

**Investigation into the circumstances surrounding the
death of a man
at HMP Wealstun in January 2010**

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

June 2011

This is the report of an investigation into the death of a man at HMP Wealstun in January 2010. He was 35 years old. I offer my sympathy and condolences to his partner, his children and his parents, and to all those others affected by his death.

The post mortem found that the man died because of acute heart failure due to the anomalous origin of his right coronary artery. It is a rare condition and one which he would have been born with. There was no indication that he was going to die and it would have been very sudden.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was conducted by a clinical reviewer on behalf of Leeds Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Wealstun for their co-operation during the course of the investigation.

The clinical reviewer makes four recommendations, all of which I endorse, in his clinical review. The man had been in prison for a number of years and was held at HMP Durham and HMP Lindholme before he moved to Wealstun. The reviewer's recommendations concern prescribing practices at all three prisons and so I will send my report to each. I have an additional recommendation to reflect my concern about the length of time that seems to have elapsed before the staff established that the man had 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.

Jane Webb
Acting Prisons and Probation Ombudsman

June 2011

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SUMMARY

The man was sentenced on 13 October 2006 to an indeterminate sentence for public protection (IPP) and ordered to serve a minimum of four and a half years before he could be considered for release. In December 2009, the Parole Board decided not to direct his release from prison because work to reduce the risk of re-offending was still required.

When he came into custody at HMP Durham in July 2005, the man told the nursing staff that he suffered from asthma and had a family history of cardiac problems. In October of the same year, he reported at the wing clinic that he suffered from high blood pressure and asked for his blood pressure to be taken. Although variable, his blood pressure was regarded as high but the doctors decided against treatment with medication at that stage.

The man was granted bail in 2006 and, whilst on bail, he was investigated in hospital for chest pain. On returning to prison, the doctor contacted the hospital who reported that the man had been investigated for cardiac problems but no treatment was necessary. His GP confirmed that he had not been taking any medication.

In August 2006, the man had acute chest pain and was prescribed pain relief. He told the doctor in November that he was not sleeping and felt depressed. An anti depressant was prescribed by the doctor and seems to have continued for the remainder of his time in prison. Medication to treat hypertension was prescribed in March and April 2007, after which his blood pressure stabilised.

In August 2008, the man transferred to HMP Lindholme and in November 2008 to HMP Wealstun. On reception at Wealstun, he told nursing staff that he had suffered two heart attacks in 2006 and was due to see a cardiologist. He was offered a GP appointment but did not attend.

In January 2009, the man saw the doctor and said that he had recently suffered two episodes of crushing chest pain. Medication to prevent chest pain was prescribed and he was referred to the local hospital. The hospital diagnosed a particular abnormality of the right coronary artery. He did not have any significant coronary heart disease and no past evidence of any heart attacks. The hospital did not suggest any treatment and discharged him back to the care of Wealstun.

The man reported in July that he was suffering from chest pains. The doctor prescribed medication to reduce acid content and reassured him about his heart. The man made no further complaint of any chest problems. He continued to receive his medication and his blood pressure was generally normal.

On the morning of the man's death, a prisoner standing by the man's cell door alerted prison staff. Officers found the man on the floor of his cell with dried blood near his mouth. An officer summoned medical assistance, including an ambulance. Paramedics attended and confirmed that the man was dead. They suggested that his death had occurred some four to six hours previously. I am concerned that so much time passed before the alarm was raised.

The post mortem report establishes that the cause of death was acute heart failure due to the anomalous origin of the right coronary artery (one of the most important arteries supplying the heart muscle itself). The clinical reviewer notes that there would have been no indication that his death was imminent.

The clinical reviewer observes that there are two related issues that remain unresolved. They concern the potentially high levels of medication reported in the toxicology report, and the discrepancy between the medication that should have been in the man's possession but was not found in his cell

The clinical reviewer makes a number of recommendations in his clinical review, all of which I endorse, and I make an additional recommendation.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from this office. He first visited Wealstun on 21 January 2010 and was given access to the man's prison records. The investigator visited the residential unit where the man had been found collapsed on the day he died. He was also shown around other parts of the prison, including the healthcare unit.
2. During this initial visit, the investigator met members of the Independent Monitoring Board (IMB) and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they felt pertinent to my investigation. (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.)
3. Leeds Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody, particularly during his time at Wealstun. They appointed a clinical reviewer to undertake the review on their behalf. The investigator asked the clinical reviewer to consider particularly medication issues that might have impacted on the cause of the man's collapse and any actions that should or could have been taken in respect of his heart problems.
4. One of my family liaison officers contacted the man's father, as his listed next of kin, to inform him of my investigation and to invite his family to ask any questions or raise any issues for consideration as part of my investigation. I hope that my findings help the man's family better understand what happened following his collapse and address any concerns they may have about the care he received.
5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner to assist his enquiries into the man's death.

