

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Anthony Heath a prisoner at HMP Dartmoor on 16 December 2017

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Heath died of a heart attack caused by a blood clot in his heart muscle and blocked arteries while a prisoner at HMP Dartmoor on 16 December 2017. He was 62 years old. I offer my condolences to his family and friends.

I am not satisfied that the healthcare that Mr Heath received at Dartmoor was equivalent to that which he could have expected to receive in the community. His declining heart condition was not recognised or managed in line with NHS guidelines, and opportunities were missed for a follow-up GP appointment.

I am concerned that news of Mr Heath's death was on social media before prison staff had contacted his family, and very troubled that there is no evidence that the prison made any attempt to contact his next of kin after his death. This is unacceptable.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**October 2018**

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# Summary

## Events

1. On 1 July 2014, Mr Anthony Heath was sentenced to eight years in prison and sent to HMP Parc. On 20 January 2015, he was transferred to HMP Dartmoor.
2. Mr Heath had a history of complex medical conditions, which included heart disease, lung disease (COPD), gastro-oesophageal reflux (chest pain due to acid leaking from the stomach), asthma and raised cholesterol levels for which he took medication. He was a smoker and was obese.
3. Healthcare staff saw him frequently to prescribe medication and monitor some of his conditions.
4. On 6 December 2017, Mr Heath complained to a nurse that he had chest pains. She completed an electrocardiogram (ECG) but noted nothing significant. She arranged for him to see a GP the next day and told him to rest in his cell.
5. When the prison GP saw Mr Heath the next day, he said the ECG result was in line with Mr Heath's known heart condition and he did not arrange a follow-up appointment.
6. On 16 December 2017, a prison officer found Mr Heath unresponsive in his cell. He immediately radioed for assistance and began cardiopulmonary resuscitation (CPR). Nurses, paramedics and an air ambulance doctor attended but, despite resuscitation attempts, Mr Heath died at 2.45pm.
7. There is no record that Dartmoor appointed a prison family liaison officer when Mr Heath died, completed a log or tried to contact his next of kin. On 30 December, Mr Heath's eldest daughter contacted the prison. She said that she had heard of Mr Heath's death through social media.

## Findings

8. The clinical reviewer found that healthcare staff missed opportunities to monitor Mr Heath's heart condition. We agree with the clinical reviewer that Mr Heath's care was not equivalent to the care that he could have expected to receive in the community.
9. The clinical reviewer said that the acute management of Mr Heath's chest pain on 6 December and the follow-up GP appointment were missed opportunities to review Mr Heath's ischaemic heart disease (IHD) management.
10. Dartmoor should have notified Mr Heath's next of kin that he had died, in line with Prison Service instructions.

## Recommendations

- The Head of Healthcare should ensure that clinical staff assess and manage prisoners with a deteriorating chronic condition effectively to enable good standards of care, including that:

- all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care;
  - clinical staff use appropriate assessment and monitoring processes, particularly to monitor cholesterol levels in line with NICE guidelines; and
  - clinical staff have up to date training in how to review patients with chronic diseases (particularly heart disease) and are aware when to escalate and when to organise further investigations.
- The Governor should ensure that:
    - a prisoner's next of kin is informed of their death, in line with national guidance; and
    - staff maintain an accurate and contemporaneous family liaison log so that there is an effective record of events, issues, concerns and action taken.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Dartmoor informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
12. The investigator obtained copies of relevant extracts from Mr Heath's prison and medical records.
13. The investigator interviewed one prisoner by telephone on 1 February 2018.
14. NHS England commissioned a clinical reviewer to review Mr Heath's clinical care at the prison.
15. We informed HM Coroner for Plymouth, Torbay & South Devon of the investigation, who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. We suspended this investigation from 2 March until 16 May 2018 while waiting for the post-mortem results. We began our investigation again when we received a copy of the post-mortem report.
17. The investigator contacted Mr Heath's daughter to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She had a number of concerns, including wanting to know:
  - what happened on 6 December when Mr Heath complained of chest pain;
  - what happened on 7 December when a prison GP saw him;
  - what happened after Mr Heath had an ECG;
  - what happened when Mr Heath was signed off work for four days;
  - how his care was managed; and
  - what happened when he was found in his cell?
18. Mr Heath's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Dartmoor

20. HMP Dartmoor holds up to 640 adult male prisoners. It has six residential wings. Healthcare services are provided by Care UK and mental healthcare is provided by Devon Partnership Trust.

