

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Asbury a prisoner at HMP Elmley on 3 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Lawrence Asbury died on 3 December of heart disease while a prisoner at HMP Elmley. Mr Asbury was 84 years old. I offer my condolences to Mr Asbury's family and friends.

Mr Asbury's arrived at Elmley with serious health issues, but his death was sudden and could not have been prevented. Nevertheless, the clinical reviewer concluded that Mr Asbury's clinical care was not of the standard he could have expected to receive in the community. In particular, healthcare staff did not appropriately follow up Mr Asbury's abnormal blood tests and the symptoms he displayed.

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

August 2017

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Summary

Events

1. On 11 November 2016, Mr Lawrence Asbury was sentenced to 11 years imprisonment for sexual offences and sent to HMP Elmley. He was 83 years old.
2. Mr Asbury suffered with water in his lungs, liver, kidneys and heart, and required an oxygen cylinder 24 hours a day. He went to hospital after sentencing and was discharged the same day before continuing to Elmley.
3. At his initial health screen, a nurse noted that Mr Asbury was an ex-smoker with a history of ischaemic heart disease, chronic obstructive pulmonary disease (COPD – the name of a collection of lung diseases including chronic bronchitis and emphysema) and chest pain. Mr Elmley was prescribed eight medications and an inhaler to treat his conditions.
4. A nurse admitted Mr Asbury to the inpatient unit, where he remained under close observation for two weeks. Several care plans were implemented addressing cardiovascular disease management, COPD, hypertension, sleep hygiene, personal emergency evacuation plan, asthma and activities of daily living.
5. While on the inpatient unit, Mr Asbury suffered with nausea and vomiting on three occasions between 13 and 23 November. On 18 November, blood tests identified renal impairment and high potassium levels, which required a follow-up appointment with a prison GP, booked for 1 December.
6. On 24 November, a prison GP assessed Mr Asbury as fit to relocate to a standard wing. On 29 November, Mr Asbury suffered with vomiting and a prison GP recorded a low blood pressure reading. He reduced his blood pressure medication and prescribed an antiemetic (medication to treat nausea and vomiting).
7. On 1 December, an officer told a healthcare assistant that Mr Asbury had chosen not to attend his follow-up appointment with the prison GP.

Events of 2 - 3 December

8. During the afternoon of 2 December, Mr Asbury told an officer he felt nauseous when he ate. The officer asked a nurse on the wing to check him. A nurse saw Mr Asbury that afternoon to administer his medication.
9. The officer gave Mr Asbury an extra blanket and locked his cell at approximately 4.30pm. She said goodnight to him and he responded.
10. On 3 December, at 6.09am, an officer support grade found Mr Asbury lying on the floor of his cell. She called a code blue emergency (which indicates that a prisoner is having difficulty breathing) over the radio. At 6.15am, senior managers and a nurse arrived. The nurse assessed Mr Asbury and declared that resuscitation was not appropriate. A prison GP confirmed Mr Asbury's death at 9.26am when he arrived on duty.

Findings

11. Although it did not affect the outcome for Mr Asbury, healthcare staff did not sufficiently explore his symptoms of nausea and vomiting, or adequately follow up abnormal blood test results. For this reason, we agree with the clinical reviewer that the standard of care Mr Asbury received at Elmley was not equivalent to that he could have expected in the community. However, Mr Asbury's death was sudden and we are satisfied it could not have been prevented.
12. It was appropriate that staff did not attempt to resuscitate Mr Asbury. However, officers that found him were not first aid trained, and it is not apparent that they ensured first that it was appropriate to not attempt resuscitation during the six minutes it took for healthcare staff to arrive.

Recommendations

- The Head of Healthcare should ensure that the causes of unexplained symptoms are fully investigated.
- The Governor must ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Asbury's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Asbury's clinical care at the prison.
16. We informed HM Coroner for Mid Kent and Midway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The investigator contacted Mr Asbury's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Elmley

19. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported an identified lead for older prisoners and the health care support offered to these men was consistent and of good quality. Social care arrangements were good. The health care team adopted a pragmatic but effective approach to chronic disease management. Complex cases were led by a GP or specialist nurse with multidisciplinary oversight.

Independent Monitoring Board

21. 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 October 2016, the IMB reported that the outpatient's department continues to run efficiently with a very caring team that monitors and cares for a wide variety of chronically ill prisoners. Non-attendance was still a major problem, but this had been addressed and was improving with new systems in place.

