Investigation into the circumstances surrounding the death of a man in January 2011, at an outside hospital whilst in the custody of HMP Shepton Mallet

Report by the Prisons and Probation Ombudsman for England and Wales

August 2011

This is a report into the death of a man at an outside hospital, whilst in the custody of HMP Shepton Mallet, in January 2011. He died of natural causes and was 42 years old. A post mortem report concluded that he died from hypertensive and ischaemic left ventricular failure (a heart attack). I offer my sincere condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by one of my colleagues. I would like to thank the Governor of Shepton Mallet and following his departure, his predecessor and his staff for their co-operation during the course of our enquiries. In particular I would like to thank the member of staff who acted as liaison for this investigation.

Somerset Primary Care Trust (PCT) were asked to produce a clinical review of the medical care the man received in custody. The PCT appointed a clinical reviewer to conduct the review, and I am grateful for his contribution to this investigation. As the man died from natural causes, the findings in the clinical review were essential to my own conclusions. The review shows that the standard of care the man received exceeded that which he could have expected in the community.

I make no recommendations but highlight a number of areas of good practice. Prison nurses were trained to use specialist equipment which meant that they were able to thoroughly assess the man and refer him promptly for specialist treatment. The restraints were removed when his health deteriorated and his family, prisoners and staff were all well supported after he died.

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

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **August 2011**

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SUMMARY

1. On 12 June 2008, the man arrived at HMP Exeter, and a nurse conducted a health screen assessment. The man's medical history included asthma, a hiatus hernia, sciatica, and he was being treated for depression. He had undergone recent tests for epilepsy, following concerns about his mental health, but was in reasonable physical health. The man initially indicated that he was suicidal and formal support measures were put in place. He was sentenced at a crown court to an indeterminate period for serious offences, with a minimum tariff of 32 months, on 22 January 2009. During his time at Exeter, he had regular contact with healthcare staff, prior to being moved to HMP Shepton Mallet on 18 December 2009.

2. On transfer to Shepton Mallet, the man saw a nurse who recorded his medical history, prescribed medication and blood pressure. In the weeks and months that followed, he had regular contact with healthcare staff, including the mental health team. On 26 November, following assessment, he was diagnosed with probable angina and referred to a specialist for further diagnostic tests. Following a specialist test on 8 December, angina was confirmed and he was referred to a cardiologist for further investigation.

3. Having experienced chest pain on 13 December, the man was admitted to accident and emergency at an outside hospital. He was discharged the same day when tests confirmed that he had not suffered a heart attack and the medication plan for the treatment of his angina should continue. He was referred for an angiogram (a test to determine how blocked an artery is, a common cause for angina pain).

4. The man continued to experience angina pain over the next few weeks, which he managed using his medication. He was regularly reviewed by nursing staff and the prison doctor. He had a number of further electrocardiogram tests (ECG - measures the electrical activity of the heart to help with diagnosis), which were normal.

5. At approximately 4.00am, on a day in January 2011, the man pressed his cell bell to alert staff that he was unwell. He was found in a state of distress, an ambulance was called and he was transferred to outside hospital. Initially, the man's condition was stabilised. However, at approximately 7.40am, in the accident and emergency department, he collapsed. Attempts to revive him were unsuccessful, and at 8.04am a doctor pronounced that he had died.

6. The man had identified his next of kin as his sister. A prison family liaison officer visited her at home later that morning to tell her of her brother's death. The prison offered financial support towards the funeral costs.

7. I am satisfied that the care the man received at Shepton Mallet exceeded that which would be expected in the community. I make no recommendations, but have commented on a number of areas of good practice.

THE INVESTIGATION PROCESS

8. The investigation was opened on 17 January 2011, when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No prisoners or staff came forward in response to these notices. The investigator met with the Governor, family liaison officer and wing staff at the prison. Nobody was available from the Independent Monitoring Board although the investigator spoke to them by telephone the following day. My investigator was provided with all the documentation relating to the man. She also went to C wing and saw cell C3-17, which had been the man's cell.

