Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Ashley, a prisoner at HMP Wakefield, on 19 February 2021

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 Paul Ashley died on 19 February 2021 of a heart attack at HMP Wakefield. He was 60 years old. I offer my condolences to Mr Ashley's family and friends.

Mr Ashley had a number of serious health conditions, including diabetes, respiratory failure and heart failure. The clinical reviewer concluded that, overall, the care that Mr Ashley received at HMP Wakefield was good and equivalent to that which he could have expected to receive in the community.

However, I am concerned that healthcare staff at Wakefield attempted resuscitation, despite an order to say that Mr Ashley should not be resuscitated in the event of a cardiac arrest.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2021**

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Summary

Events

1. In 1989 Mr Paul Ashley received a life sentence for murder. He transferred to HMP Wakefield in 2011.

2. He had several complex physical health needs, including diabetes, epilepsy and heart disease.

3. In May 2020, the healthcare team spoke to Mr Ashley about his deteriorating health and completed a Do Not Attempt Resuscitation form (DNACPR) on his behalf. The order directed that healthcare staff should not try to resuscitate him in the event of a cardiac arrest.

4. On 31 December, Mr Ashley went to hospital with shortness of breath and chest pains. He tested negative for COVID-19 and was diagnosed with pneumonia, respiratory failure and heart failure. He was discharged back to prison after four days.

5. On 23 January 2021, staff opened suicide and self-harm monitoring procedures (known as ACCT) after Mr Ashley took an overdose of paracetamol. On 2 February, he was moved to the prison's healthcare wing after officers found him with a ligature and a plastic bag on his head and suspected that he was being bullied for his medication on the wing. The ACCT was closed on 15 February.

6. On the evening of 19 February, healthcare staff found Mr Ashley collapsed in his cell. The prison called an ambulance and nurses tried to resuscitate him. The senior nurse said she knew that there was an order not to resuscitate Mr Ashley if his heart stopped, but she could not check the document, which was on a different wing.

7. Paramedics arrived and took over resuscitation, but at 6.45pm paramedics confirmed that Mr Ashley had died.

8. An inquest found that Mr Ashley had died of a heart attack.

Findings

9. The clinical reviewer said that the care that Mr Ashley received at HMP Wakefield was equivalent to that which he could have expected to receive in the community. Mr Ashley had a poor prognosis, and his death was expected.

10. Mr Ashley was found unresponsive in his cell on 19 February and staff took prompt emergency action. However, we are concerned that healthcare staff attempted resuscitation despite a Do Not Attempt Resuscitation order being in place.

Recommendations

- The Head of Healthcare should ensure that decisions about resuscitation are effectively communicated, so that staff do not attempt to resuscitate a prisoner with a DNACPR order.

The Investigation Process

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

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

13. The investigator interviewed two members of staff from HMP Wakefield on 28 April and 10 May 2021. All the interviews were conducted by telephone because of the restrictions imposed during the COVID-19 pandemic.

14. On behalf of NHS England, Spectrum commissioned a clinical reviewer to review Mr Ashley's clinical care at the prison. The clinical reviewer joined the investigator for the interview with a nurse on 28 April 2021.

15. We informed HM Coroner for Wakefield of the investigation. The inquest took place on 17 March and found that Mr Ashley died of natural causes. We have sent the Coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Ashley's next of kin to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. She did not respond with any questions.

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

Background Information

HMP Wakefield

18. HMP Wakefield is a high security prison which holds up to 750 men, many of whom are serving long sentences (10 years and over). There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for those displaying challenging behaviours).

19. Care UK provides 24-hour health and social care at Wakefield. A dedicated healthcare unit staffed by nurses and prison officers has inpatient facilities for up to 14 men. The health care team holds external accreditation for their palliative care suite for terminally ill patients.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wakefield was carried out in June 2018. Inspectors reported that the prison was calm with a positive atmosphere. They noted high standards, good practice and improvements since the previous inspection in 2014. Staff-prisoner relationships were generally good and enhanced by the keyworker scheme. Overall, living conditions and health services were good.