HMP WEALSTUN

6. HMP Wealstun is a category C training prison for adult men. It opened on 1 April 1995, following the amalgamation of HM Prisons Thorp Arch and Rudgate.

7. Wealstun was a large and complex establishment when it was two prisons within one operation. When Her Majesty's Chief Inspector of Prisons made her announced full inspection visit in 2008, she said:

“On our previous visit, we were critical of the complexity of the site, which included an open prison. On our return, the open side was empty and in the process of being converted into additional closed training places. Wealstun was clearly benefiting from the single focus that these changes had brought about. Improvements were visible across the board, with particular progress having been made in resettlement provision.

“There had been significant improvements at Wealstun since our previous visit. The prison had clearly benefited from the increased clarity of role that had come with the closure of the open prison, leaving it to focus fully on its category C training function.

“Bullying and violence reduction arrangements had also developed, although more individual work was needed with bullies and their victims. Drugs remained a significant problem, but security arrangements had been tightened proportionately to address the issue.”

8. As part of my enquiries, I endeavoured to consult the current annual report by the IMB, but discovered that no reports are available for the period after May 2007.

KEY FINDINGS

9. The man was remanded into the custody of HMP Durham on 21 July 2005 for an offence of conspiracy to commit arson and harassment charges. He was transferred to HMP Holme House for a short time, but returned to Durham on 31 August. He was released on bail in March 2006, and remanded back into custody on 14 July. On 17 July, at a Crown Court he was convicted of the charges. He appeared on 13 October at a further Crown Court and was sentenced to an indeterminate sentence for public protection (IPP) and ordered to serve a minimum of four and a half years before he would be considered for release.
10. On his first reception health screen undertaken at Durham in July 2005, the man told the nursing staff that he suffered from asthma and had a family history of cardiac problems. He was a non-smoker and took regular exercise. He had no alcohol or substance misuse problems but, because he said he had suffered from chest pains in the past, he was given an appointment to see the doctor. Unfortunately, the clinical records from any consultation that may have taken place are missing.
11. On 4 October, the man presented himself at the wing morning clinic asking if he could have his blood pressure taken because he said he was known to have high blood pressure. The nurse obliged his request and recorded the man's blood pressure as being 198/105 (which is a high reading). He was given an appointment later that day to be seen by the doctor.
12. An unidentified doctor saw the man later that day and measured his blood pressure twice. The first reading was 154/84 and the second reading was recorded as 133/92. Neither result was considered by the doctor to be of concern. He reassured the man and suggested that he should have his blood pressure checked annually.
13. The man again asked for his blood pressure to be checked on 14 December. The nurse made two recordings, one from the man's left arm (148/110) and one from his right arm (150/100). The significance of these readings is that they are broadly similar and both would be considered quite high. A nurse advised that the man should have his blood pressure monitored over the next few days and be seen by the doctor if it remained high.
14. The man was seen again on 17 and 21 December, when his blood pressure readings were again recorded as high (139/92 and 174/108 respectively). A prison doctor at Durham wrote to the man on 21 December explaining that he was reluctant to begin what would be a lifetime of medication and so he would have an appointment in the New Year (2006) to discuss alternative options. In the meantime he wanted additional blood pressure readings to be obtained.
15. Unidentified healthcare staff took the man's blood pressure on 10 January 2006 (168/116), 12 January (142/102), 25 January (169/120), 27 January (142/108) and on another unclear date in January when it was 'so high as to be unrecordable'. During this time the man had blood taken for investigation.

He also supplied urine samples and was referred to the local hospital for a chest x-ray. Nothing abnormal was discovered in the blood investigations although some protein was found in his urine, indicating that he might have a slight infection. The blood tests did not indicate the need for any treatment.

