Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Jones, a prisoner at HMP Ashfield, on 23 August 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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.

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 Gordon Jones died of a ruptured aneurysm and coronary artery atheroma at HMP Ashfield on 23 August 2015. He was 78 years old. I offer my condolences to Mr Jones' family and friends.

The investigation found that Mr Jones received some good care for his various health conditions in prison. However, he was never formally assessed for vascular disease, despite having a number of risk factors, and he missed a routine abdominal aortic screen because he moved prisons on the day it was due to take place. In light of the cause of death, it is unfortunate that HMP Ashfield was not informed about the missed appointment.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. On 14 January 2013, Mr Gordon Jones was sentenced to 14 years in prison. Mr Jones suffered from chronic obstructive pulmonary disease (COPD), but continued to smoke cigarettes and repeatedly turned down help to give up. His blood pressure was occasionally high and he was slightly overweight. In February 2015, a prison doctor diagnosed Mr Jones with atrial fibrillation (a fast and irregular heart beat).

2. In March 2015, while he was at the Isle of Wight, as part of a general screening programme healthcare staff arranged an aortic aneurysm check. On 29 July, Mr Jones was moved temporarily to HMP High Down on his way to HMP Ashfield. This was the day that he was due to have the aortic aneurysm check. No one informed healthcare staff at High Down or Ashfield that Mr Jones had missed the screening.

3. When Mr Jones arrived at Ashfield on 3 August, he told a nurse at an initial health screen that he did not have any outstanding appointments.

4. In the early hours of 23 August, Mr Jones reported having breathing difficulties. The night manager sought advice from an out of hours doctor who advised calling an ambulance. In the meantime Mr Jones collapsed in his cell, although he was still conscious. Officers attended and attempted to resuscitate him. Paramedics arrived and took over emergency treatment. Mr Jones did not respond and a paramedic recorded that he had died.

Findings

5. Mr Jones received generally good care for his COPD and his atrial defibrillation was appropriately diagnosed and managed. However, despite his risk factors, there is no record that he was ever assessed in prison for risk of vascular disease.

6. Mr Jones was offered an abdominal aortic aneurysm screen, beyond the age when it would be offered in the community. There is no record that this was because he had been identified as having any symptoms or being particularly at risk. In the light of the cause of death, it is very unfortunate that Mr Jones transferred on the day the screen had been arranged and no one flagged up for healthcare staff at Ashfield that he had missed the planned screening. However, it is unlikely that Ashfield would have been able to arrange a screen before his death or would have arranged one without an identified clinical need. We cannot know whether it would have been possible to operate, even if the aneurysm had been identified.

7. We are satisfied that the prison control room called an ambulance promptly when Mr Jones collapsed, and staff quickly began cardiopulmonary resuscitation. While it took longer than expected for an ambulance to arrive, ambulance response times are outside the remit of this investigation. There is no evidence that a prompter ambulance response would have changed the outcome for Mr Jones.

Recommendations

- The Heads of Healthcare at HMP Isle of Wight and HMP Ashfield should ensure that prisoners with known risk factors have a structured vascular risk assessment as part of reception health screening, which is reviewed as necessary.

- The Head of Healthcare at HMP Isle of Wight should ensure that when a prisoner moves prisons, healthcare staff identify all outstanding appointments to the receiving prison.

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The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

9. The investigator obtained copies of relevant extracts from Mr Jones' prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Jones' clinical care at the prison.

11. The investigator and clinical reviewer interviewed two members of healthcare staff at the prison on 17 November 2015. The investigator interviewed three prison staff by telephone.

12. We informed HM Coroner for Avon District of the investigation who gave us the preliminary cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers, contacted Mr Jones' son to explain the investigation. Mr Jones' son did not have any specific matters for the investigation to consider. Mr Jones' son received a copy of the initial report. He did not make any comments.

14. The prisons also considered our initial report and raised two factual inaccuracies which have been amended. The prisons also submitted an action plan addressing our recommendations.

Background information

HM Prison Ashfield

15. Until June 2013, HMP Ashfield was a Young Offenders' Institution. In July 2013, it reopened as a specialist medium secure adult male prison for sex offenders. It accommodates approximately 400 men and is managed by Serco.