9. Somerset Primary Care Trust (PCT) asked a clinical reviewer to conduct a review of the man's clinical care and he was provided with all relevant documentation to assist this review. I thank him for undertaking this review and for his timely report.

10. My investigator returned to Shepton Mallet again on 8 and 9 March, and interviewed six members of staff and one prisoner, jointly with the clinical reviewer. Initial feedback from the investigation was provided, in writing, to Governor Hyde on 21 March 2011.

11. My investigator contacted Her Majesty's Coroner for East Somerset to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

12. One of my Family Liaison Team contacted the man's sister on 11 February and his father on 18 February to inform them about the investigation and to provide the family with an opportunity to raise any issues about the care the man received in custody. The man's father described the contact he had with the prison liaison officer since his son's death as "more than helpful". The man's family had some general questions about his care that they wished the investigation to consider:

    - Was the medication the man received for his heart condition (angina) appropriate?

    - Was the response by staff to the alarm bell, when the man initially became unwell, proper and timely?

    - What happened when the man saw healthcare staff on 9 January, and what took place during this appointment? Did he see a doctor?

    - Has all of the man's property been returned to the family, as some of his valuables appeared to be missing?

The man's father received a copy of my draft report as part of the consultation process. In his response he said he remains concerned about the management of

his son’s medication and suggested this was a matter he may raise directly with the Coroner at the inquest.

HMP SHEPTON MALLET

13. HMP Shepton Mallet is a small prison in the South West, dedicated to holding Category C Life and indeterminate sentenced prisoners. It is the oldest operational prison in the country, and became the first Category C Lifer centre in the Prison Service in 2001. The operational capacity is 189 prisoners. The prison is organised into four residential wings, the majority in single cells, with 24 shared cells. The healthcare centre is staffed seven days a week.

HM Inspectorate of Prisons' report

14. HM Chief Inspector of Prisons last conducted an announced inspection of the prison between 14 June and 18 June 2010. The Chief Inspector noted that:

    "This very positive report, of a full announced inspection, is testament to the benefits that can flow from having a small-scale niche prison with a settled population. Despite its ageing physical environment, the prison was a very safe place, with positive staff-prisoner relationships, a reasonable amount of activities, and a strong focus on addressing the serious risks posed by the population"

    During my investigator's visits, she observed this calm environment and the positive attitude of those prisoners and staff she had informal contact with.

15. In relation to healthcare facilities:

    "Health services were commissioned by Dorset Primary Care Trust (PCT) and provided by Somerset PCT which was about to take over the commissioning … a good range of Department of Health quality and regulatory frameworks and publications was accessible to staff. For most prisoners, access to health services was equivalent to that found in the community… relations between prisoners and health care staff were generally good and there was a high level of mutual respect. ... Responses to questions about health services in our survey were mostly very positive, including that significantly more prisoners than the comparator said the care provided by the doctors was good or very good."

Independent Monitoring Board report

16. Prisons are also monitored by an Independent Monitoring Board (IMB), members of which are drawn from the local community. They have full access to each prisoner and every part of the establishment. The last annual report published by the Shepton Mallet IMB covers the period 1 April 2009 to 31 March 2010. The Board noted that:

    "Shepton Mallet continues to be a prison well served by dedicated staff, both uniformed and civilian, who noticeably go out of their way to assist prisoners and colleagues alike…there have been no problems accessing

in-patient or out-patient care when required and all waiting times have been within NHS targets."

Previous deaths in custody at Shepton Mallet

17. This man's death was the only death at Shepton Mallet in the past 12 months. All of the previous seven deaths investigated since April 2004 when this office began investigating all deaths in prison custody in England and Wales were due to natural causes. There are no similarities between those deaths and this man's. Like this investigation, my recent investigation reports have reflected well on the care provided at Shepton Mallet.

Performance rating

18. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four; 4 = Exceptional performance, 3 = Good performance, 2 = Requiring development, 1 = Serious concerns. The last performance report from 2009-2010 showed that HMP Shepton Mallet had been given an improved rating of 4, the previous two reports scored the establishment as 3.

