. On 28 February, the investigator interviewed the man's cell mate. She returned to the prison on 10 April and interviewed prison officers and healthcare staff. One nurse was interviewed by telephone at the beginning of May. The Governor was given written feedback following the interviews. One member of staff has been absent from the prison due to illness since the beginning of the investigation and could not be interviewed.
12. The local Primary Care Trust (PCT) cluster appointed a clinical reviewer to review the clinical care the man received. He reviewed the medical records and was given copies of the transcripts of interviews conducted by the investigator. He also spoke to staff involved in the man's care by telephone.
13. HM Coroner for Staffordshire was informed of the investigation and provided the investigator with a copy of the post mortem report. A copy of this report will be sent to him to assist with his enquiries.
14. The investigator also contacted the local police. They provided helpful information about medication found in the man's hand after his death.
15. One of the Ombudsman's family liaison officers contacted the man's family outlining the purpose of the investigation and inviting them to raise any concerns. The man's sister said that shortly before her brother's death, he complained of being unwell and was treated with paracetamol. She was concerned that he should have been taken to hospital when he became ill. We hope that this report gives the family a better understanding of the circumstances of his death.
16. We are very grateful to the family for considering the report at the consultation stage. They remain concerned about some aspects of the care provided to the man, in particular that he was prescribed sleeping tablets despite his history of heart problems and that he was allowed to keep so many of them in his cell. They were disappointed that staff had disposed of the tablets found in his cell without recording details of them. They also believe that he should have been taken to hospital when he was clearly unwell on 20 February.

HMP FEATHERSTONE

17. HMP Featherstone is a category C adult male training prison in the West Midlands for prisoners with more than 12 months of their sentence left to serve. It holds up to 687 prisoners in seven house units. House 5, where the man lived while at Featherstone, is the induction unit for newly arrived prisoners.
18. Healthcare services are provided by a NHS Trust. The healthcare department offers a wide range of primary care services, including health promotion and the management and treatment of long term and acute medical conditions. There is no inpatient facility. Medication is dispensed to prisoners from the treatment rooms on each house unit.

HM Inspector of Prisons (HMIP)

19. HMIP carried out a short follow up inspection of Featherstone in November 2011, following a full inspection in October 2008. HMIP praised the prison for having made progress since the last inspection. Healthcare services had improved and a senior manager had been appointed to manage the service. Almost all of the healthcare related recommendations made by HMIP in 2008 had been achieved by the time of the follow up inspection.

Independent Monitoring Board (IMB)

20. Each prison is monitored by an Independent Monitoring Board of independent, unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained. The most recent IMB annual report for Featherstone covers the period October 2010 to November 2011.
21. The Board reported that healthcare services had improved since the last report. They were particularly positive about the fact that medication is now dispensed on each house unit, noting that “staff are able to familiarise themselves with prisoners and their needs and are better able to deal with queries and give advice”.
22. The investigator spoke to a member of the IMB during her opening visit to Featherstone. The IMB had not had any contact with the man. The IMB member was positive about the prison and the professionalism of staff.

Previous deaths at Featherstone

23. The man was the fifth prisoner to die at Featherstone since 2004, when the Ombudsman began investigating all deaths in prison. There are no similarities between the previous deaths and that of the man, or in the recommendations made.