16. The Head of Primary Care Services at HMP Durham saw the man on 3 February and noted his history of high blood pressure. Because he was asthmatic, the doctor said that beta blockers should not be prescribed immediately. He wanted to await the results of the recent chest x-ray. They arrived at the prison on 21 February and showed nothing abnormal. The man's blood pressure continued to be monitored throughout the following weeks, showing varying degrees of being higher than it ought to be.
17. On 20 March, the man was released from prison on bail. He returned to Durham during his trial in July 2006. At that time he was seen by a nurse who in turn contacted the man's doctor in the community. The man's doctor in the community responded that the man was not prescribed any medication, but had been given an inhaler, even though he was not asthmatic, because 'it makes him feel better'. The man also revealed that he had been sent to the Rapid Access Chest Pain Clinic (RACPC) at outside hospital with recurrent chest pain. A copy letter to the man's doctor in the community from the hospital arrived at the prison with the results of tests carried out sometime in mid August.
18. The man started work as a cleaner on 28 July although the officer writing his weekly report recorded that he required a little more motivation than others. No other problems were reported.
19. On 10 August, the man was seen by a number of healthcare staff following an episode of acute chest pain. His blood pressure was taken a number of times, and showed slightly high readings. He was reassured and prescribed some pain relief, but no further action was deemed necessary.
20. The man was moved to B wing on 11 August. Two days later, his cellmate harmed himself. There are no details regarding this incident, save that the man was required to move cells during the night. On 18 August, he moved cells again, this time to C3 landing.
21. The letter from the RACPC clinic stated that the man had attended and been investigated for cardiac problems. He had been given an Exercise Tolerance Test (ETT) which monitors a patient's cardiac rhythms whilst they undertake exercise on a treadmill. The man was said to have had 'jumped off treadmill as he was breathless' and had not reached a point in the exercise programme where staff at the Chest Pain Clinic could measure any changes in his cardiac rhythm. The hospital concluded from this and other tests that he had no cardiac problems that warranted any treatment. This information was relayed to the man in a letter from the Head of Primary Services at Durham on 17 August. He suggested that they should continue to monitor the man's blood pressure regularly.

22. The man asked wing staff to arrange for him to see a nurse on 17 September. When the nurse arrived, he refused treatment stating that he had waited too long for their arrival.
23. On 20 September, the man was upgraded to Enhanced status on the Incentives and Earned Privileges scheme (IEP). (IEP is a system to reward good behaviour in prisons. There are three tiers – basic, standard and enhanced, with enhanced being the highest level of rewards available. Incentives can include more visits and opportunity to spend more private cash.)
24. From August until November, the man's blood pressure was monitored in response to requests from healthcare staff and the man himself. On almost all occasions, his blood pressure was raised.
25. On 6 October, the man started working in the waste management unit of the prison. The following week, on 13 October, he was sentenced to an indeterminate sentence for public protection with a minimum tariff of four and a half years to be served before any release from prison could be considered.
26. An entry in the man's wing history sheet was written on 21 October. (The history sheet is a record of important events applicable to a prisoner is kept on the wing where they are located. An entry is usually made at least weekly as a summary of an individual's behaviour during the preceding week.) The entry says 'Give credit to this inmate when he had to move location at short notice due to unfortunate circumstances'. There is no indication as to what the circumstances were or when they occurred.
27. The man completed the Challenging Offending Behaviour course on 3 November. He was sacked from his job in the waste management unit on 5 December after blaming another prisoner for the presence of a magnet on the wing. No further details of the incident are given in his wing history sheet, but the entry for two days later records that the man was eager to be in work, there were no problems with discipline and he was polite and respectful. He appears to have remained unemployed throughout December. He was given a written warning on 21 December because his newspaper was found strewn over the entrance to the wing. The man claimed that he had not thrown the paper out of the window, but had lent it to another prisoner. Despite some staff believing his version of events, the written warning stood.
28. The entries in both the man's clinical record and wing history sheet from December 2006 until August 2008 are fairly consistent throughout. In January 2008 he was assessed as suitable to hold his own medication in his possession rather than it being administered daily by healthcare staff.
29. The clinical record has numerous entries recording his blood pressure readings, most of which could be described as high. His history sheet predominantly contains entries that describe the man as a cooperative prisoner who had no problems with self harm or resettlement issues. He remained on the enhanced level of the IEP scheme. He undertook a business

course through the education department and worked in the workshops. He also participated in a relationships course and was reported to be enjoying and benefiting from the Father and Child visits scheme.

