Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Gary Ash a prisoner at HMP Stoke Heath on 10 August 2017

**A report by the Prisons and Probation Ombudsman**

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

## 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.

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

Mr Gary Ash died on 10 August 2017, at HMP Stoke Heath, of a gastrointestinal haemorrhage caused by an acute duodenal ulcer. He was 47 years old. We offer our condolences to Mr Ash's family and friends.

Before transferring to Stoke Heath, Mr Ash was at HMP Leicester, where he spent most of his time in segregation. His behaviour was often challenging and aggressive. From 31 July onwards, he complained of stomach pains and rectal bleeding. He was seen four times in eight days by three different GPs, who assessed that he did not have a serious condition.

Mr Ash transferred to HMP Stoke Heath on the evening of 8 August and was again located in the segregation unit. He continued to complain of rectal bleeding. On 9 August, nursing staff concluded that he should go to hospital. Mr Ash initially agreed to go, but later changed his mind and refused to attend hospital. He was found unresponsive in his cell the following morning.

The clinical reviewer concluded that, overall, Mr Ash received care equivalent to that he could have expected in the community. I do, however, have a number of concerns.

The GPs who saw Mr Ash at Leicester were not aware that nursing staff were administering pain relief on a daily basis, predominately at night. It is impossible to say whether the GPs would have made a different diagnosis if they had been aware of this.

I am concerned that there was no GP cover at Stoke Heath on 9 August, as there should have been. As a result, an extremely busy nurse was left to deal with Mr Ash on her own. I do not consider this amounted to equitable treatment.

Although I am satisfied that Mr Ash had the mental capacity to refuse to go to hospital, I consider that an out-of-hours doctor should have been asked to see him in prison that night.

I am also concerned that that there is no evidence that agency nurses checked Mr Ash overnight as they had been asked to do.

I have made recommendations on these points.

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

**Elizabeth Moody**
**Acting Prisons and Probation Ombudsman** **April 2018**

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# Summary

## Events

1. Mr Gary Ash was remanded into custody at HMP Leicester on 9 June 2017. This was not his first time in prison, and he had been at Leicester on a number of previous occasions. His behaviour was challenging and he spent the majority of his time at Leicester in segregation.

2. Mr Ash had disclosed a family history of bowel cancer and, while at Leicester, three different GPs assessed Mr Ash four times as he complained of constipation, stomach pains and rectal bleeding. He was diagnosed with constipation and prescribed laxatives. In addition, nurses saw him regularly and administered paracetamol and ibuprofen via a patient group direction (PGD) for relief of a variety of stomach, head, body and tooth pain.

3. On 8 August, Mr Ash was transferred to HMP Stoke Heath. On arrival, staff offered him the opportunity to go to a normal residential unit, but he refused and was again placed in segregation. On 9 August, nursing staff spoke with Mr Ash on four separate occasions as he had raised concerns about passing blood.

4. After discussion with an on-call GP service, nursing staff informed prison staff that Mr Ash should be sent to hospital. This was not possible at the time because of a shortage of staff to provide an escort. When it was possible a few hours later, Mr Ash told staff and nurses that he did not want to receive treatment and refused to attend hospital.

5. During the night, a member of staff checked on Mr Ash hourly in line with segregation unit policy. He was checked at 6.15am on 10 August, and again at 7.15am, with movement recorded on each occasion. Mr Ash was then checked intermittently throughout the morning. When, just before 9.00am, staff became concerned that he was not responding, they entered his cell. Mr Ash had no pulse and was not breathing. Staff called a medical emergency code, and confirmed with the control room that an ambulance was required.

6. Nursing staff responded promptly and began cardiopulmonary resuscitation. This continued until the arrival of paramedics who continued attempts at resuscitation. At 9.24am, Mr Ash was pronounced dead.

7. The post-mortem concluded that Mr Ash died from a gastro-intestinal haemorrhage, caused by an acute duodenal ulceration.

## Findings

### Reception and location

8. Due to his refusal to locate elsewhere, Mr Ash was located in segregation on arrival at Stoke Heath. Although he had a history of mental health issues, which included anxiety, depression and self-harm, there had been no concerns while he was in Stoke Heath or Leicester. Staff managed his needs appropriately in challenging circumstances, including Mr Ash soiling himself, possibly deliberately.

