

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Ramsey Ramsey, a prisoner at HMP & YOI Doncaster on 24 February 2021

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

## 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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## 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 Ramsey Ramsey died on 24 February 2021, of hypertensive heart disease at HMP & YOI Doncaster. Mr Ramsey was 85 years old. I offer my condolences to Mr Ramsey's friends.
4. The clinical reviewer concluded that the clinical care Mr Ramsey received at Doncaster was of a good standard and equivalent to that which he could have expected to receive in the community. She made some recommendations about secondary health screenings and the delay in certifying Mr Ramsey's death. We repeat her recommendation about the certifying of Mr Ramsey's death below.
5. We commend the care and compassion shown by both Healthcare Assistants (HCAs) to Mr Ramsey in the final hours of his life.
6. We found no non-clinical issues of concern. We make no recommendations.
7. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

## Recommendation

- **The NHS Commissioners and Clinical Commissioning Group (CCG) should consider investigating the causes of the delay in certifying Mr Ramsey's death.**

## The Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Ramsey's clinical care at HMP & YOI Doncaster.
9. The PPO investigator has investigated the non-clinical issues, including, the prison's response to COVID-19 and shielding prisoners, the security arrangements for Mr Ramsey's hospital escorts, liaison with his family and whether compassionate release was considered.
10. Mr Ramsey had no named next of kin.
11. The initial report was shared with the Prison Service and NHS England. The Prison Service and NHS England did not find any factual inaccuracies.

### COVID-19 (Coronavirus)

12. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
13. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
14. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days. A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly received or returning prisoners from the main population through 'reverse-cohorting'. Other measures include social distancing and the use of personal protective equipment (PPE).

### Previous deaths at HMP & YOI Doncaster

15. Mr Ramsey was the 24<sup>th</sup> prisoner to die at Doncaster since February 2019. Of the previous deaths, 11 were from natural causes (two of which were COVID-19 related), nine were self-inflicted and three were drug related.
16. There are no similarities between our findings in the investigation into Mr Ramsey's death and our investigation findings for the previous deaths.

## Key Events

17. On 20 August 2014, Mr Ramsey Ramsey was sentenced to 16 years in prison for sexual offences. He was sent to HMP & YOI Altcourse.
18. Mr Ramsey had a number of pre-existing medical conditions, including, type 2 diabetes and atrial fibrillation (abnormally fast heart rate). Healthcare staff created appropriate long-term condition care plans and reviewed them regularly. In addition, Mr Ramsey wore a back brace, as he had a fractured back from a previous fall.
19. On 21 October 2016, Mr Ramsey transferred to Doncaster.
20. In 2017, Mr Ramsey was diagnosed with hypertension. In May 2018, he underwent a Carotid Endarterectomy (a surgical procedure to remove a build-up of fatty deposits in the carotid arteries, which are the main blood vessels that supply the head and neck). Healthcare staff created appropriate long-term condition care plans and reviewed them regularly.
21. From April, Mr Ramsey lived in the Social Care Unit (SCU) at Doncaster. He had a comprehensive package of care with a minimum of two daily visits by carers.

### 2020

22. In 2020, Mr Ramsey was living in a six-bed dormitory on the SCU for prisoners with significant social care needs.
23. In March, restrictions began to be imposed in response to the COVID-19 pandemic. On 23 March, a national lockdown was imposed. Prison regimes were severely curtailed and face-to-face services were reduced or stopped.
24. On 3 May, Mr Ramsey was identified as clinically vulnerable to COVID-19, the category below extremely clinical vulnerable, where shielding was advised. Mr Ramsey did not shield. However, the SCU was isolated from the rest of the prison. This provided the prisoners on the SCU with a regime similar to collective shielding.
25. On 6 December, another prisoner in the SCU was showing symptoms consistent with COVID-19. Mr Ramsey and the other prisoners in the dormitory were placed in isolation. A Matron saw Mr Ramsey and told him what symptoms to look out for and to contact healthcare staff if he had any symptoms.
26. On 9 December, Mr Ramsey had a COVID-19 test, and the result was positive. He continued to isolate on the SCU and was seen by nursing staff regularly. Between his positive test and 12 December, Mr Ramsey was noted to be lethargic and dehydrated. He said that he had aches all over his body and was unable to swallow his medication.
27. On 13 December, a nurse saw Mr Ramsey. She noted that he was lethargic and confused. She carried out a NEWS-2 assessment (NEWS-2 is a tool to measure clinical deterioration in adult prisoners). Mr Ramsey scored 7, indicating that he needed urgent assessment from a critical care practitioner. She called for an

ambulance at 11.45am, and Mr Ramsey was taken to Doncaster Royal Infirmary (DRI). Mr Ramsey was diagnosed with COVID-19 pneumonia and dehydration.

28. On 21 December, Mr Ramsey was discharged from hospital and returned to the prison. He went back to the dormitory on the SCU while the prison waited for a hospital style bed for him. The healthcare team completed regular welfare checks on Mr Ramsey and carers supported him with his personal care.
29. Mr Ramsey's health started to fluctuate. Healthcare staff were concerned about his food and fluid intake, and he appeared less and less alert. At around 6.00pm on 30 December, a nurse saw Mr Ramsey and noted that he was dehydrated. He considered that if Mr Ramsey did not improve in the next 12 hours, he would need to be sent to hospital for assessment.
30. At 11.20am on 31 December, a nurse saw Mr Ramsey. He was confused and had low oxygen saturation. There was a shortage of escorting staff to escort him to hospital so healthcare staff observed Mr Ramsey until the prison had escort officers available. At around 1.45pm, Mr Ramsey was sent to hospital by ambulance. He returned to the prison around 4.30pm with a course of antibiotics.