30. One entry in his history sheet is worthy of mention as it contains information regarding his medical condition. On 25 July 2008, an officer wrote that the man was keen to move to the prison (HMP Lindholme) to which he had been allocated as part of his sentence plan. The officer wrote: 'If he has heard nothing by Monday from healthcare re appointment he will sign disclaimer and get medical hold removed'. On 14 August, the man was transferred to Lindholme.
31. When the man first arrived at Lindholme he was located on K wing, but on 9 October he told staff that he was about to be assaulted by other prisoners. He was initially moved to J wing and then to HMP Wealstun on 28 November.
32. During the first reception health screen undertaken at Wealstun on the day of his arrival, the man told the nursing staff that he had hypertension, had suffered two heart attacks in 2006 and had an outstanding hospital appointment to see a cardiologist. It was also recorded that he had a history of chest pain, and was asthmatic. His medication was recorded as amitriptyline (an antidepressant), ramipril (anti-hypertensive medication) and aspirin. The clinical review establishes that the man was able to receive a full 28 day supply of all his medications in possession from January 2008 onwards until his death in January 2010. The man declared that he had used illicit drugs, which was cocaine in 2005. There was no declared mental health problem. He confirmed that he wished to see the GP and was duly referred to the GP clinic but did not attend the appointment made on 1 December.
33. Following another request by the man to see a GP, he saw a doctor on 13 January 2009. The man told him that, over the preceding fortnight, he had had two episodes of a crushing central chest pain. One episode of pain had lasted over 40 minutes. His blood pressure was taken and recorded as normal (120/80). He was prescribed atenolol (which prevents chest pain caused by ischaemic heart disease), and given a glyceryl trinitrate spray to use should he suffer an acute attack of chest pains. Blood tests were taken. The doctor referred the man as an urgent referral to the cardiology department at outside hospital. In his referral letter of 13 January, the doctor indicated that the man was taking ramipril and aspirin but did not mention that he was also prescribed amitriptyline medication.
34. On 26 January, the man reported to nursing staff that he was feeling chest pain. He was seen by a doctor and tested for troponin levels to exclude the possibility of an acute heart attack. The man's cholesterol level was also measured as total cholesterol 5.8mmol/L, HDL 0.9 mmol/L). This was regarded as high and he was prescribed simvastatin (a medication that helps to reduce cholesterol and prevent heart disease in people at high risk and those who have already had a heart attack or stroke). A blood pressure reading was taken which showed that it remained at normal (120/80). The man did not go to his GP appointment on 2 February or an appointment with

the nurse on 10 February, although he did see the GP that day. His blood pressure reading was the same as before (120/80).

35. The man was seen by a consultant cardiologist at outside hospital on 12 February. The consultant cardiologist noted there was no evidence to support the man's self declared past history of myocardial infarction (heart attack) as it was not consistent with the echocardiogram (ECG) findings. The consultant cardiologist wrote to the doctor at Wealstun proposing that the man should have a diagnostic angiogram (a test to visualise the coronary arteries supplying the heart muscles).
36. On 19 February, the man told the nursing staff that he suffered from a migraine once a month, and that morning he had awoken with a headache and dizziness. He said he was not suffering chest pains, his blood pressure was taken (130/90) and he was prescribed paracetamol.
37. The man had a coronary angiogram test at the heart centre at outside hospital on 12 March. In his report written on the same day, the consultant cardiologist said the test showed that his right coronary artery was aberrant, meaning that it was out of place. The man was noted to have "good cardiac function/LV systolic function" which meant that his left ventricle heart muscle was working well. The consultant cardiologist proposed that a more specialised test, a coronary CT angiogram, should be undertaken to provide a more detailed observation of the route of the aberrant right coronary artery. (Computed tomography [CT] is a medical imaging method which uses an imaging computer to reveal a three dimensional image of the body's interior, in this case the heart.)
38. The man went to outside hospital for the coronary CT angiogram on 27 April. The consultant cardiologist provided a report of his findings to the doctor at Wealstun, on 25 June. He confirmed the particular abnormality of the right coronary artery. The report concluded

"In summary, this gentleman [the man] does not have any significant coronary artery disease. Moreover, there is no past evidence of any heart attacks. He should continue with medical therapy and I am discharging him back to your care."
39. The consultant cardiologist also wrote to the man: "I am pleased to report that no significant narrowings were found in the coronary arteries. All this is satisfactory". He added that he would not need to see the man again.
40. There are entries in the clinical record recording that the man's blood pressure was regularly monitored whilst he was at Wealstun. Except for one occasion, his blood pressure was consistently normal (in fact below average). He was seen by medical and nursing staff on several occasions for minor conditions, when asking for his medication and to review test results.
41. On 30 July, the man told a nurse about chest pains he said he had been suffering. He said that the pains had occurred on about 12 occasions in the

previous month and he had to use his glyceryl trinitrate spray six times. He also complained of nausea and sweating whilst suffering the pain. The man said that he had been drinking Gaviscon in excess (Gaviscon is taken to treat excess acid in the stomach.) The nurse reported the concern to a doctor.

