Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Aldoescu, a prisoner at HMP Gartree, on 6 March 2025

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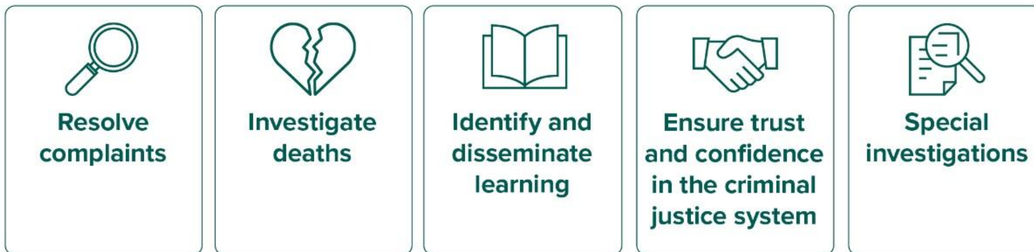
OUR VISION

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

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Anthony Aldoescu died of the effects of a synthetic cannabinoid in combination with left ventricular hypertrophy (thickening of the heart muscles of the left ventricle) on 6 March 2025, while a prisoner at HMP Gartree. He was 52 years old. I offer my condolences to Mr Aldoescu's family and friends.

Mr Aldoescu had a history of substance use. While prison staff acted appropriately by submitting intelligence reports, conducting a cell search and requesting a suspicion-based drug test, I am concerned they did not make a referral to the substance misuse team so that they could offer him support.

The clinical reviewer concluded that the healthcare Mr Aldoescu received at Gartree was at least equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **January 2026**

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Summary

Events

1. On 14 April 2005, Mr Anthony Aldoescu was sentenced to life in prison with a minimum term of five years and three months for possession of a firearm with intent to cause fear of violence.

2. Over the next 20 years, Mr Aldoescu progressed through his sentence, got a job and generally worked well and without any issues. He moved to HMP Gartree in 2023. He had a history of illicit substance use and was suspected of being involved in the supply of drugs at Gartree. Prison staff submitted several intelligence reports about his suspected drug use and involvement in drug supply and took actions including conducting a cell search and requesting a mandatory drug test, but they did not refer him to the substance misuse team.

3. At around 6.00pm on 6 March 2025, an officer went to lock Mr Aldoescu's cell and saw him sat on his bed, leant against the wall, with his head facing away from the cell door. The officer thought he saw Mr Aldoescu move and carried on locking up the remaining prisoners. He returned to the cell a few minutes later to check on him and found Mr Aldoescu unresponsive. He shouted for assistance and an officer radioed a medical emergency code, but they did not start cardiopulmonary resuscitation (CPR) immediately. At 6.10pm, nurses arrived and continued resuscitation efforts.

4. At 6.23pm, paramedics arrived at the prison. They reached Mr Aldoescu's cell three minutes later and took over treatment. At 6.43pm, an ambulance paramedic pronounced life extinct.

5. The post-mortem concluded that Mr Aldoescu died from the toxic effect of a psychoactive substance (PS) and thickening of the heart muscle of the left ventricle.

Findings

6. Mr Aldoescu had a history of substance use and was able to obtain PS in prison. In response to previous incidents, prison staff submitted intelligence reports and took appropriate action, such as conducting a cell search and requesting a mandatory drug test. However, Mr Aldoescu did not receive any substance misuse support at Gartree. He was offered intervention when he first arrived, but declined. Prison staff observed him under the influence of illicit substances several times and suspected him of being involved in the distribution of drugs but did not notify the substance misuse team. This meant they were unable to offer him further opportunities to engage.

7. Gartree's drug strategy sets out various measures to target illicit drug trafficking and reduce the demand for drugs. The substance misuse team provide interventions that include educating prisoner of the risk associated with illicit drug use and the prison also has an incentivised substance free living unit.

Recommendations

- The Governor should ensure, through a robust quality assurance process, that operational staff are aware of what action to take when they observe a prisoner under the influence, including making a referral to the substance misuse team.

The Investigation Process

8. HMPPS notified us of Mr Aldoescu's death on 6 March 2024.

9. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Gartree on 14 March. He obtained copies of relevant extracts from Mr Aldoescu's prison record and interviewed one prisoner.

11. The investigator interviewed three members of staff at Gartree on 24 April. He also interviewed one member of staff by video conference on 2 May.

