PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Swaleside in November 2011

Report by the Prisons and Probation Ombudsman for England and Wales

November 2012

This is the report of an investigation into the death of a prisoner at HMP Swaleside, in November 2011. He had been on remand at Swaleside since 6 September 2011. He died from cardiomyopathy (a disease of the heart muscle). I offer my condolences to his family and friends.

One of my investigators conducted the investigation. A clinical reviewer was commissioned to review the man's medical care. I am grateful for the clinical reviewer's report. Swaleside prison co-operated fully with the investigation. I apologise for the delay in issuing this report.

The man had been released from a four year prison sentence in September 2008, but was recalled to prison after breaching the conditions of his licence a few weeks later. He spent time at a number of prisons as well as a secure hospital. He had extensive contact with the mental health services but reported few physical health problems. A few weeks before his death, he reported swellings, which were diagnosed as possible allergic reactions and treated with antihistamines. During the early morning of the man's death, prison staff responded to an emergency alarm as the man was having difficulties breathing. After consulting an on-call doctor, staff returned to the man's cell and found him slumped across his bed, with no signs of breathing. Efforts at resuscitation were unsuccessful.

I am satisfied that the man's death could not reasonably have been foreseen. However, when he first reported feeling unwell, there was a delay in seeking medical assistance. There were also delays in the emergency response, notably in obtaining essential life saving equipment. These delays need never have occurred. A fully equipped treatment room was only a short distance from the man's cell but this was not used and staff were unaware of it. We cannot determine whether earlier intervention could have saved the man's life, but speed is critical in a situation where someone has had a cardiac arrest and Swaleside must ensure that staff are able to attend and deal with such emergencies swiftly.

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.

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Prisons and Probation Ombudsman **November 2012**

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SUMMARY

1. The man was originally released from a four-year prison sentence on licence in September 2008 but was recalled to prison the following month. He then spent time at various prisons, and was subject to regular reviews by mental health staff throughout his imprisonment. He also went to a secure hospital for assessment, where he remained until August 2011.

2. He arrived at HMP Swaleside on 6 September 2011. Mental health assessments were conducted and he reported no physical health problems to the primary care nurse.

3. On 29 September, he was assessed by the prison doctor after he had woken with a swollen hand. A full physical examination found no evidence of chest, heart or other problems that would account for the swelling. It was therefore attributed to an allergic reaction. He attended hospital for a further assessment and was prescribed a course of antihistamine. On 17 October, a further course of antihistamine was prescribed following further unexplained swelling in the man's genital area. He was also referred to a dermatology consultant.

4. In the early hours of the day the man died, he sought help from an officer as he was having difficulty breathing and believed it was another allergic reaction. Staff went to his cell and a nurse assessed him. She checked the man's pulse and, blood pressure, which were slightly raised, and his oxygen levels, which did not indicate a serious concern. The nurse also noted that the man had some swelling in his leg. The nurse then went back to the healthcare department and telephoned the on-call doctor, who advised her to give the man further antihistamine medication and refer him to the prison doctor later that day.

5. Following the telephone call, the nurse, escorted by an officer, returned to see the man. She did not take an emergency bag as she intended just to administer medication. When the officer and nurse entered the cell, they found him slumped on his bed, unconscious. The nurse asked for an ambulance to be called and for the emergency bag to be brought from the healthcare wing. She then gave cardiopulmonary resuscitation. There was a delay in obtaining the emergency bag as it had been locked in a room and the nurse had the only key.

6. Paramedics arrived around 25 minutes after the man had been discovered. They continued the resuscitation efforts but, at 5.53am, he was pronounced dead. As the man's mother, his next of kin, lived abroad, the news of his death was initially notified to a family friend.

7. The investigation has concluded that while the man's death was not foreseeable, there were unnecessary delays in obtaining emergency equipment. Recommendations were made about the provision of treatment rooms, maintenance of equipment and the need to request medical assistance quickly when prisoners report serious illness.

THE INVESTIGATION PROCESS

8. The investigator opened the investigation on 15 November, when he visited HMP Swaleside. Notices were issued informing staff and prisoners of the investigation. They asked anyone who had information, pertinent to the investigation, to contact him but no responses were received as a result of these notices directly by the investigator.

9. Eastern and Coastal PCT commissioned a review of the medical care provided to the man while in custody which was carried out by the clinical reviewer. The clinical reviewer's report is attached in full at annex 1.