Prison Service Orders (PSO) and Assessment, Care in Custody and Teamwork (ACCT)

19. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – 'Suicide prevention and self-harm management' - details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and an ACCT assessment is carried out within 24 hours by a member of staff who has the required training.

20. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

Risk assessments

21. Each time when a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Categorisation

22. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. A category C prisoner cannot be trusted in open conditions, but does not have the resources and will to make a determined escape attempt. Prison Service Order (PSO) 0900, gives guidance on appropriate assessment to determine a prisoner's category.

KEY EVENTS

23. The man was born in April 1968 and, before entering custody, lived in Newquay. He was divorced and had one child. He was remanded into custody at HMP Exeter on 12 June 2008. He was later convicted of serious offences and was sentenced to an indeterminate public protection sentence with a minimum tariff of 32 months, at a crown court on 22 January 2009. (Release at the end of the tariff period is not automatic and will only take place once this period has been served and the Parole Board is satisfied that the risk of harm the prisoner poses to the public is acceptable.)

24. Upon arriving at Exeter on 12 June 2008, the man underwent a healthcare initial assessment. Healthcare staff confirmed with his GP that he had a recent EEG (electroencephalogram is a test that records brain activity) to establish if he had temporal lobe epilepsy, following concerns about his mental health and the impact upon his offending behaviour. (The man had disclosed convulsions from the age of 14, but not in the recent past.) He was prescribed carbamazepine (also known as Tegratol Retard, used to manage epilepsy and depression). The man also said that he was prescribed becotide and ventolin inhalers (for asthma management) and suffered from sciatica (a pain that radiates out from the lower back, down the buttocks and into one or both of the legs, right down to the calf). The man had a history of drug and alcohol misuse. He was a smoker.

25. The man also disclosed a history of self-harm and current suicidal thoughts. Due to his disclosure that he did not want to remain alive, he was located in the healthcare unit and ACCT procedures were initiated and he was referred to the mental health team (MHT). He received support following assessment by the MHT, a care plan was devised and he remained subject to these formal support procedures until a review on 10 July, a month later, when the decision was made to close the process. This decision was reviewed on 15 July, in consultation with the man, and it was agreed that ongoing formal support was not necessary. He continued to take the prescribed anti-depressant medication and was employed in the workshop, where he received positive reports. Despite still suffering from depression, he responded well and became more settled.

26. Following a referral by a prison doctor to the neurological department of an outside hospital on 29 July 2008, the man was examined at this hospital on 14 October. A letter from a consultant neurologist confirms that the man was assessed, that his epilepsy was controlled by carbamazepine medication and that he should continue with this treatment. The consultant neurologist concluded that any mood swings were unlikely to be a result of the man's epilepsy but referred him for a further MRI scan (magnetic resonance imaging, used to diagnose health conditions that affect organs, tissue and bone) and an EEG. These diagnostic tests were completed on 7 November, and both were within normal limits.

27. The man transferred to Shepton Mallet on 18 December 2009. This was a progressive move to further his sentence plan and would allow him to

undertake specific offending behaviour programmes. A nurse completed a first night assessment. He underwent a more comprehensive health assessment on 21 December, with a further nurse. The man disclosed that he suffered from sciatica, had asthma and eczema and smoked. His weight was recorded as 78.89kg and blood pressure 132/88 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low). His prescribed medication was listed as:

- paroxetine (used for treating depression)
- salbutomal (for the management of asthma)
- diclofenac (for pain relief)
- carbamazepine
- nefopam (for pain relief)
- loratadine (used to treat allergies).

28. The man disclosed his history of depression and told the nurse that he was looking forward to starting work on managing his emotions and beginning to address the issues linked to his offending behaviour. A routine referral was made to the mental health nurse for further assessment and review of his medication.

29. On 23 December, a routine urine sample was referred to an outside hospital as there were traces of blood. However, no abnormalities were diagnosed, and the man was informed that no further action was necessary. Over the next few weeks, he had frequent contact with healthcare staff, which is recorded in his medical record. During interview a nurse confirmed that an entry is automatically recorded if a patients notes are viewed or they are prescribed their medications on the wing. The entries do not reflect specific medical intervention or examination, although they demonstrate that healthcare staff were able to monitor the man during routine daily contacts.