12. NHS England commissioned a clinical reviewer to review Mr Aldoescu's clinical care at the prison.

13. We informed HM Coroner for Leicester of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's office contacted Mr Aldoescu's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked what happened before he died. We have addressed this in the report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies but identified that one of the attachments was not a transcript (as listed). HMPPS action plan is annexed to this report.

16. Mr Aldoescu's mother received a copy of the draft report. They did not make any comments.

Background Information

HMP Gartree

17. HMP Gartree holds prisoners mainly sentenced to life imprisonment and other indeterminate sentences. Practice Plus Group provides integrated healthcare. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Gartree was in January 2023. Inspectors reported that too many illicit items, including drugs, were entering the prison, and further action was required to reduce supply. Inspectors found that although prison leaders had taken some appropriate steps to disrupt the supply of drugs into the prison, prisoners told them that they could easily access illicit substances, and this had caused some prisoners to build large debts and be at risk of violence.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2024, the IMB reported that it remained concerned that drugs and other illicit items continued to infiltrate the prison by a variety of means. They reported that despite stringent procedures for preventing illicit items entering the prison, they were still reaching prisoners and drone activity continued to be a problem, particularly at night.

Previous deaths at HMP Gartree

20. Mr Aldoescu was the twelfth prisoner to die at Gartree since March 2022. Of the previous deaths, two were self-inflicted, one was drug related, seven were from natural causes and one was of unknown cause. Since Mr Aldoescu's death and up to the end of August 2025, there have been four further deaths at Gartree, three from natural causes and one self-inflicted. There were no similarities between any of these and Mr Aldoescu's death.

Psychoactive substances (PS)

21. Psychoactive substances are substances that affect mental processes. Synthetic cannabinoids are substances that mimic the effects of cannabis. They can be hard to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

22. PS can affect people in several ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is

associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Parole Board

23. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to assess their suitability for transfer to open conditions and to decide whether they can safely be released into the community once they have served the minimum sentence imposed by the courts.

Key Events

24. On 14 April 2005, Mr Anthony Aldoescu was sentenced to life imprisonment with a minimum term of five years and three months for possession of a firearm with intent to cause fear of violence. He was sent to HMP Gloucester.

25. Over the next 18 years, Mr Aldoescu progressed through his sentence and spent time at various prisons. He had ten Parole Board reviews, and, on each occasion, the panel did not direct release or transfer to an open prison.

HMP Gartree

26. On 25 July 2023, Mr Aldoescu transferred from HMP Lowdham Grange to HMP Gartree. A nurse conducted an initial reception screen and noted that he had a history of illicit substance use. Mr Aldoescu said he would be willing to work with the prison’s substance misuse team and the nurse referred him.

27. On 28 July, a substance misuse recovery worker, visited Mr Aldoescu to conduct an initial assessment, but he declined. There is no evidence that staff observed him under the influence of illicit substances again that year.

2024

28. On 28 February 2024, prison staff submitted an intelligence report stating that they had observed Mr Aldoescu under the influence. There is, however, no record that staff considered a referral to the substance misuse team.

29. On 6 April, prison staff submitted an intelligence report stating that Mr Aldoescu and another prisoner were facilitating drugs coming onto the wing. Again, there is no record that staff considered a substance misuse referral.

30. On 7 July, prison staff moved Mr Aldoescu to the therapeutic community (TC Plus, a 12-bed therapeutic unit within Gartree for prisoners with learning difficulties and/or disabilities), for an induction period. However, he was subsequently deselected from the unit when he admitted to using illicit substances. There is no record that prison staff considered a substance misuse referral. Mr Aldoescu moved to the over 50s section of H wing on 31 October.

31. On 16 November, prison staff submitted an intelligence report stating that since Mr Aldoescu’s arrival on H wing, there had been several reports of prisoners under the influence and inferring that he was responsible for bringing drugs to the wing. Once more, there is no record that staff considered a substance misuse referral.

32. On 28 November, an officer recorded that he met with Mr Aldoescu and introduced himself as his new key worker. He noted that Mr Aldoescu had a prison job and spoke weekly to his family and friends.

33. On 20 December, prison staff submitted an intelligence report stating that around two hours after they observed Mr Aldoescu associating with a prisoner suspected of having significant involvement in the supply of illicit substances around the prison, two prisoners on H wing required hospital treatment for the effects of substance use.