10. The investigator wrote to the Coroner, to inform him of the investigation and to request a copy of the post mortem report. This gave the cause of death as cardiomyopathy.

11. One of our family liaison officers explained the purpose of the investigation to the man's family. His family were concerned about the availability of emergency medical equipment in the prison, and why he was left alone when he was so ill. We have commented on these issues in the report.

12. The investigator visited Swaleside on 13 January and conducted interviews with eight staff. He reported his initial findings to the Governor of Swaleside and followed this up in writing.

13. The delay in issuing our draft report is regretted. This was due, in part, to a delay in receiving the clinical review then compounded by workload pressures within the Ombudsman's office.

14. Although no responses to notices were received directly from prisoners, a prisoner at Swaleside, did contact the organisation INQUEST. He told them that he had information relating to the man' death. The prisoner's details were passed on to the investigator by INQUEST. Unfortunately, due to an oversight by the investigator, the prisoner was not interviewed during the investigation, and arrangements were made for him to be spoken to after the draft report had been issued. The prisoner provided a written account of what he had overheard from his cell on the morning of the man's death. The information provided has not altered the findings of the investigation. The written account provided by the prisoner has been added to this final report as an additional annex.

15. Following the issue of the draft report, the man' family raised a number of questions, these have been answered in correspondence.

HMP SWALESIDE

16. HMP Swaleside opened in 1988 and forms part of the Sheppey cluster of three prisons, together with Elmley and Standford Hill. The prison is primarily a centre for life-sentenced prisoners but also holds those serving shorter sentences. As a category B training prison for adult male prisoners, it runs a number of educational, practical and offending behaviour courses. (A category B prison is for prisoners who do not require maximum security, but for whom escape should be made very difficult).

17. The healthcare centre has an 18-bed inpatient unit, providing 24-hour care for the most seriously ill prisoners. There is a general practitioner (GP) service Monday to Friday, with out of hours care provided by South East Health.

Previous deaths at HMP Swaleside

18. There have been 21 deaths at the prison since April 2004, when the Ombudsman became responsible for investigation of deaths in prison custody. The circumstances of these previous deaths were not similar to those in this case.

Her Majesty's Inspectorate of Prisons

19. HM Inspectorate of Prisons made a short unannounced follow up inspection of HMP Swaleside between 4 and 7 July 2011 of a full inspection in April 2008. The 2011 inspection report noted that the healthcare department had been refurbished since the last inspection and was a good environment for the treatment and care of prisoners. Inspectors found that prisoners had satisfactory access to primary care services, staffing levels were good and there was an improved culture of open access to health services. At the full inspection in 2008, the Inspectorate noted that there were no healthcare facilities on the wings and that all healthcare was delivered in the main department. Emergency equipment was held in the main healthcare department and checked daily. All healthcare staff had received annual updating in cardiopulmonary resuscitation.

Independent Monitoring Board (IMB)

20. Each prison in England and Wales has an Independent Monitoring Board (IMB), whose members are drawn from the local community. Their role is to ensure standards of decency and care are maintained. The latest annual report by the IMB at Swaleside says of healthcare:

> "This has been the first full year of commissioning a GP practice based on Sheppey to provide GP services at Swaleside. It has proved to be very popular with the staff and prisoners, especially the latter as they now have a certain amount of choice as to who they see.

"Patient Representative meetings continue to meet bi-monthly – the representatives on each wing act as advocates on behalf of their peers and as a conduit to resolve difficulties. The group has improved communication between the wings and Healthcare."

Cell call bell

21. All prison cells are fitted with a call bell, which can be pressed by the prisoner to alert staff in an emergency. This illuminates a light outside the cell and emits a buzzing noise, which identifies the cell to staff. There is also a central panel in a wing office showing all cells, which lights up when a bell is pressed.

Cardiopulmonary resuscitation (CPR)

22. This is an emergency procedure, which is performed in an effort to manually preserve intact brain function until further measures are taken to restore spontaneous blood circulation and breathing, in a person in cardiac arrest.

Automated External Defibrillator (AED)

23. These are portable units, designed to analyse heart rhythm, usually taking 10-20 seconds before advising whether a controlled electric shock is required. They are designed to be easy to use by non-medical persons, who require little training to operate them correctly. The AED is usually limited in its use as it is only able to analyse and deliver a shock, and therefore of limited use to trained health professionals, who are able to diagnose and treat a wider range of problems with manual or semi-automatic units. In view of this, paramedics on arrival at an emergency will usually replace the AED with their own equipment.