### Emergency response and CPR

9. When Mr Ash was discovered, just before 9.00am, the emergency response was prompt and healthcare staff arrived quickly. Following their arrival, healthcare staff coordinated Mr Ash's life support well.

### Clinical care

10. The clinical reviewer concluded that, overall, the care Mr Ash received at Stoke Heath and Leicester was equivalent to that which he could have expected to receive in the community.

11. However, the clinical reviewer also identified some significant concerns:

    - Nursing staff at Leicester administered pain relief, predominately during the night, over ten consecutive days, without informing the GPs. This information was, therefore, not available to the GPs when they assessed Mr Ash.
    - Although there should have been GP cover at Stoke Heath on 9 August, the GP was absent and no cover had been arranged. As a result, Mr Ash was not seen by a doctor before he died.
    - There is no evidence that the two agency nurses carried out any clinical observations of Mr Ash overnight.

12. We share the clinical reviewer's concerns and repeat her recommendations on these points here. (The clinical reviewer has made other recommendations that the Head of Healthcare will want to address.) In particular, we do not consider the lack of GP cover at Stoke Heath on 9 August amounted to equitable treatment.

13. We are also concerned that healthcare staff did not ask an out-of-hours doctor to attend the prison to see Mr Ash on the night of 9 August after he refused to go to hospital. We consider this was an oversight. In saying that, we recognise that the nurse on duty was under extreme pressure and had dealt with a number of medical emergencies across the prison that day. We, therefore, question whether there was sufficient nursing cover in place.

## Recommendations

- The Head of Healthcare at Leicester should develop a PGD template, based on national community therapeutic guidance, that can be scanned onto SystmOne. This should include maximum days of PGD use before reporting to the GPs, in line with community guidance of four days.
- The Head of Healthcare at Stoke Heath, working with the healthcare provider and Her Majesty's Prison and Probation Service, should assure NHS England that GP and nursing cover at Stoke Heath is both safe and equal to the community.
- The Head of Healthcare at Stoke Heath should investigate further the issue of the agency nurses not checking on Mr Ash overnight on 9 August as requested by a nurse.

## The Investigation Process

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

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

16. The investigator obtained copies of relevant extracts from Mr Ash's prison and medical records. Along with the clinical reviewer, he interviewed four members of nursing staff at Stoke Heath on 26 September 2017. The clinical reviewer also interviewed nursing staff and GPs at Leicester as part of her review.

17. We informed HM Coroner for Shropshire of the investigation and he sent us the post-mortem report. This indicated the cause of Mr Ash's death as acute gastrointestinal haemorrhage caused by a bleeding chronic duodenal ulcer.

18. The investigator sent a letter to Mr Ash's next of kin to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. He received a telephone call from Mr Ash's nephew, who confirmed that he would like to receive a copy of our report.

19. Mr Ash's family received a copy of the initial report. They were concerned by our findings, but did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

### HMP Leicester

20. HMP Leicester is a local prison that holds 325 men. It primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Leicester was conducted in October 2015. Inspectors reported that healthcare clinics had a high non-attendance rate of above 20%, often because prisoners could not be escorted. They found that waiting times to see the GP were reasonable. Urgent GP appointments were available daily and out-of hours GP arrangements were satisfactory.

22. Most life-long conditions were managed by the GPs, but formal care planning associated with nurse-led clinics was underdeveloped. The inspection team commented that monitoring of external hospital appointments had improved, with external hospital appointments available weekly, although too many had been rescheduled because of a lack of escort staff. HMCIP jointly inspected the healthcare at Leicester with inspectors from the Care Quality Commission (CQC). Following the inspection, the CQC issued a requirement to improve notice to HMP Leicester.

### Independent Monitoring Board

23. 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 January 2017, the IMB at Leicester reported that healthcare services had improved during 2016. They commented that in November 2015, the Care Quality Commission (CQC) had issued an improvement notice and, when they completed a re-visit in April 2016, found that all the clinical elements had been addressed. Twenty-four-hour nursing and medical provision continued for both routine and urgent care.

### HMP Stoke Heath

24. HMP/YOI Stoke Heath is a category C training prison in Shropshire, which holds up to 745 adult and young adult sentenced men. Shropshire Community Health NHS Trust provides primary healthcare services, with South Staffordshire NHS Foundation Trust providing secondary mental health services. GP cover is normally available at Stoke Heath between 8.00am and midday. After this, ‘Shropdoc’ provides an out-of-hours GP service.