2025

34. On 12 January, an officer noted that prison staff conducted an intelligence led search of Mr Aldoescu's cell but did not find anything suspicious.

35. On 24 January, an officer saw Mr Aldoescu for a keywork session and noted that he continued to get on well with his peers on the wing and had daily phone contact with his mother. He added that TC Plus had asked Mr Aldoescu to meet with them to discuss their outreach programme, but he declined, stating that he did not want to talk to them.

36. On 21 February, an officer visited the wing to see Mr Aldoescu for a keywork session. He noted that Mr Aldoescu expressed frustration about his work as an in-cell food-packer ending (when the contract was withdrawn) and that he would see what other opportunities were available.

37. On 28 February, prison staff submitted an intelligence report stating that they had observed Mr Aldoescu under the influence of an illicit substance. They suggested a Mandatory Drug Test (MDT), but there is no record that it took place. There is also no record that staff considered a substance misuse referral.

Events of 6 March

38. The investigator watched CCTV and body worn video camera (BWVC) footage, obtained prison statements and Ambulance Service records. The following account is taken from all those sources.

39. At 4.29pm, CCTV shows Mr Aldoescu entered the cell of another prisoners, and left around a minute later. At interview, Mr Hudson-Jones told the investigator that Mr Aldoescu replaced some vapes that he had given him. Mr Aldoescu then went in and out of his own cell, before finally entering his cell and shutting the door at 4.51pm.

40. At 5.40pm, the other prisoner approached Mr Aldoescu's cell, looked through the observation panel and walked away. He did not tell us why he went to Mr Aldoescu's cell, but said the TV was on and that he did not see anything else.

41. At around 6.00pm, an officer looked through the observation panel on Mr Aldoescu's cell door to check he was there and to lock the door. He told us that he saw Mr Aldoescu sat on his bed, leant against the wall, with his head facing away from the cell door. He said that he believed he saw Mr Aldoescu move and decided to lock up the other prisoners on the landing before going back to check on him, as he suspected he might have been asleep or under the influence of illicit substances.

42. At 6.03pm, the officer returned and opened Mr Aldoescu's cell door to check on him. He requested assistance from another officer, who was nearby. Both officers entered the cell, closely followed by a third officer. They noticed vomit around Mr Aldoescu's mouth, and their efforts to rouse him were unsuccessful. At 6.08pm, an officer radioed a medical emergency code blue (indicating that a prisoner is unconscious or has breathing difficulties) and staff in the control room called an ambulance. They laid Mr Aldoescu on his back on the bed and started cardiopulmonary resuscitation (CPR).

43. At 6.10pm, two nurses arrived with the medical emergency response bags and entered the cell. They used suction to help clear Mr Aldoescu's airway and assisted with CPR. At around 6.17pm, they moved Mr Aldoescu on to the floor and continued CPR.

44. At 6.23pm, paramedics arrived at the main gate. At 6.26pm, they arrived at Mr Aldoescu's cell. The paramedics took over the resuscitation effort but at 6.43pm, pronounced life extinct.

Events after Mr Aldoescu's death

45. On 6 March, prison staff submitted an intelligence report stating that prisoners had said that just before evening lock-up on 6 March, Mr Aldoescu had allegedly gone around the wing asking other prisoners for drugs.

46. In July the Coroner received an anonymous letter purporting to be from a member of staff at Gartree expressing concern at the response when Mr Aldoescu was found unconscious.

Contact with Mr Aldoescu's family

47. At 8.30pm, the prison appointed a Custodial Manager (CM) as the family liaison officer FLO and an officer as her deputy. They identified that Mr Aldoescu had named his mother as his next of kin and arrived at her address at 1.35am on 7 March. They broke the news and offered support.

48. Both the FLO and deputy provided ongoing support to Mr Aldoescu's family until his funeral, which took place on 2 April. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

49. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

50. On 6 March, a prison manager, debriefed the staff involved in the emergency response and staff and prisoners were offered support. The local Samaritans branch attended the prison, and Listeners were deployed to offer support to prisoners. We are satisfied that the postvention response was adequate.

Post-mortem report

51. The post-mortem report found that Mr Aldoescu died from the toxic effects of the synthetic cannabinoid MDMB-FUBINACA in combination with left ventricular hypertrophy (thickening of the heart muscle of the left ventricle).

