

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Swaleside in June 2009**

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

**June 2010**

This is the report of an investigation into the death of a man at HMP Swaleside on 3 June 2009. He died after being found collapsed on the floor of his cell. A post mortem examination concluded that he had died as a result of ischaemic heart disease.

I would like to extend my condolences to the man's family and all those who knew him on their loss. I apologise that my investigation has taken some time to complete and for any additional distress this may have caused.

The investigation was led by an Investigator from my office. We are grateful to the Governor of Swaleside and his staff for their assistance and cooperation. A clinical review of the man's care was commissioned from Eastern and Coastal Kent PCT, and I am grateful for the Clinical Reviewers timely review.

The man came into prison already having had a heart attack, for which he had received extensive hospital treatment. Although he told healthcare staff about the heart attack, it seems that the information was not followed up. However, his blood pressure was monitored regularly from 2006 and, in 2008, medication was prescribed. Unfortunately, this medication caused side effects which meant that the man only took it in small quantities.

A fellow prisoner found the man in his cell. Although an officer attended immediately, he did not have a radio and had to shout for assistance. This meant that the alarm bell was pressed instead of an emergency call being put over the radio. As a result the emergency equipment did not arrive as soon as it could have done. However, it is unlikely that this would have meant that the man would have survived this heart attack. Nevertheless, like the clinical reviewer, I do not believe that the care the man received at Swaleside was equivalent to what would have been expected in the community.

I make three recommendations. One concerns the treatment of prisoners who have already suffered a heart attack, and the others concern the provision and use of radios at Swaleside.

**Jane Webb**  
**Acting Prison and Probation Ombudsman**  
**March 2010**

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## SUMMARY

The man was remanded in custody in 2003 after being charged with the murder of his estranged wife. He suffered a heart attack in 2000, and underwent heart surgery. He was given medication, but stopped taking it as he suffered from side effects.

After being remanded, he was taken to HMP Wormwood Scrubs. During a health screening, he explained that he had previously had a heart attack. Although it was noted in his medical notes that his local hospital should be contacted to substantiate his history, this was never done.

The man was convicted in January 2004. Shortly afterwards, he transferred to HMP Belmarsh and subsequently, in 2005, to HMP Swaleside. Again, his medical history was noted on reception, but no further action was taken.

From 2006, he regularly attended a blood pressure clinic, and his blood pressure was found to be within normal limits. On 2 October 2008, he saw a smoking cessation advisor and was also prescribed aspirin to thin the blood. However, his blood pressure was raised the next month and he was prescribed bendroflumethiazide, a diuretic which helps to lower the blood pressure.

The man next saw a doctor on 12 March 2009, when he reported that his gums were bleeding and he had stopped taking his medication. His blood pressure at this time was normal. The man started taking the medication again, but at a reduced level.

On 3 June 2009, the man collapsed in his cell and was found by a fellow prisoner collapsed on the floor. Staff attended quickly, but attempts to resuscitate him were unsuccessful and he was pronounced dead at the scene by paramedics.

I concur with the clinical reviewer that the standard of care the man received at Swaleside fell short of what he would have expected in the community. I make three recommendations as a result of this investigation. The first concerns the treatment of prisoners who have previously had a heart attack. The other two concern the provision of radios and the use of emergency codes at Swaleside.

## **THE INVESTIGATION PROCESS**

1. After the Ombudsman's office was notified of the man's death, Investigator A was appointed to conduct the investigation. Notices were issued to staff and prisoners at Swaleside informing them of the investigation and providing contact details should they wish to provide any information. In the event, no other witnesses came forward.
2. The Eastern and Coastal Kent Primary Care Trust were commissioned to provide a clinical review of the man's medical care while he was at Swaleside.
3. Investigator A contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to him to assist his enquiries into the man's death.
4. One of the Ombudsman's Family Liaison officers, contacted the man's family to give them the opportunity to contribute to the investigation and raise any concerns they may have had.
5. Investigator A visited Swaleside and interviewed 12 members of staff. She also spoke informally to a prisoner who knew the man.

