Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Quinn, a prisoner at HMP Berwyn, on 1 January 2019

A report by the Prisons and Probation Ombudsman

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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

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 Michael Quinn died on 1 January 2019, of acute myocardial insufficiency and severe coronary artery atheroma at HMP Berwyn. He was 57 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the healthcare Mr Quinn received at Berwyn was equivalent to that which he could have expected to receive in the community. He was, however, concerned that healthcare staff failed to carry out a secondary health screen as they should have done, did not have a coordinated approach to food refusals and reported chest pains. He was also concerned about the lack of 24-hour healthcare cover at the prison.

I am concerned that when Mr Quinn complained of chest pains on two occasions on 31 December and again on the morning of 1 January, prison staff assessed Mr Quinn's condition without the benefit of any medical knowledge or training. I am also concerned about staff actions during the emergency response.

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

Susannah Eagle
Deputy Prisons and Probation Ombudsman **April 2023**

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Summary

Events

1. On 6 October 2016, Mr Michael Quinn was remanded to HMP Durham charged with the supply of class A drugs. He was 55 years old. On 3 February 2017, he was sentenced to nine years imprisonment.

2. Mr Quinn did not report any pre-existing medical conditions.

3. On 1 June 2018, Mr Quinn was transferred to HMP Berwyn. During his initial health screen, healthcare staff did not identify any significant medical conditions. However, they did not complete a secondary health screen as they should have done.

4. On 14 December, a nurse saw Mr Quinn after he reported chest pains. Most of his observations were within the normal range, but his heart rate was raised. There is no evidence to indicate that healthcare staff explored this further or referred Mr Quinn to a prison GP for further review.

5. At 11.00pm on 31 December, Mr Quinn rang his emergency cell bell, and a prison officer responded immediately. Mr Quinn told him that he was experiencing chest pains and a feeling of heaviness in his arms. The officer said that there were no healthcare staff on duty and advised Mr Quinn to drink fluids and rest. The officer informed the Custodial Manager on duty, and she advised him to update her if Mr Quinn's condition deteriorated.

6. At 11.35pm, Mr Quinn rang his emergency cell bell again. He told the officer that his condition had not improved and that he wanted a doctor or paramedics to see him. The officer did not think that Mr Quinn was displaying any symptoms that suggested he needed urgent medical assistance. Therefore, he did not seek medical advice.

7. At 4.40am, the following morning, Mr Quinn's cell mate rang the emergency cell bell. When the officer arrived at the cell, he saw Mr Quinn lying face down on his bed, gasping for breath. The officer called for assistance. Mr Quinn's cell mate put him in the recovery position while the officer waited for other staff to arrive so they could enter the cell. At 4.42am, staff arrived and entered the cell. An officer radioed a medical emergency code. Control room staff telephoned for an emergency ambulance immediately. Staff began cardiopulmonary resuscitation (CPR).

8. At 5.03am, paramedics arrived at the cell. They took over Mr Quinn's care and treatment, but at 5.36am on 1 January, a paramedic confirmed that Mr Quinn had died.

9. The post-mortem report gave Mr Quinn's cause of death as acute myocardial insufficiency and severe coronary artery atheroma.

Findings

13. The clinical reviewer concluded that the healthcare Mr Quinn received at Berwyn was equivalent to that which he could have expected to receive in the community.

14. He did, however, identify a number of concerns about Mr Quinn's care, including the lack of a secondary health screen after Mr Quinn arrived at HMP Berwyn, the lack of a coordinated approach to food refusals, the lack of management of prisoners presenting with chest pains and the lack of 24-hour healthcare cover at the prison.

15. We are concerned that when Mr Quinn complained of chest pains on two occasions on 31 December and again on the morning of 1 January, prison staff assessed Mr Quinn's condition without the benefit of any medical knowledge or training and did not seek emergency medical advice.

16. We are also concerned that on 1 January, when staff identified concerns about Mr Quinn's welfare, emergency response policies were not followed as they should have been.