Previous deaths at HMP Elmley

22. Mr Asbury was the eighth prisoner to die from natural causes at Elmley since January 2015. There have been two deaths since. There were no similarities between the circumstances of Mr Asbury's death and previous deaths at the prison.

Key Events

23. On 11 November 2016, Mr Lawrence Asbury was sentenced to 11 years imprisonment for sexual offences and sent to HMP Elmley.
24. When he arrived at Elmley, Mr Asbury was 83 years old. At his initial health screen, a mental health nurse noted that Mr Asbury was an ex-smoker, had ischaemic heart disease, chronic obstructive pulmonary disease (COPD – the name of a collection of lung diseases including chronic bronchitis and emphysema) and a history of chest pain.
25. Mr Asbury told the nurse that he had been to hospital after his court appearance, and discharged the same day before arriving at Elmley. He suffered with water in his lungs, liver, kidneys and heart and required an oxygen cylinder 24 hours a day.
26. Mr Asbury took lansoprazole (to treat acid reflux), bumetanide (a diuretic), isosorbide and bisoprolol (to treat high blood pressure), spironolactone (a potassium-sparing diuretic), artovastatin (to treat high cholesterol), clopidogrel and rampiril (to prevent heart attacks and strokes), and inhalers. He had all of his medication with him when he arrived. He was required to take his medication under supervision due to memory loss.
27. The nurse noted that although Mr Asbury was able to live independently, he appeared frail and used a walking trolley. He located him on the inpatient unit and referred him to a prison GP. He created care plans for management of cardiovascular disease, COPD and hypertension.
28. Another nurse assessed Mr Asbury the same day and created further care plans for sleep hygiene, a personal emergency evacuation plan, asthma and activities of daily living.
29. On 13 November, Mr Asbury told a prison GP that although he felt better, he thought he had food poisoning, as he had been unwell the night before. The GP prescribed an antiemetic (to treat nausea and vomiting) and instructed a nurse to carry out observations and inform a GP if there were any concerns. Another GP reviewed Mr Asbury the following day. He told her he felt better.
30. A locum prison GP examined Mr Asbury on 17 November, and noted that he had not been able to eat because food was getting stuck in his throat and causing him to vomit. He was short of breath and unable to speak in full sentences. The GP prescribed Complian (a nutritional drink) and planned to conduct urgent blood tests.
31. On 18 November, a prison GP recorded the blood test results, which identified significant renal impairment and raised potassium levels. He booked an appointment for Mr Asbury to see a prison GP on 1 December.
32. On 23 November, at 9.45am, a nurse recorded Mr Asbury's observations and noted an oxygen level of 77%. At 11.26am, a prison GP examined him. Mr Asbury complained of nausea and vomiting. He noted Mr Asbury's oxygen level had risen to 92% and his blood pressure was within normal range (110/70). (A

blood pressure reading between 90/60 and 120/80 is considered normal.) He planned to monitor the vomiting and to prescribe antiemetics if it continued.

33. A prison GP assessed Mr Asbury on 24 November, and noted that he looked okay, was speaking well and walking around. He carried out routine observations, which raised no concerns and concluded that he was well enough to be discharged from the inpatient unit. He noted that Mr Asbury was happy with the decision.
34. On 29 November, Mr Asbury was not eating but able to tolerate water. A nurse referred him to a prison GP, who noted that Mr Asbury had vomited several times in the last 24 hours. He was shaking and low blood pressure (90/60). The GP noted he looked alert and happy, and well orientated. He reduced Mr Asbury's bisoprolol medication from 5mg to 2.5mg, and prescribed metoclopramide (an antiemetic) and carboscictin (to treat COPD).
35. On 1 December, Mr Asbury did not attend his appointment with the prison GP to discuss his abnormal blood test results from 18 November. An officer told a healthcare assistant that Mr Asbury had been aware of his appointment and chosen not to attend.
36. When Mr Asbury returned to a standard location, he saw a member of healthcare staff three times a day to administer his medication. There were no other healthcare checks planned.

