Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronnie Gaunt, a prisoner at HMP Risley, on 15 April 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Ronnie Gaunt died of cardiac hypertrophy with coronary artery atheroma on 15 April 2020 at HMP Risley. He was 38 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Gaunt received at HMP Risley was equivalent to that which he could have expected to receive in the community. She noted that Mr Gaunt had minimal contact with healthcare staff and his death was sudden and unexpected. She made one recommendation about secondary health screens, which we repeat below.

5. We found no non-clinical issues of concern.

6. Mr Gaunt's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

7. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Recommendations

- **The Head of Healthcare should ensure that prisoners receive a secondary screen within seven days of their initial reception health screen.**

The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Gaunt's clinical care at Risley.

9. The PPO investigator investigated the non-clinical issues relating to Mr Gaunt's care, including Mr Gaunt's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

10. The PPO family liaison officer wrote to Mr Gaunt's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions or concerns.

Previous deaths at HMP Risley

11. Mr Gaunt was the ninth prisoner to die at Risley since April 2018. Of the previous deaths, four were from natural causes, two were self-inflicted, one was drug-related, and one was a homicide. There are no similarities between our findings in the investigation into Mr Gaunt's death and our investigation findings for the previous deaths.

Key Events

12. On 9 April 2019, Mr Ronnie Gaunt was remanded to HMP Manchester, charged with a violent offence. On 4 November, he was sentenced to three years and six months in prison. He was transferred to HMP Risley on 21 November.

13. When he arrived at Risley, a nurse saw Mr Gaunt for his initial health screen. Mr Gaunt was generally fit and well and did not take any prescribed medication. His clinical observations were normal. Mr Gaunt said that he had used cocaine in the past but did not have any substance misuse issues. The nurse noted that Mr Gaunt was under the influence of alcohol when he committed his offence. Mr Gaunt told the nurse that he did not have any mental health concerns and that his family was a protective factor for him. Healthcare staff recorded in his medical record that Mr Gaunt had no significant mental health issues or mental health diagnoses. There is no evidence that healthcare staff completed a secondary health screen within seven days of the initial health screen as they should have done.

14. Mr Gaunt had minimal contact with healthcare staff. As part of his induction, Mr Gaunt saw a prisoner substance misuse peer mentor on 22 November. He also received support and advice about harm reduction.

Events of 16 April 2020

15. At around 6am on 16 April 2020, a prison officer completed a roll check. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. Mr Gaunt was in his cell and the officer did not note any concerns.

16. At around 11.35am, an officer unlocked Mr Gaunt's cell. Mr Gaunt was lying unresponsive on his bed. The officer radioed a medical emergency code blue (indicating a prisoner is unconscious or has breathing difficulties) and the control room called an ambulance immediately. Prison officers quickly arrived at Mr Gaunt's cell. The officer did not start cardiopulmonary resuscitation (CPR) because Mr Gaunt was cold, felt stiff and pooling of blood was visible on his arms.

17. A nurse and a prison paramedic arrived very shortly afterwards. They agreed with the officer's decision not to start CPR and noted that Mr Gaunt had rigor mortis in all of his limbs. At 11.45am, the paramedics arrived at the prison. At 11.50am, they confirmed that Mr Gaunt had died.

18. At 12.15pm, a governor telephoned Mr Gaunt's mother to tell her that Mr Gaunt had died. The prison appointed a family liaison officer, who provided support and information to Mr Gaunt's family. In line with national policy, the prison made a financial contribution to the cost of the funeral.

Post-mortem report

19. The post-mortem report concluded that Mr Gaunt died of cardiac hypertrophy (where the heart muscles thicken, and the blood volume increases) with coronary artery atheroma (a form of heart disease).

20. Toxicology tests did not detect any drugs or alcohol in Mr Gaunt's blood and urine.

Inquest

The inquest, heard on 20 July 2023, concluded that Mr Gaunt died from natural causes.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **July 2023**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100