### HM Inspectorate of Prisons

21. The last inspection at HMP Dartmoor was in August 2017. Inspectors reported that while the availability of primary care assessment was reasonable, it had been affected by staff shortages. It noted that nurses' clinics were often interrupted or cancelled, with nurses having to cover alternative tasks.
22. Inspectors also noted that the standard of monitoring of some patients with long-term conditions had deteriorated since their previous inspection and found cases in which diagnostic tests had not been ordered.
23. However, as in their previous inspection, they noted that there was particularly good support for older prisoners and those with disabilities.

### Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who helped to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 2016, the IMB reported that relationships between staff and prisoners were good, even though staff often worked under extremely difficult and challenging circumstances.

### Previous deaths at HMP Dartmoor

25. Mr Heath was the twelfth prisoner to die at Dartmoor since January 2015, the eighth from natural causes. There were no significant similarities between Mr Heath's death and previous deaths.

## Key Events

26. On 1 July 2014, Mr Anthony Heath was sentenced to eight years in prison for sexual offences and sent to HMP Parc. On 20 January 2015, he was transferred to HMP Dartmoor.
27. During his initial health screen, Mr Heath said that he had heart disease, chronic obstructive pulmonary disease (COPD, a lung disease), gastro-oesophageal reflux (chest pain due to acid leaking from the stomach), asthma and raised cholesterol levels for which he took medication. He was a smoker and was obese.
28. A senior nurse made an appointment for Mr Heath to see a prison GP. A prison GP prescribed medication for his conditions and noted that Mr Heath needed frequent blood pressure checks and checks on his cholesterol levels.
29. To help control his symptoms, Mr Heath frequently saw healthcare staff at both prisons as they checked his blood pressure and occasionally checked his cholesterol levels. Healthcare staff frequently issued glyceryl trinitrate (GTN) sprays to ease his chest pain and offered smoking cessation advice. Prison GPs issued repeat prescriptions for his medications and intermittent prescriptions for the GTN spray. The clinical reviewer noted that over a two-year period, Mr Heath requested GTN sprays six times a year on average.

### December 2017

30. On 6 December, Mr Heath was working in the recycling centre when he complained of chest pains. A nurse attended and noted that Mr Heath was pale and clammy. She checked his observations and how he used his GTN spray. She noted that the first spray was effective but when repeated, was ineffective. She completed an electrocardiogram (ECG), which did not indicate anything of significance. She told him to rest in his cell. She told staff that if he had further chest pains, they should call an ambulance. She booked a GP review for the next day.
31. A prison GP saw Mr Heath the next day. Mr Heath said he still had chest pain which eased when he used the GTN spray. The GP checked his observations and reviewed the ECG results. He noted that there were abnormalities which had been identified in 2015. He diagnosed “atypical chest pain” which he said was unlikely to be angina. He said that Mr Heath should rest for four days and prescribed him paracetamol.

### Events of 16 December 2017

32. Mr Heath was in a single cell. He was last seen at lunchtime when he collected his meal and asked an officer to unlock his cell door at 1.30pm so that he could go to work. After lunch at approximately 1.35pm, the officer went to Mr Heath’s cell to unlock his cell door. He said that when he opened the door, he saw Mr Heath lying on his bed, facing the television. He called out to him but there was no response. He immediately radioed an emergency code blue (which indicates that a prisoner is unconscious, not breathing or having breathing difficulties). The control room called an ambulance immediately. The officer went into the cell

with a colleague, shook Mr Heath's leg and called his name. Mr Heath was unresponsive, so he checked his pulse and for breathing. Both officers started CPR.

33. A senior nurse heard the emergency radio call and attended immediately. She noted that although Mr Heath was not breathing and was unresponsive, CPR was ongoing. He was cool but not cold to the touch. Paramedics attended and continued with resuscitation efforts.
34. Records show that the ambulance was called at 1.36pm and arrived at the prison at 1.58pm. An air ambulance also attended and continued emergency treatment. At 2.45pm, the air ambulance doctor declared that Mr Heath had died.