## **2021**

31. On 6 January 2021, a prison GP saw Mr Ramsey. She noted that he was lethargic, dehydrated and refusing most food. She spoke with a doctor at DRI who suggested that Mr Ramsey should have urgent blood tests, and if he was dehydrated, he should be sent to hospital. That afternoon, Mr Ramsey had a set of blood tests taken.
32. At around 1.00pm on 8 January, a prison GP saw Mr Ramsey. He noted that Mr Ramsey had abdominal distention (a swelling of the abdomen), low blood pressure, no appetite and was extremely drowsy. He was concerned that Mr Ramsey had possible urinary sepsis.
33. The prison made a 999 call and at 1.40pm, an ambulance arrived. At around 2.15pm, paramedics took Mr Ramsey to DRI.
34. Mr Ramsey remained in hospital for nearly a month. On 10 January, he signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form. This meant that he did not want to be resuscitated if he had a heart attack or if he stopped breathing.
35. While in hospital, Mr Ramsey's mental capacity was assessed because he was refusing food and medication. On 27 January, the hospital and the prison's healthcare team began discharge planning for Mr Ramsey to return to Doncaster.
36. On 4 February, Doncaster Social Services agreed to fund a care plan for Mr Ramsey. The following day, the prison held a multi-disciplinary team (MDT) meeting to plan for Mr Ramsey's discharge. An open-door policy was agreed as Mr Ramsey was fully dependent on others for his care. He was refusing food, fluids and medication. The prison had been advised that he was now assessed as lacking capacity and was unable to engage with his care planning.

37. On 6 February, Mr Ramsey was discharged from DRI and returned to Doncaster. He was located in a therapeutic room on the SCU. Mr Ramsey received consistent and thorough care from clinical and social care staff in line with his palliative care plan.

### Events of 24 and 25 February

38. At around 7.40am on 24 February, Healthcare Assistant (HCA) A visited Mr Ramsey and carried out a NEWS-2 assessment. She noted that he scored 8 and she informed the Nurse in Charge, who in turn notified a prison GP. Mr Ramsey's NEWS-2 score was not escalated, which was in line with his palliative care plan.
39. At around 3.00pm, a prison GP and HCA A saw Mr Ramsey. They noted that he was lethargic. HCA A said that she would stay with Mr Ramsey for support and reassurance. She stayed with him until the end of her shift at 8.00pm.
40. HCA B took over from HCA A and stayed with Mr Ramsey. Around 9.00pm, she noted that he was not responding and that his breathing was slowing. She alerted a Prison Custody Officer (PCO), who attended Mr Ramsey's cell. Mr Ramsey had stopped breathing and the PCO radioed for healthcare staff to attend.
41. At around 9.10pm, a nurse attended Mr Ramsey's cell. She noted that there was no heart or breathing sounds and Mr Ramsey's eyes were fixed and dilated. She called for an ambulance and advised them that Mr Ramsey had died and that this needed certifying.
42. Yorkshire Ambulance Service advised that it would contact NHS 111 to determine how best to get someone out to the prison to certify Mr Ramsey's death. At around 2.00am on 25 February, a paramedic rang the nurse and told her that an out-of-hours GP would come and certify Mr Ramsey's death, but it could take up to six hours.
43. No GP attended the prison. At around 8.30am, a nurse rang NHS 111. She was advised that the case had been allocated to an out-of-hours GP, but they had not picked it up and the case had been closed.
44. At 9.24am, the Head of Healthcare arrived in the prison that morning and certified Mr Ramsey's death.

### Post-mortem report

45. The pathologist gave Mr Ramsey's cause of death as hypertensive heart disease (a long-term heart condition caused by high blood pressure). He also had diabetes mellitus (diabetes), chronic kidney disease and COVID-19, which did not cause but contributed to his death.

## Clinical Findings

46. The clinical reviewer concluded that the care that Mr Ramsey received at Doncaster was equivalent to that which he could have expected to receive in the community.
47. We commend the care and compassion shown by both HCAs to Mr Ramsey in the final hours of his life.

### Management of Mr Ramsey's risk of infection from COVID-19 and risk to others

48. In spite of the measures to control the risk of infection and to protect prisoners, it appears that Mr Ramsey contracted COVID-19 in prison, as he had not left the prison in the previous months.
49. Mr Ramsey was located on the Social Care Unit (SCU) throughout the COVID-19 pandemic, which was isolated from the rest of the prison population. On his discharge from hospital on 21 December 2020 and 6 February 2021, he returned to the SCU where he was cared for until his death.
50. Healthcare staff had PPE policies and supplies in place from the beginning of the pandemic with no reported shortages. Staff testing at Doncaster started in November 2020.

### *Certifying Mr Ramsey's death*

51. On 24 February 2021, healthcare staff noted that Mr Ramsey was not breathing. A nurse called Yorkshire Ambulance Service to come and certify his death.
52. There was a breakdown in communication between NHS 111 and the out-of-hours GP, and no GP attended the prison to certify Mr Ramsey's death. The Head of Healthcare certified Mr Ramsey's death at 9.30am, on the morning of 25 February, a delay of around 12 hours.
53. The clinical reviewer was concerned that Mr Ramsey's death was certified by the Head of Healthcare, 12 hours after his death was first noted. This was clearly beyond the control of the healthcare team. We recommend:

**The NHS Commissioners and Clinical Commissioning Group (CCG) should consider investigating the causes of the delay in certifying Mr Ramsey's death.**

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

**March 2022**

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