# Investigation into the circumstances surrounding the death of a man at HMP Ashwell in October 2009

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

**July 2010**

This is the report of an investigation into the circumstances surrounding the death of a man on 12 October 2009. The man died whilst using the gymnasium at HMP Ashwell. His health was good and his death was sudden. Despite a faultless response to the emergency, he died from acute myocardial infarction, that is a heart attack.

The man arrived at Ashwell in March 2007 having spent the previous 15 years in various prisons following his conviction for murder. He was serving his second life sentence, having already been released in 1981 on life licence for another murder committed in 1971. The Parole Board had not recommended him for early release because he had to serve a tariff of 20 years before becoming eligible for parole. However, the man had been working steadily through his life sentence plan.

I would like to extend my personal condolences to the man's family and friends for their loss. The loss of a loved one at any time is difficult, but especially so when they are still relatively young, die unexpectedly and are in custody.

This investigation was carried out by an investigator from my office. A clinical review, for which I am most grateful, was undertaken by a doctor on behalf of Leicestershire County Primary Care Trust. I would also like to thank the Governor of HMP Ashwell, and his staff, for their help and co-operation during this investigation.

I make one recommendation in this report together with a suggestion that Leicestershire County and Rutland PCT consider the implications of the further recommendations made by the Clinical Reviewer in his clinical review.

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **July 2010**

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## SUMMARY

The man was sentenced to life imprisonment for the second time in 1991, having been previously convicted of murder in May 1972 and released on life licence after serving ten years in prison. He had spent 27 of the last 37 years in prison. He was held in a number of prisons during his second life sentence and arrived at HMP Ashwell in March 2007. At that time he was slightly overweight, he had developed diabetes in 2006, had raised cholesterol levels and was a long-term smoker. He had no other known health problems.

During his time at Ashwell, the man became determined to reduce his weight, maintain control over his diabetes and he made several attempts to give up smoking. He had already started taking medication to help reduce his cholesterol levels. His health was good and his diabetes was under control. He became the gym orderly in June 2008 and was a trusted prisoner who would help supervise some gym activities (with the support of prison staff).

On 12 October 2009, just after lunch, the man arrived in the gymnasium for the afternoon session. Whilst the prison staff were checking the prisoners into the gymnasium, he started to do some warm up exercises (this was normal practice for all gymnasium users). At approximately 2.15pm, the man suddenly collapsed in the cardio vascular exercise room. The alarm was raised by other prisoners and urgent staff assistance was called for via the radio. Nursing staff arrived with emergency equipment within two minutes and they started cardio pulmonary resuscitation. Nurse A, who was one of the first healthcare workers on the scene, asked for an ambulance to be called and for the doctor who was on site to be summoned.

The doctor arrived and assisted with emergency treatment including using the defibrillator. The paramedics arrived at 2.30pm bringing their own defibrillator, and the doctor assisted by administering adrenaline to help re-start the man's heart. Unfortunately all their efforts failed and the life saving efforts ceased at 2.39pm.

## THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from this office. He first visited Ashwell on 14 October 2009 and was given access to the man's prison records. The Investigator visited the gymnasium where the man collapsed and died on 12 October. He was also shown around other places within the prison such as the healthcare unit and the unit where the man lived during his time at Ashwell.

2. During this initial visit, the Investigator met with members of the Independent Monitoring Board (IMB) and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they felt pertinent to my investigation. (Each prison has an Independent Monitoring Board. IMB members are independent and unpaid. They monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.)

3. Leicestershire County and Rutland Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody, particularly during his time at Ashwell. They appointed a doctor to undertake the review on their behalf. The clinical reviewer and the investigator conducted joint interviews of healthcare staff on 15 January 2010. The clinical reviewer was asked by the investigator to particularly consider the emergency response to the man's collapse and any actions that should or could have been taken in respect of coronary care before his death.

4. One of my family liaison officers, contacted the man's daughter, as his listed next of kin, to inform her of my investigation and to invite her to ask any questions or raise any issues for consideration as part of my investigation. The man's daughter was very appreciative of the efforts the prison had made to help her through this difficult time. She said that she was reassured by her visit to the prison and the memorial service held in the man's honour. The man's daughter asked for additional clarity around the emergency response and whether everything was done as quickly as it could have been – a matter that is largely covered within this report and was further highlighted at the man's inquest in May 2010. There is no evidence to suggest that there was any delay in resuscitating the man as competent nursing staff began CPR within three minutes of him collapsing. Furthermore, a doctor arrived very promptly as did paramedic staff. I hope my findings help the man's family better understand what happened following his collapse and addresses any concerns they may have about the care he received.

5. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion of this investigation, a copy of my report was sent to the Coroner to assist his enquiries into the man's death. On 27 May, an inquest into the circumstances of the man's death was held at Leicester Coroner's Court. The jury found that he died of natural causes.

At the Coroner's inquest, the investigator became aware that the man's father, mother and siblings were attending the inquest. The investigator introduced himself and explained that this office had been liaising with the man's daughter throughout the course of the investigation. The man's family had not had chance to see the draft report, but wanted to receive a copy from us and have a chance to comment. The Family Liaison Officer arranged that they have a copy of the report after the inquest.

**HMP ASHWELL**

6. HMP Ashwell is a category C prison in Leicestershire. It was converted in 1955 from an old army camp into an open prison without any physical barriers to deter prisoners from absconding.

7. In 1987 Ashwell underwent a radical change from an open prison to a category C prison. A fence was erected around the perimeter to act as a low level security deterrent to prisoners escaping. Category C prisoners are usually those who do not have the capacity to escape, or are thought to be unlikely to try and escape as they are nearing the end of their sentence.

8. Prisoners at Ashwell are encouraged to develop and accept personal responsibility for their actions and to develop the motivation to improve themselves. They are encouraged to prepare themselves for their eventual release back into the community. The staff at the prison say that they firmly believe that the resettlement programme begins at the onset of custody and that they are committed to developing a constructive, challenging and positive regime for prisoners whilst offering the appropriate interventions and life skills to achieve this.

9. In April 2009, the prison was the subject of concerted indiscipline. A large number of prisoners within the jail refused to go into their cells and violence had started including fires being set. (The man was not one of the prisoners involved.) The fires resulted in a large loss of cellular accommodation and the operational capacity was reduced from 619 to its present 204.

10. Her Majesty's Chief Inspector of Prisons said in her 2007 report following an unannounced short follow up inspection, that Ashwell 'was a generally improved prison'. Her report also said that healthcare services had improved since her previous visit and that there was a good programme of activities offered in the gymnasium.

11. The Independent Monitoring Board's (IMB) annual report for 2008 – 2009 says 'an excellent nursing staff is provided by the Leicestershire County and Rutland Primary Care Trust'. The report also observes however 'There are a number of issues with Healthcare provision that threaten the service they should be providing to their clients and they have been formally raised with the Senior Management Team' (this was in relation to substance misuse services). Their report goes on to say :

    'The introduction of chronic disease management for prisoners with long-term conditions has been identified and these have commenced with an annual over 55 year old clinic, this has been successful and highlighted prisoners with undiagnosed healthcare needs. They are due to look at prisoners with a diagnosis of Asthma within the next four to six weeks. This programme will then continue with other long term conditions such as Heart Disease, Diabetes and Epilepsy.'

12. In respect of the gymnasium, the IMB report says:

‘The Gym continues to deliver effective and interesting qualifications that prisoners enjoy. The success rate of prisoners passing qualification in the gym is impressive and their revised PE programme caters for all prisoners, whatever their capability levels.’

13. There has been one other death due to natural causes at Ashwell since the Ombudsman first started investigating all deaths in prison custody in 2004. There are no obvious similarities between the man’s death and the earlier investigation.

## KEY FINDINGS

14. The man was remanded to HMP Highdown on 31 October 1992 and moved to HMP Brixton on 27 October 1993 whilst still on remand. He was sentenced to life imprisonment with a tariff of 20 years on 19 November, then allocated to HMP Gartree as his first stage lifer prison. He arrived there on 13 December 1993. He was moved to HMP Swaleside on 14 September 1999 and to HMP Rye Hill on 7 March 2002 to allow offending behaviour work to take place. He moved to HMP Highpoint on 7 June 2005, HMP Stocken on 28 October 2005 and Ashwell on 13 March 2007. All these transfers were generated by his sentence and offender management plans and were designed to provide more skills based training work with a view to his eventual release.

