

**The death in custody of a male prisoner
at HM Prison Shepton Mallet on 6 July 2004**

**Report by the Prisons and Probation Ombudsman
for England and Wales
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This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Shepton Mallet on 6 July 2004. The prisoner collapsed and died in the prison at approximately 12:57 that day.

A post mortem examination showed that the prisoner's death was caused by a pulmonary embolus and deep vein thrombosis.

The investigation was carried out on my behalf by my colleague. An independent clinical review was commissioned into the management of the prisoner's health needs while he was at Shepton Mallet prison. This was carried out by a representative of the South West Dorset Primary Care Trust.

My thanks go to the Primary Care Trust for their valued contribution to this investigation and to the Governor and staff of Shepton Mallet whose ready cooperation has been much appreciated.

I make six recommendations.

I understand that the symptoms of pulmonary emboli are difficult to detect. The independent clinical review suggests that this may be particularly so when a patient also presents - as did this prisoner - with symptoms of anxiety, a tendency to over-breathe, and suggestions of asthma. In this respect, as in other aspects of his life, the prisoner was not blessed with good fortune.

Stephen Shaw CBE
Prisons and Probation Ombudsman

2. Summary

The prisoner was born at Ashton under Lyne, Lancashire, in 1948. He was handicapped from birth by a cleft palate, poor eyesight, and a degree of deafness.

In 1969, he was found guilty of arson and sentenced to life imprisonment. He was released on a life licence in 1977 but recalled to prison in 2002 after a further offence. After being recalled, the prisoner was initially held at Manchester prison, but was transferred to Dartmoor in June 2003. He was moved to Shepton Mallet in July 2003.

Whilst at Shepton Mallet, the prisoner developed breathing difficulties and chest pains. He collapsed and died in the prison on 6 July 2004 at the age of 56. A post mortem examination concluded that he died from pulmonary embolus and deep vein thrombosis.

The recommendations made in this report derive in large part from the clinical review. They relate to the improvement of routine and emergency medical management procedures, diagnostic and referral issues, and record keeping.

3. Investigation methodology

The investigation was opened by my colleague on 8 July 2004 when notices to staff and to prisoners announcing the investigation were issued within the establishment.

On 15 July my investigator met with the Governor, the Head of Custody, the chairman of the local branch of the Prison Officers' Association, and the chairman of the establishment's Independent Monitoring Board. They were briefed on the nature and scope of the investigation and asked to encourage staff and prisoners to submit any concerns or views they had to my investigator.

An independent clinical review of the management of the prisoner's healthcare needs whilst he was in custody at Shepton Mallet was carried out by a representative of the South West Dorset Primary Care Trust.

My investigator met with the prisoner's sister and her family at Shepton Mallet on Sunday 18 July 2004. They raised a number of concerns that they wanted the investigation to address.

No staff or prisoners were interviewed.

4. The deceased

The prisoner was born, one of three siblings, at Ashton under Lyne, Lancashire. Prior to entering prison in 1969, he had lived with his mother and father. The prisoner was born handicapped by a cleft palate, poor eyesight, and a degree of deafness. He had little social life beyond his family and the church and never had a girlfriend. He had also suffered from epilepsy for a number of years.

The prisoner had been in trouble with the police since the age of 11. In 1962, he was sent to an Approved School for offences of arson and malicious damage. He left Approved School at the age of 16 with no qualifications, but was nevertheless always employed, normally in the retail trade.

At the time of the offence which resulted in his imprisonment in 1969, the prisoner was living with his parents and two sisters in Middleton. He was charged with setting fire to an extension building at the rear of the family house. He was found guilty and, aged 21, was sentenced to life imprisonment. He was released on a life licence in 1977 but recalled to prison in 2002 after committing a further offence. The prisoner was initially held at Manchester prison, but was transferred to Dartmoor in June 2003 and moved again to Shepton Mallet in July 2003.

Staff described the prisoner as a polite but quiet person. He was friendly with a select group of other prisoners, regularly attended church services, and undertook the offending behaviour work he was set, as well as education classes.

5. Shepton Mallet prison

Shepton Mallet is a small closed prison for life sentenced prisoners, and is located in the market town of the same name in Somerset. The establishment can hold up to 186 prisoners.

Her Majesty's Chief Inspector of Prisons carried out a short unannounced inspection of Shepton Mallet in November 2003. No recommendations were made in respect of healthcare.

Three prisoners have died at Shepton Mallet in the last two years: two from natural causes and one by suicide.