Ambu-bag

24. A bag valve mask, also known as an ambu-bag is use to ventilate a patient in a medical emergency when the breathing is insufficient or has ceased completely. The ambu-bag is used to manually provide mechanical ventilation in preference to mouth-to-mouth resuscitation.

KEY EVENTS

25. The man was released on licence from a 4-year prison sentence in September 2008. However, the licence was revoked the following month, and he returned to custody. After his recall to prison, he spent time at a number of prisons.

26. During his imprisonment, the man seriously assaulted his offender supervisor, prison staff and a police officer who attended to interview him. On several occasions, he was also subject to monitoring under the suicide and self-harm monitoring procedures as a result of cutting himself. In addition, he had regular reviews with the Mental Health In-Reach Team (MHIRT), and his medication was regularly reviewed.

27. In June 2010, he was transferred to HMP Lewes for his court appearance in relation to offences committed in prison. He attended court and transferred to Lewes on 28 June. During his initial health assessment, he reported that he was withdrawing from heroin, which he had been using in his previous prison. A urine test confirmed that he had morphine in his system, and he began a methadone (synthetic heroin substitute) detoxification programme, which ended in August 2010.

28. The day after the initial health screen, a psychiatrist assessed the man. She recorded his previous mental health history and what the man perceived to be his main current concerns. The psychiatrist concluded that the man showed no current signs of mental illness, but might benefit from attending a treatment programme for personality disorders. A referral was made for him to be seen by the primary care nursing staff; also for an electrocardiogram (ECG) to be carried out, as he had been having palpitations; and for his medication to be monitored.

29. In October 2010, the mental health team completed a report recommending to the court that the man be sectioned under the Mental Health Act 1983, section 37/41. Over the following months, the man's mental health continued to result in unpredictable behaviour and minor acts of self-harm and he was located in the healthcare wing for closer observations. On 5 January 2011, he was transferred from Lewes to the care of Ashen Hill, a secure hospital, for a period of assessment. He remained there until 28 August 2011, when he and a number of other patients attempted to escape. The escape attempt was prevented, but he assaulted nursing staff in the process. The police charged him with further offences of assault and attempted escape, and he was remanded back into the custody of Lewes prison the following day.

30. On his return to Lewes, Senior Nurse completed a brief reception medical screen, as the healthcare team at Lewes already knew the man. One of the nurses spoke to the doctor Ashen Hill, who considered that the man could be managed on a normal wing.

31. The next day, Dr A, a prison GP, saw the man. He told her that he had been using Subutex (heroin substitute) at Ashen Hill, to get 'high' and that he felt

nauseous and dizzy. The doctor recorded that his pulse rate was 80 bpm. (A normal pulse rate for a man of the man's age is considered to be between 60-100 bpm.) He was prescribed medication to alleviate his symptoms of nausea and the doctor asked the drug treatment team to monitor him.

32. Further contact was made between the MHIRT at Lewes and staff at Ashen Hill to share information about the man's care. Ashen Hill confirmed that the intention was to refer him to Broadmoor Hospital, a high security psychiatric hospital, but they were unsure how long this process would take. A week later, on 6 September, he transferred to HMP Swaleside, as it was a more secure environment, and would provide a full regime.

33. During his time in custody, the man had few problems with his physical health and staff continued to check progress on the referral to Broadmoor. He settled well and staff reported that he had caused them no concerns. Although he did not present a problem on the residential wing, he believed that he should actually be held in healthcare. He submitted an application on 25 September, asking why he had been located on a residential wing. The next day staff explained he had been moved to Swaleside to be managed on a normal wing, and did not need to be admitted as an inpatient to healthcare.

34. On 29 September, the man woke in the morning with swelling to his right hand. He was seen by Nurse A, who recorded that the man' hand was swollen and hot to the touch. There was no evidence of insect bites, but the hand was tender and painful. The nurse checked his temperature and pulse rate, both of which were normal, and referred him to the GP, with a possible diagnosis of either an allergic reaction or deep vein thrombosis (DVT).