KEY EVENTS

24. The man was remanded into custody at HMP Hewell on 19 June 2009, charged with burglary. It was not his first time in prison. On his arrival, a nurse carried out the first reception healthscreen (which assesses whether the prisoner has any immediate mental or physical health needs). The nurse noted that he had suffered a serious heart attack in 2001 and had undergone angioplasty surgery (an operation which widens the arteries taking blood to the heart). She wrote that, in 2005, he had been diagnosed with angina (chest pain which is caused by coronary heart disease). He said that he was prescribed ramipril (which treats high blood pressure and heart failure and improves survival after a heart attack), simvastatin (to lower cholesterol), bisoprolol (for angina) and aspirin (which is often prescribed to help prevent heart problems). He was also prescribed a glyceryl trinitrate (GTN) spray, which helps to ease the pain caused by angina attacks.
25. The man said that he had a history of substance misuse and had been prescribed methadone (a heroin substitute) but also injected heroin. The nurse recorded that he had never tried to harm himself.
26. The following day, the man was examined by prison doctor. He agreed to be placed on a methadone detoxification programme (where the patient is prescribed a decreasing dose of methadone until they are no longer physically dependent on it). The doctor also prescribed the medication that the nurse had listed.
27. The man had a mild angina attack on 10 July and was examined by a prison doctor. He said that it was his first angina attack since 2005 and had been brought on by him lifting heavy boxes while working in the prison kitchen. The doctor noted that he was a "very sensible man" who knew to use his GTN spray when he experienced chest pains. However, the doctor wrote that the man might need to be referred for specialist treatment if the angina attacks occurred too frequently. The doctor told him to request another appointment if the pain returned and was not resolved by using the GTN spray. Four days later, on 14 July, he was convicted of burglary and received a four year prison sentence.
28. Between 14 July and 24 August, the man failed to attend three medical appointments, including one at the coronary heart disease clinic at Hewell. (Some prisons run clinics for prisoners suffering certain long term conditions, such as asthma, diabetes and heart disease. Prisoners identified as suffering the conditions are invited to attend so that they can be monitored. As in the community, prisoners are generally responsible for ensuring they attend appointments.) The reasons for his non-attendance are not known.
29. On 26 August, the man attended a coronary heart disease review with a nurse. The nurse recorded his weight, blood pressure, pulse rate and body mass index (BMI - a measure which can help to assess whether the individual is a healthy weight for their height). His BMI indicated that he was a healthy weight and the other readings were within the normal ranges. The nurse wrote that the man smoked between eight and ten cigarettes a day but wanted to give up and was

on the waiting list for the smoking cessation course. She also wrote that he did not need any advice on his diet or exercise.

30. The man experienced chest pain again on 15 September. A nurse examined him and took his pulse, blood pressure and other vital readings, which were all within normal ranges. He said that he had used his GTN spray twice and was feeling better.
31. He complained of chest pain again on 1 February 2010. Initially he was assessed by a nurse who referred him to the doctor. A prison doctor examined him later that morning, noting that he had been experiencing “constricting pain” across his chest for the previous two nights. He said that he had felt a similar pain across his abdomen the previous year. He said that the pain lasted for about ten minutes. The doctor recorded that the pain returned when pressure was applied to the lower end of his breast bone. His chest sounded clear and the doctor concluded that, on this occasion, the pain was most likely the result of muscle strain rather than a heart problem. He prescribed an anti-inflammatory medication (which helps to relieve muscle related pain) and an indigestion aid and told him to return if the symptoms got any worse. He did not complain of any further pain in the following months.
32. On 19 July, a doctor reviewed the man’s medication and on 27 July, another doctor saw him to review his heart condition. The doctor arranged for the man’s blood to be tested. The doctor reviewed the blood results on 17 August. His cholesterol level was 5.5 (which is higher than normal) but he missed an appointment on 2 September to discuss the test results. (High cholesterol levels can be dangerous, particularly for those who already suffer heart problems.)
33. A doctor saw the man on 9 September and discussed the raised cholesterol level. He said that he would prefer to try to control his cholesterol by adopting a low fat diet rather than raising his dose of simvastatin.
34. His blood was tested again on 6 October and the cholesterol level was 5.2. He missed another review appointment on 28 October and the doctor wrote that he would increase the dose of simvastatin regardless if he did not attend the next scheduled appointment. He did attend an appointment on 11 November and the doctor advised that the low fat diet was not reducing his cholesterol level enough. The doctor raised the simvastatin dose from 40 milligrams (mg) to 60mg.
35. The man was released on licence on 17 December 2010. (Prisoners who receive prison sentences of more than 12 months but less than life, are automatically released when they have served half of their sentence. They are released on licence, which means that they must abide by certain conditions set before they leave prison. If they break the conditions of their licence, they can be recalled to prison to serve the remainder of their sentence.) One of his licence conditions was that he must live at a hostel in Coventry, which he did not do. Having breached the terms of his licence, he was recalled to Hewell on 4 July 2011 to serve the remainder of his sentence.