### HM Inspectorate of Prisons

25. The most recent inspection of HMP Stoke Heath was conducted in April 2015. Inspectors said that in the six months to the end of March 2015, there had been 185 periods of segregation, which was high. The average stay in the separation and reintegration unit was not excessive, at eight days, and few prisoners spent long periods there.

26. In relation to healthcare, the inspectors noted that not all new arrivals had an initial health screening on reception, which missed some significant health risks and needs for treatment, especially for prisoners on remand. There were also no routine follow-ups. Prisoners did not always receive prompt access to their medication, particularly when they first arrived, but there was good access to primary care services, including the GP.

### Independent Monitoring Board

27. Stoke Heath's IMB published its annual report for the year to April 2017 in August 2017. The Board said that there had been a small increase in the use of the segregation unit over the reporting year, mainly due to the security team being pro-active and introducing random cell searches, which had resulted in numerous finds of illicit items. Conditions and the facilities of the unit were generally good and staffing levels were adequate. All paperwork was completed and the Board were told of newly arrived prisoners and advised of review dates. A 100% of reviews were held within the specified time limit and attended by a Governor, healthcare and an IMB member. The nurse was always asked whether a prisoner had any medical concerns and a safety algorithm completed. If a prisoner was not deemed suitable for segregation, he was returned to normal location.

### Previous deaths at HMP Stoke Heath

28. Mr Ash is the second prisoner to die of natural causes at Stoke Heath since May 2017. There were no similarities between the circumstances of Mr Ash's death and the previous death at the prison.

### Segregation Units

29. The purpose of segregation units is to keep prisoners apart from other prisoners or from certain groups of prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air.

# Key Events

### HMP Leicester – 9 June to 8 August

30. On 9 June 2017, Mr Gary Ash was charged with burglary, had his conditional licence revoked and was remanded to HMP Leicester.

Segregation

31. Mr Ash was initially located on the induction wing. He was relocated to the segregation unit on 24 June, after he climbed on the netting that separated landings and refused to come off unless he was relocated to segregation.

32. Mr Ash's behaviour was initially challenging, with threats toward staff and racial abuse. Mr Ash settled in the segregation unit, but when staff tried to relocate him onto a normal residential wing, he refused. This was consistent with Mr Ash's behaviour during previous sentences.

33. Mr Ash told staff that he wanted to move out of the Leicester area. A transfer to HMP Leeds became available but, although Mr Ash was initially happy to go, on the day of transfer, he refused, telling staff that his head was "not in the right place".

34. When Mr Ash arrived at Leicester, a nurse recorded that he appeared fit and well, had no underlying health concerns and was not in receipt of any medication. She recorded that there were no issues and no need for onward referrals. A GP review in early July indicated that no healthcare issues were raised.

35. During the next two weeks in July 2017, paracetamol and ibuprofen were administered to Mr Ash almost on a multiple daily basis by nursing staff via a patient group direction (PGD) for relief of a variety of stomach, head, body and toothache pain. (A PGD is an agreed protocol for nurses to be able to administer specific medications in specific circumstances when a GP is not present to prescribe. A PGD for moderate pain relief is common in residential healthcare settings and is established for use now and again. Any regular use should be reviewed by the GP for further investigation if the cause is unknown, or regular prescription.)

36. All the entries by the GPs completing the segregation unit reviews during this time stated that no healthcare issues had been raised for Mr Ash, despite the high level of pain relief predominantly administered during the night period.

37. On the morning of 31 July, Mr Ash complained of generalised pain, which he said was "unbearable", and of bleeding from his rectum. He was seen by prison a GP. On examination, Mr Ash's abdomen was soft and non-tender. The GP assessed that there was no evidence of a serious condition, but that Mr Ash was constipated with a possible viral illness. He prescribed a laxative and pain relief medication.

38. On 1 August, Mr Ash complained of back and bowel pain. He was seen by a nurse and advised to allow more time for the laxative to work. Paracetamol and ibuprofen were given via PGD in the early morning and late evening.

