Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Ajidahun a prisoner at HMP Chelmsford on 20 September 2016

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*

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 John Ajidahun died on 20 September 2016 of viral heart disease at HMP Chelmsford. Mr Ajidahun was 27 years old. I offer my condolences to Mr Ajidahun's family and friends.

Mr Ajidahun died of a rare cardiac condition and healthcare staff promptly referred him to hospital when he exhibited symptoms, they also complied with the hospital's advice regarding medication, scans and further appointments. However, a prison GP did not review Mr Ajidahun on either of the two occasions the hospital discharged him, and staff did not draw up a care plan or discuss his case at a multi disciplinary team meeting. There is no evidence that gym staff were aware of Mr Ajidahun's condition. Staff understanding of the emergency code system at the prison was confused.

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 **July 2017**

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Summary

Events

1. On 30 December 2015, Mr John Ajidahun was sentenced to 30 weeks imprisonment for possession of drugs and then, on 11 March 2016, to 51 months imprisonment for possession of an offensive weapon and drugs. He had been sent to HMP Chelmsford on remand on 21 December 2015 and remained there. At his first night screen he was not on any medication and did not report any problems.

2. On 16 August 2016, in the early hours of the morning, a nurse saw Mr Ajidahun in his cell. He reported chest pains and the nurse arranged for him to be seen the next day by a doctor and for an ECG to be done. (ECG - electrocardiograms measure the electrical rhythm of the heart.) The next day, the ECG detected an irregular heart rhythm so the doctor sent Mr Ajidahun to the local accident and emergency department. Hospital staff there admitted him and he was discharged on 20 August with a diagnosis of inflamed heart muscle and instructions for the prison to arrange an MRI scan, an exercise tolerance test, hospital follow up in 6 weeks' time and to prescribe various medications.

3. On 26 August, Mr Ajidahun told a nurse he had chest pains again and, on 28 August, he was readmitted to hospital. He was discharged on 6 September, having been diagnosed again with heart inflammation and other related issues. The hospital revised his medication and requested that the prison arrange an echocardiogram within 2 weeks and, dependant on those results, an appointment with a cardiologist. (Echocardiograms produce an image of the heart's structures.)

4. On 15 September, Mr Ajidahun again told a healthcare support worker he was unwell and she signed him off work. On 20 September, his cell mate alerted officers that Mr Ajidahun was taking a long time to wake up but he was breathing. A Senior Officer asked healthcare staff to attend and, when Mr Ajidahun failed to respond to their treatment, they broadcast an emergency code, prompting control room staff to call an ambulance. Paramedics attended but could not resuscitate Mr Ajidahun. They transferred him to hospital but pronounced him dead at 10.32am.

Findings

5. Care in respect of prompt referrals to hospital was good. The prison prescribed Mr Ajidahun with all required medication and arranged the appointments and scans requested by the hospital. The resuscitation attempt at the prison was carried out in line with best practice.

6. Although the hospital discharged Mr Ajidahun with a rare and dangerous condition, a prison doctor did not review him after either of his discharges. Neither were any care plans drawn up or his case discussed at a multi disciplinary team meeting. It does not seem that information about Mr Ajidahun's condition was shared with the gym even though healthcare staff knew that he used it frequently (although apparently not after he was diagnosed with cardiac

issues). We have not seen any evidence that gym staff carried out a full induction when he joined.

7. Understanding of the emergency code system at Chelmsford was poor. There was confusion about which codes should be used, what they mean and who should call an ambulance.

Recommendations

- The Head of Healthcare should ensure that GPs automatically see and create care plans for prisoners returning from hospital with new diagnoses and treatments.
- The Head of Healthcare should create Supported Living Plans and share these with prison staff where appropriate.
- The Governor should ensure that prisoners wishing to use the gym complete and sign a PAR-Q as part of their induction in line with PSI 58/2011.
- The Governor and the Head of Healthcare should ensure all staff are familiar with and understand the emergency code protocol.

The Investigation Process

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

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

10. NHS England commissioned a clinical reviewer to review Mr Ajidahun's clinical care at the prison and did one joint interview with the investigator.

11. We informed HM Coroner for Essex and Thurrock of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Ajidahun's brother, to explain the investigation and to ask if they had any matters he wanted the investigation to consider. He raised the following points which are either covered in this report or in more detail within the clinical review:

- He felt nurses at the prison did not take his condition seriously
- Did healthcare staff check on Mr Ajidahun each time he was discharged from hospital?
- Why was he never taken to hospital at night when his condition was worse?
- Why was he not taken to hospital straight away on the morning he was found unresponsive?
- Exactly what medication was he on?
- Why was he not located on the healthcare wing when he was on so much medication?