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 2019 to 2020, the IMB reported that Wakefield continued to provide a regime that was, overall, just, consistent and inclusive. The IMB reported that levels of violence were relatively low and ere investigated properly. ACCT documentation was generally good, as were health services.

Previous deaths at HMP Wakefield

22. In the two years before Mr Ashley's death, there were 19 deaths at Wakefield, 18 from natural causes and one self-inflicted. There are no significant similarities between Mr Ashley's death and the previous deaths at Wakefield.

Key Events

23. In April 1989, Mr Paul Ashley was sentenced to life in prison for murder and sent to HMP Albany.

24. Mr Ashley was diagnosed with numerous complex physical and mental health problems, including heart disease, hypertension, angina, epilepsy, schizophrenia and personality disorders. He also had type 2 diabetes.

HMP Wakefield

25. In 2011, Mr Ashley was transferred to HMP Wakefield. His health needs were assessed, and the healthcare team continued to monitor and manage his physical health conditions. Mr Ashley's previous self-harm was noted, and he was under the care of a psychiatrist. In 2014, Mr Ashley had an operation to amputate his left leg due to a diabetic ulcer and started using a wheelchair.

26. In October 2019, healthcare professionals discussed Mr Ashley's deteriorating health, and agreed that his prognosis was poor. He was placed on the Dying Well in Custody Charter and Gold Standards Framework and reviewed at monthly meetings. (The Dying Well in Custody Charter and Gold Standards Framework aim to improve the quality of care for people nearing the end of life in prisons.)

27. In May 2020, the healthcare team spoke to Mr Ashley about his poor health and completed a Do Not Attempt Resuscitation form (DNACPR) on his behalf. The Head of Healthcare, two GPs and a hospital respiratory consultant agreed that this was in Mr Ashley's best interests. They did not discuss it with Mr Ashley because of his ongoing mental health issues. They were particularly concerned about the impact on his wellbeing. This review was in line with COVID-19 guidance at the time.

28. On 1 June 2020, Mr. Ashley was sent a letter advising him to shield as he was considered at high risk from COVID-19. Mr Ashley signed a disclaimer and refused to shield.

29. On 3 July 2020, Mr Ashley's mental capacity was assessed as he continued to refuse to go to hospital appointments. The assessment indicated that he had capacity to make decisions about his healthcare. It was agreed that discussing his DNACPR with him could still cause a decline in his mental health, so the DNACPR remained in place.

30. In August, there was intelligence that Mr Ashley was being bullied for his medication. He also said that he had not been taking his prescribed dihydrocodeine or pregabalin (both painkillers that are often abused and traded in prisons), so these prescriptions were stopped.

31. On 19 August, Mr Ashley was seen by a prison GP for shortness of breath and chronic anaemia that Mr Ashley had refused to have investigated at hospital. The GP prescribed Mr Ashley gabapentin (for nerve pain). In October, Mr Ashley asked to be prescribed pregabalin again. A GP prescribed soluble pregabalin to prevent bullying or diversion.

32. On 20 October, Mr Ashley was located in the prison's healthcare unit to monitor his health more closely and assess his social care needs. He went back to the wing on 26 November at his own request.

33. On 31 December, Mr Ashley said that he was short of breath and had chest pain. A nurse assessed him using a NEWS2 tool and his score was 7, indicating that he needed to go to hospital urgently. (NEWS2 is a tool to detect acute illness and health deterioration.)

34. At hospital, Mr Ashley was diagnosed with pneumonia, respiratory failure and heart failure. He tested negative for COVID-19. He returned to Wakefield on 4 January to the reverse cohorting unit (RCU) where returning or newly arrived prisoners isolate to avoid spreading COVID-19. Mr Ashley tested negative for COVID-19 again on 8 January.