30. The man reported to a nurse on 11 January, saying that he coughed at night time and his asthma was worse. His medication was altered and he was prescribed a different inhaler. The man was advised to keep a diary of his peak expiratory flow rate PEFR (used to test lung function). The following day the man asked the nurse to move him to another cell as he thought that his current cell was cold which was making his condition worse. He was told to ask staff on his wing and he was subsequently moved to a different cell.

31. Over the next week, the man had further contact with healthcare staff who were concerned that he had not taken his paroxetine and nefopam medication. He told staff that he was forgetful. Following an assessment by a nurse on 20 January, the man was given his medication each morning, and was supervised taking it. During this assessment his chest was examined but as he had not completed his PEFR diary, he was asked to do this for another seven to ten days to gain a more accurate record.

32. A doctor examined the man on 22 January, at the request of healthcare staff who observed his forgetfulness and that he was not complying with his medication. The man was told that to manage his pain sufficiently he needed to take his medication according to the instructions. He was referred to the pain clinic for further advice and prescribed paracetamol. A full set of blood tests was requested.

33. On 25 January, the doctor again assessed the man following a referral by a nurse. He was refusing to take paracetamol for pain relief as he did not think they worked. The blood test results were also discussed and he was told that all were normal. His liver function test (LFT) was to be repeated in three months as there were raised alkaline phosphates present (a possible indicator of other underlying conditions if the levels continue to be raised). Following a repeated blood test on 12 May, the man's liver function had returned to normal and no further action was necessary.

34. The man was assessed by a doctor on 29 January for a skin infection for which he was prescribed flucloxacillin antibiotics. She reminded healthcare staff to monitor him taking his medication due to his forgetfulness. This medication was reviewed on 1 February, and fexofenadine (an antihistamine used for allergic reactions) was prescribed, but the doctor noted that the condition was much improved.

35. Two days later, the man had an asthma review with a nurse. He reported an improvement and was given advice on how to manage his condition. The same day, a doctor reviewed the man's medication which was diclofenac, carbamazepine and fexofenadine.

36. The man began the intensive sex offender treatment programme (SOTP) on 19 April. Prisoners are required to undertake specific offence focussed work to help reduce the risk they will pose upon eventual release. During interview his personal officer said;

    "We'd had lengthy discussions about that [SOTP]; he was quite happy that he wanted to do the work that was set to him and you know do everything he could to reintegrate himself back into society. He had a very positive outlook with things and very 'I've done wrong and I want to sort things out'."

37. Over the following months, the man was regularly reviewed by healthcare staff for his asthma and pain management. In addition, he engaged with the mental health team and was seen regularly. There is an entry by a nurse dated 30 April, which notes that the man's medication compliance remained poor. On the same day, a doctor reviewed the man's medication and prescribed omeprazole (acts in the stomach to decrease the production of stomach acid) as he had reported suffering from indigestion (caused by stomach acid coming into contact with the sensitive, protective lining of the digestive system).

38. On 28 May, due to feeling drowsy in the morning which was affecting his attendance on the SOTP, the man's fexofenadine medication was varied and

he was prescribed loratadine (a non-drowsy anti-histamine) instead. In addition, he continued to have his medication for pain management and asthma reviewed and had regular contact with the MHT.

39. The man had a routine asthma assessment on 3 August, and his blood pressure was raised when he attended a pain management clinic (144/90). He explained that he was a little stressed and was advised to rest and weekly blood pressure checks over the next three weeks were to be undertaken to monitor any changes. The following week on 10 August, the man's blood pressure was recorded as 152/100. He explained that this might be because he had found the SOTP course stressful that day.

40. The following week on 16 August, the man's blood pressure had fallen to 138/99. He said that he felt less stressed and had decided to change his diet and increase his level of exercise. He had an appointment the same day with a doctor, who gave him advice on stopping smoking. He declined at this time, but agreed to continue trying to increase his amount of exercise and reduce the salt in his diet. He was to be reviewed in one month.