39. On 2 August, a prison GP examined Mr Ash again as Mr Ash was very worried that he remained constipated and could not sleep. He concluded that there was no evidence of any serious illness or of intra- abdominal pathology. He prescribed night sedation.

40. On 3 August, Mr Ash was given paracetamol and ibuprofen by PGD at midnight and at 4 am. He complained of pain all over and vomiting and said he was "shitting blood". In the morning, he was seen by a nurse, who noted that he was verbally aggressive and complaining of bleeding a lot from his rectum. The nurse advised him to give the laxative more time to take effect.

41. Mr Ash continued to complain of "crushing" abdominal pain and poor sleep due to the pain, and said he had not eaten for a couple of days. In the afternoon, he was seen by another nurse, who advised him to drink more fluid and issued night sedation. He was given a mild laxative and paracetamol and ibuprofen at 10pm, followed by paracetamol at about 3am and ibuprofen at 5.40 am on 4 August, all via a PGD.

42. On 4 August, a prison GP reviewed Mr Ash, noting that he had not opened his bowels for nine days and that laxatives were not helping. He could not detect any abnormality and prescribed a stronger laxative. He advised further review if Mr Ash remained unwell and that bowel investigations should be considered to rule out underlying bowel cancer.

43. On 5 and 6 August, further paracetamol and ibuprofen was administered via PGD for a variety of back, bowel and unspecified pain.

44. Early on the morning of 7 August, segregation unit staff asked a nurse to assess Mr Ash as he was complaining of passing blood when he tried to open his bowels. The nurse noted there was a small amount of faeces in the toilet with fresh blood. Mr Ash threatened to cut his throat if he was not taken to hospital. The nurse noted that Mr Ash had not had a proper bowel movement for eleven days and continued to have a dull abdominal ache that was aggravated by movement and relieved by nothing. Vital observations were normal but the nurse noted that Mr Ash was shivering. He also noted a prison GP's comment about a possible diagnosis of bowel cancer. The nurse contacted the GP out-of-hours service and was advised to continue with vital observations, including weight, and to follow up with the prison GP.

45. A prison GP examined Mr Ash later that morning, and recorded that he was aggressive and threatening. He noted that there was no abdominal distension, typically a symptom of an underlying disease or dysfunction in the body. Mr Ash denied any recent weight loss, he appeared well, his abdomen was soft and non-tender, and his anus was normal with no masses or blood. He recorded that Mr Ash had demanded to go to hospital, and that he had explained to Mr Ash that there was no clinical reason to do so at that time. He advised Mr Ash to continue with the stronger laxative. He also recorded that Mr Ash should have blood tests, but did not specify what tests were required.

46. Further paracetamol and ibuprofen were given by PGD mid-afternoon and late evening for unspecified reasons.

47. On 8 August, Mr Ash told clinical staff at midday that he had now opened his bowels. He was later assessed as being medically fit for transfer to Stoke Heath as no healthcare concerns were raised. (The segregation unit at Leicester had been full for some time, and the opportunity to transfer some prisoners arose. Mr Ash had apparently been in the unit the longest and was, therefore, chosen to move, despite his resistance.)

### HMP Stoke Heath – 8 August to 10 August

48. When he arrived at Stoke Heath on the evening of 8 August, Mr Ash refused to go to a normal wing and was placed in the segregation unit.

49. An officer was on duty in the segregation unit and said that he was made aware that Mr Ash was being brought to the unit at around 6.00pm. Mr Ash arrived on the unit at 6.20pm and he showed him to a cell and explained the unit routines. Mr Ash asked about medication and he told him that the nurse would contact the unit once any medication had been sorted out.

50. Segregation unit staff at Stoke Heath told us that they were not aware that Mr Ash had had any medical issues at Leicester. They said he was difficult to deal with and they struggled to establish a rapport because he did not want to be at Stoke Heath.

51. Mr Ash refused a health screen on arrival and only allowed a nurse to check his blood pressure and pulse, which were normal. She noted that Mr Ash was very aggressive and agitated because he had not wanted to transfer. She said that she did not receive any health information from HMP Leicester about Mr Ash's health status prior to transfer, but she did not see any overt signs of pain during the reception screen. She also noted that he was pale and gaunt and that he told her that he was "shitting blood". She told Mr Ash that she would send a faecal sample pot to the segregation unit for him to use, and would book him to see a GP the following day. She recorded that Mr Ash threatened to cut his throat if she did not sort his medication out, but he was unable to tell her what medication he required. Mr Ash mentioned sleeping tablets (zopiclone) but she said that he was not prescribed this and a previous prescription from Leicester had run out.