42. The doctor saw the man the next day, 31 July. She diagnosed oesophagitis (inflammation of the gullet due to stomach acid which often causes spasmodic chest pain). She prescribed an alternative to Gaviscon, namely lansoprazole, which reduces acid content in the stomach, and advised the man to continue the medication for a month. An ECG test was done as well as a blood pressure check (145/98). The doctor reassured the man about his heart, but she advised that he should continue his medication for blood pressure.
43. The clinical record indicates that between August and December 2009, the man was seen by staff approximately once a month when he asked for and collected his repeat medication. He was also seen by nursing staff in regard to toothache and minor backache. There is no record of the man complaining about his health such that he needed to see a doctor, and no indication that he complained about any further chest problems. The last occasion when he asked for his medication (a repeat prescription) was on 22 December 2009. He collected the medication on 1 January 2010.

The day of the man's death

44. On a morning in January 2010, a prison officer came on duty at 6.50am to relieve the night staff on the wing where the man's cell was located. The officer conducted a roll check. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks take place at specified times during the day and night, usually at shift handovers, and staff must sign that the roll is correct.
45. In interview with my investigator, the officer recalled that he saw the lower half of a prisoner lying on the floor of his cell and did not notice whether he was on a mattress. He was not alarmed because he knew that a number of prisoners felt more comfortable on the floor "if they've got a bad back or something like that". He continued the roll check and reported that the number of prisoners was correct.
46. Although there is no record, the weekend routine includes the cells being unlocked at 9.00am.
47. Two officers said that, at approximately 10.30am, they were spoken to by a prisoner. The prisoner was standing outside the man's cell and he asked the officers to go there immediately. On reaching the cell, they saw that the man was lying on the floor covered in a blanket. A substance, which appeared to be dried blood, had run from the left corner of his mouth. One of the officers tried to find his pulse but was unable to do so and he said that the man was cold to the touch.

48. Wealstun's Incident Log records that the officer who had conducted the roll check that morning used his radio at 10.30am to call for assistance from healthcare and Oscar 1. (Oscar 1 is the senior officer on duty who can be contacted by radio to respond to emergencies.) The two officers who had earlier been spoken to by a prisoner told the investigator that two staff from healthcare responded to the call and came to the man's cell 'within seconds' as they were already on the wing. The staff nurse examined the man but could not find a pulse. He noted that he was not breathing, was cold to the touch and that rigor mortis had set in. The two officers who had earlier been spoken to by a prisoner said that the principal officer, who was the Oscar 1 officer, arrived within two minutes of the call being made to her.
49. The staff nurse told the investigator that he radioed the Control Room asking for an ambulance to be called. The Incident Log records the time that the request was made as 10.32am, with Control Room staff calling the ambulance three minutes later at 10.35am. The Control Room asked the staff with the man whether their request was a Code Blue or Code Red. (Code Blue indicates a person has breathing /respiratory problems and Code Red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment.) The staff nurse explained that it was in order for paramedics to attend the prison to certify death.
50. The Incident Log records that the ambulance arrived at the prison at 10.52am. (The prison Death in Custody record sheet records the time of arrival as 10.42am and two paramedics entering the cell at 10.49am, but I consider the Incident Log timing to be more reliable as the log was maintained contemporaneously.) The paramedics confirmed that the man was dead and told Oscar 1 and the nurse from healthcare that they considered that he had died between four to six hours earlier.
51. The prison family liaison officer made arrangements for the man's family to be informed. He asked for assistance from staff at HMP Acklington (which is nearer to their home) and they confirmed, at 1.23pm on the day of the man's death, that two of their family liaison officers would visit the next of kin. The following day, the Governor of Wealstun wrote to several family members to express her condolences, indicating that she was able to assist with the funeral expenses. She wrote to the Acklington family liaison officers that the man's father had been impressed by their sensitive handling of his son's death and appreciated the advice and information that they gave when they visited him.
52. The post mortem report recorded the cause of the man's death as acute cardiac failure due to the anomalous origin of the right coronary (one of the important arteries supplying the heart muscle).