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

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Chelmsford

15. HMP Chelmsford is a local category B prison holding up to 745 mainly adult men. The older part of the prison has four wings and the newer part has three (a first night and induction wing, a drug treatment wing and a mixed wing including older prisoners). There is also a twelve bedded, twenty four hour healthcare department in the newer part of the prison.

16. Health services are provided by Care UK. The healthcare centre is in the newer part of the building, has twelve inpatient beds and offers twenty four hour care.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Chelmsford was in April 2016. Inspectors reported that the prison's previous progress had stalled and there had been some deterioration in outcomes but a competent management team was trying to address this. The inspection of health services was jointly undertaken with the Care Quality Commission (CQC) and a number of areas were identified as requiring improvement. The CQC issued notices relating to the provision of appropriate care and treatment, safe care and deploying staff to ensure service users' needs were met.

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 August 2016, the IMB reported that compared to the year before they had received a significant increase in applications regarding healthcare matters (66 compared to 45). A third of these were about medication issues. The board also noted that there were difficulties recruiting and retaining healthcare staff and there was also a shortage of prison staff in healthcare. It concluded that Care UK failed to deliver the level of service required to meet prisoners' general healthcare needs.

Previous deaths at HMP Chelmsford

19. Mr Ajidahun's death was the first natural cause death at Chelmsford since 2012.

Key Events

20. On 21 December 2015, Mr John Ajidahun was remanded into HMP Chelmsford. On 30 December, he was sentenced to 30 weeks imprisonment for possession of drugs and, on 11 March 2016, was sentenced to 51 months imprisonment for possession of an offensive weapon and drugs.

21. On 21 December 2015 when Mr Ajidahun first entered custody, a nurse completed Mr Ajidahun's first night screen. She noted that he had a damaged hand that had been operated on 18 months ago, but he had not attended the follow up appointment. She advised him to apply to see the GP about it. He was not on any regular medication and did not report any chest pain.

22. Mr Ajidahun had a second health screen on 14 January 2016, with a healthcare support worker. He noted Mr Ajidahun's blood pressure reading was within the normal range at 125/60. Mr Ajidahun also wished to stop smoking and, although the healthcare support worker put him forward for smoking cessation sessions which he attended, it is not clear from the records if he stopped smoking. Mr Ajidahun's body mass index was 27, which is classed as overweight.

23. Mr Ajidahun joined the gym, although the prison have not been able to confirm when or provide his induction paperwork. They have provided details of his attendance in July (nine times) and August (five times) and the last date he used the facility was 15 August.

24. On 16 August, at 4.45am, a nurse went to see Mr Ajidahun in his cell. He complained of chest pain and shortness of breath. He was able to speak normally and told her he had experienced the pain over a few days, mainly first thing in the morning. She was unable to get a clear pulse reading because it was very rapid. She asked him to attend healthcare the next morning and noted that an electrocardiogram (ECG- tests the electrical rhythm of the heart) should be done before he saw a GP. She also noted that Mr Ajidahun was a keen gym user.

25. The next day, 17 August, a nurse took Mr Ajidahun's pulse blood pressure, which was normal at 132/88. A prison GP recorded that the ECG showed evidence of atrial fibrillation (irregular rhythm). He also noted that Mr Ajidahun was fit and well, used the gym and did not take 'drugs or substances'. Although he described Mr Ajidahun's chest as clear and there were no murmurs (a murmur can denote a serious underlying condition), he identified multiple ectopic (extra) heart beats. He arranged for Mr Ajidahun to go to accident and emergency for further assessment and review.

26. Mr Ajidahun was taken to hospital that morning and transferred to the Cardiac Centre at another hospital later that day.

27. After a series of tests (electrocardiograms, echocardiograms and blood tests) the hospital discharged Mr Ajidahun on 20 August, with a diagnosis of perimyocarditis. Perimyocarditis is an inflammation of the heart muscle and is a serious and rare condition. The discharge summary explained that staff had treated Mr Ajidahun with medication, and his health had improved. It recommended the prison arrange for him to have an MRI scan (magnetic

resonance imaging creates a picture of the body's internal structures), an exercise tolerance test (measures the heart's electrical activity during exercise) and follow up at hospital in 6 weeks' time. They provided the prison with a list of medications and doses.

28. A nurse saw Mr Ajidahun when he returned to prison. She noted that he appeared well and the recommended investigations listed in the discharge letter. She noted that she had sent a task through SystmOne (an electronic instruction through the electronic medical records) to the administrators. A GP did not see Mr Ajidahun, but two doctors did ensure he received his prescriptions.