41. The doctor reviewed the man on 20 September, when his blood pressure was recorded as 150/95. He reflected that he had been continuing with his life style changes, had lost some weight and was reducing the number of cigarettes he smoked. The man was told that he would be reviewed in two months and, if his blood pressure had not reduced, he might need to start treatment for hypertension (high blood pressure).

42. During the next few months the man continued to attend the SOTP programme, which he completed on 3 November. He was regularly reviewed by healthcare staff and was treated for a number of minor ailments. Further, he completed some specific self-help workbooks linked to issues relating to his self esteem and anger management which he found beneficial.

43. On 11 November, the man had influenza and a headache and was told to rest in his cell. His blood pressure was recorded as 138/89. He was seen four days later by a doctor who reviewed the man's omeprazole medication and suggested that this should be reduced. The doctor said that if his symptoms persisted, then an endoscopy would be considered to diagnose any specific stomach problems.

44. The man moved to C wing in mid November. He moved from a shared cell on B wing to a single cell on the third landing. To get to his cell he needed to go up two flights of stairs. During interview, in response to being asked about the man's reaction to moving, his personal officer told me that:

> "No he [the man] was quite happy with that; it's one of our better cells and C wing is an all single cell, so it's a bit quieter and tends to attract the more sensible inmates because they've got, you know it's better for them to be honest. And he was certainly amongst the more sensible ones."

Further, his friend told the investigator that "… yes he was happy; he was just happy to have his own space".

45. On 26 November, the man told a nurse that he had been experiencing pain to the left side, usually after some exertion, and that he woke with heaviness to his chest and pain in both arms. A doctor assessed him and the man said that the pain was a three (on a scale of one being low and ten being very high) and his blood pressure was recorded as 142/88. He had chest pain radiating to his jaw, but was not sweaty and had no shortness of breath. She prescribed a GTN spray (glyceryl trinitrate for the management of angina) and advised him how to use this medication. In addition, she prescribed aspirin (to reduce the 'stickiness' of platelets in the blood which helps to prevent blood clots forming), ordered blood tests and referred him to the Rapid Access Chest Pain (RACP) clinic.

46. On 29 November, all of his blood tests were recorded as being within the normal range and so no further action was required. A nurse reviewed the man who reported that he had not experienced any chest pain over the weekend.

47. Four days later on 3 December, the man was assessed by a doctor. He had experienced further pain, which settled when using the GTN spray. He was told to tell staff if any pain continued after using his medication. The result of an ECG completed during this contact was normal. The man was told that he would be referred to take an exercise ECG and he was referred to a nurse for further healthy lifestyle advice. The referral for the ECG exercise test was made on 8 December. During interview the doctor said:

   "I was wondering really whether his angina was becoming unstable, which by that I mean coming on at rest, like it had done from the beginning, as well as on exercise. But he was having it at rest sometimes; although it was responding to GTN it was happening quite often now and we hadn't got a diagnosis. So I felt that the time had come really to send him in [to hospital]."

48. A nurse saw the man on 9 December, when she gave him healthy lifestyle advice, encouraged him to stop smoking, promoting a healthy diet and exercise. She also provided him with British Heart Foundation (BHF) leaflets explaining angina and the benefits of losing weight and reducing his cholesterol.

49. On the morning of 13 December, the man was assessed by a nurse as he had complained of increased frequency of chest pain, which was radiating into his arms and that he needed to use his GTN spray twice since waking. His colour was pale and he told the nurse that he had not slept well. His blood pressure was recorded as 116/73. The nurse completed an ECG, and referred the man to the doctor. During interview the nurse explained:

   "I'm aware that he'd been to see the GP about that [chest pain] and felt it appropriate to do a few interventions and find out again what was going on

for him. Because it didn't really seem to be settling and I wasn't sure if it was related to anxiety."

50. Later the same day, following further pain, the man was taken to the accident and emergency department at outside hospital. Following an ECG at hospital that was normal, he was prescribed a statin (used to help lower cholesterol) and isosorbide mononitrate (for the treatment of angina) and returned to Shepton Mallet. A referral was made for an angiogram (a test to determine how blocked an artery to the heart is, which is a common cause for angina pain).