36. On the evening of 4 July, a nurse assessed the man's mental and physical health. He said that he had been using illegal drugs while at liberty. The local community drugs team confirmed that he had been prescribed subutex (another heroin substitute) until mid-June, when the prescription was stopped because he was not collecting the medication as directed. The nurse recorded that he was still being prescribed ramipril, bisoprolol, aspirin, simvastatin and the GTN spray to treat his heart problems. He said that he was still smoking cigarettes, but "not many". A prison doctor prescribed all of the medications except for the GTN spray later that day. It is not clear why the GTN spray was not prescribed, but later medical entries indicate that he had one in his possession. He was also placed on a 21 day methadone detoxification programme.
37. The man was given all of his medications, except methadone, in possession, meaning that he kept the medication in his cell and was responsible for taking the correct doses. He did not complain of any heart or chest problems in the following weeks and the only entries in his medical record relate to the repeat prescribing of his medication.
38. He transferred from Hewell to Featherstone on 5 January 2012. On his arrival, a Healthcare Assistant (HCA) reviewed his health. She noted that he was prescribed his medication in possession. The HCA recorded details of his history of heart problems and "mild" angina attacks. She noted that he exercised regularly and had an active job in the prison kitchen. She also recorded that she had given him smoking cessation advice because he was still smoking. The following day, a prison doctor prescribed bisoprolol, aspirin, simvastatin and ramipril.
39. The man shared a double cell (2-27) on the second floor landing of house 5, the induction unit. (All new prisoners spend their first few weeks at Featherstone on house 5. While there, they complete the prison induction which gives them information about the prison regime.) Early entries in his prison record indicate that staff generally found him to be a mature prisoner who was settling well into the prison regime.
40. On 13 January, a doctor noted that the man had last had a blood test in late 2010 and requested that another blood test be done. He also noted that the man was no longer being monitored by hospital specialists having had his last hospital appointment in 2001.
41. On 30 January, another prison doctor reviewed the man's blood test results. The doctor noted that his cholesterol level was 5.5 and that he should be given an appointment with a doctor to discuss the results. The doctor also directed that the man undergo an electrocardiogram (ECG, which tests the rhythm and electrical activity of the heart). The ECG was carried out on 9 February and showed no current problems.
42. The doctor spoke to the man about his blood test and ECG results on 14 February. The doctor told him that there were no signs of any serious concerns but that his cholesterol levels were still high. He arranged for another blood test to be carried out in April. The doctor noted that the man's brother had died in

December and the man said that he was having trouble sleeping. The doctor prescribed 14 days worth of promethazine (an antihistamine medication which is sometimes prescribed as a short term measure to help people sleep). His heart medication was re-prescribed on 17 February.

43. The man's cell mate was interviewed as part of the investigation. He said that he and the man had shared a cell for about a week. He said that the man began to complain of feeling ill on the evening of Saturday 18 February. He told the cell mate that he felt like he had a bad cold or flu as he was shivering and had a headache. In interview, the cell mate said that he developed the same symptoms a few days later.
44. On 19 February (a Sunday), a nurse was dispensing medication on house 5. The man came to the treatment room (which is also on the second floor landing, close to his cell) complaining of a high temperature and a head ache and so she gave him paracetamol. The investigator spoke by telephone to the nurse who could not remember having seen the man on 19 February. She said that she was not aware of his medical history, however, she did not think that he had presented as seriously unwell. She said that if he had, she would have taken his blood pressure and pulse readings. She explained that, on Sundays, nurses can either consult the out of hours doctors service or refer prisoners to the local hospital if they have concerns about them. She said that nurses are allowed to dispense, at their discretion, paracetamol to prisoners who complain of feeling unwell. Prisoners are also able to buy paracetamol with their own money from the prison canteen service (the prison shop, from which they can purchase buy toiletries and other items on a specified list). She did not see the man again.
45. At about 8.20am the following morning, 20 February, the HCA was dispensing medication on house 5. In interview, she said that she is normally based on house 5 with another HCA. She said that, when she arrived on the house unit, she received a brief update of the weekend's events from the officers. They said that the man had complained of flu-like symptoms over the weekend and had been seen by a nurse. She said that she knew of his history of heart problems because she had sat in on an earlier appointment he had with a doctor. She also knew that an ECG had been carried out recently.
46. The man's cell mate said that he went to the treatment room on house 5 that morning to ask for medicine for the man. He was told that the man would have to come to the treatment room himself if he needed medication. An officer was also working on house 5 that day. In interview, she said that she saw the man waiting near the treatment room and that he looked unwell. The HCA also saw him waiting and assumed that he wanted her to authorise his absence from work. However, shortly after, another prisoner told her that the man had returned to his cell because he felt weak and ill. The HCA told officers on the unit that she would authorise his absence from work and assess him in his cell once she had finished her morning duties.
47. The officer said that she spoke to the man that morning. He told her that he had a "constant headache, like a migraine". He also said that he felt faint and the officer described him as a bit unsteady on his feet.