16. Healthcare is provided by an amalgamation of Hanham Health, Bristol Community Health and Avon and Wiltshire Partnership Mental Health Trust. The healthcare unit provides on-site chronic disease management including diabetes, respiratory and cardiovascular disease screening.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Ashfield was in August 2015. Inspectors found that the transition process for the change of role had been managed well. Health services were effective and responsive. The inspection report noted that a nurse saw new prisoners when they arrived and followed up immediate identified health risks appropriately. Primary care services were very good, except for dental services. Prisoners were relatively positive about access to health professionals. The report recommended that all staff in regular contact with prisoners should be trained in resuscitation techniques, including how to use an automated defibrillator

Independent Monitoring Board

18. 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 June 2015, the IMB reported that the prison provided a safe, secure, and decent environment for prisoners in its care. A new healthcare centre had opened in July 2015, which the IMB considered an improvement.

Previous deaths at HMP Ashfield

19. Mr Jones' death was the first death at Ashfield since the prison changed its function in 2013.

HM Prison Isle of Wight

20. HMP Isle of Wight is an amalgamation of two prisons, Parkhurst and Albany, and holds approximately 1,100 men, mostly convicted of sex offences. Care UK provides healthcare services at the prison. There is a healthcare inpatient unit at the Albany site, providing 24-hour care for prisoners with a wide range of health needs.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Isle of Wight was in June 2015. Inspectors reported that health services were good and long-term medical conditions were

managed well. After deaths at the prison, the prison held multidisciplinary reviews to help identify any lessons to be learned.

Independent Monitoring Board

22. In its latest annual report, for the year to December 2014, the IMB for Isle of Wight reported that the prison provided a good level of outpatient care and that most missed appointments were because of prisoners refusing to attend.

Key Events

23. On 14 January 2013, Mr Gordon Jones was sentenced to 14 years in prison for sexual offences. He initially went to HMP Hewell. Mr Jones had chronic obstructive pulmonary disease (COPD, the name for a collection of lung diseases, including chronic bronchitis and emphysema), which was treated with inhalers. He smoked cigarettes but repeatedly declined help and advice to give up smoking. He was slightly overweight.

24. On 20 May 2013, Mr Jones transferred to the Isle of Wight. On 22 May, a prison GP recorded Mr Jones' blood pressure (taken at his initial health screen on 20 May) was raised at 172/93. She planned to check it again in two to three weeks. There is no record of this but on 4 July a nurse recorded a reading of 139/82 (which was slightly high).

25. On 19 July, a prison GP noted that Mr Jones' blood pressure was variable and arranged for him to wear an ambient cuff to monitor his blood pressure over time to give an average reading. On 9 August, he recorded that Mr Jones' blood pressure was 'perfectly fine'.

26. On 10 August, another prison GP recorded the results of a chest X-ray, which found that Mr Jones' heart size was normal and there were no abnormal changes in the tissues of the lungs. He did not consider any further action was necessary. Mr Jones' blood pressure readings remained variable in 2014 and into 2015

27. On 23 February 2015, a prison GP examined Mr Jones, who had a cold and was short of breath. The GP noted Mr Jones' heart rate was irregular and considered he might have atrial fibrillation (rapid and irregular heart rate). An ECG (electrocardiogram) the same day indicated Mr Jones had significant atrial fibrillation. The GP referred him to the cardiology service at hospital and asked for a 24-hour ECG test. He prescribed anti-coagulant medication, because an irregular heart rhythm increases the likelihood of blood clots.

28. On 24 February, a prison GP noted that blood test results probably excluded the possibility of heart failure, but referred Mr Jones for another chest X-ray. On 3 March, the X-ray revealed no changes from the previous report except that Mr Jones' thoracic aorta was swollen. The GP prescribed bisoprolol (a beta-blocker) and rivaroxaban (an anti-coagulant).

29. On 11 March, a cardiologist at hospital wrote to a prison GP querying the need for a 24-hour electrocardiogram, as he understood that Mr Jones might have already had an electrocardiogram suggesting atrial fibrillation. He asked the GP to clarify this and suggested the cardiology department formally assess Mr Jones and carry out an echocardiogram (a scan showing the heart's structures).

30. On 13 March, a healthcare administrator recorded that Mr Jones had been offered abdominal aortic screening. (This is usually offered as part of a national screening programme when a man reaches 65. It is not normally offered to older men, unless they specifically request it.) On 23 March, Mr Jones agreed to have a screen. No date was fixed at the time, as Hampshire's NHS screening service would only visit the Isle of Wight to carry out screens when there was a full clinic.

