

**Prisons &
Probation**

Ombudsman
Independent Investigations

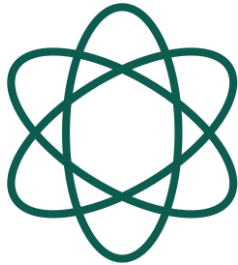
Independent investigation into the death of Mr Masih Ullah, a prisoner at HMP Lowdham Grange, on 5 August 2019

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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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 Masih Ullah died of heart failure on 5 August 2019, after being found collapsed in the gym toilet at HMP Lowdham Grange. He was 37 years old. I offer my condolences to Mr Ullah's family and friends.

Mr Ullah was diagnosed with heart disease at his previous prison, HMP Full Sutton. While the clinical reviewer was satisfied that overall, the clinical care he received there was equivalent to that he could have expected to receive in the community, I am concerned that prison staff failed to take him to several hospital appointments.

Mr Ullah did not have a face to face consultation with a GP during the 13 days he spent at Lowdham Grange, despite reception staff noting that he had a heart condition. The clinical reviewer considered this was a missed opportunity to undertake a full medical assessment and discuss referral to a cardiologist.

I am also concerned that prison staff at Lowdham Grange allowed Mr Ullah to attend the gym despite him stating on a health questionnaire that he had a heart condition and that a doctor had advised him not to take part in physical activity.

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

July 2020

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Summary

Events

1. Mr Masih Ullah was serving an 18-year sentence for drug and firearm offences.
2. In July 2018, while at HMP Full Sutton, Mr Ullah collapsed on his way back from the gym. He was subsequently diagnosed with a heart condition. Over the next year, he was prescribed appropriate medication and attended cardiology appointments at the hospital (although he also missed several hospital appointments because the prison failed to take him).
3. On 24 July 2019, Mr Ullah was moved to HMP Lowdham Grange. When he arrived at Lowdham Grange, a nurse noted that he had a heart condition. Several days later a prison GP remotely prescribed Mr Ullah with his regular medication. He was not seen for a face to face appointment.
4. On 5 August, a prisoner found Mr Ullah collapsed in the gym toilet and alerted staff. The physical education instructor (PEI) said that Mr Ullah was breathing but making strange noises. He called a medical emergency code. A nurse attended and moved Mr Ullah from the toilet into an open space and put him in the recovery position. When Mr Ullah stopped breathing she started cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived and took over. Paramedics were unable to resuscitate Mr Ullah and pronounced him dead at 11.15am.
5. The post-mortem report concluded that Mr Ullah died from acute left ventricular failure (when the main pumping chamber of the heart stops working properly), caused by coronary artery stenosis (narrowing of the blood vessels that supply the heart muscle).

Findings

6. The clinical reviewer found that, in the main, the clinical care Mr Ullah received at Full Sutton was equivalent to that which he could have expected to receive in the community. However, she noted that he was not taken to five hospital appointments. On three occasions, this was because prison healthcare staff had not put the appointment in the diary.
7. We are also concerned that healthcare staff at Full Sutton did not consider placing Mr Ullah on clinical hold (where prisoners are not transferred between prisons for a period of time for clinical reasons) given he was under the care of a hospital consultant for a serious heart condition. Also, healthcare staff at Full Sutton failed to give a handover to healthcare staff at Lowdham Grange when Mr Ullah was moved there.
8. The clinical reviewer was concerned that Mr Ullah was not seen face to face by a GP during his time at Lowdham Grange. This meant that there was a missed opportunity for a medical assessment and consideration of a referral to a local cardiologist.

9. We are also concerned that Mr Ullah was allowed to use the gym even though he had said on the gym induction questionnaire that he had a heart condition and that a doctor had advised him not to take part in physical activity.