48. At 12.10pm, the HCAs and another HCA colleague went to the man's cell to check him. He said that he had been suffering flu-like symptoms since the weekend. They took his pulse, which was 94 beats per minute (slightly higher than normal). His blood pressure was 135/75mmHg, his blood oxygen level was 97 percent and his temperature was 37 degrees, all of which were within normal ranges.
49. The HCA who was interviewed said that the man complained of no other symptoms and did not mention any tightness or pain in his chest. He told her that he had taken some paracetamol over the weekend and that he would take some more and try to eat something. She advised him to alert the officers if he felt worse and she would come back to see him. She said that, if she had been concerned about him, she could have sought advice from the doctors or nurses on duty. She also said that another ECG could have been carried out if there had been any indications that his symptoms were linked to his heart problems.
50. At some point on 20 February, the man met a drugs worker with the Counselling, Assessment, Resettlement, Advice and Throughcare service (CARATs – the service working with drug misusing prisoners). Unfortunately, she has been unwell and absent from the prison for the duration of the investigation and was not available for interview. However, she made notes of their meeting in his CARATs file. The notes make no mention of him being unwell.
51. The officer said that she kept a close eye on the man during the afternoon. She explained that prisoners on house 5 were unlocked that afternoon and so his cell door was also open, making it easy for her to check him regularly. She said that he slept most of the afternoon but told her he was fine. As far as she knew, he did not ask to see healthcare staff again that day.
52. At about 6.00pm that evening, the man came out of his cell to collect his dinner and have a shower. The officer said that he looked "a bit perkier". He returned to his cell for the night at about 7.00pm. All cells at Featherstone are fitted with an emergency call bell which prisoners can use to alert staff at times when they are locked in their cells. Use of the call bells is recorded by an electronic system. The call bell in his cell was not pressed during the night of 20 February.
53. The man's cell mate told the investigator that he and the man spoke for the last time some time around 7.00pm. He had the top bunk bed and the man the bottom. He said that he fell asleep early that evening but woke again at around 9.00pm. He said that he was woken by the "normal noises" that the man made while he slept. He banged on the bed and the noises stopped. He said that he did not hear anything more from him that night.
54. At about 8.15am another officer unlocked the cell doors on the second floor landing of house 5. In interview, he said that, as he unlocked the man's cell, he looked through the observation panel in the door. The room was dark and the observation panel only gave him a partial view of the two beds. However, he could see that both men were still in bed and assumed that they were asleep. He continued to unlock the other cells on the landing. When he had finished

unlocking cells, he and the officer who was interviewed positioned themselves outside the treatment room to monitor prisoners collecting medication.