29. On 26 August, a nurse saw Mr Ajidahun. He told her he had had crushing chest pain in the night which had lasted a few hours. Although he felt better by the morning he wanted healthcare staff to know because of his recent diagnosis. She took observations which she recorded as 'in range' but did not note the actual readings. She told him to continue with his medication, to attend his ECG appointment and GP review on the Monday (in 3 days time) and to tell staff in the meantime if the pain returned.

30. The next day a nurse saw Mr Ajidahun. He complained of pain in his chest and told the nurse he was due an ECG. The nurse recorded vital signs which were all within normal range. He noted that Mr Ajidahun's ECG was booked for the next day.

31. In the early hours of 28 August, at approximately 2.00am, a nurse went to see Mr Ajidahun in his cell. He was rolling on the floor reporting pain, which he said he had had for 3 days but was now much more intense. She requested an ambulance. An ECG was completed and paramedics noted a change in Mr Ajidahun's ECG reading, so took him to hospital.

32. Doctors diagnosed Mr Ajidahun with acute severe myocarditis with evidence of active heart disease and possible differential sarcoid (lumps or nodules). An MRI scan and an echocardiogram had revealed parts of his heart were dilated and their function impaired. Doctors altered his medication, stopping rampiril and introducing prednisolone (a steroid used to treat inflammation) and the discharge summary requested that the prison arrange another echocardiogram in 2 weeks, and possibly an appointment with a cardiologist depending on the result. The hospital discharged Mr Ajidahun on 6 September.

33. On Mr Ajidahun's return, a prison GP prescribed the necessary medication and recorded that Mr Ajidahun had myocarditis, but he did not see him.

34. On 13 September, a nurse spoke to Mr Ajidahun when he stopped her on the wing. He wanted her to attend an adjudication hearing (where he was facing a charge of assault) the next day to explain that he was unwell, on steroids and that they had affected his mood. She recorded that she told him healthcare staff could not be used to his end.

35. On 15 September, a healthcare support worker saw Mr Ajidahun and deemed him physically unfit to return to work. He told her he was generally unwell but when she asked him for symptoms he just said he felt drained and sleepy. She advised him to rest and keep eating and drinking.

36. On 20 September, an officer unlocked Mr Ajidahun's cell between 8.05am and 8.10am. The incident log indicates she went into the cell and thought he was still asleep. She continued to unlock other cells but Mr Ajidahun's cell mate came to tell her that he was worried about Mr Ajidahun because he would not wake up. She went to the cell and checked that Mr Ajidahun was breathing, which he was. Directly afterwards, at approximately 8.15am, she went to tell a Senior Officer (SO), who was at the door to the wing, what was happening. He phoned for healthcare to attend but did not use any emergency codes at this point. The SO and the officer returned to Mr Ajidahun's cell and the SO then called a code 2 (which indicates blood loss). When Mr Ajidahun failed to respond to the officers' attempts to rouse him, even though he was still breathing and had a pulse, the SO then called a code 1 (indicating problems breathing) over the radio – it was 8.24am. Staff in the control room called an ambulance as soon as the code 1 was broadcast.

37. Two nurses attended from healthcare and, with the officer, moved Mr Ajidahun onto the floor. He was warm, his pupils were unresponsive to light, he was incontinent of urine and had a weak pulse. A nurse noticed he has stopped breathing and started CPR (cardio pulmonary resuscitation is an emergency procedure combining chest compression and artificial ventilation).

38. A Custodial Manager (CM) had heard the code 1 from his office and took an oxygen cylinder to the scene. A prison GP also attended and helped with the resuscitation attempt. A nurse attached defibrillator pads but the machine advised them not to administer a shock. Staff moved Mr Ajidahun out of his cell to provide more space to try and resuscitate him manually. The defibrillator then advised to shock Mr Ajidahun, but it was not successful. Paramedics arrived at approximately 8.32am and continued resuscitation attempts. Emergency doctors also arrived at approximately 9.30am.

39. The paramedics took Mr Ajidahun to hospital at approximately 9.45am. Staff did not apply restraints.

40. Hospital staff continued to try and resuscitate Mr Ajidahun but they were unsuccessful. They pronounced Mr Ajidahun dead at 10.32am

Contact with Mr Ajidahun's family

41. The prison appointed a family liaison officer as soon as paramedics took Mr Ajidahun to hospital. He and prison manager visited Mr Ajidahun's partner at 10.00am to tell her that paramedics had taken him to hospital. They offered to take her to the hospital and, while she was getting ready, the family liaison officer received a call from the prison escorting staff to confirm that Mr Ajidahun had died. He broke the news to Mr Ajidahun's partner, arranged for a friend to come to be with her and helped her make calls to family members to break the news. He stayed in touch with the family offering ongoing support and a visit to the prison.