Recommendations

- The Head of Healthcare should review the management of those prisoners reporting chest pains to ensure they are referred appropriately for further investigation.
- The Governor and Head of Healthcare should ensure that a system is in place to ensure:
    - **staff accurately and consistently record when prisoners refuse food;**
    - **ensure that there is a clear plan to manage food and fluid refusals including GP intervention;**
    - **the management of urine test results for the purpose of ongoing monitoring of prisoners; and**
    - **there is a system in place to preserve all documentation relating to a prisoner's refusal of food and or fluids.**
- The Head of Healthcare should ensure that a secondary reception screening is carried out in line with NICE guidance NG57.
- The Governor should ensure that staff seek medical advice or request medical assistance immediately if a prisoner reports serious or potentially life-threatening symptoms such as breathing difficulties or chest pain.
- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

- The Governor and the Head of Healthcare should ensure that a copy of this report is shared with all staff named in it and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

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

18. The investigator obtained copies of relevant extracts from Mr Quinn's prison and medical records.

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

20. In August 2021, we suspended our investigation at the request of North Wales police who conducted a criminal investigation. They decided not to take any action against the night staff. We resumed our investigation in May 2022.

21. On 21 September 2022, the investigator and clinical reviewer interviewed two members of staff at HMP Berwyn.

22. We informed HM Coroner for Northeast Wales District of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

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

Background Information

HMP Berwyn

25. HMP Berwyn is a category C prison, near Wrexham. It opened in 2017 and was designed to hold around 2,100 men. Berwyn has three houseblocks (Alwen, Bala and Ceiriog) each divided into eight communities. Healthcare services are provided by Betsi Cadwaladr University Health Board. Healthcare is available 24 hours per day and the GP out of hours provision is available for advice outside the normal working hours.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Berwyn was in May 2022. Inspectors considered that healthcare support had deteriorated since the previous inspection in 2019. Inspectors were also concerned that staff vacancies in primary care services were having a negative effect on service delivery, and that prisoners faced long waits for routine appointments. However, inspectors were pleased to note that social care support for prisoners who might need assistance with daily tasks were working well.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to 28 February 2022, the Board considered the level of healthcare provision available to prisoners was generally as good as that in the community.

28. The Board also noted that the healthcare department at Berwyn had introduced a scheme in which prisoners acted as health and wellbeing peer mentors.

Previous deaths at HMP Berwyn

29. Mr Quinn was the third prisoner to die at HMP Berwyn since 2018. Of the previous deaths, one was from natural causes and one was a drug-related death. There have been eleven further deaths since Mr Quinn's death, nine from natural causes, one self-inflicted and one drug related. There are no similarities between our findings in the investigation into Mr Quinn's death and our investigation findings for the previous deaths.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

31. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the

process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

32. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction 64/2011, Management of prisoners at risk of harm, to self and from others (Safer Custody).

Key Events

33. On 6 October 2016, Mr Michael Quinn was remanded to HMP Durham charged with the supply of class A drugs. He was 55 years old. Mr Quinn did not report any pre-existing medical conditions and during his initial health screen, healthcare staff did not identify any medical concerns.

34. On 3 February 2017, Mr Quinn was sentenced to nine years imprisonment.

35. On 1 June 2018, Mr Quinn was transferred to HMP Berwyn.

36. A nurse carried out Mr Quinn's initial health screen. She recorded his weight as 99.6 kilograms. Mr Quinn said that he was unhappy about moving to Berwyn and that he would either attack any prisoner he had to share a cell with or refuse food. She referred him to the prison's Mental Health and Learning Disabilities Team (MHLDT) for further review. There is no evidence in Mr Quinn's medical records to indicate that healthcare staff carried out a secondary health screen in line with NICE (National Institute for Clinical Excellence) guidance.

37. A nurse, from MHLDT saw Mr Quinn. He told her that he was still having difficulty accepting his daughter's death (who had died a year ago) but had no thoughts of self-harm. She told him that although he may not wish to engage with MHLDT, he could refer himself for support at any time should he feel the need. She also referred him for support from the prison's chaplaincy department. Mr Quinn had little significant contact with healthcare staff during the months that followed.

38. On 29 November, staff began monitoring Mr Quinn under ACCT suicide and self-harm procedures after he banged his head on the cell wall. During the weeks that followed, Mr Quinn occasionally refused food and attempted to harm himself. He continued to be managed under ACCT procedures and prison and healthcare staff had regular interactions with him.

39. On 14 December, a nurse saw Mr Quinn after he reported chest pains. She took a note of his observations, which were within the normal range except for his heart rate, which was raised. There is no evidence that healthcare staff went on to explore the cause of his raised heart rate or that they referred Mr Quinn to a prison GP for review.