35. Afterwards, prison GP B at Swaleside, saw the man. The doctor said that when he assessed the man he carried out a series of routine observations, as he would regardless of the symptoms. This included checking his chest and heart, which were normal. He identified no abnormality of the circulation in his hand or fingers. His immediate view was that the man had experienced an allergic reaction. The doctor explained that he administered an injection of Piriton, an antihistamine, in case it was an allergic reaction. He also planned for the man to attend the local hospital to be seen by a specialist to rule out any other underlying cause.

36. Prison GP B arranged for the man to be temporarily admitted to the prison healthcare inpatient unit while an escort to the local hospital was arranged. That afternoon, the man was seen in the William Harvey Hospital accident and emergency department. The hospital confirmed that the most likely cause was an allergic reaction and prescribed further antihistamine medication. The man returned to Swaleside that evening. Nurse B spoke to him on his return and he was given a further dose of medication, supplied by the hospital.

37. The hospital sent no documents about the diagnosis. Nurse B said that this was quite normal, and that it was rare for the prison to receive a transfer of care letter. In cases where the prison healthcare team needed more information

about the treatment, they would telephone to request it. Nursing staff at Swaleside said that this was a regular issue for them.

38. On 2 October, the man again asked the healthcare manager, when he saw him on a residential wing why he was not an inpatient in healthcare. The healthcare manager explained the reasons again.

39. The investigator asked the healthcare manager about the man's treatment and the plans for his longer-term care. He said that he was on regular medication to treat his mental health problems, and was also receiving support and supervision from the MHIRT. The man believed that he should be transferred to Broadmoor because of his escape attempt from the medium secure unit at Ashen Hill, but, the mental health team did not consider the man required admission to a high security hospital.

40. On 6 October, the man reported sick and was seen and assessed by a locum GP. The locum GP recorded that the man's left hand was swollen, and additionally he had swelling to his genital area. The man told the locum GP that he believed prison staff were poisoning the soap. The doctor assured the man that this was not the case and that it was an allergic reaction. The doctor examined the man, his chest was clear, and there were no other signs of swelling in any other areas. He diagnosed allergic contact dermatitis and prescribed a further course of antihistamine medication. He also advised the man to let a nurse know if the symptoms became worse.

41. During the evening on 6 October, wing staff telephoned healthcare and told Prison Officer A, a healthcare officer that the man had been vomiting. On examination in healthcare, the man said that he had taken all seven of the antihistamine tablets that he had been prescribed that afternoon. He explained to the officer that one tablet had not worked and he believed he could take them when he felt like it.

42. Officer A told the investigator that it seemed the man had not taken the medication with the intent of harming himself, it was more a case of ignorance of how to use them. She recalled contacting a telephone advice line about overdose of medication. The indication was that the antihistamine would not pose a risk, apart from nausea. When the man's observations were recorded, his blood pressure was slightly raised. Due to this and his vomiting, healthcare staff admitted him overnight to the inpatient unit, for closer observation. Officer A said that it was made clear to the man that he would be there only for that night.

43. On 10 October, the man reported sick and was assessed by Prison GP B. He complained of a burning sensation when passing water. He told the doctor that there was no blood in his urine and he had no pain or swelling in his testicles. The doctor examined him, recorded that mild tenderness around his lower abdomen, and diagnosed a lower urinary tract infection. He advised the man to drink plenty of fluids and return if the symptoms persisted. The doctor was asked whether he had been aware of the earlier examination and entry on the medical record by the locum GP about swelling to the man' genitals. He said

that he had been aware but, when asked, the man said he no longer had the swelling. He had asked the man whether he could examine him but he had declined. The doctor explained that a patient must agree to an examination of a private area.

44. The man woke up on 17 October, with a further episode of swelling to his genital area, and reported sick. Prison GP B assessed him and recorded that the genital area was swollen, but there was no evidence of other symptoms. He diagnosed idiopathic urticaria, and planned for the man to be given a further injection of antihistamine. Urticaria is a type of skin rash that results from an allergic reaction or an abnormal immune response of the skin. The doctor was asked by the investigator to explain the diagnoses. He said that 'idiopathic' means that no reason for the condition can be identified and that this was only his provisional diagnoses. He had continued to consider other reasons for the man's recurring condition.