42. Mr Ajidahun's funeral was held on 4 October 2016 and the family liaison officer and a SO attended. The prison made a contribution to the funeral in line with national policy.

Support for prisoners and staff

43. After Mr Ajidahun's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Ajidahun'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 Ajidahun's death.

Post-mortem report

45. The coroner concluded that the cause of death was lymphatic myocarditis (inflamed heart muscle).

Findings

Clinical care

46. The clinical reviewer concluded that the care Mr Ajidahun received was equal to that he might have received in the community but that, in some areas, his care could have been better.

47. Mr Ajidahun had a serious and rare cardiac condition, but after hospital doctors diagnosed him no prison GP saw him to confirm what the hospital had told Mr Ajidahun or to monitor his condition more closely. Healthcare staff did not draw up care plans to structure how they would look after him and the diagnosis did not trigger a multi disciplinary care meeting to discuss his case and ensure everyone was sighted on his condition, were monitoring him and knew how to refer him appropriately.

48. The clinical reviewer felt that, had healthcare staff held such a meeting, they could then have created a 'Supported Living Plan' - a document to communicate to staff that an individual has a serious condition, explain what is wrong, record advice given to the prisoner, and setting out what symptoms to expect. We agree with the clinical reviewer that, in addition to a GP review and an MDT, it would have been prudent to do this for Mr Ajidahun.

49. Records indicate that Mr Ajidahun was a keen gym user; we were told that the last time he used the gym was on 15 August, just before his first admission to hospital on 16 August. A prison GP told us that healthcare staff do have conversations with gym staff where there are concerns about a prisoner's suitability to use it, but gym staff have said that this did not happen after Mr Ajidahun was diagnosed with a serious heart condition.

50. The investigator asked for Mr Ajidahun's gym induction paperwork. PAR-Q (Physical Activity Readiness Questionnaire which helps to assess an individual's suitability for exercise) assessments should be completed for prisoners wishing to join the gym. Prison Service Instruction (PSI) 58/2011 states that "PAR-Qs must be completed for all prisoners on PE induction prior to completing any PE activity" and they should be signed by both the prisoner and member of staff. No copy has been provided. We make the following recommendations:

    The Head of Healthcare should ensure that GPs automatically see and create care plans for prisoners returning from hospital with new diagnoses and treatments.

    The Head of Healthcare should create Supported Living Plans and share these with prison staff where appropriate.

    The Governor should ensure that prisoners wishing to use the gym complete and sign a PAR-Q as part of their induction in line with PSI 58/2011.

The emergency response

51. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is

called automatically in a life-threatening medical emergency. It also requires that the protocol distinguishes between the types of emergency (severe blood loss or breathing difficulties/chest pains so that health care staff know what equipment to take to the scene).

52. HMP Chelmsford's emergency code system reflects the requirements detailed above but whereas most prisons use code red or blue to demarcate between breathing difficulties or blood loss, Chelmsford uses 1 (for breathing difficulties) and 2 (for blood loss). If either code is broadcast, staff in the control room immediately call an ambulance.

53. Our investigation suggests that staff at Chelmsford do not fully understand the code system and are not using it correctly. An officer found Mr Ajidahun on his bed and fetched a SO, who called a code 2. After failing to secure a response for two minutes, they called a code 1.

54. The investigator asked the duty governor on the day what she understood the local policy was. She said there was an escalation system in place - a code 2 summoned healthcare staff for a non-emergency, and a code 1 requested their attendance for an emergency situation and prompted staff in the control room to call an ambulance immediately. This is not what the prison's local policy says should happen, but reflects the actions taken by prison staff on the day.

55. The clinical reviewer and the investigator also asked a prison GP what his understanding of the emergency code system was, and he was not clear even though he said he had responded to 'quite a few'. He said different terms for the codes were used and did not know what the exact system was for calling an ambulance.

56. Although we feel that codes red and blue are more intuitive, the prison's policy of a code 1 and 2, dated 21 November 2015, complies with the PSI. What is clear is that staff are not aware of the policy – either that there is a difference between types of emergency or that the control room staff should immediately call an ambulance for either code. Although the clinical reviewer does not feel this would have made a difference for Mr Ajidahun, we urge the Governor and the Head of Healthcare to ensure staff familiarise themselves with the policy, as it could in other circumstances.

The Governor and the Head of Healthcare should ensure all staff are familiar with and understand the emergency code protocol.

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