40. On 19 December, a Healthcare Support Worker (HSW) from the MHLDT saw Mr Quinn. He told her that although he had no thoughts of suicide or self-harm, he had been refusing food for the past 19 days. She took a note of his observations, which were within the normal range. She recorded his weight as 92.1 kilograms, 7.5 kilograms less than his recorded weight when he arrived at Berwyn. She referred Mr Quinn to the MHLDT for further review and opened a food refusal log.

41. During an ACCT case review on 21 December, Mr Quinn told a Custodial Manager (CM) and a nurse that he was choosing to continue to refuse food and was intending to stop ordering milk.

42. On 31 December, a Healthcare Assistant (HCA) saw Mr Quinn. She noted that he was low in mood. He asked her how long it would take for him to starve himself to death as he claimed he had not eaten since 29 November. She took a note of his

observations, and they were all within the normal range and recorded his weight as 91 kilograms.

43. At 11.00pm, Mr Quinn rang his emergency cell bell. Officer A responded immediately (we were unable to interview the officer due to him being seriously injured in a road traffic accident). Mr Quinn told him that he had chest pains and a heavy feeling in his arms, and that he wanted to see a member of healthcare staff. The officer informed him that there were no healthcare staff on duty and instead advised him to drink fluids and to rest. He returned to the wing office and telephoned a CM, the senior manager on duty. He told her about Mr Quinn's chest pains, and the advice he had given him. She told him to update her should Mr Quinn's condition deteriorate. They did not contact the out of hours GP service for medical advice or call for an ambulance in line with the prison's local emergency response protocol, as they should have done.

44. At 11.35pm, Mr Quinn rang his emergency cell bell again. He told Officer A that his condition had not improved and that he wanted to see a doctor or paramedics. He considered that Mr Quinn was talking clearly and did not appear distressed, nor did he display any symptoms that led him to believe he needed urgent medical assistance, and therefore did not seek medical advice.

45. At 2.30am on 1 January 2019, an Operational Support Grade (OSG) checked Mr Quinn. In her written statement she said that when she arrived at his cell, Mr Quinn was sitting slightly upright at the end of his bed with his hand resting against his head. She noted that his eyes were closed but that he was moving his right hand, and that it appeared that he was trying to get some rest.

46. At 4.40am, Mr Quinn's cell mate rang the emergency cell bell. Officer A responded immediately. When he arrived, he saw Mr Quinn lying face down on his bed, gasping for breath. He shouted to him through the door, but Mr Quinn did not respond. He noticed there was a pool of brown mucus next to Mr Quinn's head and that his face had a blue tinge. He radioed a code blue (indicating that a prisoner is unconscious or is having breathing difficulties). Control room staff telephoned for an emergency ambulance immediately.

47. Officer A told Mr Quinn's cell mate to put him in the recovery position, and to make sure his airway was clear. He waited for other staff to arrive so he could open the cell door.

48. At 4.42am, more staff arrived at the cell. They opened the cell door and Officer B attempted to clear Mr Quinn's airway, but he was unable to. He and Officer A then lifted Mr Quinn onto the floor. Officer B commenced CPR and Officer A tried to clear Mr Quinn's airway. He then proceeded to blow air into Mr Quinn's mouth. However, he noted that out of five attempts, only one inflated his lungs.

49. At 4.45am, another officer arrived and assisted with CPR.

50. At 4.55am, an officer arrived at the cell with a defibrillator. She attached it to Mr Quinn's chest, and it advised to continue with CPR.

51. At 5.03am, paramedics arrived at the cell. They applied an oxygen mask and gave Mr Quinn an adrenaline injection (adrenaline can increase the likelihood that the

heart will regain a normal rhythm) and asked the officers to continue with CPR. The paramedics used suction to try and clear Mr Quinn's airway and administer oxygen, but they were unsuccessful.

52. Shortly afterwards, a third paramedic arrived at the cell. He administered a second dose of adrenaline, and they continued to try and clear Mr Quinn's airway. Paramedics checked for signs of a pulse, but there were none. Paramedics told the officers to continue with CPR for three more minutes. At 5.36am on 1 January, paramedics confirmed that Mr Quinn had died.