55. The cell mate said that he was woken up when the officer unlocked the cell door. As he got out of bed he checked the man, who was half sitting up in bed, with part of his body covered by the bedsheets. His feet were on the floor. The cell mate said that he looked blue in colour and, when he touched him, was very cold.
56. He shouted to the male officer, who was across the corridor. The officer went into the cell and the cell mate told him that he thought the man had died. The officer called the man's name and touched his shoulder. He found that he was stiff and cold. Because the HCA was only across the landing, he called to her, asking her to come to the cell. At 8.23am, the officer used his radio to alert the prison to a code blue emergency. At Featherstone, a code blue emergency is called when someone is not breathing. (Code systems are in place in many prisons across England and Wales. Using a code system in medical emergencies helps to ensure that medical staff bring the right equipment to the scene.) A senior officer and two officers quickly arrived at the cell
57. The HCA said that she picked up the emergency medical bag and the oxygen as she left the treatment room. She said that, on entering the cell it was quickly apparent that the man had been dead for some time. She said that his skin colour had changed and, when she touched him to try to find a pulse, she realised that rigor mortis was present. (Rigor mortis is the stiffening of the body which occurs naturally and normally a few hours after death.) Because she was certain that he had died, she did not consider attempting cardiopulmonary resuscitation (CPR – the delivery of chest compressions and rescue breaths to keep oxygen moving around the body).
58. A nurse arrived at the cell at about 8.30am. He checked the man for signs of life and also concluded that rigor mortis was present. He agreed that it was not appropriate to try to resuscitate him. A doctor also attended and checked him. The doctor certified death at 8.40am.
59. After the man's death, the HCA noticed that he was holding a GTN spray in his right hand. The investigator contacted the local police, who confirmed that a GTN spray, with an expiry date of April 2013, was found in his right hand.
60. The HCA also told the investigator that a quantity of the man's prescribed medication was found in his cell after his death. She felt that the amount of medication found indicated that he had not been taking his medication as prescribed. The medication was not taken by the police as part of their routine investigation into his death; instead it was passed to Featherstone's Head of Healthcare. Unfortunately, he disposed of the medication without recording details of the number of tablets or type of medications remaining.

Contact with the man's family

61. The man had nominated his sister as his next of kin and emergency contact. The Governor and the deputy governor visited her at her home, to break the news of his death.
62. The appointed prison family liaison officer contacted the man's sister by telephone the following day. She also contacted his adult son.
63. In line with national guidance, the prison offered to contribute to the cost of the funeral, which members of prison staff attended. The family was offered the opportunity to visit the prison.

Support for staff and prisoners

64. Following the man's death, his cell mate was moved into a cell with a relative also at Featherstone. The Governor and deputy governor visited him in the afternoon. An officer arrived on the wing at 8.30pm and made an entry in the wing observation book noting that he had been given a full handover by evening staff. The officer wrote that he had spoken to the cell mate and told him to press his cell bell if he needed to talk. The cell mate told the investigator that he had received good support from wing officers and knew where to find additional support if he needed it.
65. Immediately after the man was found, prisoners on house 5 were locked in their cells. Staff visited each cell and explained what had happened. That day, Listeners (prisoners who are trained and supported by the Samaritans to provide a confidential listening service to other prisoners) were brought to the wing to offer support to the prisoners. Other prisoners at Featherstone were informed of the death by way of a notice from the Governor. All prisoners being monitored under suicide prevention measures were reviewed that day.
66. Staff interviewed said that they had been well supported after the death. In line with national guidance, staff involved met later that day to discuss what had happened and were offered support.

Results of the post mortem

67. The post mortem examination found that the man died as a result of coronary artery atherosclerosis and thrombosis. Coronary artery atherosclerosis is the build up of fatty deposits and cholesterol in the artery walls. A coronary thrombosis is another term for a heart attack, which can be caused by the narrowing of the arteries caused by atherosclerosis.

ISSUES

68. The local PCT appointed a clinical reviewer to review the clinical care the man received at Featherstone. He considered several aspects of the medical care. As part of our investigation into the death, we and the clinical reviewer reviewed his prison medical records dating from June 2009 to December 2010 and from July 2011 to his death on 21 February 2012.

Monitoring and treating the man's known heart conditions

69. The clinical reviewer notes that, in May 2007, the National Institute for Health and Clinical Excellence (NICE) published national standards of care for patients with a history of heart attack. The guidelines focus on both early interventions following a heart attack and longer term care. As the man suffered his heart attack in 2001 it is the latter aspect that is most important in considering the care he received at Featherstone.