## **HMP SWALESIDE**

6. Swaleside is one of three prisons on the Isle of Sheppey which make up the Sheppey Cluster. The other prisons are HMP Elmley and HMP Standford Hill. Swaleside is a Category B training prison, housing prisoners serving four years or more or having at least 18 months left to serve on their sentence. It has an operational capacity of 954.
7. Healthcare has been provided by the Eastern and Coastal Kent Primary Care Trust since 2004. The prison also provides opportunities for work and education, and a number of offending behaviour courses designed for prisoners to progress to resettlement.
8. Swaleside has a high proportion of foreign national prisoners (meaning prisoners who are not nationals of the United Kingdom). In 2009, the prison had a population of between 30 and 40 per cent of foreign national prisoners, compared to the national prison population figure of 14 per cent.

### **Performance rating**

9. Prisons in England and Wales are assessed for performance by the National Offender Management Service (NOMS). For public prisons, NOMS use a combination of the Prison Performance Assessment Tool (PPAT, which looks at 33 indicators) and the public prison weighted scorecard (which looks at a set of 44 indicators). Each establishment is then given a rating between one and four (one being “serious concerns” and four “exceptional performance”). Swaleside is measured as part of the Sheppey Cluster of prisons, with Elmley and Standford Hill. For the last four quarters, the Sheppey Cluster has been given a rating of three, or “good performance”.

### **Her Majesty’s Inspectorate of Prisons**

10. Each prison in England and Wales is subject to inspection by the HM Chief Inspector of Prisons. The last inspection of Swaleside was an announced inspection conducted in March and April 2008. The Chief Inspector, in her foreword to the inspection report, found “... Swaleside to be a safe and respectful prison, which was impressive given the many serious offenders held”.
11. The inspection team also looked at the provision of healthcare at Swaleside. The following judgement was made:

“Health services offered prisoners access to a broad range of clinical specialisms in the prison and through external NHS sources. The management of long-term illnesses was good, as was the GP service. ... Despite the positive aspects, prisoners were extremely dissatisfied with perceived poor attitudes by healthcare staff, who they claimed denied them access to some services.”

12. Foreign national prisoners told the inspection team that they felt supported by staff who understood their position. 91 per cent of foreign national prisoners who responded to a survey said that they were treated with respect. The inspection team also found that the prison library was well resourced, with prisoners having good access to legal material.

### **Independent Monitoring Board (IMB) report**

13. Every prison is monitored by an Independent Monitoring Board, members of which are drawn from the local community. They have full access to prisoners and every part of the establishment, and produce an annual report for the Secretary of State for Justice. In their last published report, covering the period from May 2008 to April 2009, the IMB described the prison as “a well run prison ... staff and prisoner relationships are excellent and the personal officer scheme is effective”. Healthcare had improved following refurbishment of accommodation, and the introduction of a consultative committee with representatives from each wing.

### **Previous PPO investigations at Swaleside**

14. This is the 14th death at Swaleside since the Ombudsman took responsibility for investigating deaths in custody in 2004. Of these, nine have been the result of natural causes. As a result of one of these investigations cases, a recommendation was made which is of relevance to this report. This said:

“The prominent identification of individuals in custody at high risk of medical problems must be urgently implemented, and appropriate Care Plans prepared.”

Since the man’s death, there have been a further two deaths, both of which were as a result of natural causes.