ISSUES

When the man was found

53. In an interview with my investigator, the officer who had conducted the roll check on the morning of the man's death confirmed that on that day he arrived at approximately 6.50am to take over from the night staff on the wing where the man was located. He told my investigator that he completed the roll check (counting the prisoners in their cells) by opening the flap of each cell door and satisfied himself that there was a person in the cell.
54. In the man's cell, the officer saw the lower half of a person on the floor and thus was able to physically count the prisoner's presence. He said that he did not notice anything untoward at that time. My investigator asked the officer whether he considered it unusual to see a prisoner lying on the floor. The officer said that he did not because some prisoners found the beds uncomfortable. (The prisoner who alerted staff and the officer who conducted the roll check that morning both told my investigator that the man was lying on his back covered in a blanket in what appeared to be a natural sleeping position.)
55. My investigator asked the officer who had conducted the roll check that morning if there was a mattress on the cell floor and he replied:

"I didn't see him on a mattress but I saw him on the floor and I saw, as far as I can remember I saw his feet and his belly. And the rule of thumb is that as long as you see somebody in there you can account for that person."
56. The investigator also asked the officer to explain the weekend morning procedure that follow the roll check. The officer explained that the cells of prisoners on cleaning duty are opened at approximately 8.40am to 8.45am. All the remaining cell doors are unlocked at 9.00am. The procedure at weekends differs from that on weekdays because breakfast is not served as a meal. Instead it is given to prisoners the previous evening for them to eat when they like.
57. The officer who had conducted the roll check that morning told my investigator that there is not necessarily any interaction between prison staff and prisoners when the roll check is carried out. Similarly, no contact is required when the cells are unlocked unless the prisoner leaves his cell and approaches a member of staff. As some prisoners sleep until lunchtime, that may be the first time they are spoken to at the weekend. The officer added "generally people don't actually go into the cells and wake them [prisoners] up". He confirmed that this was normal custom and practice on the wing where the man was located.
58. The man was discovered lying on the floor in his cell by a fellow prisoner who alerted prison staff to his concern. The fellow prisoner told my investigator that he raised the alarm somewhere between 10.20 am and 10.45 am. (This

has subsequently been noted as close to 10.30 am.) There is little doubt that, in this particular case, had the man been discovered at 7.00am when the roll was checked or 9.00am when cells were unlocked, there would have been no difference to the outcome. The paramedics who attended at 10.52am judged that the man had died between four and six hours earlier which was before both the check and the unlock.

59. However, I consider it unfortunate that it was a prisoner, rather than a member of staff, who found the man and that the discovery was not made until approximately an hour and a half after the cell was unlocked.
60. In a number of previous investigations I have reported on significant delays between cells being unlocked and the discovery that a prisoner has died. I believe that clearer or renewed guidance is required about the actions to be taken by prison officers when unlocking cells, particularly at morning unlock. In a previous report I quoted from the Prison Officer Entry Level Training (POELT) manual, which states:
- “Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”

61. In view of the apparent delay before the man was found I recommend:

The Governor should review the guidance to staff at Wealstun on unlocking arrangements to ensure that the well-being of prisoners is adequately addressed.

Starting treatment for raised blood pressure

63. The clinical reviewer raised a number of concerns, together with recommendations, in his report that I address below. He is of the opinion that some medical practitioners would have started treatment for the man's high blood pressure at an earlier point.
64. Two prison doctors at Durham had considered the possibility of starting treatment at an earlier stage, but for different reasons had concerns. One of them set out his reservations in a letter to the man of 21 December 2005. He said, "You are only a young man and once you start on blood pressure treatment it is a lifetime commitment." At that time, the doctor proposed more basic tests which he would discuss with the man.
65. In a letter of 15 February 2006 addressed to his GP in the community (in the expectation of the man's imminent release), the Head of Primary Care Services at HMP Durham said;

"I have held off putting him [the man]] on any medication partly because of the fluctuation in the levels of his blood pressure and partly because a beta-blocker, which I would have thought fairly appropriate, is contraindicated as he has asthma."

He went on to say that he was uncertain whether the man's blood pressure should be treated or not.

66. The clinical reviewer concludes that the investigations conducted by the medical staff at Durham, which included referral to hospital for a 24 hour blood pressure reading, appear to have been appropriate and sensible. He acknowledges that the time the man spent outside prison on bail (March 2006 to July 2006) interrupted the continuity of care provided by Durham.
67. In early 2007, the man was diagnosed with borderline persistent hypertension and mildly raised diastolic blood pressure. In March 2007, he was prescribed Bendrofluazide (water tablet) and the following month in addition ramipril (an anti-hypertensive medication). Bendrofluazide was subsequently omitted from his prescription. The clinical reviewer finds that:

"... by the middle of 2007 more acceptable readings were being seen on treatment. The care given for this particular problem thereafter is good and I have no particular further comments regarding the control of his blood pressure in the prison setting."