Recommendations

- The Head of Healthcare at Full Sutton should ensure that staff:
 - record all pending outpatient appointments;
 - ensure that arrangements are in place to facilitate prisoners' attendance at outpatient appointments; and
 - record the reasons for non-attendance.
- The Head of Healthcare at Full Sutton should ensure that staff consider placing prisoners on clinical hold where they are attending hospital for a serious health condition, and record that they have done so.
- The Head of Healthcare at Full Sutton should ensure that when a prisoner receiving ongoing care from a hospital specialist is transferred to another prison, staff provide a full handover to the receiving prison.
- The Head of Healthcare at Lowdham Grange should ensure that when prisoners arrive with a serious health condition, they are seen promptly by a GP for a face to face consultation.
- The Governor and Head of Healthcare at Lowdham Grange should assure themselves that the new process (where prisoners who answer 'yes' to any of the healthcare questions on the gym induction form, are prevented from using the gym until healthcare staff have confirmed that they are fit to do so) has been fully implemented and is fully embedded.
- The Governor should ensure that this report is shared with a PEI and that a senior manager discusses the Ombudsman's findings with him.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. No one responded
11. The investigator obtained copies of relevant extracts from Mr Ullah's prison and medical records.
12. The investigator interviewed three members of staff at Lowdham Grange on 30 September 2019.
13. NHS England commissioned an independent clinical reviewer to review Mr Ullah's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
14. We informed HM Coroner for Nottingham of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Ullah's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The concerns that she raised have been addressed in the clinical review.
16. Mr Ullah's family received a copy of the initial report. They pointed out one factual inaccuracy. This report has been amended accordingly. Mr Ullah's family also raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Lowdham Grange

18. HMP Lowdham Grange is a medium security prison, managed by Serco, which holds a maximum of 888 men. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services, which includes 24-hour nursing cover.

HMP Full Sutton

19. HMP Full Sutton is a high security prison near York, which holds up to 626 men. Spectrum Community Health CIC provides a range of integrated health services. Healthcare staff are on duty for 24 hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite.

HM Inspectorate of Prisons

Lowdham Grange

20. The most recent inspection of HMP Lowdham Grange was in August 2018. Inspectors reported that time out of cell and access to association and exercise were good for most prisoners. Recreational gym provision was reasonably good but indoor facilities and equipment were very poor and the floor in the weights room was damaged and hazardous. Monitoring of the library and the gym use was weak and it was difficult to determine who used them.
21. Inspectors found that all health care staff and approximately 85% of prison custody officers (PCOs) were trained in emergency responses. They understood the code system to call for assistance in medical emergencies and the need for ambulances to be requested promptly. The code system was displayed in the wing offices. The health care emergency bags on each house block were well equipped and checked regularly but PCOs did not have access to them.

Full Sutton

22. The most recent inspection of HMP Full Sutton was in January 2016. Inspectors found that healthcare provision was reasonable overall and that all prisoners had full access to an appropriate range of services. Of 79 external hospital appointments scheduled for the previous two months, 33 had been cancelled by the prison, which could have had an impact on the health needs of patients. However, proposed cancellations were assessed and prioritised by the GP.

Independent Monitoring Board

23. 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.

Lowdham Grange

24. In its latest annual report for the year to January 2019, the IMB reported that there have been significant management changes in the prison during this reporting period: a new Director took up post in November 2016 and a new Head of Healthcare in January 2017. The IMB reported that the two had developed an excellent working relationship that had led to open, constructive discussion and innovations that were starting to improve services to prisoners while taking into account the need to use prison resources effectively.

Full Sutton

25. In its latest annual report for the year to December 2019, the IMB reported that in December 2018 there were seven nurse vacancies, and some healthcare staff on long-term sick. General medical primary care services and outpatient access had been little affected by staff shortages. However, some chronic disease management programmes, for example pulmonary disease management provided in the gym and programmes for elderly prisoners, had had to be curtailed.

Previous deaths at HMP Lowdham Grange

26. Mr Ullah was the eighth prisoner to die at HMP Lowdham Grange since August 2017. Of the previous deaths, two were from natural causes, three were drug-related and two were self-inflicted. There are no similarities between Mr Ullah's death and previous deaths at Lowdham Grange.

Previous deaths at HMP Full Sutton

27. There have been nine deaths at Full Sutton since August 2017. Of the previous deaths, seven were from natural causes, one was self-inflicted and one was a homicide. There are no similarities between Mr Ullah's death and the deaths at Full Sutton.

Key Events

28. On 12 March 2016, Mr Masih Ullah was remanded in custody charged with drug and firearm offences. He was sent to HMP Leeds. He was later sentenced to 18 years imprisonment. On 24 November, he was moved to HMP Full Sutton.