Healthcare at Shepton Mallet is provided by the Mendip Primary Care Trust. The prison has a very small healthcare centre with no in-patient facilities. At the time of the investigation, the healthcare staff complement comprised:

- A healthcare manager
- A registered general nurse
- A registered mental nurse
- Two doctors

Administrative support for the healthcare centre is provided for only 16 hours per week.

The centre is open from 7:30am until 5:30pm seven days a week and the staff remain on call to the prison outside working hours.

The establishment's role as an all-lifer establishment is relatively new. However, my investigator saw evidence of good staff/ prisoner relationships and a positive regime.

6. Events leading to the prisoner's death

The following events are recorded in the prisoner's Medical Record (IMR):

25 July 2003

The prisoner arrived at Shepton Mallet from Dartmoor. He told the doctor that he suffered from blackouts. He was located in a shared cell in the main prison.

28 July 2003

The prisoner told the doctor that he had become increasingly short of breath on exertion.

15 August 2003

The IMR recorded that there had been no improvement in the prisoner's breathing and that he actually felt worse. The doctor suggested that he should try salbutamol inhalations, as a result of which the prisoner's peakflow increased from a previous reading of 450 to a new reading of 520.

14 September 2003

The prisoner had a persistent dry cough.

23 September 2003

The prisoner suffered a mild epileptic fit during the night.

27 September 2003

The prisoner went to the healthcare centre and wanted to talk about his situation. He told staff that he was not eating well, was worried about the fact that his parents were about to move into sheltered accommodation, and that he would have nowhere to live on release, and that he found it difficult to get on with his cellmate. He was re-located to a single cell.

8 February 2004

Healthcare staff were called to the chapel to see the prisoner because he had become short of breath and was suffering chest pains. The doctor doubled his dose of inhaled steroids.

16 March 2004

Healthcare staff were asked to see the prisoner in his cell. He had experienced a severe asthma attack. He was advised to rest.

20 March 2004

The prisoner complained that his mood was low, that he felt dizzy and could not eat. He was given advice about how to deal with his anxiety and it was suggested to him that he should drink plenty of water.

9 April 2004

The prisoner was seen by a doctor in a workshop after he had collapsed. The prisoner stated that this had been one of his "usual turns".

25 May 2004

The prisoner asked to see the healthcare staff as his breathing had been difficult. He was referred to the doctor.

26 May 2004

The doctor referred him to the chest pain clinic in Bristol for further assessment because of his breathing difficulties and chest pains after exertion. The details of the referral were faxed to the chest pain clinic the next day.

29 May 2004 (a bank holiday weekend)

The prisoner reported to the healthcare centre very short of breath. A nurse wrote in his IMR:

"Presented at H/C 09:45 V SOB (very short of breath). Grey. Looked ghastly. O2 (oxygen) given-notes revealed had not had GTN (glycerine trinitrate tablets). Same given, and instruction in use. Recovered 20 mins. ECG performed. Normal. B/P 83/55. P.111."

The nurse recorded that she discussed the prisoner's condition with the doctor who advised her to continue "to watch observations at present".

30 May 2004

The prisoner was described in his IMR as looking better when seen in the healthcare centre.

2 June 2004

A doctor wrote in the IMR, "On reviewing his symptoms I do not think this is cardiac pain. His risk factors for CHD (Chronic Heart Disease) are low....."

Plan: for remedial gym to increase fitness level and improve self confidence....."

7 June 2004 The prisoner was due to attend a chest pain clinic in the Royal United Hospital in Bath, but the appointment was postponed by the hospital.

28 June 2004

The prisoner attended the chest pain clinic that had been postponed from 7 June. In a follow up letter to the prison doctor, the Clinical Assistant in Cardiology wrote:

"On examination of his cardiovascular system he was mildly

dyspnoeiac at rest, even after the short walk into the clinic room. His heart sounds were normal and his chest was clear. There was no ankle oedema. Because of his breathlessness we arranged an echocardiogram today which demonstrated marked pulmonary hypertension and a reversed E:A ration with mild diastolic LV dysfunction. The valves were normal. In view of this we were obviously unable to exercise him but we are arranging for him to have a VQ scan and to be seen in outpatients by the consultant.”

There is some doubt as to when that letter arrived at the prison. The healthcare staff reported that it did not arrive at the prison prior to the reviews that took place on 2 and 5 July.

30 June 2004

Healthcare staff were called to the wing because the prisoner was struggling for breath and was vomiting. He was described in his IMR as looking pale, slightly cyanosed and suffering from mild chest pain. Wing staff were briefed on how to manage a recurrence.