Investigation of chest pain

68. The man complained intermittently of experiencing pains in his chest. He was referred to cardiologists on a number of occasions by doctors in Durham, Lindholme and Wealstun. The investigations led to the discovery of the anomalous origin of his right coronary artery. The clinical reviewer reports that his research led him to conclude that an anomalous origin of the coronary artery can lead to, amongst other things, sudden death. He adds:

"... there does not appear to be a beneficial or specific treatment [for this problem], and although coronary artery resiting or grafting has been tried, it was not considered or offered in the case of [the man]."

The clinical reviewer also observes that no explanation was given by the cardiologists as to the cause of the chest pains. On the last occasion when the man was seen by a cardiologist, no further treatment was suggested and he was discharged back to the care of Wealstun.

69. The clinical reviewer concludes that the man's chest pains were fully investigated from a cardiological point of view. He finds the care provided by Wealstun:

“was good and particularly thorough in commencing new medication, performing useful investigations and making an urgent referral to cardiologists”.

Prescription of amitriptyline

70. With regard to the man being prescribed amitriptyline to treat depression, the clinical reviewer says in the Commentary Section of his clinical review

“There appears to have been scant attention paid to his [the man’s] regular prescription for amitriptyline other than just to dispense it to him. ... there appears to be no medication review for this particular drug [amitriptyline] and no indication of why it was being prescribed on a regular basis. If the medical officers and healthcare staff believed it was being prescribed for chronic depression then there should have been at least some sort of formal depression review in the 13 months of custody at Wealstun.”

71. The clinical record says that the man was prescribed amitriptyline to treat depression (initially also insomnia), and he was being monitored as a result. The clinical reviewer has, however, been unable to find any record either of a diagnosis of a depressive illness, or an assessment of the effectiveness of the drug. He is not convinced that the man had any significant depressive illness and considers that the medication may have been prescribed instead of sleeping tablets (as a substitute for the sleeping tablet, zopiclone, which had been prescribed to the man in July and August 2006). The clinical reviewer regards the use of amitriptyline for this purpose as 'poor practice'.

72. I endorse the following three recommendations made by the clinical reviewer.

The Heads of Healthcare at HMP Durham, HMP Lindholme and HMP Wealstun should ensure that the standard guidelines for the treatment of depression are used such that assessment, treatment and review are clearly followed and documented in the medical records.

Medication reviews should be undertaken within three months of transfer, and then on at least a six monthly basis for all regularly prescribed medications.

Indications for starting regular treatment and its continuation (at medication reviews) should be clearly documented.

In Possession medication

73. I share the clinical reviewer’s surprise:

“that the decision to allow in possession medications [amitriptyline] was not formally reviewed and especially in view of the possible diagnosis of depression”.

He acknowledges that there was appropriate discussion and assessment when it was initially agreed, in January 2008, that the man could keep his medications in possession. However, he has been unable to find a record of any review after the initial decision was made in January 2008.

74. The absence of another risk assessment is especially important in the light of the amount of medication found in the man's cell after he died. Significant amounts appear to be missing. The clinical reviewer estimates that there should have been at least 28 days supply of amitriptyline tablets left in the man's cell whereas none were found. On 22 December 2009, the man made a request for medication and the following day a repeat prescription was completed for 28 amitriptyline tablets each of 50mg and 25mg, one each to be taken daily and 28 aspirin, one daily. The man collected the medication on 1 January 2010. There was an empty packet of amitriptyline 50mg tablets found in the cell and, though not explicitly stated, the implication is that no packet of 25mg amitriptyline tablets was found. As well, several months supply of atenolol was discovered, even though this ceased to be prescribed to the man by July 2009. The absence of some tablets and the presence of others may indicate that the man did not follow the instructions for his medication.
75. The clinical reviewer finds that the absence of any amitriptyline tablets in the man's cell is an unresolved issue.
76. A serious untoward incident report, required by the Primary Care Trust in circumstances such as this, was written soon after the man's death. It refers to "all outstanding medication has been recovered from the patient's cell and accounted for". In view of the discrepancy between the clinical reviewer's comments in the clinical review and the extract from the serious untoward incident report quoted above, the investigator asked Wealstun further questions in November 2010. He was told that there is no list of the medication removed from the man's cell which would support the assertion in the serious untoward incident report that all medication had been accounted for.
77. Nevertheless, in the light of all these circumstances, I endorse the recommendation made by the clinical reviewer:

The Heads of Healthcare at HMP Durham, HMP Lindholme and HMP Wealstun should ensure that reviews of 'in possession' medication are undertaken at appropriate intervals and risk reassessed at these times.