51. The next day, the man was seen by a nurse. She confirmed that he should rest in his cell and encouraged him to re-read the BHF booklet to help increase his awareness of the potential triggers for an angina attack. The nurse saw the man again on 23 December, and continued the healthy lifestyle maintenance programme. The man told her that he was managing well, was reducing his sugar intake and had increased his level of exercise. The following day the nurse recorded that the man's level of compliance with his medication had improved.

52. On 31 December, a doctor reviewed the man who told her that he was still getting angina pain. She increased his isosorbide mononitrate medication. His blood pressure was recorded as 130/80.

53. Two days later, the man told a nurse that he woke with chest pain and used his GTN spray to good effect. However, he had another angina attack on the way back from healthcare having collected his other medications. The man had panicked as a result of not having his GTN spray with him. His breathing was difficult and the symptoms of tingling in his arms increased. She completed another ECG test that concluded that his sinus rhythm (a term used for the rhythm of the heart) was normal. She explained the impact of stress on his symptoms and that he should keep a diary of each angina episode.

54. A doctor examined the man on 5 January, and he reported almost daily angina attacks. The doctor diagnosed ischaemic heart disease (caused when the coronary arteries (which supply the heart muscle with blood and oxygen) become narrowed or blocked with a build-up of fatty material. If an artery becomes too narrow, it can prevent the heart muscle from receiving enough oxygen-containing blood. This can cause severe chest pain and discomfort – known as angina). The doctor told the man that he was on the waiting list for an angiogram. The same day he had an asthma assessment and agreed to start the Quit Smoking group.

55. On 9 January at 9.15am the man pressed his cell bell as he was experiencing his third angina attack that morning and was panicking. A code blue alarm was raised which is an emergency call over the prison radio, blue indicating that the person has breathing or respiratory problems. The codes allow the medical staff to bring the appropriate equipment. Healthcare staff attended straight away. A nurse examined the man, who explained that he was worried

about his condition and acknowledged that he had panicked. He was advised how to recognise the symptoms and how to manage them using his GTN spray. He was advised to rest, and ask for assistance at lunchtime to collect his meal as he was on the third landing, and he needed to avoid over exertion. He described the pain he experienced as zero on a scale of one to ten.

56. During interview my investigator wanted to establish if consideration had been given to moving the man to a lower landing at this time, in order that he did not use the stairs. The nurse explained to the investigator that she preferred prisoners to remain on upper floors, which encourages them to take some exercise rather than becoming too sedentary. Further, the man's personal officer commented:

> "I think if there'd been major concerns about him being able to get about we would have at that point moved him down onto the 1s. But to be fair he still seemed to be getting about fine, it wasn't like he was gasping for breath halfway up the stairs. I mean he was still going up to work and things like that without any major problems."

57. Wing officers recorded the man's medical issues in the wing observation book, which is used to raise staff awareness of any particular difficulties. During interview, an OSG (Operational Support Grade) confirmed that when he started his night duty at 8.30pm he had discussed with another colleague concerns that the man had experienced an angina attack that morning and reviewed the information contained in the wing observation record. Having read the concerns, the OSG chose to make a number of additional checks on the man over the next few hours, which are recorded in the night observation record.

Events on the day of the man's death

58. At 4.00am the man pressed his cell bell to call for assistance. An OSG responded immediately and looked through the observation window of the cell. The OSG saw that the room light was on and the man was collapsing onto the floor, and "seemed to be fitting". The OSG called for immediate assistance using his radio and was quickly joined by two officers. The senior officer (SO) gave permission for the sealed key pouch to broken. (During the night officers do not carry keys. There is an emergency cell key held in a sealed pouch for which permission must be sought from a senior officer to break.)

59. The OSG collected other keys from those staff attending and locked himself behind a wing gate on the ground floor to ensure that the security of the prison could not be compromised, and the man's cell was opened. An ambulance was called at 4.05am and the OSG was instructed to facilitate its route from the main gate to the wing when it arrived.