45. After he had seen the man, prison GP B discussed his condition with a doctor at the dermatology department of Medway Hospital. He explained about the man's history of unexplained swellings and his latest symptoms. He advised that the man had no respiratory symptoms and no swelling had been observed in his lips, tongue or throat and that the swelling was not itchy. The doctor told prison GP B that it was appropriate to continue with antihistamines and asked for a referral letter to be sent to him at the hospital. The prison GP B wrote to him that day and suggested that the man might be suffering from angioedema (a spontaneous swelling of areas of skin or mucous membranes), or Steven Johnsons Syndrome, (a rare potentially life threatening skin disease resulting from a severe reaction to infection or drug interaction). Due to this, he stopped lansoprazole, a medication that had been prescribed for excess stomach acid, as it was believed to cause Steven Johnsons Syndrome.

46. A consultant psychiatrist at Broadmoor Hospital, visited Swaleside on 3 November to assess the man. He found no evidence of psychotic behaviour and did not consider him suitable for Broadmoor but, due to the complexity of the case, further discussion was required with both Broadmoor and Ashen Hill.

Emergency response on the day the man died

47. On the day the man died, it was recorded in the observations book that the man pressed his cell call bell at 3.45am, which was answered by the night officer, Operational Support Grade (OSG). The OSG said that before this, she had been checking on the man regularly, as he was an 'E' list prisoner (regarded as a risk of escape following the attempt at Ashen Hill). Each time she did so he was lying on his bed. When she went to his cell to answer the cell call bell, he told her that he was having difficulty breathing, and that he had an allergy. The OSG asked the man if he had eaten anything that he was allergic to but he said he had not. The OSG told the investigator that the man's colour was normal.

48. The OSG recorded in the wing observation book that the man had pressed his cell bell at 3.45am. The investigator examined the electronic cell bell records and found there was no record of the man's bell being pressed at that time. The closest time before this was 3.12am and this was answered at 3.13am. The OSG was asked if she was able to explain why there was no electronic record for 3.45am, but she was unable to do so. The investigator has confirmed with Swaleside that on 9 February the cell call system was working correctly and all recorded times are correct.

49. The OSG returned to the wing office. She telephoned both the orderly officer (in charge of the prison at night) and duty nurse at 3.45am, to report that the man was complaining of being unable to breath. Officer B was the orderly officer on the day the man died, which meant that he was responsible for the security of the prison and the staff on duty. The officer had previously been temporarily promoted to senior officer and worked regularly on nights, but on the day of the man's death, he was covering for the night manager who was ill. He explained to the investigator that the OSG told him that the man was having breathing difficulties and had asked to see a nurse. He then telephoned Nurse B, the duty nurse in healthcare, but the OSG had already contacted her.

50. Officer A said that he had no previous knowledge of the man, but spoke to colleagues who told him that the man was or had been an 'E' list prisoner. Two officers then went to the healthcare wing to collect Nurse B. At night, the nurse is locked in the healthcare wing. When they are required in another area of the prison, they are collected by an officer and escorted around the prison. One officer will remain in the in-patients area of healthcare, until the nurse returns. On the day the man died, this was Officer C.

51. Officer B made his way to H wing along with another member of staff. Nurse B was close behind with the officer escorting her. At night, staff do not carry keys, but have access to a single cell key, which is carried in a sealed pouch. In the event that emergency access is required to a cell, staff can break the seal and use this key. Additionally, the orderly officer carries keys for access around the prison. As a security precaution, when opening a cell at night, the orderly officer will give all their keys apart from a cell key to a member of staff who will remain behind a locked gate. This ensures that if a prisoner overpowers staff while unlocked, the problem is contained. On arrival at H wing,

Officer B gave his keys, apart from a cell key to the OSG, who then locked the staff onto the wing, and she remained behind the locked gate.

52. When the staff entered the man's cell, he was sitting on his bed in his underwear and breathing quite heavily. They said that he was quite agitated and told Nurse B that he could not breathe. The nurse had taken an emergency medical equipment bag. She monitored the man's oxygen levels, which she recorded was 99%, pulse was 105bpm and his blood pressure was 130/70 the pulse and blood pressure were slightly raised, but not excessively. The nurse said that she managed to get the man to relax and explained to him that he needed to answer her questions, so that she could help him.