31. On 25 March, a prison GP diagnosed Mr Jones with restless leg syndrome, after Mr Jones described a creeping sensation in his legs. The GP prescribed medication to help alleviate the symptoms. On 21 April, another GP recorded that prison staff had told Mr Jones that he would be moving to another prison soon. He arranged a 'medical hold', which meant that Mr Jones would not move until he had had an outstanding cardiac assessment at hospital.

32. On 25 June 2015, a consultant cardiologist examined Mr Jones, who had an echocardiogram at the hospital. The consultant reported that Mr Jones had long-standing atrial fibrillation and an irregular pulse for approximately 50 years. He said there was nothing to suggest active ischaemia (heart disease) or a previous heart attack and Mr Jones did not have heart failure. He did not think there was any need for further cardiology input. The consultant said he did not consider there was any benefit in investigating any further for underlying coronary artery disease, in the absence of any symptoms. He considered Mr Jones had peripheral vascular disease as he had complained of pains in his leg (which can by a symptom), but did not specify any treatment or make any recommendations about this.

33. It was planned that Mr Jones would move to HMP Ashfield and a clinical team manager at the Isle of Wight agreed that the move could go ahead as Mr Jones had now seen the cardiologist and there was no follow up appointments. He did not mention the planned aortic aneurysm screening. On 29 July, Mr Jones was transferred to HMP High Down for a few days, on his way to Ashfield. The same day, NHS Hampshire's screening service visited the Isle of Wight and Mr Jones missed the aortic aneurysm screen. At an initial health screen at High Down, a nurse noted Mr Jones' medication, but no other issues.

34. On 3 August, Mr Jones arrived at Ashfield. Mr Jones told a nurse at an initial health screen, that he felt okay. His pulse was 142/72 (slightly high) and his pulse 66 beats per minute (within normal limits). The nurse recorded that Mr Jones had recently seen a cardiac specialist, but did not have any outstanding appointments. A prison GP prescribed his medication the same day.

35. On 5 August, a nurse recorded Mr Jones' blood pressure was 150/76 (high) and his heart rate 50-89 beats per minute (within normal limits). She recorded he had a family history of angina (Mr Jones' mother) and that Mr Jones had declined any assistance from the smoking cessation service.

36. At 2.50am on 23 August, Mr Jones used the cell intercom system and told an officer in the prison's control room (where internal and external communications are coordinated) that he had breathing problems and needed to see someone. The officer telephoned a colleague who was covering the wing, who went to see Mr Jones. Mr Jones walked to the cell door and told the officer he was finding it hard to sleep, as he had stomach pains and had difficulty breathing even though he had used his inhaler.

37. The officer radioed his colleague at approximately 2.52am and asked for the night orderly officer, (the member of staff in charge of the prison that night). The night orderly officer and a colleague went immediately to Mr Jones' cell, who repeated what he had told the officer.

38. As Mr Jones was conscious and mobile, the night orderly officer and his colleague went to the wing office (approximately 15 metres away) to call the out of hours doctor. The night orderly officer told Mr Jones' cellmate to ring the cell bell and speak to the control room immediately if Mr Jones' condition deteriorated. He spoke to a GP, who advised calling an ambulance immediately.

39. At 3.09am, while the night orderly officer was speaking to the doctor, Mr Jones' cellmate contacted the officer in the control room and said that Mr Jones had collapsed. At 3.10am, the officer alerted staff to attend the cell. An officer and the night orderly officer went into the cell and found Mr Jones on the floor, but conscious. The night orderly officer asked the officer in the control room to call an ambulance, which was called at 3.11am.

40. Two officers arrived at the cell. Shortly afterwards Mr Jones lost consciousness. The officers began cardiopulmonary resuscitation and one officer took Mr Jones' cellmate to a different cell.

41. The control room asked for an update on the arrival time for the ambulance at 3.29am and was told it was a high priority call, but it was not possible to give an estimated time of arrival. The control room rang again at 3.39am and told the operator that Mr Jones was unconscious. There was still no estimated time of arrival for the ambulance. Paramedics arrived at 3.51am and took over emergency treatment. Mr Jones did not respond and, at 4.34am, a paramedic recorded that he had died.

Contact with Mr Jones' family

42. The acting deputy Director went to the prison after he learnt of Mr Jones' death. Mr Jones' records indicated he had said he had no next of kin. The police had contact details for Mr Jones' son and informed him the next day. The acting deputy Director contacted him shortly afterwards to offer support.