Contact with Mr Quinn's Family

53. At 7:00am, the prison appointed a family liaison officer (FLO). At the time of Mr Quinn's death, Mr Quinn's son was also a prisoner at HMP Berwyn. The FLO visited him, accompanied by a prison chaplain, and broke the news of his father's death.

54. Later that morning at 10:30am, the FLO and a CM arrived at Mr Quinn's parent's home to inform them of their son's death. The family asked if Mr Quinn had been on a hunger strike, as his son had informed them he had been. They also asked if Mr Quinn had taken his own life. The CM told the family that although Mr Quinn had said he was on a hunger strike, his cell mate had confirmed that he was in fact still eating and drinking. He also reassured the family he had not taken his own life.

55. The family asked if he had had a heart attack, as another family member had recently died, and the death had been attributed to a heart attack. The CM informed them they would not know the cause of death until the coroner had concluded their investigations.

56. He explained that the prison would contribute towards the cost of the funeral and that if the family had any questions or concerns, they should contact him directly. He arranged for Mr Quinn's parents to visit their grandson the following day to offer him support.

57. On 5 January, Mr Quinn's brother contacted the FLO and told him he had been informed by a source, who he would not name, that Mr Quinn had been asking for help throughout the night as he had been suffering from breathing difficulties, but he had been ignored. He wanted to know if that information was correct. He also said that a CM had informed him that his brother had had a clash of personalities with another officer. He wanted to know if the officer was on duty the night Mr Quinn died. The prison confirmed that he was not on duty that night.

Support for prisoners and staff

58. After Mr Quinn's death, a CM took all of the staff involved to the prison's command suite to give them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The Duty Governor arrived at the prison shortly afterwards and also joined the staff for the debrief.

59. The paramedics who responded to the incident also attended and confirmed Mr Quinn's airway was blocked. They reassured staff that regardless of any efforts made it would not have been possible to clear the obstruction.

60. The prison posted notices informing other prisoners of Mr Quinn's death. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Quinn's death.

Post-mortem report

61. The post-mortem report gave Mr Quinn's cause of death as acute myocardial insufficiency (heart failure) and severe coronary artery atheroma (blockage of the arteries).

Inquest

62. At the inquest held on 24 November 2025, the coroner concluded that whilst not seeking earlier medical attention cannot be said to be the sole cause of Mr Quinn's death, it is probable that his life would have been prolonged by more timely assessment and treatment and therefore the failure to procure such help has more than minimally contributed to him dying at that time - put succinctly Michael Quinn died as a result of a natural occurring disease process, but it happening on the 1st of January 2019 was the result of neglect.

Events following Mr Quinn's death

63. Following Mr Quinn's death, North Wales Police carried out an investigation into the circumstances of his death and also the actions of staff on duty on the night he died. At the conclusion of their investigation, the police did not take any action against any member of staff at Berwyn.

Findings

Clinical care

64. The clinical reviewer concluded that clinical care Mr Quinn received at Berwyn was equivalent to that which he could have expected to receive in the community.

65. The clinical reviewer did, however, identify some shortcomings in Mr Quinn's care.

Management of Mr Quinn's chest pain

66. On 14 December 2018, a nurse reviewed Mr Quinn after he reported experiencing chest pains. She took a note of his observations and noted that his heart rate was raised. There is no evidence in Mr Quinn's medical record to indicate that healthcare staff went on to explore the nature of his chest pain, that he was referred to the GP for further review or that he had any investigations such as an ECG to exclude a cardiac cause. The clinical reviewer considered that given Mr Quinn had episodes of chest pain, was refusing food for 15 days and feeling short of breath, more should have been done to address his symptoms. We recommend:

The Head of Healthcare should review the management of prisoners reporting chest pains to ensure they are referred appropriately for further investigation.

Management of Mr Quinn's food refusal

67. At the time of Mr Quinn's death, Berwyn had a food refusal policy in place. The policy says that when it becomes apparent that a prisoner is not regularly taking food and or fluids, staff should complete food monitoring sheets and record any items of food or drink already in a prisoner's cell and complete them daily to accurately record the prisoner's food and fluid intake.