Events of 2-3 December

37. An officer told the investigator that during the afternoon of 2 December, Mr Asbury complained of nausea when he ate. Although Mr Asbury did not appear unwell or have concerns himself, she asked a nurse to check on him. A nurse checked Mr Asbury and told her she would notify Hotel 1 (duty healthcare staff who responds to serious illness and emergencies).
38. The nurse told the investigator that she administered Mr Asbury's medication that afternoon but could not recall him feeling unwell, or referring him to Hotel 1. There were no entries in Mr Asbury's medical record on 2 December indicating that anyone else assessed him, or that a referral happened.
39. Mr Asbury said he was cold and the officer gave him an extra blanket and locked his cell at approximately 4.30pm. She said goodnight to him and he responded. The prison was unable to provide a cell bell record for Mr Asbury's cell for 2 and 3 December.
40. At 6.09am on 3 December, an officer support grade (OSG) conducted morning checks and saw Mr Asbury lying on the floor of his cell. She alerted her colleague. They opened the cell door and she felt for a pulse, which she could not detect. They were not first aid trained. She called a code blue emergency (which indicates that a prisoner is having difficulty breathing) over the radio.
41. A senior manager heard the code blue at 6.09am and arrived at 6.15am, followed by a nurse. The nurse assessed that Mr Asbury's arm was stiff, his face was cold and there was no pulse. She advised staff that resuscitation was not appropriate. The ambulance service operator confirmed that the ambulance had

been cancelled. She contacted the out of hours GP service at 6.39am. A prison GP arrived on duty at 9.00am and confirmed Mr Asbury's death at 9.26am.

Contact with Mr Asbury's family

42. On 3 December, the prison appointed an officer as the family liaison officer. At 9.45am, he visited the home of Mr Asbury's wife with a prison chaplain. She was not in.
43. Later that day, two chaplains visited her address again. She was not in and a chaplain left a note for her to contact him at the prison.
44. The following day, Mr Asbury's wife had still not contacted the chaplain. He visited her again, along with police officers who had also been trying to deliver the news. Again, she was not at home. A short while later a police officer telephoned her mobile and spoke with her, by which point she had returned home. The chaplain told Mr Asbury's wife and daughter the news in person.
45. The chaplain returned Mr Asbury's property to his wife on 7 December. On 12 December, Mr Asbury's wife and daughter visited the prison. They viewed his cell and met the Governor.
46. In line with national policy, the Prison Service offered to contribute toward the costs of Mr Asbury's funeral in line with national policy. Mr Asbury's family declined the offer.

Support for prisoners and staff

47. After Mr Asbury's death, a senior manager 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.
48. The prison posted notices informing other prisoners of Mr Asbury'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 Asbury's death.

Post-mortem report

49. The post-mortem concluded that Mr Asbury died of ischaemic heart disease (coronary artery disease). COPD was a contributing factor to his death.

Findings

Clinical care

50. Mr Asbury had been at Elmley for three weeks when he died. He was elderly, with numerous health conditions and required a brief hospital admission after sentencing before arriving at Elmley. At his initial health screen, a prison nurse appropriately assessed Mr Asbury and located him on the inpatient unit for two weeks. Healthcare staff closely monitored him and implemented several care plans until a prison GP assessed him as well enough to move to a normal location.
51. Two days before he died, Mr Asbury had a follow-up appointment with a prison GP to discuss abnormal test results. A wing officer told a healthcare assistant that Mr Asbury had chosen not to attend. This was not followed up further, with a visit by a member of healthcare staff, or a re-scheduled appointment.
52. The clinical reviewer concluded that the standard of care Mr Asbury received was not equivalent to that he could have expected in the community. The clinical reviewer stated that insufficient action was taken to identify the cause of Mr Asbury's nausea, vomiting and hypotension, which could have been caused by underlying electrolyte disturbance or arrhythmia. The clinical reviewer also concluded that further investigations were necessary to establish whether Mr Asbury's renal impairment was stable or represented a change. Plans to conduct further blood tests were also not properly followed through. The clinical reviewer has made two recommendations, which the Head of Healthcare will need to address. We make the following recommendation:

The Head of Healthcare should ensure that the causes of unexplained symptoms are fully investigated.

Emergency response

53. The two members of staff who conducted morning checks were not first aid trained. Healthcare staff on night duty do not hold keys and have to be collected and escorted by an officer. Although the investigator was told by a senior manager that this does not cause a delay, it took six minutes for a nurse to arrive and for any potential first aid to begin. It is not clear if the first officers on scene checked to ensure that Mr Asbury was dead. Although it was not appropriate to begin life saving treatment to Mr Asbury, in different circumstances this delay in treatment could have serious consequences. The Governor must ensure that there is a sufficient distribution of trained staff and sufficient access by healthcare staff. We therefore make the following recommendation:

The Governor must ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity.

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