43. Mr Jones' funeral was on 17 September. The prison arranged and paid for the funeral in line with national policy.

Support for prisoners and staff

44. After Mr Jones' death, the acting deputy Director debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

45. The prison posted notices informing staff and prisoners of Mr Jones' death, and offering support. Officers spoke to Mr Jones' cellmate individually and offered support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Jones' death.

Cause of death

46. The coroner gave the preliminary cause of death as ruptured aneurysm and coronary artery atheroma.

Findings

Clinical care

47. The clinical reviewer was satisfied that Mr Jones received good care for his COPD. Atrial fibrillation was appropriately identified and treated. Although some care was good, the clinical reviewer had some concerns about assessment of vascular disease and the missed aortic aneurysm screening, which we set out below. In his clinical review, he also identified a need for some improvements in clinical record keeping, which the Head of Healthcare at HMP Isle of Wight will need to address.

Vascular disease

48. There is no record that Mr Jones had a vascular risk assessment at any of his reception screens during his time in prison, either at the Isle of Wight or when he arrived at Ashfield. Mr Jones had intermittent high blood pressure and the consultant cardiologist noted that the pains in Mr Jones' leg indicated peripheral vascular disease. Although the cardiologist did not recommend statins to reduce cholesterol, or any further intervention, there was nothing noted in Mr Jones' medical records to indicate that he was regarded as having established vascular disease. The clinical reviewer considered that, in the absence of an established diagnosis, there should have been a structured risk assessment. The use of statins should have been considered and the reasons documented, if it was thought that this was inappropriate. We make the following recommendation.

The Heads of Healthcare at HMP Isle of Wight and HMP Ashfield should ensure that prisoners with known risk factors have a structured vascular risk assessment as part of reception health screening, which is reviewed as necessary.

Aortic aneurysm screening

49. Mr Jones was offered and accepted abdominal aortic aneurysm screening. Mr Jones was past the age (65) when abdominal aortic aneurysm screening is usually offered as part of the NHS national screening programme and there is nothing in his clinical record to indicate that there had been a specific reason for the screen (although a chest X-ray had shown his thoracic aorta was swollen). The health service manager at HMP Isle of Wight told us that HMP Isle of Wight and NHS Hampshire offer the opportunity for aortic aneurysm screening to everyone in prison over 65 and run a screening clinic each time there are sufficient people on the list.

50. Unfortunately, Mr Jones did not have the screening as he moved to HMP High Down on the day of the clinic. Healthcare staff at Isle of Wight did not flag up the missed screen on his medical record because the screening was a local arrangement and they did not know if HMP Ashfield and its local NHS areas offered the same screening service. When Mr Jones arrived at Ashfield, he said he did not have any outstanding appointments.

51. It is regrettable that Mr Jones did not have the screen before he left the Isle of Wight, which would have identified the aneurysm, but we accept that a routine health screen is not usually sufficient reason to hold up a transfer unless there are other clinical indications. The clinical reviewer noted that it is not possible to say whether the aneurysm would have been operable or whether it would have been too risky to attempt a repair. However, for continuity of care it would have been good practice for healthcare staff, to have flagged up that Mr Jones had missed a planned abdominal aortic aneurysm screen on 29 July. This should have prompted healthcare staff at Ashfield to check whether Mr Jones still wanted to be referred for a screen. We recognise that it is highly unlikely that a screen could have been arranged before Mr Jones died. We make the following recommendation:

The Head of Healthcare at HMP Isle of Wight should ensure that when a prisoner moves prisons, healthcare staff identify all outstanding appointments to the receiving prison.

Emergency response

52. When Mr Jones first reported having breathing difficulties in the early hours of 23 August, an officer checked him quickly and found he was alert and responsive at the time, so did not regard it as an emergency. He asked the night orderly officer to attend, who appropriately called the out of hours GP for advice. As soon as Mr Jones collapsed, officers went into his cell, started cardiopulmonary resuscitation, and requested an ambulance.

53. The staff did not use an emergency medical code, as we would usually expect, but the control room officer promptly called an ambulance and asked for regular updates. The ambulance service controller said it was a high priority call, but it appears to have taken longer than expected for an ambulance to arrive. Ambulance response times are outside the remit of this investigation but this is something the Director of Ashfield might want to discuss with the local ambulance service to help reduce any avoidable delays in future. We are satisfied that prison staff acted quickly and appropriately in calling an emergency ambulance.

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