68. On 1 December 2018, Mr Quinn told staff that he would be refusing food and fluids. A CM recorded his comments in a food refusal log. During the time Mr Quinn said that he was refusing food, there were a number of occasions where staff witnessed him eating and drinking. The entries in the ACCT document indicated inconsistencies in the number of days that Mr Quinn went without food or fluids. On 3 December 2018, a prison GP recorded that Mr Quinn had been refusing food and fluids for five days. However, later that day, during an ACCT review, it was recorded that he had been refusing food and fluids for three days. Mr Quinn's weight was recorded on number of occasions, with a variation of approximately seven kilograms.

69. We asked the Head of Healthcare about the food refusal log. He told us that he could not recall if there was a system in place for recording the refusal of food, or if there was a central document for all staff to record their observations. He also said that when healthcare staff reviewed a prisoner that was refusing food or fluid, they would record notes on the prisoner's medical records. It is not clear if they also recorded those comments on the food refusal log. He said that at the time of Mr Quinn's death, communication and collaborative working between healthcare staff and prison staff was not as effective as it could have been. The clinical reviewer considered that this lack of consistency evidenced a lack of a coordinated approach to food refusal at the time of Mr Quinn's death.

70. Despite repeated requests, the prison failed to provide the investigator with a copy of the food refusal log. However, we note that some entries about Mr Quinn's food refusal were in the ACCT document and in Mr Quinn's medical records. We make the following recommendation:

The Governor and Head of Healthcare should ensure that a system is in place to ensure:

- **staff accurately and consistently record when prisoners refuse food;**
- **ensure that there is a clear plan to manage food and fluid refusals including GP intervention;**
- **the management of urine test results for the purpose of ongoing monitoring of prisoners; and**
- **there is a system in place to preserve all documentation relating to a prisoner's refusal of food and or fluids**

Reception health screening

71. The National Institute for Clinical Guidance (NICE) NG57 (assessing diagnosing and managing physical health problems of people in prison) recommends that a healthcare professional should carry out a second stage health assessment for every person received into prison. It is also recommended that the second stage health screen should be carried out within seven days of the prisoner's initial health screen.

72. On 1 June 2018, Mr Quinn transferred to Berwyn from HMP Lindholme. A prison nurse carried out an initial health screen when he arrived at the prison. However, there is no evidence in his medical records to suggest that healthcare staff completed a secondary health screen, which is contrary to NICE guidance. We recommend:

The Head of Healthcare should ensure that a secondary reception health screen is carried out in line with NICE guidance NG57.

Emergency response during the night

73. In the event of a medical emergency during the night, Berwyn's emergency response local protocol advises staff to report any incident to the Night Orderly Officer, who in turn will telephone an out of hours GP for advice. In the case of a life-threatening incident, they should telephone for an emergency ambulance. The Night Orderly Officer should also report the incident to the Duty Governor.

74. At 11.00pm and again at 11.35pm on 31 December, Mr Quinn told Officer A that he was experiencing chest pain and a feeling of heaviness in his arms. The officer, who had no medical training, concluded that Mr Quinn did not seem seriously ill and did not call for medical advice or an ambulance. A CM also did not consider seeking urgent medical advice contrary to the local policy.

75. We make the following recommendation:

The Governor should ensure that staff seek medical advice or request medical assistance immediately if a prisoner reports serious or potentially life-threatening symptoms such as breathing difficulties or chest pain.

Entering cells where there is risk to life

76. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present, one of whom should be the night orderly officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.

77. The PSI says that before going into a cell, staff should make every effort to get a verbal response from the prisoner. This, together with what the member of staff observes and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

78. When Officer A responded to Mr Quinn's emergency cell bell at 4.40am on 1 January 2019, he saw him lying face down on his bed, gasping for breath. He shouted to him through the door, but he did not respond. He noticed a pool of brown mucus next to Mr Quinn's head and that his face had a blue tinge. We are concerned that given Mr Quinn's presentation, he did not go into the cell immediately. He was clearly aware that Mr Quinn was seriously unwell because he instructed Mr Quinn's cell mate to place him in the recovery position. Despite this, he still waited for other staff to arrive before he entered the cell which is contrary to prison policy. We make the following recommendation:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

Learning Lessons

79. We have identified several concerns in this report. We consider it is important that staff learn from our findings. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that a copy of this report is shared with all staff named in it and that a senior manager discusses the Ombudsman's findings with them.

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