## KEY FINDINGS

15. The man was sentenced to life imprisonment at a local Criminal Court for the murder of his wife. He was ordered to serve a minimum of 14 years. He had previously been remanded in custody for this offence to HMP Wormwood Scrubs on 27 January 2003. During the reception process, he was seen by a member of healthcare staff (it is not clear from the notes who he met). He said that he had an angioplasty (a procedure in which the coronary artery is repaired) after suffering a heart attack in 2000. Although he was prescribed medication, he had stopped taking it because of the side effects. It was recorded that he showed no signs of any mental health problems.
16. After a visit to the triage clinic on 10 February as he had fallen off a chair, the man next attended healthcare on 21 October as he was concerned about his blood pressure. It was checked and found to be 129/82 (which the clinical reviewer describes as being “within the normal range”). A plan was drawn up to write to the Hospital where the angioplasty was performed in 2000 and ask for further details, but there is no evidence that this was ever done.
17. Following his conviction, the man transferred to HMP Belmarsh on 29 March 2004. He was seen again in reception, and it was noted in his medical record that he had “some history”. He was referred to the wing surgery. He chose, however, not to wait for the doctor and instead signed a disclaimer saying he did not need medication and knew how to make an appointment to see a doctor if he needed to.
18. On 15 April, he attended healthcare as he felt something “hitting” on his chest and he had a pain in his shoulder. There was no chest pain, and he did not become breathless on exertion. He was examined, and the doctor recorded that he was “clinically ok”. The doctor also recommended that an electrocardiogram (ECG) be conducted, that is a procedure which monitors the electrical activity of the heart, but there is no record to show whether it took place.
19. The following year, on 4 March, the man transferred to HMP Swaleside. A reception health screen was conducted by the senior medical officer. He recorded the man’s medical history, including the heart attack, and stated that he was fit for work and exercise. He did not take any observations or blood pressure readings.
20. In July 2005, the man attended his appeal against his conviction. During this time, he was held at HMP Pentonville for two days. After his appeal was dismissed on 28 July, he returned to Swaleside where he declined to see the doctor on arrival in reception.
21. During the summer of 2005, he experienced further pain in his shoulder. He was offered physiotherapy, but did not attend his appointments. He was, however, prescribed diclofenac, an anti-inflammatory drug.

22. On 13 April 2006, the man went to a blood pressure clinic (he had missed an earlier appointment on 23 March). He said that he was a smoker, and nicotine replacement was offered to help him stop. Although he did not exercise, the man said that he tried to eat healthily given the dietary constraints of the prison catering. His blood pressure was recorded as 126/82, again within normal levels.
23. The man next attended healthcare on 4 August. He complained that he was suffering from vitiligo, a loss of pigment in his skin, although was otherwise physically well. Blood tests were taken, which showed a raised level of haemoglobin (which the clinical reviewer suggests “could indicate a thickening of the blood and is often related to smoking”), a normal thyroid function and slightly raised level of glucose.
24. Over the next 18 months, he attended the blood pressure clinic on four occasions. Each time, his blood pressure was recorded as within normal limits. The only other entry in his medical record was for an appointment on 16 October 2007, when he complained of toothache. He was given an antibiotic (amoxicillin) and a pain killer (co-codamol).
25. In the meantime, in June 2007, the man complained that he was being restricted in the telephone numbers he was allowed to call. In his response, the Deputy Head of Offender Management, said that the decision had been made because of public protection issues resulting from a former offence. The man rejected this response, taking the case to a judicial review at the end of 2008 (this was outstanding at the time of his death).
26. The man applied for enhanced status under the Incentives and Earned Privileges scheme (IEPS) on 14 November 2007. The application was granted, with the assessor noting his continued good behaviour and attitude towards staff.
27. On 22 July 2008, he attended healthcare as he was suffering from insomnia and palpitations during the night. An ECG was taken, although no results were recorded. His blood pressure remained within normal limits.
28. After being referred to a smoking cessation advisor on 13 August, the man was seen in the healthcare clinic again on 2 October. He was concerned that he still needed follow up care after the angioplasty, and asked whether he needed an ECG. Observations were taken, and were found to be normal. He was referred again to the smoking cessation advisor. The next day, he saw a prison doctor, who prescribed aspirin to thin his blood.
29. The man went to healthcare on 17 October, and was diagnosed with pharyngitis (a sore throat). He was prescribed antibiotics for a week.
30. Further blood pressure readings were taken on 28 November and 16 December. On these occasions, his blood pressure was found to be raised. On the second occasion, the man was prescribed bendroflumethiazide (a

thiazide diuretic used to treat high blood pressure). His blood pressure was taken again on 21 December and 28 December and was found to be normal.