15. When the man arrived at Ashwell, the first entry in his wing history sheet said that he was pleased to be at Ashwell as it had taken him 18 months to get there. The entry also said that he appeared to be a polite individual. He asked for release on a home detention curfew when he first arrived at the prison, but this was not granted and he accepted the decision without any problems.

16. The man was asked to move wings on 1 May 2007 and initially he refused to change. However, after being spoken to by staff, he agreed to move to B wing later that day. On 17 May, he was moved to A wing, this time without any problems. He also started work in workshop 4 (a footwear workshop) at about this time. In November he changed his place of work to workshop 8 which assembled window frames and chairs.

17. In April 2008, the man applied to become an orderly in the prison gymnasium. It is not clear from the records when he became an orderly, but an entry in his wing history sheet for 14 June said that he was working as a gym orderly and was working well.

18. The man began to study for the National Vocational Qualification in sport and recreation in September 2008. His personal officer noted in November that he had met all his offender management targets. He had completed courses in anger management, relationships and drugs awareness, achieving several educational qualifications. The man was described as someone who kept himself to himself, spending much of his spare time in his own room.

19. The entry in the man's wing history sheet for February 2009 reported that he was still awaiting news about the application he made in August 2008 to be allowed out on a town visit. Officer A (his personal officer) wrote that he was 'waiting patiently'.

20. On 2 April, the man was seen by Nurse B because he was having problems with his ears. He had been feeling unwell with a cold and had experienced 'hissing in his ears' for a week. When the nurse examined him, she found he had a build up of wax in his ears and gave him some sodium bicarbonate to help break it down. He had his ears syringed on 21 April.

21. Despite the major disturbance at Ashwell in April 2009, the man remained at the prison. Officer A wrote in the man's wing history sheet 'has remained a gym orderly after the riot of 11 April because he is well thought of by staff'. In his July monthly update Officer A wrote that the man had 'suddenly found a sense of humour. He will now talk about things to me and is far less guarded than he was'. Officer A spoke with the man's probation officer, (Officer B), about his change in demeanour. Officer B was aware that the man had been taking part in some 'in-depth psychology sessions' and thought these might account for his 'new found positive attitude'.

22. On 12 May the man was seen by Doctor B (one of the prison doctors) for routine blood tests. He was also seen on 2 June by Nurse C for a routine urine test as part of a well man clinic. Neither assessment visit found anything of significance wrong with the man.

23. On 19 August, he was given an incentives and earned privileges (IEP) warning after entering a staff office at an inappropriate time. (IEP is a system to reward good behaviour in prisons. There are three tiers – basic, standard and enhanced, with enhanced being the highest level of rewards available. Incentives can include more visits and opportunity to spend more private cash.) This did not affect the man's enhanced privileges level as prisoners are given three chances before any formal action is taken.

24. The man was unhappy with a psychology report written about him in early October. Officer A noted in his personal officer report that the man was challenging parts of the report, but that he was doing this in a calm and appropriate way.

**12 October**

25. On the morning of 12 October, the man went to work in the gymnasium as normal. Nothing abnormal occurred during the morning gym sessions and he, and the other orderlies left the gym at approximately 11.30am and returned to their cells in readiness for their lunch.

26. At about 2.00pm on 12 October, the man returned to his place of work, the gymnasium, along with other prisoners who were scheduled to use the gym that afternoon. The man, in common with the other prisoners, was checked into the gym by Physical Education Instructor (PEI) B and PEI A. He began to carry out the routine warm up exercises.

27. About 15 minutes later, at approximately 2.15pm, one of the prisoners in the gymnasium, Prisoner A, shouted for assistance from staff. PEIs A and B ran to Prisoner A who directed them to the cross trainer equipment (a cross trainer is a cardio vascular machine on which people exercise by walking). When they reached the machine, they found that the man had collapsed and did not respond. Prisoner A and another prisoner, had taken the man off of the equipment and laid him on the floor on his side.

28. PEI B (who is first aid qualified) checked the man to see if he was breathing and ensured that his mouth and airway were clear. Meanwhile, PEI A had radioed the communications room with an 'urgent message' for healthcare staff to attend the gymnasium immediately. (In response to an urgent message the communications room puts the radio system into a 'talk through' mode, so that all staff with a radio can hear all the transmissions.)