35. On 23 January, Mr. Ashley took an overdose of paracetamol and was taken to hospital. He refused medical treatment and returned to the RCU at Wakefield on 24 January. Staff assessed that he was at risk of suicide or self-harm, so started ACCT monitoring. (ACCT is the care planning process for prisoners identified as being at risk of self-harm or suicide.)

36. On 26 January, Mr Ashley was reported to have lost his sense of taste and smell, both symptoms of COVID-19. He was tested for COVID-19 (it was negative) and told to isolate in his cell for 10 days.

37. On 2 February, Mr Ashley tied a ligature in his cell and put a plastic bag over his head. He was still subject to ACCT monitoring and a mental health nurse reviewed him. Mr Ashley told the nurse that he would not harm himself if he moved to the healthcare unit. Officers suspected that prisoners on the wing might have been bullying him for his medication again. His observations were increased, and he was admitted to the healthcare unit.

38. On 15 February, Mr Ashley was no longer considered at risk of suicide or self-harm, so staff stopped ACCT monitoring, but he remained on the healthcare wing.

Events of 19 February 2021

39. At 6.00pm on 19 February, a senior nurse asked an officer to unlock Mr Ashley's cell to give him his evening medication. The officer told the investigator that he had seen Mr Ashley earlier in the day and that he had seemed his usual friendly self.

40. When they got to his cell at about 6.12pm, they found Mr Ashley slumped in his wheelchair. The senior nurse checked his vital signs and confirmed that he was unresponsive. She and the officer moved Mr Ashley to the floor so that she could start resuscitation. Another nurse called a code blue (a medical emergency code indicating that a prisoner is having difficulty breathing).

41. The prison called for an ambulance immediately and the paramedics arrived at Mr Ashley's cell at 6.30pm and continued CPR. At 6.45pm, the paramedics confirmed that Mr Ashley had died.

Contact with Mr Ashley's family

42. Mr Ashley's next of kin was a friend. When Mr Ashley was taken to hospital on 31 December, an officer was appointed as the prison's family liaison officer.

43. At 8.15pm on 19 February 2021, the officer called Mr Ashley's friend and informed her that Mr Ashley had died. He offered his condolences and support.

44. The prison arranged Mr Ashley's funeral, which took place on 1 April 2021. Wakefield offered to contribute to the cost of the funeral, in line with national instructions.

Support for prisoners and staff

45. After Mr Ashley's death, the Head of Healthcare 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.

46. The prison posted notices informing other prisoners of Mr Ashley'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 Ashley's death.

Post-mortem report

47. A post-mortem examination was not conducted. An inquest hearing at Wakefield Coroner's Court on 17 March 2021 found that Mr Ashley died of a heart attack caused by heart disease and a blood clot in his artery. He also had longstanding diabetes, which did not cause but contributed to his death.

Findings

Clinical care

48. The clinical reviewer concluded that the care Mr Ashley received at HMP Wakefield was of a good standard and equivalent to that which he could have expected to receive in the wider community.

49. The reviewer said that there were no concerns relating to Mr Ashley's mental healthcare. She said that medical record entries were well documented, and Mr Ashley was actively involved in decisions about his care when appropriate, despite appropriate limitations due to his deteriorating mental health.

50. The reviewer also said that Mr Ashley's location in the prison was appropriate, and that his move from the main wing to the healthcare unit following suspicion of bullying was good practice.

51. We are however concerned that, although Mr Ashley had a DNACPR order in place, healthcare staff still tried to resuscitate him, and this was then continued by the ambulance paramedics.

52. The senior nurse told us that she knew about the order, but she could not check its status as it had remained on Mr Ashley's previous wing when he moved to the healthcare unit.

53. The clinical reviewer said that decisions about CPR should be communicated between healthcare professionals whenever a patient is transferred between establishments or between different areas of an establishment. We make the following recommendation:

    The Head of Healthcare should ensure that decisions about resuscitation are effectively communicated, so that staff do not attempt to resuscitate a prisoner with a DNACPR order.

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