70. The guidelines make the following key recommendations:-

- Patients should be involved in decisions regarding the care they receive.
- Smokers should be advised to stop and offered smoking cessation services to support this.
- Patients should exercise regularly.
- Patients should be advised to adopt a Mediterranean style diet.
- Patients should be offered the following drug combinations:
 - Ace Inhibitor (such as ramipril)
 - Beta blocker (including bisoprolol)
 - Aspirin
 - Statin (including simvastatin)

In addition, blood tests to monitor urea and electrolytes are recommended to be undertaken no less than annually.

71. After he had suffered a heart attack, the man was prescribed ramipril, bisoprolol, simvastatin, aspirin and a GTN spray. The medications continued to be prescribed to him while in prison, in line with the NICE guidance. While he was at HMP Hewell, he was placed on the list for the coronary heart disease clinic and underwent specific coronary heart disease reviews (although he sometimes missed scheduled appointments). Exercise and diet were discussed. It is also noted that he was on the waiting list for the smoking cessation course at Hewell, but he was released on licence before completing the course.

72. He arrived at Featherstone in January 2012. He said that he exercised regularly and was given advice about stopping smoking. Shortly after his arrival, his blood was tested and his cholesterol level was still high. He was due to have his blood tested again in April 2012.

73. On 9 February, an ECG was carried out, which showed no cause for concern. As part of this investigation, the ECG reading was reviewed by the GP Clinical Lead for the PCT, who confirmed that it showed nothing of immediate concern. The clinical reviewer writes that healthcare staff did not miss any signs, either in

the ECG reading or the blood tests, that might have compromised the man's survival. He concludes that the man received care in accordance with the NICE guidelines while in prison.

Responding to the man's illness on 19 – 20 February

74. The cell mate said that the man began to complain of feeling shivery and having a head ache on the evening of 18 February. On 19 February, the man went to the treatment room and spoke to a nurse. She recorded that he was complaining of a high temperature and a head ache and she gave him paracetamol.
75. The following day, the man continued to complain of flu-like symptoms, including feeling weak and having a head ache. Two HCAs assessed him in his cell and took a number of observations. Except for his pulse rate (which was slightly above the normal level and is discussed later), the readings were normal. The HCA who was interviewed said that the man did not mention having any chest pains. After he was assessed in his cell on 20 February, he apparently did not seek any further medical advice or treatment.
76. Evidence in the medical record suggests that he was well informed about his heart condition. The HCA was also aware of his history of heart problems. We have not found any evidence to suggest that healthcare staff missed any opportunities to predict his heart attack in the days preceding his death. The clinical reviewer notes that the "watchful approach" adopted by healthcare staff in relation to his symptoms was appropriate.

The man's prescribed medication

77. As noted earlier, while in prison, the man continued to be prescribed relevant medications to treat his heart condition. However, some issues relating to his medication were raised during the investigation.
78. On his arrival in prison in June 2009, the man was prescribed a GTN spray to help resolve the pain of an angina attack. When he returned to custody in July 2011, the GTN spray was not prescribed either at Hewell or Featherstone. It is not clear why the Hewell doctor did not prescribe this medication. However, later entries in the medical record suggest that he had a GTN spray in his possession. After his death a GTN spray was found in his right hand. The spray had an expiry date of 2013 and was therefore in date and likely to be effective if used.
79. The spray might have been one prescribed to him by his community doctor while he was on licence which he brought into with him. However, there is no record of this either in his medical record or the documents relating to his transfer from Hewell to Featherstone.
80. On 14 February 2012, the man was prescribed 14 tablets of promethazine to keep in his possession. The clinical reviewer notes that promethazine is licensed for short term insomnia due to its sedative properties. However, prescribers are cautioned about prescribing the medication to patients with severe coronary artery disease because promethazine can increase the pulse rate. In patients

already suffering coronary artery disease, a raised pulse rate can result in angina-like symptoms.