29. Nurse A and a Pharmacy Technician, who were in the healthcare centre, heard this urgent message at 2.18pm. They ran the 200 metres to the gymnasium carrying the emergency equipment with them. During this time PEI B, who had started to put the man into the recovery position as he had been informed (he thinks by Prisoner A) that the man had had a fit (a seizure), was checking him for signs of life. Nurse A moved the man onto his back and checked him for vital signs (that is his pulse, breathing and blood pressure). She found that he did not respond, was not breathing, had no pulse and was cyanosed (blue in colour).

30. With the help of the Pharmacy Technician and PEI B, Nurse A started cardiopulmonary resuscitation (CPR). She also asked PEI A to arrange for an ambulance to attend urgently. PEI A radioed for an ambulance and then telephoned the communication centre with details of the man's condition. Nurse A also asked the duty doctor, Doctor A, to come immediately to the gymnasium.

31. Staff continued CPR until Doctor A arrived at approximately 2.25pm. In the interim, Nurse A had positioned the automated external defibrillator (AED) so that it could be used if required. (An AED is a sophisticated, reliable, safe, computerised device that delivers an electrical shock to a person in cardiac arrest. It gives voice and visual instructions to guide the person using the machine, and is suitable for use by lay people and healthcare professionals. AEDs analyse the person's heart rhythm, determine the need for a shock, and then deliver a shock. A semiautomatic AED advises the need for a shock, but this has to be delivered by the operator when prompted.) When Doctor A arrived, the AED instructed that a shock should be administered to try and re-start the man's heart. Two shocks were administered, with CPR continuing in between.

32. At approximately 2.30pm the paramedic first responder arrived and used his AED to check the man. He also tried to get access to his veins to administer drugs to treat a cardiac arrest. He was unable to reach the vein but Doctor A was successful, and they gave the man some adrenaline in an effort to restart his heart.

33. Despite strenuous endeavours on the part of all the staff in attendance, their efforts to revive the man were not successful. At 2.39pm the decision was made by those present to stop resuscitation efforts. The man was pronounced dead at this time by Doctor A.

34. The prison's emergency plans for a death occurring were activated, and staff were gathered in the segregation unit to write their reports and have a hot

debrief. Staff care and welfare services were made available to those who needed them. Prisoners who had been in the gymnasium were visited by various members of staff and offered assistance with care and support, as were other prisoners throughout the prison. The police were informed and attended, together with all the other procedures that have to be followed in such circumstances.

35. The Governor of Ashwell, and his Family Liaison Officer, visited the man's family within two hours to break the news of his death. Subsequently, the man's family visited the prison (including the gymnasium) and had the opportunity to talk with friends and staff who had known him. A memorial service was held and a book of condolence was opened. The family have expressed their gratitude for the kindness shown them by everyone at Ashwell.

## ISSUES

36. The Clinical Reviewer, says in his report that the man's underlying medical conditions (diabetes and high cholesterol), had been properly identified and treated throughout his time in prison. Furthermore, the man had been encouraged to make lifestyle changes and he had positively responded to these suggestions. He was reducing his weight, he maintained a healthy diet, undertook regular exercise and had been supported in his efforts to give up smoking. There had never been any suggestion that the man might have any underlying heart disease. No one was aware of any history or complaints of chest pain by the man.

37. One issue of concern identified by the Clinical Reviewer was the monitoring of the man's blood glucose levels. Although the man independently monitored his own glucose levels each day, it is good practice for diabetic patients to have full blood tests (known as Hb1Ac tests) each year. His last test was carried out in February 2007 whilst he was at HMP Stocken. However, the Clinical Reviewer is quite clear that this was not a contributory factor in the man's death. He says that the man had 'excellent control' as regards his diabetes, with no recorded episodes of illness resulting from high or low blood sugar levels.

38. The Clinical Reviewer thinks though, that this failure may indicate a problem within the health services monitoring processes within Ashwell (and possibly other prisons in England and Wales). He suggests that Offender Health (part of the Department of Health) should consider a standard mechanism for evaluating the healthcare of prisoners who suffer from chronic disease. In community doctor's surgeries around the country, the patient's birthday is used as a trigger for annual reviews of long-term conditions. The Clinical Reviewer suggests the same system should be used by prison healthcare providers.