52. When interviewed, the nurse said that Mr Ash's threat to self-harm had not concerned her. In her opinion, he had said it out of frustration and as an attempt to gain medication. She said that he did not present as being at risk to himself and she took no further action. Despite Mr Ash not having a prescription for zopiclone, she said that she felt that, due to his frustration, he might benefit from a single dose for that evening, and contacted the out-of-hours GP service for a prescription to be raised.

53. The nurse on night duty went to the segregation unit during the night to see Mr Ash at the request of prison staff. She said that Mr Ash was aggressive and agitated, and complained that nobody had done anything about his pain and rectal bleeding for 12 days. She noted that there was possible evidence of vomit with a small amount of fresh blood present on the floor, along with what looked like dark, possibly bloodstained, loose faeces.

54. The nurse said that she offered Mr Ash paracetamol, but he insisted he wanted something stronger and refused to allow her to check his pulse or take other observations. She also took Mr Ash a single dose of zopiclone that had been prescribed by the on-call GP service.

55. At 9.45am on 9 August, a mental health nurse went to the segregation unit to issue medication. An officer told her that Mr Ash had complained of feeling unwell. She reviewed him and documented that she found Mr Ash in bed. He appeared to have purposely been doubly incontinent and was refusing to shower. She recorded that Mr Ash said that he was in pain, and was argumentative and aggressive. She offered Mr Ash paracetamol, which he refused, but she left him the faecal sample pot.

56. No GP was available to carry out the scheduled round of the unit on 9 August. The GP who was scheduled to attend was absent and no cover had been arranged.

57. During the morning, the duty Governor visited prisoners in the segregation unit and spoke with Mr Ash. Mr Ash told him that he did not want to be at Stoke Heath and wanted to return to Leicester.

58. An officer said that he heard Mr Ash shouting from his window, "I'll shit this block up. I will do whatever I have to get out of here". He said that he took Mr Ash's comments to indicate that he had started a dirty protest. A Custodial Manager (CM) came onto the unit and, along with the officer, went to speak with Mr Ash. Mr Ash said that he had soiled himself and had diarrhoea. The officer said that he offered Mr Ash a shower and a change of clothing, but he declined and said that he could not be bothered.

59. The officer said that he continued to check on Mr Ash throughout the morning and, at 11.30am, took him some lunch. He offered Mr Ash some hot water, which he declined. He contacted healthcare and spoke to a nurse, telling her that Mr Ash had been complaining of feeling unwell and that a mental health nurse had told him someone would come and see him.

60. The nurse said that she went to the segregation unit at some point after 2.00pm. She was unsure of the exact time due to the number of calls she had already attended that day. She said that Mr Ash told her that he had not opened his bowels for 11 days and had been bleeding rectally for the same period. She told Mr Ash that she had read his notes and that Leicester had recorded that he had opened his bowels.

61. The nurse told him that she would need to reassess him. She checked his blood pressure, which was normal, and his pulse, which was significantly raised, and his temperature, which was also raised. She noted that Mr Ash was lying in very soiled boxer shorts that were very bloodstained and there was also blood on the sheet. The blood was not fresh but dark in colour, indicating that the bleeding was coming from higher up in his bowel. She said that the sample pot that had been provided earlier was on the sink, and contained a small amount of faeces. She placed the sample pot in a sealable microbiology bag to send to the laboratory.

62. The nurse noticed the smell of melena - old blood in faeces that has an iron-like smell - in Mr Ash's cell. She said that Mr Ash appeared very grey and looked

anaemic. She told the segregation unit staff that she was considering sending Mr Ash to hospital, but needed to review his medical notes and speak with senior colleagues first.

63. As Mr Ash had passed dark bloodstained faeces and presented with an elevated pulse, clinical nurse manager and the nurse agreed that he may have some form of slow intestinal bleed that was nearer to his stomach. They noted that the bleeding was not fresh blood and did not present as an emergency haemorrhage. However, they agreed that he needed to go to hospital for further investigation.