Findings

Illicit substances

52. The post-mortem examination confirmed that Mr Aldoescu died from the effects of synthetic cannabinoids in combination with left ventricular hypertrophy.

53. Mr Aldoescu had a history of substance use and was suspected of being involved in the distribution of illicit drugs around the prison. We are satisfied that, for the most part, prison staff submitted appropriate intelligence reports and acted on them by conducting a cell search and requesting a suspicion-based drug test.

54. However, Mr Aldoescu did not receive any substance misuse support at Gartree. Other than the referral made in 2023, in which he declined to engage, there is no record that staff made a substance misuse referral when they suspected he was under the influence.

55. HMPPS's Drug Strategy, published in April 2019, highlights the importance of building a picture of the security risks to enable prisons to better to target their resources to tackle them. At the time of Mr Aldoescu's death, Gartree had a drug strategy dated 2025. The strategy set out measures to target illicit drug trafficking, including the use of intelligence, the use of drug detection dogs and drug testing. It also set out measures to reduce the demand for drugs, which included the provision of support services through a clearly defined and effective referral process. In terms of educating prisoners of the risk associated with using illicit substances, the prison told us that the substance misuse team hold welfare sessions, one-to-one session and group work. The prison also has an incentivised substance free living unit.

56. The seven recorded incidents involving Mr Aldoescu relating to illicit substances were spread over 20 months. However, the intelligence reports related to supply were not shared at the multi-disciplinary drug strategy meetings (held monthly). This meant that staff were unable to establish a complete perspective and offer Mr Aldoescu intervention. The Head of Reducing Reoffending and Drug Strategy, told the investigator that he had discussed the issue with the Head of Security and the drug strategy team now received all drug related intelligence, including that for prisoners who were suspected of being involved in the distribution of illicit drugs. We are satisfied that this action was appropriate.

57. Prison staff did not make a substance misuse referral after seeing Mr Aldoescu under the influence. The Head of Reducing Reoffending and Drug Strategy told us that every prisoner observed under the influence and identified in the daily briefing, should be referred to the substance misuse team. As there is no evidence this happened in Mr Aldoescu's case, over a period of months, it indicates that there is a gap in knowledge among some staff about what action to take when they suspect a prisoner is under the influence. We accept that Mr Aldoescu was not frequently observed under the influence and was difficult to engage, but substance misuse referrals would have allowed staff to offer him further opportunities to engage. We make the following recommendation:

    The Governor should ensure, through a robust quality assurance process, that operational staff are aware of what action to take when they observe a

prisoner under the influence, including making a referral to the substance misuse team.

Clinical care

58. The clinical reviewer concluded that the standard of healthcare Mr Aldoescu received at Gartree was at least equivalent to the care he would have received in the community. Mr Aldoescu had not presented with any cardiac issues at Gartree.

Governor and Head of Healthcare to note

The emergency response

59. When Mr Aldoescu was found unresponsive, officers spent nearly four minutes trying to get a response from Mr Aldoescu before they established that he was not beathing and started CPR. While we recognise the distressing nature of finding a prisoner unresponsive, it is crucial that staff start CPR at the earliest opportunity.

60. Prison staff started CPR while Mr Aldoescu was on his bed, which continued for around 16 minutes after healthcare staff arrived. Performing CPR on a patient who is lying on a bed (or other soft surface) can reduce its effectiveness. The clinical reviewer considered that staff should immediately transfer a prisoner to a hard surface, such as a floor, to ensure optimal chest compressions. The Governor and Head of Healthcare will want to reflect on this learning.

Head of Healthcare to note

Preparedness for medical emergencies

61. Healthcare staff responded promptly to the code blue, but a nurse noted that she was not aware of the seriousness of the emergency prior to her arrival. In line with PSI 03/2013 on medical response codes, Gartree's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties. Healthcare staff responding to emergencies should therefore be prepared for the possibility that CPR is in progress. While the clinical reviewer considered that it did not materially impact on the outcome for Mr Aldoescu, in other cases, it could be crucial. The Head of Healthcare will, therefore, wish to consider if there is any broader learning about the use of the code systems at Gartree and staff's preparedness for medical emergencies.

Inquest

62. At the inquest which took place on 13 May 2026, the Coroner concluded that Mr Aldoescu died of misadventure, compounded by the poor communication and information sharing about his drug abuse risk in the weeks prior to his death.

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