60. An officer arrived at the man's room and observed that "he looked very, very pale, but in no huge discomfort at that point". The senior officer was in the

room with the man and reassured him that medical help was on the way. The ambulance service arrived at 4.13am and the paramedics began to assess the man. At this point his pain had subsided, his blood pressure was returning to normal and his pulse was recorded as 68 (a normal pulse after a period of rest is between 60 and 80 beats per minute).

61. The man told the senior officer that he thought going to hospital was a "waste of time" as he felt better. In response to this, the senior officer alerted one of the paramedics to contact the on call nurse at home (as Shepton Mallet do not have full time health cover a nurse is always on duty for night staff to seek advice if necessary), as she had recent knowledge of the man's medical history. Initially, given the absence of symptoms and that he had responded well to the GTN spray, the paramedics were reluctant to transfer him to hospital. However, in the course of the conversation, the nurse expressed her concern that the man had experienced a number of angina attacks whilst resting. She said that he might have unstable angina and so transfer to hospital was appropriate, which the paramedic eventually agreed to.

62. The man was able to walk from his cell, unassisted. He was taken to the ambulance restrained by an escort chain, and escorted by two officers. During interview one of the officers told me that the man repeatedly scored his pain level as "two out of ten". The ambulance left Shepton Mallet at 4.55am and during the journey to outside hospital the man fell asleep and was heard to be snoring.

63. The ambulance arrived at the hospital at 5.39am. The man was immediately assessed and blood tests taken. Over the next few hours, his blood pressure and pulse were regularly taken by nursing staff and he was due to be moved to the medical assessment unit. At 7.30am the man asked to use the toilet and, at his request, he was allowed to walk a distance of approximately ten metres to the toilet, escorted and still subject to the escort chain restraint, and accompanied by an officer.

64. One of the officers on escort duty told me in interview that the man was in the toilet for four to five minutes. When he came out he was very pale and asked if he could rest. The officer encouraged him to "just take your time". His colleague offered his arm to the man which he used to assist him to walk back to his bed. During this walk back to his bed, the man collapsed to the floor. Nurses arrived immediately, the chain was removed and he was taken to the resuscitation area.

65. The man was able to respond to the nurses and scored his pain as "two out of ten" and that he was aware that he was in hospital. Unfortunately his condition quickly deteriorated and for the next 20 minutes nursing staff and doctors performed CPR (cardio pulmonary resuscitation – an emergency procedure where the heart and lungs are made to work manually by compressing the chest). At 8.04am, a doctor pronounced that the man had died and one of the officers contacted the prison's duty governor to break the news.

66. The duty governor was appointed as the prison's family liaison officer. Due to the man's nominated next of kin living some distance from the establishment, she contacted HMP Woodhill to ask them to break the news to the family. The Governor at HMP Woodhill carried out this duty and visited the man's sister to inform her of his death. The prison's family liaison officer at Shepton Mallet established contact with both the man's sister and father later the same day, advising them that the prison would assist with funeral costs. Arrangements were made for the man's property to be sent to his sister at the family's request. Initially, some of his valuables were missing, however, these were located with the police, and subsequently returned to his family. The man's father told my family liaison officer that he was satisfied with the contact with Shepton Mallet, describing it as "more than helpful".

67. A post mortem was undertaken on 12 January which recorded the cause of death as hypertensive and ischaemic left ventricular failure (a heart attack).

ISSUES

68. When the man arrived at Shepton Mallet at the end of 2009, he was in reasonable health. He disclosed a history of drug and alcohol misuse, suffered from sciatica and was asthmatic. He continued to smoke. The man was a little overweight and during his time at Shepton Mallet, actively tried to make healthy lifestyle changes, recognising that this would assist his general well-being. His efforts were supported by staff.

Clinical care

69. The clinical review looks at the care and treatment a prisoner receives in prison, ensuring that it is appropriate and comparable to that which is available in the community. I agree with the clinical reviewer who is satisfied that the care the man received exceeded that which is expected in the community. I hope that I have already answered the questions raised by his family in respect of his medical care and treatment whilst he was at Shepton Mallet.