Prison record keeping

78. As noted earlier, a clinical review was conducted by a clinical reviewer on behalf of the Leeds Primary Care Trust. He reviewed the medical records for the man from his reception into Durham on 21 July 2005 until the date of his death in Wealstun in January 2010. The clinical reviewer finds that the documents relating to the reception screening at HMP Holme House (where the man had been transferred for a short time) were incompletely copied. The

record made available to him does, however, clearly show that neither the man nor healthcare staff at Holme House had any particular concerns about his health.

79. The clinical reviewer finds that most records for the period between July 2006 and July 2008 when the man was at Durham were complete and relatively comprehensive. However, the first reception screening documents (relating to July 2006 when the man returned there after a period on bail) were incompletely copied. Some of the records were made in both handwritten and computerised form by the same medical practitioner on the same day, which the clinical reviewer considers is unnecessarily confusing and “not good practice”.

Toxicology Report

80. A toxicology report concludes that "both paracetamol and codeine concentrations were higher than expected within the therapeutic range" and the amitriptyline concentration found in the blood samples taken at post mortem examination “may have represented high therapeutic range use”.
81. Codeine had not been prescribed to the man and paracetamol was last prescribed on 4 October 2009, for toothache. The clinical reviewer states that interpretation of the data provided in the toxicology report on the levels of amitriptyline found in the man at post mortem is beyond his expertise. The potentially high levels of prescribed and non prescribed drugs found in the man’s blood at post mortem remain an unresolved issue.

CONCLUSION

82. The man had the potential for serious cardiac problems because of his family history of heart disease, the undiagnosed anomalous origin of his right coronary artery and his high blood pressure.
83. Although he had a long history of complaining of chest pain, which was thoroughly investigated by various specialists, he had not complained of any health issues requiring review by doctors in the five months prior to his death, and the clinical reviewer says “there was no indication at all that a sudden cardiac related death was imminent”.
84. The clinical reviewer concludes:

“[The man] probably died of natural causes” having suffered a sudden and major arrhythmia (an interruption of the normal heart rate) of such severity that this led to a massive and catastrophic loss of normal cardiac output due to acute cardiac failure. Death would have been very sudden.”
85. Two issues remain unresolved. The first is the discrepancy between the medication that should have been still remaining in the man’s possession, but was not found in his cell. The second is the information in the toxicology report that after the man’s death both potentially high levels of amitriptyline, which had been prescribed, and codeine, which had not been prescribed, were found in his body.
86. Finally, I am concerned that the man apparently lay dead in his cell when the roll was checked and later when the door was unlocked. The staff carrying out these duties are not required to communicate with prisoners and neither officer noticed anything untoward. By 10.30am, when the man was found by a fellow prisoner, the paramedics estimated he had already been dead for between four to six hours. I appreciate that it was the weekend, when some prisoners like to lie in, but nevertheless I recommend that the Governor reviews the unlocking arrangements to make sure that these circumstances are not repeated.

RECOMMENDATIONS

The following recommendations were made in the draft version of the report. The service's response is included in italics following each recommendation.

To the Governor of Wealstun

1. The Governor of Wealstun should review the guidance to staff on unlocking arrangements to ensure that the well-being of prisoners is adequately addressed.

Service response: Recommendation accepted. A notice was sent to all staff, reminding them that they must get a response from each prisoner at roll check.

To the Heads of Healthcare at Durham, Lindholme and Wealstun

2. The Heads of Healthcare at HMP Durham, HMP Lindholme and HMP Wealstun should ensure that
 - the standard guidelines for the treatment of depression are used such that assessment, treatment and review are clearly followed and documented in the medical records.
 - medication reviews should be undertaken within three months of transfer, and then on at least a six monthly basis for all regularly prescribed medications.
 - indications for starting regular treatment and its continuation (at medication reviews) should be clearly documented.

Service response: Recommendations accepted. The Governors of all three prisons have confirmed that policies and national guidelines are in place to cover all aspects of the above recommendations and all staff have been reminded.

3. The Heads of Healthcare at HMP Durham, HMP Lindholme and HMP Wealstun should ensure that reviews of 'in possession' medication are undertaken at appropriate intervals and risk reassessed at these times.

HMP Durham Safer Custody Team Lead sent a response in regard to the above recommendation that he had confirmed with the Head of healthcare that policies and national guidelines were in place.