1 July 2004

The prisoner was seen on the wing by healthcare staff. The following entry was made in his IMR:

“Seen on wing at 11.45. Oxygen given. C/o same symptoms as yesterday evening-brought on by coughing which means he is unable to catch his breath, panics and brings on asthma symptoms. Reassurance given- advised to RIC (rest in cell) until he sees doctor tomorrow.”

There is no evidence that he saw the doctor the next day.

2- 5 July 2004

Further entries were made in the IMR showing that the prisoner continued to have breathing difficulties and other concerns. Wing staff were sufficiently worried about his state of health to call out nursing staff on each occasion.

4 July 2004

The following entry was made in the IMR:

“Seen at 10pm last night following call from wing staff concerned about the amount of pain he was in. On questioning he denied experiencing any pain in his back/chest or anywhere else! Just frustration about not being able to settle very well and sleep. Not really an appropriate reason to call out nursing staff. This explained. No breathing difficulties particularly evident. Night staff advised to monitor. Seen this morning, not managed to get dressed as finds this too difficult. Breathing short but not really a problem despite his saying he was having to use a paper bag frequently to control

his breathing. He was well able to discuss the difficulties he's been having.

Kalms to be given to aid relaxation. See doctor on Monday morning.

Seen later in the day, Kalms given. Has made some effort to get dressed and came out of cell onto the wing."

6 July 2004 The prisoner was interviewed by a Probation Officer in a room some distance from his wing. On several occasions the interview was interrupted so that his panic and hyperventilation could be brought under control. At about 11:40 am it was decided that the interview should be terminated so that the prisoner could return to his cell. He was given oxygen before starting the journey. He was assisted by wing and nursing staff as he made his way up an external flight of stairs towards the wing, resting frequently on the way. When he reached the top of the stairs he became increasingly weak and soon collapsed. He was given more oxygen and placed in the recovery position. At approximately 11:50 an ambulance was called. It is recorded in the IMR that a paramedic crew arrived two minutes later. It is also recorded that his pulse and respirations were difficult to establish, and that his pupils were fixed and dilated. CPR was commenced but discontinued after 20 minutes when no sign of life could be detected.

7. Concerns expressed by the family

On 18 July 2004, my investigator met the prisoner's sister along with her husband and son after they had attended a memorial service held in the prison. They were told of the nature and scope of the investigation and were given an opportunity to express whatever concerns they had about their brother's treatment in prison.

The family explained that their concerns were related to events that happened in the last week of the prisoner's life. He had telephoned his sister on the Tuesday before he died to say that he had been taken to hospital for a treadmill test but the staff in the hospital were so concerned about his medical condition that the test did not take place. Instead, he was given a scan the result of which was the finding of what appeared to be a clot on his lung. He had therefore been booked to see a consultant on 21 July, the purpose of which was to try to rule out the presence of the clot. However, the prisoner was partially deaf and could therefore not pick up on everything that was said to him.

The prisoner's relatives were not sure that what he told them on the phone was accurate. Nevertheless they felt that if the hospital were sufficiently concerned about the possible presence of a clot to arrange an appointment with a consultant they should have kept him in hospital. In his last conversation with them, the prisoner had said to his family that he was very frightened about his breathing difficulties.

My investigator discussed these concerns with the representative of the Primary Care Trust who confirms in his report that the prisoner was indeed seen by a clinical assistant doctor on 28 June when it was discovered that he had a significant problem relating to blood circulation in his lungs which required investigation. A letter from the Clinical Assistant in Cardiology at the Royal United Hospital in Bath, dated 29 June, also confirms this. It also shows that no exercise tolerance test (or, in layman's terms, treadmill test) took place. (See entry against 28 June in Section 6 above.)

My investigator was also advised that the comments made by the Clinical Assistant in the same letter show that he was not so concerned about the prisoner's condition at that stage as to recommend that he should be kept in hospital.

8. Emergent issues

The main issues that have emerged from this investigation are:

- Between September 2003 and February 2004, the prisoner experienced episodes of shortness of breath. Between 8-10 February 2004, he suffered a further episode which should have prompted a referral to specialist services at the very least.
- On 29 May 2004, the prisoner presented in a condition of partial collapse in the prison. He had required oxygen, and he was given glycerine trinitrate tablets and aspirin. This indicates that the nursing staff had at least angina if not a full-blown heart attack in mind. It is of concern that too much emphasis was placed upon the normal ECG findings. In spite of twice being updated by the nursing staff, no doctor saw the prisoner for three days. The doctor who carried out the clinical review for this investigation states in his report that the prisoner ought to have been sent to outside hospital at this stage. However, the fact that the prisoner was seen a month later by a specialist at the Royal United Hospital in Bath, without being admitted for observation or for treatment, suggests that an earlier referral to hospital may have had the same outcome.
- The Primary Care Trust representative was told by the medical staff at Shepton Mallet that whenever a prisoner had to attend an outside hospital under escort, the staffing levels in the prison were adversely affected. I am concerned that in some situations this could inhibit medical staff in making referrals to secondary care services. However, I have no specific evidence that this occurred in this case.
- On 28 June 2004, the prisoner was seen by a clinical assistant doctor at the Royal United Hospital in Bath. The Primary Care Trust representative sought reassurance from the consultant cardiologist at the hospital that all appropriate steps had been taken and that an appropriate degree of urgency had been attached to further tests ordered because of findings on echocardiography. He specifically asked if it might have been in order to start treatment “blindly” for blood clots. The cardiologist felt that the further tests ordered by his clinical assistant should have been done first, before any treatment was started. It was therefore appropriate that the prisoner be returned to Shepton Mallet at this time. It is reasonable to assume that the fact that the prisoner was not admitted to hospital at the time of this appointment was because the authorities at the Royal United Hospital did not feel his condition at that time warranted his admission.
- The prisoner’s medical record contains a letter to the prison written by the doctor who saw him on 28 June 2004. The letter is recorded as having been typed on 29 June, seven days before the prisoner’s death. There is no record of either when the prison medical authorities received the letter or when they read it. The letter states that the prisoner had a significant problem relating to blood circulation in his lungs which needed investigating in the imminent future. The Primary Care Trust

representative suggests that the prisoner might have been admitted to hospital earlier if a doctor with knowledge of this letter had been involved in the assessment of his symptoms between 2-5 July, just before he died. However, no doctor saw the prisoner between 29 June and 5 July, the day before he died, despite a note in his IMR from nursing staff that a doctor should see him on 2 July.

- A member of the healthcare staff at Shepton Mallet told my investigator that, although the IMR does not make this clear, before the prisoner died, a follow-up appointment had been made for him to undergo further tests at the Royal United Hospital in Bath on 12 July. The onus for arranging such an appointment and for communicating it rested with the Nuclear Medicine Department of that hospital and not with anyone at Shepton Mallet. The fact that no record could be found to show when the letter had been received and who had read it indicates poor record keeping.

9. Conclusions

I draw the following conclusions from the investigation:

- the episode of breathing difficulties experienced by the prisoner between 8 and 10 February 2004 should have prompted a referral to specialist services.
- the fact that three days elapsed before the prisoner was seen by a doctor after he had presented in a state of partial collapse on 29 May 2004 is a matter of serious concern.
- there is evidence of some poor record keeping by staff in the healthcare centre at Shepton Mallet. I understand, however, that a new system for date-stamping incoming correspondence has been introduced in the centre since this investigation began.

I am also disturbed that a concern over staffing levels could, on occasions, inhibit clinical staff from making a referral to an outside hospital. I do not suggest that this happened in this case, but the Governor should be alert to the possibility that this could occur in respect of other prisoners.

At the consultation stage, the Governor commented that it was important to emphasise that the prisoner did respond well to re-breathing techniques in a paper bag. The Governor felt that it was therefore evident that his breathing difficulties were panic related and no indicators at examination or on testing revealed any pathology.

The Governor also pointed out that patients are not compromised if there is an emergency, and that the prison had been working very hard with the Primary Care Trust to reduce the number of cancellations of routine outpatient appointments.

10. Recommendations

1. It is good clinical practice to assume a diagnosis of myocardial damage on a clear history until proven otherwise by both serology and cardiography, and so sending the prisoner to hospital on 29 May would have been more appropriate. This should be drawn to the attention of all the medical staff at Shepton Mallet so that different management procedures can be adopted in the future.
2. Early referrals must be made to specialist consultants where there is any doubt in the diagnosis of adult onset asthma.
3. Decisions on whether to admit acute cardio-respiratory cases to hospital should be based on clinical findings rather than on the results of an ECG.
4. The risk to the life and health of prisoners, rather than staffing implications, must be the primary factor to be taken into account when considering emergency referral to outside hospital. The Governor of Shepton Mallet should continue to make this clear to her staff.
5. All incoming mail must be date-stamped and passed to an appropriate clinician for review and further action if required. The clinician must annotate the report accordingly and ensure any requests for further clinical management or care are implemented.
6. Adequate steps should be taken to establish protocols to guide healthcare professionals in the management of life threatening medical conditions. These must be developed in partnership with the PCT using existing NHS protocols.