31. On 13 December, the man was notified by the UK Borders Agency that he was liable to deportation as a result of his offence. He was asked to complete a form detailing his immigration history, which he did.
32. The man next attended healthcare on 12 March 2009, when he saw Doctor A, he said that he had stopped taking his medication as it was making his gums bleed. His blood pressure was taken and remained normal, although a cholesterol reading was also taken and was just above the normal range. A further blood test was taken and he was found to have a slightly high level of creatinine (a higher level of creatinine can be a sign of deterioration of kidney function). He discussed the result with Doctor A on 16 April as he was concerned about it. Doctor A said that a repeat test had been ordered and, if the creatinine level continued to rise, the underlying issue would be addressed. There is no evidence that the test was carried out.
33. An IEPs review was held on 9 May. As the man was not complying with his sentence plan, he was warned the following day by Principal Officer A that he would be downgraded to standard if he did not comply in the future. On 15 May, the man was interviewed by a prison psychologist to complete part of the sex offender treatment plan. He said that he was appealing against his conviction and did not want to participate in the programme.
34. On 29 May, the man went to healthcare again and demanded to see the doctor about his blood pressure. He said that he had just taken his final bendroflumethiazide tablet and needed some more. A Nurse took the man's blood pressure, which he found to be raised, and advised him to see the doctor the following week. He also reminded the man that it was his responsibility to reorder his medication. The man was given a fresh supply of medication on 1 June.
35. The same day, an OASYS (an offender assessment system) board was convened. It examined the man's cooperation with his sentence plan and found that he was still failing to engage with staff. As a result, and in line with Principal Officer A's warning on 10 May, the man's IEP status was changed to standard.

### **Events of 3 June**

36. During the day, the man spoke with a friend and fellow prisoner. (Prisoner A) Prisoner A recalled that the man had complained some days earlier about not feeling right, and that he had gone to visit healthcare. Prisoner A did not think, however, that the man looked unwell. They spoke shortly before they were locked in their cells for dinner, and Prisoner A agreed that he would visit the man later so that he could use his typewriter.
37. Shortly after being unlocked from his cell at around 6.10pm, Prisoner A went to the man's cell. He saw him lying face down on the floor and, as he often

practised yoga, thought he was playing a joke. He asked the man to get up but soon realised that he was not getting a response. He then screamed for assistance.