81. The man had been prescribed one 25mg tablet each night, but following his death, although no formal record was kept, the investigator was told that only two tablets remained, suggesting that he took 12 tablets over seven days (or diverted them to other prisoners). The clinical reviewer writes that the 25mg dose would be unlikely to cause any problems to him. However, if he either deliberately or accidentally took more, a raised dose might have induced an angina attack. He also suggests that the promethazine might account for the raised pulse rate on 20 February. It is worth reiterating, however, that in the days leading to his death, the man did not complain of an angina attack or of any chest pains. In fact, the HCA told the investigator that the man said he had stopped taking promethazine because it made him “feel funny”. The clinical reviewer concludes that the prescription of promethazine is unlikely to have resulted in his heart attack, however, he is critical of the decision to prescribe 14 days supply of the medication in possession. A variety of medications can be prescribed as sleeping aids and some have a higher potential for misuse and overdose. We make the following recommendation:

The Head of Healthcare should ensure that medication to aid sleep is only provided to prisoners in possession after a specific risk assessment has been carried out.

82. Following the man’s death a quantity of medication was found in his cell. The HCA told the investigator that she thought the quantities found suggested that he had not been taking his prescribed medications as directed. Unfortunately, the Head of Healthcare disposed of the medication without logging any further details and so we are unable to determine with any accuracy his level of compliance. The clinical reviewer notes that medication compliance issues are common across the wider population. He also emphasises that even good compliance with medication prescribed to reduce the risk of further potentially fatal heart problems will not eliminate the risk of such an event occurring. Nevertheless, it is important that evidence which could be significant in other cases is kept. We make the following recommendation:

The Governor should ensure that the details of all items found in the cell of a deceased prisoner, including prescribed medication, are recorded and retained until the conclusion of all investigations.

The emergency response

83. The man was found unresponsive in bed at around 8.20am. The cell mate, the officer and the HCA all told the investigator that, on looking at and touching him, they were quite sure that he had been dead for some time. All of the evidence gathered as part of the investigation corroborates their view. He was described as blue in colour, cold to the touch and with rigor mortis present. At 8.40am, a doctor confirmed that he had died.

84. The clinical reviewer writes that to have attempted resuscitation would have been distressing for staff, undignified for the man and ultimately of no benefit. National guidance makes clear that staff should not attempt resuscitation if rigor mortis is clearly present. We conclude, therefore, that the decision not to attempt resuscitation was appropriate.

CONCLUSION

85. The man suffered a serious heart attack in 2001 and had a history of angina. He was being prescribed appropriate medication in the community, which continued on his remand into custody in 2009. While in prison, he underwent checks and his heart disease was monitored. There is evidence to suggest that he understood the importance of diet, exercise and stopping smoking as preventative measures against future heart problems.
86. In January 2012, he transferred to Featherstone. In late January, his blood was tested and on 9 February, he underwent an ECG. The results of both tests indicated that, apart from higher than normal cholesterol levels, there was no immediate cause for concern.
87. On 18 February, the man began to complain of feeling unwell with a headache and flu-like symptoms. The following day, his vital signs were checked and indicated no concerns. However, he was found unresponsive in bed at 8.20am. Healthcare staff concluded that he had been dead for some time and so no resuscitation was attempted. The post mortem examination found that he died as a result of a heart attack due to fat building up in his arteries.
88. The clinical reviewer concludes that the man's heart disease was treated in line with national guidelines and that he received an equivalent standard of care to what he might have received in the community. We make two ancillary recommendations about the use of medication to aid sleep, and the preservation of evidence.

RECOMMENDATIONS

The NOMS response to the recommendations is detailed in italics beneath each recommendation.

1. The Head of Healthcare should ensure that medication to aid sleep is only provided to prisoners in possession after a specific risk assessment has been carried out.

NOMS has accepted this recommendation, noting that “the Healthcare team complete risk assessments specific to individual prisoners regarding in possession medication and only issue sleeping medication following these risk assessments.”

2. The Governor should ensure that the details of all items found in the cell of a deceased prisoner, including prescribed medication, are recorded and retained until the conclusion of all investigations.

NOMS has accepted this recommendation, noting that “This will be communicated to all staff via a Governor’s Notice. The Head of Healthcare will ensure their staff fully understand this requirement and the prison’s death in custody contingency plans will be updated to reflect this recommendation.”