64. At around 4.00pm, the nurse returned to see Mr Ash. She said that she thought initially that Mr Ash could have a perforated bowel, so needed to check his temperature. When she returned to see Mr Ash, a mental health nurse accompanied her.

65. The nurse said that initially Mr Ash was agitated and uncooperative but he eventually allowed her to retake his observations. His pulse was raised. She used a stethoscope to listen to Mr Ash's bowel for movement and could hear it moving quite well. She said that she asked Mr Ash three times whether he had ingested anything that he should not, and he replied, "I don't do that sort of stuff".

66. The nurse explained to Mr Ash that she had concerns that his pulse was raised and would therefore arrange for him to attend hospital. Mr Ash asked her whether the hospital would test for cancer, and she reassured him that he had already completed the first test by providing a stool sample.

67. The officer told Mr Ash that he would need to clean himself up before he could be taken to hospital. He offered Mr Ash a shower, which he accepted. Staff also provided a clean set of clothes. The officer and nurse then left the cell at approximately 5.00pm.

68. The nurse contacted a CM and told him that Mr Ash would need to be sent out to Accident and Emergency. The CM asked her to contact Shropdoc (who provide an out-of-hours GP service to the prison) and see whether a GP would come into the prison and assess Mr Ash, because Mr Ash was not considered at that time to be an emergency.

69. The nurse explained to the CM that calls to the Shropdoc service could not be made until 6.00pm, and he replied that if Mr Ash did need to be sent out to hospital, he would not have escort staff available until around the same time as they were serving the evening meal.

70. The nurse left the segregation unit to issue medication elsewhere and to contact Shropdoc. She made the call to Shropdoc at 6.45pm. A GP telephoned her back at around 7.30pm and she read the GP the summary made by a prison GP at Leicester on 7 August. She also told the GP about Mr Ash's presentation and his observations, and the GP agreed that he should be seen at hospital. She then telephoned the segregation unit and told the officer that Shropdoc had agreed that Mr Ash should go out to hospital. However, the officer told her that Mr Ash had begun another dirty protest, and covered himself in faeces. He said that Mr Ash presented a biohazard in this condition and, as a non-emergency, would not be taken to hospital.

71. At 8.00pm, the nurse telephoned the clinical nurse manager to ask for advice as she wanted Mr Ash to attend hospital, but he could not do so in his current state. The manager advised her to call Shropdoc again and update them, and also to inform the Duty Manager of her concerns about Mr Ash. She contacted Shropdoc and was called back by the same GP as before. She told the GP that due to Mr Ash now presenting as a biohazard, the prison had requested that a GP attend the prison. The GP said that this would be possible, but might take some time. They both agreed that their observations should continue. The nurse agreed with the GP that if Mr Ash's pulse had come down to a safe range, a GP would attend the prison, otherwise he would still need to go to hospital.

72. The nurse returned to the segregation unit to speak with Mr Ash at 10.30pm. A CM, the senior manager on night duty, and two agency nurses who would be covering the night duty, accompanied her. Due to his dirty protest, the nurse had to put on protective clothing before entering Mr Ash's cell.

73. When the nurse went into his cell, Mr Ash said, "Have you got my zopiclone?" She told him that he was not prescribed zopiclone, and she was worried about him and needed to recheck his observations. She explained to Mr Ash that Shropdoc had said that if his pulse remained high, he should go to hospital, but if it had fallen, a doctor would come into the prison. Mr Ash told her to get out of the cell. She said that Mr Ash spoke quite aggressively, so she left the cell.

74. The nurse and CM returned to the cell with the CM's body-worn camera switched on. At the cell, the nurse said to Mr Ash, "I am concerned about you, do you understand?" Mr Ash replied, "No". He continued to refuse to attend hospital, despite its importance being stressed again by all the staff present. He stated that he understood but wanted them to leave him alone. He refused to sign a disclaimer form but all discussion was recorded on the body camera.

75. The nurse returned to the healthcare unit and handed over to two agency nurses. She asked them to keep an eye on Mr Ash during the night, and she left the prison at 11.40pm. The clinical record does not indicate that the agency nurses completed any clinical observations of Mr Ash overnight.