38. Officer A responded to Prisoner A's call for help. He went into the cell and found another prisoner there. (Prisoner B) Prisoner B told Officer A that he thought that the man had had a fit. The man was lying face down, and Officer A tried unsuccessfully to get a response from him. The officer rolled the man into the recovery position and, as he did not have a radio, also shouted to staff to get more assistance.
39. Almost immediately, Senior Officer A arrived at the cell. She checked to see if the man was breathing and found that he was not. She also failed to find a pulse.
40. In the meantime, Officer B also heard Officer A's shout for help and pressed the general alarm before going to the cell. She moved the other prisoners and returned them to their cells.
41. As a result of the alarm, Nurse A (who was carrying the Hotel 1 radio and was therefore the designated emergency response nurse on duty) went immediately to the cell accompanied by a Healthcare Worker (HCW). Nurse A could not obtain a response from the man either and she asked for an emergency ambulance to be called. She took readings using a pulse oximeter (a machine which measures the oxygen saturation of the blood and the pulse), finding no pulse and an oxygen saturation rate of 63 per cent (a normal reading would be around 97 to 99 per cent).
42. Nurse A asked for a defibrillator (a machine which can deliver electrical pulses to try and restart the heart) to be brought to the cell. Senior Officer B who had also attended following the alarm, ran to healthcare to collect it, returning within three or four minutes. In the meantime, Senior Officer A and the healthcare staff began administering cardio-pulmonary resuscitation (CPR) to the man.
43. When Senior Officer B returned, Nurse A removed the man's shirt and applied the defibrillator pads. The defibrillator advised that there was no shockable rhythm, and that CPR should continue. An ambu-bag (a mechanical device used to administer oxygen) was also used. Nurse A continued to try the defibrillator to see whether she should administer a shock.
44. The paramedics arrived at the man's cell at 6.41pm, after being escorted through the prison by Senior Officer B. Nurse A gave them a verbal handover, and the paramedics changed the oxygen cylinder and used their own defibrillator. Again, this advised not to shock but to continue CPR. The paramedics tried to insert an airway using a laryngoscope (a medical instrument which can be used to insert a tube into the throat), but were unable to do so because there was fluid in his airway. They did manage to insert a liner into one of his veins, and gave two doses of epinephrine (also known as adrenaline, a drug used to treat the effects of a heart attack).

45. At 6.55pm, the paramedics and Nurse A agreed that there was no more they could do for him, and they pronounced his death. Senior Officer B arranged for the cell to be sealed and kept a log of events. The coroner arranged for the man's body to be removed to the mortuary.
46. Staff ensured that Prisoner A was cared for, and he was offered the chance to speak to a Listener (who are prisoners trained by the Samaritans to provide a confidential listening service to fellow prisoners). Other prisoners were checked, although there were no prisoners on the wing who were subject to monitoring procedures at that time.
47. A hot debrief was held at 8.30pm, where staff had the opportunity to discuss what had happened, and statements were given to the police. Staff were also given details of the Care Team, should they need further support.

### **Following the man's death**

48. A post mortem examination was carried out at a local hospital, on 8 June. The pathologist who conducted the examination, concluded that the man died from ischaemic heart disease. A toxicology report was also requested, with no positive results returned.
49. Following an invitation from the prison the man's brother visited on 10 June. He was shown to the man's cell and allowed to take a few photographs and a pair of glasses. He later met both the Governor and Deputy Governor.
50. The man's funeral took place at the local Mosque. It was attended by the Imam from the prison. The man was then buried in a traditional Muslim ceremony at the local cemetery. The Imam met the man's family, and answered some of their questions about what had happened to him in prison, and arranged for his property to be returned. He also passed on the condolences of the prison managers and staff.

## ISSUES

### Clinical care

51. The clinical reviewer comments that, in her opinion, the standard of care the man received at Swaleside “fell short of that which would have been expected in the community”. In particular, the Clinical Reviewer criticises the failure to address any of the risk factors of a further heart attack that he presented when he came into prison and when he transferred to Swaleside.
52. In particular, the Clinical Reviewer notes that the man’s medical records were not obtained when he was first remanded in custody in 2003 (even though it was recorded in his medical notes, on 21 March 2003, that they should be requested from his local hospital. There was a further opportunity to address these issues when the man transferred to Swaleside in 2005 which was also missed. As the reception process at all three prisons took place more than five years ago, and with the advent of electronic medical records, it may be that this issue has been addressed in the meantime. I therefore do not make a recommendation on this point, although the Head of Healthcare will wish to assure himself that previous medical records are being received when appropriate. I will also arrange for a copy of my report to be sent to the Head of Healthcare at Wormwood Scrubs and Belmarsh.
53. The Clinical Reviewer suggests that the risk factors associated with the man’s previous heart attack should have been examined at a cardiac clinic. Although he did attend a clinic on 2 October 2008, when he was prescribed aspirin and spoke to a smoking cessation advisor, and subsequently had his blood pressure and cholesterol checked, I believe that this should have occurred much earlier.
54. Although the man was prescribed medication to treat his blood pressure, the Clinical Reviewer believes the wrong medicine was prescribed. In particular, he was prescribed bendroflumethiazide, but the Clinical Reviewer says there is no evidence to suggest that it prolongs life after a heart attack. After the man stopped taking the medication, there is no evidence that anything else was offered as an alternative. The man continued to take bendroflumethiazide, but irregularly.
55. The Clinical Reviewer believes that the man’s medical needs should have been properly identified when he entered prison, and that the National Institute of Clinical Excellence (NICE) guidelines were not followed. Had they been followed, an antihypertensive would have been prescribed much earlier. Although the Clinical Reviewer identifies that the prison doctor should keep up to date with the latest guidelines for secondary prevention, I believe that the Head of Healthcare should be responsible for ensuring that healthcare staff comply with national guidelines, and thus I make the following recommendation.