70. The clinical reviewer makes no specific recommendations in his review, and concludes:

> 'The health care given to him by the nurses, doctors and other staff of the Health Care Team during his time in HMP Shepton Mallet was excellent and exemplary, according with the best standards of General Practice. Indeed, the care he received from the nurse led and GP service in HMP Shepton Mallet Health Care probably exceeds that possible in the community, not least because of the easy access to health care, the intensive follow up, and the fact that daily medication collection gives many opportunities for new illnesses to be assessed and monitored at an early stage.'

Nurse led healthcare provision

71. Shepton Mallet has a small healthcare team. All the nurses are trained to use diagnostic equipment inside the prison, such as the ECG machine. This is good practice and means that prisoners do not have to go to hospital for the initial tests. A mental health practitioner was able to use this equipment when assessing the man, and made a prompt referral for further investigation, which ensured that he received timely intervention.

72. The availability of an on call nurse was integral to the decision to transfer the man to outside hospital. The accessibility of up to date contact telephone numbers and night staffs awareness of this service was another example of good practice.

73. The man's angina condition was quickly diagnosed, following the early symptoms of angina and he received appropriate treatment. He was readily able to access medical care from healthcare staff, the prison doctor and was seen promptly at outside hospital for further diagnostic tests.

Communication of the man's death

74. The staff who unlocked the man during the night in response to his alarm bell, were told of his death by telephone in the afternoon of the same day. They were told of his death personally, and still had time to rest following their night shift. However, during interview a number of staff told my investigator that they had not been "officially" informed of the man's death and only found out from other staff members. Whilst it is best practice that those directly involved in the care of an individual should be given the news in person, I believe that in this case information was unavoidably shared informally.

Prison family liaison contact

75. As outlined in PSO 2710, follow up to deaths in custody, it is desirable that a senior representative from the prison, or an appointed liaison officer breaks the news of a death to the next of kin in person. Due to the distance from the prison, and to ensure the family were notified as soon as possible, the liaison officer made the correct decision to ask colleagues at HMP Woodhill. The Shepton Mallet liaison officer then quickly established contact, which the family describe as very helpful.

Prisoner support

76. A notice to prisoners was issued the same day by the Governor, announcing the man's death and that support via the Listeners Scheme or Samaritans was available. During interview, the man's friend told me that support within the prison was good, saying "they [the staff] were great". He went on to say:

> "The chapel staff have said I can go up there and talk to them whenever I want to, which is good because they're always open anyway. I'll see members of chaplain staff wandering about then they'll stop and ask me how I am or I'll ask them questions. Yes, it's like the wing staff, they know how to, they'll ask me how I am."

77. A memorial service was held at Shepton Mallet on 21 January, which was well attended by some of the man's family members and his peers.

Staff support

78. Support was immediately made available to the escorting officers returning from the hospital by the chaplain and the care team, following a debrief. During interview, all staff told my investigator that they were contacted by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing support.

Restraints

79. The man was subject to a risk assessment as all prisoners are, which required him to be restrained, using an escort chain, when attending outside hospital. My investigator was satisfied that the risk assessments were full and

up to date and the correct level of restraint was used. I was pleased to note how quickly these restraints were withdrawn by the escorting officers when the man became critically ill.

Record keeping

80. The electronic record was used well to detail each contact that the man had with healthcare staff. Regular, informative, entries demonstrated the level of care shown to him and the support that he received from nursing staff. The entries pertaining to the diagnosis and treatment for his emerging heart condition clearly showed a holistic approach to his care and timely referral for specialist intervention.

CONCLUSION

81. I judge that the man received appropriate treatment whilst he was in custody. The standard of care that he received at Shepton Mallet ensured that his recently diagnosed heart problems were well managed and he had timely access to specialist assessment, with an appropriate medication plan.

82. I believe that the man was treated with dignity and respect during the time he was at Shepton Mallet. Following his death, the family were advised in person by a Prison Service representative, despite the distance and support with the funeral was offered. The prison appropriately followed the guidance given in PSO 2710, "Follow up to death in custody".