76. Prison night staff continued to check on Mr Ash hourly throughout the night in accordance with segregation unit policy, and no issues were reported. On 10 August, at 6.15am, a Healthcare Assistant (HCA) went to the segregation unit to check on Mr Ash. She said that the member of staff on duty told her that Mr Ash had been settled during the night and she looked in on him through the observation panel. She said she noted movement and was satisfied that Mr Ash was sleeping.

77. An officer arrived for duty at 7.15am and began a count of prisoners on the unit. She told the investigator that she reached Mr Ash's door at about 7.18am, and tried to gain a response from him by kicking his door. She said that she noted movement from Mr Ash and that he "grunted". She said that whenever she does a roll count she ensures that she gets a reaction from the prisoner, to satisfy herself that the prisoner is alive and well.

78. Staff checked on Mr Ash intermittently between 7.15am and 8.45am, on each occasion trying to elicit a response. They said that he was lying on his bed

facing the wall, and despite movements of the covers being noted, they thought that he was ignoring them, as this is how he had behaved the previous day. At 8.45am, an officer checked on Mr Ash as he thought that he might interact better with him as they had built up a rapport the previous day.

79. The officer looked into the cell through the observation panel. He said that Mr Ash was now lying on his front with the covers over his lower half. He kicked the door and shouted to Mr Ash, asking if he wanted breakfast. He began to unlock the door, but Mr Ash did not react, and he could not see signs of breathing.

80. The officer said that he was concerned when he did not get a response. Mr Ash needed at least three staff to be present when his cell was opened, due to his previous behaviour. However, he unlocked the door and stood in the doorway, continuing to call to Mr Ash. He said that he could not see any signs that Mr Ash was breathing and when he still got no response, he closed the door and went to the unit office. He asked two officers to return to the cell with him. He entered the cell with another officer at approximately 8.55am and, on checking Mr Ash, found that he had no pulse and was not breathing. He used his radio to call a medical emergency code, and confirmed with the control room that an ambulance was required.

81. Nursing staff responded within a few minutes of receiving the emergency call and they began cardiopulmonary resuscitation (CPR), continuing until the arrival of paramedics. The prison control room and ambulance service records indicate that the control room telephoned the emergency services at 8.57am. Paramedics were with Mr Ash by 9.07am and they continued to attempt resuscitation but, at 9.24am, Mr Ash was pronounced dead.

## Contact with Mr Ash's family

82. Shortly after Mr Ash's death, the prison appointed a family liaison officer. Mr Ash's nominated next of kin was his nephew. The family liaison officer and a Principal Officer visited Mr Ash's nephew at 11.55am on 10 August. They informed the family of Mr Ash's death. The family liaison officer spent some time at the address, meeting other members of Mr Ash's family and providing advice and support.

83. Mr Ash's funeral was held on 30 August 2017. The prison contributed to the costs in line with national guidance.

## Support for prisoners and staff

84. After Mr Ash's death, a governor debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

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

## Post-mortem report

86. The post-mortem concluded that Mr Ash died from a gastro-intestinal haemorrhage, caused by an acute duodenal ulceration.

# Findings

## Reception and location

87. Due to his refusal to locate elsewhere, Mr Ash was immediately located in the segregation unit on arrival at Stoke Heath. We consider that in these particular circumstances, Mr Ash was appropriately managed and located at Stoke Heath. All documentation relevant to Mr Ash's period of segregation was fully completed.

## Emergency response and CPR

88. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. On establishing that Mr Ash was unresponsive, the officer made a code blue call on his radio. This was picked up by other officers and healthcare staff who arrived promptly. An ambulance was also called without delay. We consider that the initial emergency response was appropriate.

89. A defibrillator was on the unit and immediately made available to staff. There was no delay in the defibrillator being used. CPR was prompt and performed it to a high standard and a full record was made on Mr Ash's medical notes.

## Clinical care

### HMP Leicester

90. The clinical reviewer has considered the care provided to Mr Ash at HMP Leicester.

91. Mr Ash was seen regularly by GPs when he complained of constipation and rectal bleeding. The clinical reviewer commented that in most cases rectal bleeding is benign, especially in those under 50, and is generally caused by piles or an anal fissure. However, it is important to rule out colorectal or anal cancer and inflammatory bowel disease as potential causes.