53. Nurse B checked the man's mouth and could see no swelling of the lips, tongue and interior of his mouth or the throat. She told the investigator that she noticed that his left foot and lower leg appeared swollen. Having checked his medical record before going to the wing, she was aware that he had seen the GP for such issues previously. The nurse explained to the man that, in view of his previous issues with swellings, she was going to return to the healthcare wing and contact the on-call doctor for advice. She told the investigator that she left the wing at around 4.30am, so had spent quite some time with the man, reassuring him and monitoring his condition. When she left the wing, the nurse took the emergency bag with her and returned it to the healthcare wing, where it was locked away.

54. Nurse B told the investigator that if she had felt that the man's condition required hospital treatment when she first assessed him, she would have had no hesitation in arranging for him to be taken to the local hospital. However, from the observations that she had taken, the nurse said that she did not consider that the man was suffering from anything life threatening. When she left the man's cell he was calm and understood that further advice was being sought.

55. Before leaving the wing, Officer B explained to the OSG that the nurse was going to contact the on-call doctor, and asked her to keep an eye on the man, as she patrolled the wing. Nurse B had advised that the man needed to try to remain calm.

56. Officer B said that within a short time of arriving back in the operations office from H wing, he received a radio call from the OSG who said that the man was kicking his cell door and saying that he was not being given any answers. Officer B told the OSG that the nurse had contacted the on-call service and was waiting for the doctor to call her back, but other than that, he had no other information.

57. Nurse B told the investigator that the on-call doctor, called her back within 20 minutes at around 4.50am. She said that this was relatively quick, as it could take up to an hour. She explained to the doctor that the man had complained of being unable to breathe, but that she had taken his pulse, blood pressure and oxygen levels, all of which were relatively normal. She also explained the man's previous medical history of swellings and that he had recently been

prescribed antihistamines. The doctor advised the nurse to give the man, 10mg cetirizine, an antihistamine and watch him take it, advise him to try and relax, and book an appointment to see the GP later that day. The nurse said that it would be normal practice to place someone on the doctors list if she had been called out to see a prisoner during the night, regardless of the advice.

58. While Nurse B had been speaking to the on-call doctor, Officer B had received a further message from the OSG to say that the man was again kicking his cell door and saying he could not breathe. Officer B said that this was around 4.45am. The nurse then told him that she had spoken with the doctor and had medication to give to the man. She was then collected again from the healthcare wing and returned to H wing at around 4.55am. On this occasion, the nurse said that she did not take the emergency bag with her, as she was going to deliver medication and did not consider it an emergency.

59. When the staff arrived at H wing, they were again met by the OSG who told Nurse B that the man had been shouting and kicking his door since he had been seen. Although she had told him that the nurse was waiting to hear from the doctor, he was not happy. The OSG said that she had last seen the man between 4.55am and 5.00am, and he had been sitting on his bed, 'blowing in and out.' The nurse told the OSG that she would go up and speak to him, and that she had the medication he needed.

60. When they entered the cell, the man was in a seated position on his bed, but slumped to one side. Nurse B told the investigator that it appeared that whatever had happened had been sudden as the man was still holding a bottle of drink in his right hand. Officer B had entered the cell ahead of the nurse, looked at the man, and said that he looked very pale. The nurse swapped positions with the officer and tried to gain a response from the man, but was unable to do so. She then lifted his legs onto the bed and told the staff present that they needed to call 999 immediately. A call to the Ambulance Service was made by the control room at 5.05am. The nurse said that the man was very pale, and his eyes were 'glassy.' She began cardiopulmonary resuscitation (CPR) and asked for the emergency bag to be collected from the healthcare wing.

61. There was some delay in bringing the bag to H wing, as it was locked in a room, and the officer in healthcare did not have access to it. Officer C, who was in healthcare, covering for Nurse B, finally managed to access the bag by forcing up a door hatch and climbing underneath. The bag was then taken directly to H wing. When interviewed, staff could not be clear about how long this took, but it would have taken at least 5-10 minutes to access the bag and deliver it to H wing.

62. It was discovered during the investigation that there is a treatment room on H wing, a short walk from where the man's cell, which can be accessed by nursing staff with the keys that they carry. The investigator was told by the healthcare manager that oxygen and a defibrillator are available in the room. There is also telephone access and a computer system for nursing staff to look up medical records. The healthcare manager said that he had believed that the

availability of the room was known by all healthcare staff, but accepted that this might not have been the case. Both nursing staff and discipline staff, some of whom had worked at Swaleside for a number of years, who were on duty on the day the man died, were unaware of this facility and the investigator was told that the rooms had not been routinely used for at least two years, despite the equipment inside being regularly maintained.