Full Sutton

29. On 8 July 2018, Mr Ullah collapsed on his way back from the gym. He said that he had a sudden pain in his shoulder. Mr Ullah was seen by a nurse who did an echocardiogram (ECG). She found that his heartbeat was abnormal and sent him to hospital. Tests showed that Mr Ullah had obstructions in the blood vessels of the heart which had caused him to have a heart attack. A cardiologist performed a non-surgical procedure to treat the narrowing of the arteries to the heart and prescribed aspirin and ticagrelor (used to reduce the risk of heart attack). On 11 July, Mr Ullah was returned to prison.
30. On 7 August, Mr Ullah had a further episode of chest pain. A nurse carried out an ECG and noted abnormalities. She sent him to hospital. On 10 August, Mr Ullah had surgery to insert a stent into his coronary artery. He was returned to Full Sutton on 11 August.
31. When Mr Ullah returned to prison, his condition was managed with medication. A prison GP completed a fitness to work assessment. She said that Mr Ullah was not fit to work but could do cardiac rehabilitation and yoga.
32. On 17 October, Mr Ullah started a cardiac rehabilitation programme. He was given a book on self-management and told to liaise with the gym staff about exercise.
33. On 1 November, a prison GP saw Mr Ullah after he complained of pain in his left shoulder. He told him to take a GTN spray (a spray that is used to relieve chest pain) and increased his regular medication. He also wrote to the hospital cardiologist for further advice. The cardiologist said that Mr Ullah's medication should be increased, and that he would arrange a hospital appointment for an ECG.
34. On 28 February 2019, Mr Ullah was taken to the hospital for an ECG. Following this appointment, the prison GP received a letter from the hospital which said "Mr Ullah is due to be seen in clinic again in April [2019]. If the angina has not resolved by then it is likely we will proceed to further investigations of his coronaries". Mr Ullah was due to attend a hospital appointment on 11 April but the hospital recorded that he did not attend (although prison records note that he attended).
35. On 24 July, Mr Ullah was moved to HMP Lowdham Grange.

Lowdham Grange

36. A nurse completed an initial and secondary reception screen. She noted that Mr Ullah had a family history of heart disease and that he had previously had a heart attack, suffered with angina (chest pain caused by reduced blood flow to the heart muscles), and had had surgery to insert stents into his coronary arteries. She noted

that his ischaemic heart disease management was to be ongoing. She also recorded that Mr Ullah had no outstanding hospital appointments.

37. On 29 July, a prison GP reviewed Mr Ullah's medical notes and prescribed his medication. This was done remotely and the prison GP did not see Mr Ullah face to face.
38. On the same day, Mr Ullah attended the prison gym. He had a gym induction with Physical Education Instructor (PEI), which included completing a health questionnaire. Mr Ullah stated on the questionnaire that he had a heart condition and had previously been advised by a doctor not to take part in physical activity. Despite this, Mr Ullah was allowed to use the gym equipment including lifting heavy weights.
39. On 5 August, Mr Ullah attended the gym and was seen lifting weights. At approximately 9.50am, another prisoner found Mr Ullah collapsed on the floor in the gym toilet. He told the PEI. When the PEI got to the toilet, he saw Mr Ullah slumped over the toilet. He said that Mr Ullah was breathing but was making strange noises. At 9.55am, he called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).
40. A nurse responded to the code blue. She found Mr Ullah to be breathing but not responsive. She moved him from the toilet into an open space and put him in the recovery position while she was checking for a pulse. At 10.09am, Mr Ullah stopped breathing so she started cardiopulmonary resuscitation (CPR).
41. At 10.26am, ambulance paramedics arrived and continued with CPR. Air ambulance crew arrived at 10.40am. Paramedics gave Mr Ullah adrenaline and a defibrillator shock but could not establish a pulse. They pronounced Mr Ullah dead at 11.15am.

Contact with Mr Ullah's family

42. On 5 August, after Mr Ullah's death, the prison appointed a prison officer as the family liaison officer (FLO). The FLO went to Mr Ullah's next of kin's house with the prison Imam and a prison Director. They broke the news of Mr Ullah's death. They offered Mr Ullah's family support and discussed the funeral arrangements.
43. The prison contributed towards Mr Ullah's funeral in line with national guidelines. The funeral took place on 9 August.

Support for prisoners and staff

44. After Mr Ullah's death, the prison 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.
45. The prison posted notices informing other prisoners of Mr Ullah's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ullah's death.

