Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rex Case, a prisoner at HMP Ashfield, on 3 June 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*

Summary

1. 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.

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

3. Mr Rex Case died in hospital from pneumonia on 3 June 2021, whilst a prisoner at HMP Ashfield. He was 77 years old. We offer our condolences to Mr Case's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Case received at Ashfield was equivalent to that he could have expected to receive in the community. She made four recommendations.

5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure that the NEWS2 tool is used consistently to monitor clinical deterioration.
- The Head of Healthcare should provide appropriate training to ensure healthcare staff are competent in the use of NEWS2.
- The Head of Healthcare should audit the long-term conditions project to ensure that systems are in place to manage long term health conditions in line with NICE guidelines.
- The Head of Healthcare should review and implement the 'Care of prisoners' pathway, to ensure there is a smooth transition between hospital and prison.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Case's clinical care at HMP Ashfield.

7. The PPO investigator has investigated non-clinical issues, including Mr Case's location, the security arrangements for his hospital escorts, liaison with his family, and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Case's next of kin, his son, to explain the investigation. He did not respond to our letter.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Previous deaths at HMP Ashfield

10. Mr Case was the fourth prisoner at Ashfield to die since June 2019. All the previous deaths were from natural causes. We have previously made a recommendation about the management of long-term health conditions.

Key Events

11. In January 2016, Mr Rex Case was sentenced to 13 years and five months in prison for sexual offences. He was moved to HMP Ashfield on 15 June 2016.

12. Mr Case had hypertension (high blood pressure), rheumatoid arthritis, peripheral vascular disease (a progressive circulation disorder), anaemia (iron deficiency), and heart disease.

13. On 19 May 2021, Mr Case complained of feeling tired and generally unwell. He continued to feel worse over the next six days. The nurses that attended to him during this period advised plenty of fluids, rest, and requested a GP review.

14. On 25 May, Mr Case began vomiting. The prison GP advised that if Mr Case deteriorated further, a hospital transfer would be necessary. Staff arranged for an ambulance to take Mr Case to hospital. He was escorted by two officers and was not restrained.

15. On 29 May, while in hospital, Mr Case had a heart attack. Hospital staff arranged for him to be taken in an emergency ambulance to the Bristol Heart Institute, where he had an angiogram (a special type of X-ray used to examine blood vessels) and had two stents inserted.

16. On 31 May, Mr Case returned to Ashfield. Two officers accompanied Mr Case, and he was not restrained.

17. On 1 June, the prison GP reviewed Mr Case and noted breathlessness and chest crackles. The GP suspected Mr Case had a chest infection. Staff arranged for an ambulance to take Mr Case to hospital. Two officers escorted him, and he was not restrained.

18. On 2 June, hospital staff informed the prison that Mr Case was on oxygen and antibiotics for the chest infection.

19. On 3 June, Mr Case died in hospital.

Post-mortem report

20. The post-mortem report concluded that Mr Case died of bronchopneumonia (lung inflammation) as the result of chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases) and myocardial infarction (heart attack), and coronary artery atheroma (build-up of fatty deposits around the heart).

Louise Richards
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