63. Once the emergency bag arrived, Nurse B gave the man oxygen at a rate of 15 litres, via an ambu bag. While she was giving oxygen, an officer continued CPR. The defibrillator was placed on the man and advised the staff that no shock could be given, and CPR continued until the paramedics arrived at 5.25am.

64. Nurse B gave the ambulance staff a full handover. The paramedics then introduced an airway into the man' throat and continued CPR. They also administered adrenaline via a cannular inserted into his arm. The paramedics attached their own defibrillator, which also advised no shock, and they told the nurse that their checks had confirmed that the man was asystolic (no heartbeat). Treatment continued until 5.53am, when paramedics stopped the attempts to resuscitate the man and he was pronounced dead.

Events after the man's death

65. After the man's death, the prison held a debrief with the staff involved in the attempts to resuscitate him. The actions of all staff and any immediate issues were discussed and recorded. They were also offered emotional support if they wanted it. In addition to support for the staff involved, the prison arranged for case reviews to be carried out with all prisoners who were subject to ACCT monitoring.

66. Governor A was appointed as the prison's family liaison officer. Initially, a family friend was notified as the man's mother lived abroad. Due to the distance between the prison and the home of the family contact, he telephoned to break the news and explain the circumstances of the man's death. The family friend told the governor that he was unsure how the man's mother would react to the news of her son's death, and said that he wished to be the person to contact her. The governor explained that there would be an inquest and that the prison would assist with funeral arrangements if the family wished. He met the man's mother on 11 November, and was able to explain more about the events leading to his death. He then maintained regular contact with the family. The prison assisted with the funeral arrangements and, in line with the policy on deaths in prison custody, contributed towards these costs.

ISSUES

Clinical care

78. The post mortem concluded that the cause of the man's death was cardiomyopathy, a disease of the heart muscle resulting in the heart not being able to beat effectively. Following a discussion with the clinical reviewer, the pathologist agreed to send samples of the man's heart to a specialist pathologist for a second opinion. The outcome is not yet known but we understand that the cause of death is unlikely to change. Nevertheless, the clinical reviewer discusses issues surrounding the cause of death.

79. The clinical reviewer considers this is a complex case as there were underlying symptoms that might have had a bearing on the man's death. He points out that cardiomyopathy mostly occurs in teenagers or young adults and is the second most common cause of death in this group. It is also a genetic condition, which usually occurs as sudden death, but there is no evidence of it among other members of the man's family. Some of the man's symptoms reported to healthcare staff support a diagnosis of an allergic reaction but there was no evidence of this from the post mortem. His complaints of breathing difficulties were thought to be due to anxiety and the nurse called to the emergency on the night of his death, found he was breathing normally.

80. The clinical reviewer has doubts about the cause of death, which are being further explored, but the investigation has found no irregularities in the management of the man's general clinical care. Although he had extensive mental health assessments and reviews, there was little contact with healthcare for physical ailments. Given the recorded cause of death, which is often sudden, we are satisfied that staff could not have foreseen the man's death. However, the clinical reviewer believes it is possible that the man could have been saved if there had been no delays and this is discussed below.

Requesting medical assistance at night

79. In the early hours of the morning in which the man died, he used his cell bell to call for help. The investigator requested a record of the timings of cell bells that were pressed during the evening and early morning of 8/9 February. These show that the man had pressed his cell call bell on a number of occasions between, 3.00am and 5.00am, but no call is recorded at 3.45am. The OSG recorded in the wing observation book that the man first complained of being unable to breathe at 3.45am.

80. When asked for an explanation of this anomaly, the OSG was unable to provide one. Other staff confirm the timing of the OSG's call to medical staff at 3.45am, but this was 30 minutes after the nearest recorded cell bell call at 3.12am.

81. Swaleside confirmed to the investigator that on 8/9 February the cell call system was working effectively and that all timings were considered to be exact. Without an explanation from the OSG, it can only be assumed that there

was a delay of at least 30 minutes between her last contact with the man and her initial call to Nurse B and Officer B. This is a concern.