39. The Clinical Reviewer explains that GP services and their local PCTs use the Quality Outcomes Framework (QOF) to help monitor patients with long-term conditions like diabetes (and heart conditions, even though this was not a problem for the man). Again, he urges Offender Health to consider their use in improving health services for prisoner patients.

    **Offender Health should consider issuing national guidance to prison healthcare providers on the advisability of using quality outcomes for chronic disease management for the prisoners in their care. In addition, they could suggest a standardised approach to review dates of such long term conditions for these patients, such reviews to be undertaken during the month of the prisoner's birthday.**

40. A further point made by the Clinical Reviewer is that the man had a history of diabetes and smoking and this meant that he was at higher risk of ischaemic heart disease. However, the man's death was an 'unforeseen and unpredictable event'. He had been encouraged whenever possible to manage his own health and risk factors. The Clinical Reviewer says the

healthcare staff should be congratulated for their strenuous efforts to try and help him stop smoking and also the encouragement they gave to help him reduce his weight. It is clear that the man was well motivated and took a close interest in his health and fitness. Physical fitness had become a very important part of his life. He gained a lot from his daily involvement with activities in the gymnasium in particular the NVQ in Sport and Recreation, Level 2.

41. The clinical review, contains additional recommendations and I urge Leicestershire and Rutland PCT to consider implementing them too.

**Response to the emergency**

42. I believe, like the Clinical Reviewer, that the response to the emergency when the man collapsed on 12 October was faultless. Fully qualified first aid trained PEI staff were on hand immediately and they provided first aid to the man by checking his airway and putting him into the recovery position. Nursing staff arrived within minutes, fully equipped with emergency life saving equipment. The lead nurse, Nurse A, had extensive previous experience on a busy coronary care unit in a hospital. The Pharmacy Technician had recently received basic life support training (as had all the staff working within the healthcare unit). An ambulance was summoned immediately it was asked for and preparations were made to receive it into the prison. Nurse A and the Pharmacy Technician, started CPR as soon as they arrived and continued until a doctor arrived, which was approximately ten minutes after the man was taken ill. The AED was used to shock the man and he was given adrenaline in an effort to help re-start his heart. The paramedic team arrived within 15 minutes of him first collapsing. Sadly, many of my reports do not describe such well coordinated responses to emergencies. All of these resources and efforts were brought to the man's aid, but unfortunately his life could not be saved.

43. The Clinical Reviewer praises the fact that all the prison's healthcare personnel are trained in basic life support, including the Pharmacy Technician. He says that the decision to train everyone who works in the healthcare centre is equivalent to the practice within the NHS and should be encouraged more widely. It meant that two properly trained staff were able to support each other during the initial resuscitation attempt. PEI's (physical education instructors) are also trained first aiders and they were on site to help. There was a doctor in the prison – and she arrived very promptly, as did the first responder paramedic. If the man was to have had any chance of surviving his heart attack, the people who could have helped him were all there, properly equipped and very quickly. As the Clinical Reviewer says:

'On this occasion the man had care which at least matched, and generally greatly exceeded, the best that would have been available in the environment outside the prison gates.'

## CONCLUSION

44. Although the man had some healthcare problems, in particular diabetes and high cholesterol levels, he was balancing that by eating a healthy diet and taking regular exercise. This was in an attempt to reduce his weight, and he had had some success over the years. In addition, he had been supported by healthcare staff to give up smoking. Even though it had been reported he might have a family history of heart problems (his father was thought to have died from heart disease – but this was not accurate), he was making positive efforts to reduce his risk of heart disease.

45. Unfortunately, on 12 October 2009, the man suffered a sudden myocardial infarction (heart attack) because of coronary artery thrombosis and coronary artery atherosclerosis (a narrowing of the coronary artery and blockage of that artery by fatty tissue). Despite valiant and professional efforts by all around him, he could not be saved and he passed away at 2.39pm in the gymnasium at Ashwell.

## RECOMMENDATION

Although the governor has accepted the following recommendation, Offender Health have yet to comment.

Offender Health should consider issuing national guidance to prison healthcare providers on the advisability of using quality outcomes for chronic disease management for the prisoners in their care. In addition, they could suggest a standardised approach to review dates of such long term conditions for these patients, such reviews to be undertaken during the month of the prisoner's birthday.