92. National Institute for Clinical Excellence (NICE) guidance for unexplained rectal bleeding in someone less than 50 years old is that they should be checked for weight loss and iron deficiency anaemia. Mr Ash did not have his weight checked at Leicester. A prison GP advised on 7 August that blood tests should be arranged to check normal body function, which would have included a full blood count for anaemia plus kidney, thyroid, and liver function, but these tests were not completed because Mr Ash was transferred to Stoke Heath the next day.

93. The clinical reviewer concluded that, overall, GPs at Leicester managed Mr Ash's symptoms in line with community guidance and that treatment was equivalent to that which Mr Ash could have expected to receive in the community.

94. However, the clinical reviewer expressed concern that nursing staff at Leicester administered pain relief to Mr Ash for lower abdominal pain, predominately during the night, over ten consecutive days via PGD without informing the GPs. The clinical reviewer considered that this was not good nursing practice. One of the symptoms of a duodenal ulcer is abdominal pain predominately at night, but this information was not available to the GPs when they assessed Mr Ash.

95. We, share the clinical reviewer's concern about the poor communication and make the following recommendation:

**The Head of Healthcare at Leicester should develop a PGD template, based on national community therapeutic guidance, that can be scanned onto SystmOne. This should include maximum days of PGD use before reporting to the GPs, in line with community guidance of four days.**

### Transfer to HMP Stoke Heath

96. After Mr Ash told clinical staff on 8 August that he had opened his bowels, no healthcare objections were raised to him transferring to Stoke Heath. We accept that this was not an unreasonable decision at the time. All the GPs believed that there were no clinical findings at the time to suggest that Mr Ash was not fit to be transferred, as bowel obstruction had been ruled out and he had reported that he had opened his bowels earlier that day.

### HMP Stoke Heath

97. The clinical reviewer concluded that the care Mr Ash received at Stoke Heath, in the short time he was there, was of a good standard and equivalent to that he could have expected to receive in the community, except for the inability to transfer him to hospital when healthcare staff initially advised it – although the clinical reviewer said this was outside the control of healthcare staff.

98. The clinical reviewer was, however, concerned that although there should have been GP cover at Stoke Heath on 9 August, the GP was absent and no cover had been arranged. In addition, the out-of-hours GP service could not be contacted before 6pm.

99. We share the clinical reviewer's concern about the lack of GP cover. It is clear from interviews and documentation that the nurse was under extreme pressure on 9 August, dealing with a number of medical emergencies across the prison. It was her view that given his raised pulse and description of symptoms, Mr Ash required further observation and assessment at hospital.

100. However, given the lack of GP cover, she did not have the support of a second opinion and, despite requesting the attendance of a GP using the on-call service, she was ultimately left to deal with Mr Ash in isolation. We do not consider the lack of GP cover to have offered equitable treatment and we also question whether there was sufficient nursing cover. We welcome and repeat the recommendation made by the clinical reviewer on this point:

**The Head of Healthcare at Stoke Heath, working with the Healthcare provider and Her Majesty's Prison and Probation Service, should assure NHS England that GP and nursing cover at Stoke Heath is both safe and equal to the community.**

101. As the nurse did not initially consider that Mr Ash needed to go to hospital as an emergency, we do not consider that it was unreasonable for the Duty Manager to say that he could not go until escort staff were available, and that he needed to shower first.

102. It appears that Mr Ash was willing to shower and go to hospital when this was first raised at about 4pm. It is impossible to know why he later refused to go to hospital, although nursing staff suggested with hindsight that he may have been frightened he would diagnosed with bowel cancer. Although his refusal appears irrational, we are satisfied that it was a decision that Mr Ash had the mental capacity to make.

103. However, the concerns about Mr Ash's health remained. We, therefore, consider that healthcare staff should have insisted that an out-of-hours doctor attend and examine him in prison. We consider that it was an oversight not to do this.

104. The nurse had taken two agency nurses with her to see Mr Ash on her last visit at around 10.30pm, so that they were aware of the issues. She asked these two nurses to continue to monitor Mr Ash during the night. While there is evidence that segregation unit staff did check on him regularly, there is no evidence that the agency nurses did any checks at all. We repeat the clinical reviewer's recommendation on this point:

**The Head of Healthcare at Stoke Heath needs to investigate further the issue of the agency nurses not checking on Mr Ash overnight on 9 August as requested by the nurse.**

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

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

T | 020 7633 4100
F | 020 7633 4141