### **Contact with Mr Heath's family**

35. Mr Heath had listed his wife as his next of kin. There is no record that Dartmoor appointed a prison family liaison officer when he died, completed a log or tried to contact his next of kin. Staff recalled that the police had tried to contact the next of kin but they could not supply any further information.
36. On 30 December, Mr Heath's eldest daughter contacted the prison. She said that she had heard of Mr Heath's death through social media and would be his next of kin.
37. A prison chaplain said that on 30 December, the Deputy Governor asked him to visit Mr Heath's cell to check for any family contact information, as the police were unable to contact his next of kin. (There are no records of who asked the police to contact the family.) He said that no details were found in the cell.
38. On 2 January 2018, the chaplain rang Mr Heath's daughter to offer condolences and support. Mr Heath's daughter arranged the funeral, which was held on 17 January. In line with national policy, the prison contributed towards the cost.

### **Support for prisoners and staff**

39. After Mr Heath's death, the Head of Offender Management and the duty manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Heath's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Heath's death.

### **Post-mortem report**

41. The post-mortem report established that Mr Heath died from myocardial infarction (a heart attack) caused by coronary artery thrombosis (a blood clot in the heart muscle) and coronary artery atherosclerosis (the build-up of fatty material in the artery).
42. The report also noted that the pathologist found that Mr Heath's heart had an area of infarction (tissue death due to a lack of blood supply) which was "no more than a few days old" surrounded by tissue that had changes indicative of

previous infarction which, in the pathologist's opinion, had occurred "several weeks" earlier. There was also evidence of severe ischaemic heart disease, with critical narrowing in two of the three main coronary arteries. There was a clot in one coronary artery which was responsible for the infarction.

# Findings

## Clinical review

43. The clinical reviewer said the clinical care that Mr Heath received in prison was not equivalent to that which he would have expected to be provided in the community by an NHS practice.
44. The clinical reviewer said that Mr Heath was using significant amounts of GTN spray, but no-one investigated why.
45. On 6 December, Mr Heath had two episodes of chest pain. He said the nurse did not record the duration of the episodes. The clinical reviewer said that Mr Heath's chest pain lasted at least 20 minutes, did not respond to the GTN spray and therefore should have been regarded as likely to be a heart attack.
46. The clinical reviewer said that after Mr Heath's ECG, a prison GP did not review him until the next day. He also noted that there was no follow-up appointment, changes to his medication or review of his GTN spray. He said that Mr Heath had poorly controlled ischaemic heart disease as he needed to use GTN spray regularly.
47. Mr Heath had a long history of heart disease. Healthcare staff had prescribed medication and reviewed his other medical conditions. The clinical reviewer said that in line with National Institute for Health and Care Excellence (NICE) guidelines, there should have been a target-based approach to reduce Mr Heath's cholesterol levels. There is no evidence that this happened. We therefore recommend that:

**The Head of Healthcare should ensure that clinical staff assess and manage prisoners with a deteriorating chronic condition effectively to enable good standards of care, including that:**

- **all treatment and care is fully documented in prisoners' medical records to allow effective continuity of care;**
- **clinical staff use appropriate assessment and monitoring processes, in particular to monitor cholesterol levels in accordance with NICE guidelines; and**
- **clinical staff have up to date training in how to review patients with chronic diseases (particularly heart disease) and are aware of the triggers for escalation and when to organise further investigations.**

## Family liaison and record keeping

48. Prison Rule 22 requires the Governor to inform families as soon as a prisoner dies. Prison Service Instruction (PSI) 64/2011 requires that wherever possible, a family liaison officer and another member of staff visit the next of kin or nominated person to break the news of a death in a timely manner so that the family do not find out about the death from another source. If the next of kin lives a long distance away, the prison should consider whether to ask a family liaison officer from the nearest prison to break the news.

49. Mr Heath had listed his wife as his next of kin. Dartmoor did not appoint a FLO or complete a FLO log, and there is no evidence that prison staff tried to contact her. There is no record of when and why the police were contacted. Dartmoor should have sent a prison officer that day to break the news to Mr Heath's wife or considered using a family liaison officer from a nearer prison to save travel time.
50. Mr Heath's daughter heard of her father's death through social media and rang the prison on 30 December. It is disappointing that there is no evidence that anyone returned her call until the next day when the prison chaplain rang her. We make the following recommendations:

**The Governor should ensure that:**

- **a prisoner's next of kin is informed of their death, in line with national guidance; and**
- **staff maintain an accurate and contemporaneous family liaison log so that there is an effective record of events, issues, concerns and action taken.**



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