**The Head of Healthcare should ensure that all relevant staff are aware of, and implement appropriately, the latest NICE guidelines on secondary prevention for patients who have had a heart attack.**

56. The Clinical Reviewer also comments that the reception screening form at Swaleside does not allow sufficient information to be recorded. She recommends that it is redesigned to ensure that health assessments can be expanded, referrals for further health care noted and responsibility for these referrals attributed to individual member of staff. I do not repeat the recommendation in full, but would draw the attention of the Head of Healthcare to this section of the clinical review.

### **Use of radios and emergency codes**

57. Although it is unlikely that the outcome for the man would have been different, I am concerned about the communication that took place after Prisoner A found the man in his cell. Officer A had to shout for assistance from his colleagues, and it is fortunate that Senior Officer A and Officer B were able to hear him and respond. At interview, Officer A explained that there would usually be two members of staff on the landing, both of whom would have radios. He was there as an extra member of staff, but there was no additional radio for him to draw. Had Officer A had access to a radio, it is possible that the confusion described below would not have occurred, as he would have been able to alert all staff to the emergency that was taking place.

**The Governor should review whether radio provision is adequate.**

58. Officer B pressed the general alarm before proceeding to the man's cell, which ensured that Nurse A attended quickly with a Healthcare Worker. However, she did not have the equipment she required as she was unaware of the type of emergency she would be presented with. While there was only a small delay whilst Senior Officer B fetched the equipment, this could have been avoided with better communication.
59. Swaleside operates a system of "codes" for alerting staff (and in particular healthcare staff) to emergencies. In line with many other prisons, the codes in use are blue for an incident involving breathing difficulties, and red for those involving blood issues. Staff then respond to the emergency with the correct equipment. In this case, Officer B pressed the alarm rather than using the radio, which led to equipment having to be collected after the healthcare staff had arrived at the scene.

**The Governor should ensure that all staff are aware of the importance of the correct use of emergency codes.**

## **CONCLUSION**

60. The man had already suffered a heart attack before committing the offence which resulted in his imprisonment. He had also stopped taking his medication because of the side effects. When first remanded in custody, these details were noted in his medical record, although it seems that no further information was sought from the hospital that had previously treated him.
61. The clinical reviewer has identified that the man was not prescribed medication for high blood pressure for some time after his arrival at Swaleside. When he was, he again found that the medication caused side effects but was not offered an alternative. As a result, he did not take the medication as prescribed, but took it less often. It is impossible to be sure whether this contributed to the heart attack which eventually killed him.
62. Although the response to the man being found in his cell was not helped by problems in communication, staff made every effort to resuscitate him. They worked well together, but sadly were unable to revive him.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that all relevant staff are aware of, and implement appropriately, the latest NICE guidelines on secondary prevention for patients who have had a heart attack.

**Recommendation accepted by prison**

2. The Governor should review whether radio provision is adequate.

**Recommendation accepted by prison**

3. The Governor should ensure that all staff are aware of the importance of the correct use of emergency codes

**Recommendation accepted by prison**