82. When Nurse B arrived at the wing to assess the man after being called by the OSG at 3.45am, she recorded that his pulse, blood pressure and oxygen levels were normal so there is no evidence than any delay at that stage impacted on the man's condition. However, the OSG would not have known this when she saw him and it could have led to a more serious situation. It is particularly important to call healthcare staff at night when there are lower staffing levels. We make the following recommendation:

The Governor should ensure that staff request medical assistance immediately if a prisoner reports serious or potentially life-threatening symptoms such as breathing difficulties.

Delay in obtaining medical equipment

83. The man's family raised concern about the availability of emergency medical equipment on H wing. We also have concerns about this and the time it took to treat the man on the night he died.

84. After initially assessing the man, the nurse had to return to the healthcare centre to view his computerised medical records and to use the telephone to contact the on-call GP. When she then returned to the wing to give the man the medication directed by doctor, she did not take the emergency bag with her containing the defibrillator. Unbeknown to her this was required to assist with the resuscitation of a now unconscious, pulseless, patient. We accept that at this time the nurse could not have foreseen this and was returning simply to administer the medication indicated by the GP.

85. There was a further delay when the officer who was asked to collect the emergency bag was unable to do so as it had been locked away and only the nurse who was now on H wing had access. Through good fortune, the officer was able to break into the room to get the bag, but this should not have happened.

86. A further concern is that this particular delay was preventable, as there is a treatment room equipped with a defibrillator and oxygen on H wing. During the investigation, it became apparent that both nursing staff and officers, some of whom have worked at Swaleside for some time, were unaware that such a facility existed. The investigation also learnt that the treatment room also has computer equipment, to enable nurses to access prisoners' medical records, as well as a telephone. This means that there was no need for the nurse to leave the wing. The clinical reviewer says that if the nurse had been aware of facilities that were available close by, the whole process would have been quicker, saving valuable time. He points out that every second is critical for a successful outcome to be achieved when someone has had a cardiac arrest.

87. The investigation found that the decisions not to use the medical facilities on H wing were taken at least two years ago, due to staffing and financial pressures

and were made prior to Nurse B starting work at Swaleside. The situation should not be allowed to happen again. It is important that all prison staff, especially nurses, are aware of and have access to these facilities. While we appreciate that the maintenance of these rooms and the equipment contained within them has cost implications, the prison has a duty to maintain acceptable standards of care.

88. We are also aware that the practice of locking away the emergency bag has been reviewed since the man’s death and this practice has ceased. However, we make the following recommendations in relation to medical equipment:

    The Governor and Head of Healthcare should ensure that sufficient emergency medical equipment and facilities are readily available on all wings to ensure an appropriately swift response to an urgent situation at all times, particularly at night.

CONCLUSION

89. The majority of the man's contact with the healthcare department was for mental health conditions and superficial injuries caused by self-harm. He reported few physical ailments and these were addressed promptly.

90. The man's medical symptoms included swellings, for which he had been prescribed appropriate medication. On the day of his death, when he reported feeling unwell during the night, the nurse checked all his vital signs which were not at a level that raised concern of anything life threatening at that time. When the nurse spoke with the on-call GP and relayed the man's previous medical history and his current observations, there was again nothing to suggest that he was experiencing anything other than another episode of allergic swelling. In the view of the clinical reviewer, the man was appropriately prescribed antihistamine.

91. Although pathological enquiries into the cause of death continue, our investigation concludes that the man's death could not have been foreseen. However, there is a concern about unnecessary delays in obtaining vital life saving equipment in an emergency. Whether earlier availability would have changed the outcome for the man cannot be known but swift intervention in such situations is vital if there is to be any possibility of saving lives.

RECOMMENDATIONS

1. The Governor should ensure that staff request medical assistance immediately if a prisoner reports serious or potentially life-threatening symptoms such as breathing difficulties.

   The Prison Service accepted this recommendation and said:

   Notice to all staff to be issued to remind them of the correct protocol for requesting immediate medical assistance. The target date for this to be actioned by is 31 July 2012.

2. The Governor and Head of Healthcare should ensure that sufficient emergency medical equipment and facilities are readily available on all wings to ensure an appropriately swift response to an urgent situation at all times, particularly at night.

   The Prison Service accepted this recommendation although this would be subject to finance, and said:

   Capital bid to be submitted by Head of Works services & Heath Care Manger for the provision of fully equipped treatment rooms on all wings. The target date for this to be actioned by is 31 August 2012.