Post-mortem report

46. The post-mortem report concluded that Mr Ullah died of acute left ventricular failure (when the main pumping chamber of the heart stops working properly), caused by coronary artery stenosis (narrowing of the blood vessels that supply the heart muscle).

Findings

Clinical care at HMP Full Sutton

47. The clinical reviewer concluded that, overall, the standard of care and treatment that Mr Ullah received at Full Sutton was equivalent to that he could have expected to receive in the community.
48. The clinical reviewer noted, however, that between September 2018 and April 2019, Mr Ullah missed five hospital appointments while at Full Sutton. We were told that three appointments were missed because they had not been put into the diary by healthcare staff and one was cancelled by the prison due to family visits. According to hospital records, Mr Ullah failed to attend the last appointment booked for him, on 11 April 2019 (although the prison recorded that he had attended).
49. We are also concerned that healthcare staff did not consider placing Mr Ullah on clinical hold (where prisoners are not transferred between prisons for a period of time for clinical reasons) given that he was under the care of a hospital cardiologist. Also, healthcare staff at Full Sutton did not give a handover to staff at HMP Lowdham Grange about the care Mr Ullah had been receiving for his heart condition, which meant that they did not know that they needed to follow this up. Therefore, we make the following recommendations:

The Head of Healthcare at Full Sutton should ensure that staff:

- **record all pending outpatient appointments;**
- **ensure that arrangements are in place to facilitate prisoners' attendance at outpatient appointments; and**
- **record the reasons for non-attendance.**

The Head of Healthcare at Full Sutton should ensure that staff consider placing prisoners on clinical hold where they are attending hospital for a serious health condition, and record that they have done so.

The Head of Healthcare at Full Sutton should ensure that when a prisoner receiving ongoing care from a hospital specialist is transferred to another prison, staff provide a full handover to the receiving prison.

Clinical care at HMP Lowdham Grange

50. The clinical reviewer concluded that, overall, the standard of care and treatment that Mr Ullah received at Lowdham Grange was not equivalent to that he could have expected in the community. The clinical reviewer was concerned that even though Mr Ullah had a serious heart condition, he was not seen for a face to face appointment with a GP at Lowdham Grange. This was a missed opportunity to complete a full medical assessment, make a new referral to a local cardiologist or follow up on any missed appointments. This also meant that a care plan and exercise programme were not put in place or discussed with Mr Ullah.

The Head of Healthcare at Lowdham Grange should ensure that when prisoners arrive with a serious health condition, they are seen promptly by a GP for a face to face consultation.

Mr Ullah's use of the gym at HMP Lowdham Grange

51. When Mr Ullah completed a gym induction questionnaire at Lowdham Grange on 29 July 2019, he marked 'Yes' to two questions: 'Has your Doctor ever said that you have a heart condition and that you should only do physical activity recommended by a Doctor?' and 'Has your Doctor or other medical professional advised you against taking part in physical activity?'. The form says, 'In the event I have answered yes to any question I am advised to seek medical advice prior to taking part in any exercise; I agree to contact healthcare professionals for advice prior to participating in PE activities.'
52. Mr Ullah did not seek advice from healthcare staff but despite this, prison staff allowed him to use the gym facilities including lifting heavy weights.
53. The PEI said at interview that at the time of Mr Ullah's gym induction, the onus was on the prisoner to seek advice from healthcare staff and to not use the gym until they had done so. The PEI said that at the time, he was not required to approach healthcare staff himself, or check that the prisoner had done so, as this was the prisoner's responsibility. He said, however, that the process had been changed since Mr Ullah's death. The current process was that if a prisoner answered 'Yes' to any of the questions, the PEI would email regimes and healthcare staff and the prisoner would be prevented from using the gym until healthcare staff had agreed they were fit to do so.
54. We recognise that the induction questionnaire was worded in a way that put the onus on the prisoner to seek healthcare advice before using the gym. However, we find it difficult to understand why a trained PEI would not have asked Mr Ullah if he had sought medical advice after seeing his induction questionnaire. We make the following recommendations:

The Governor and Head of Healthcare at Lowdham Grange should assure themselves that the new process (where prisoners who answer 'yes' to any of the healthcare questions on the gym induction form, are prevented from using the gym until healthcare staff have confirmed that they are fit to do so) has been fully implemented and is fully embedded.

The Governor should ensure that this report is shared with the PEI and that a senior manager discusses the Ombudsman's findings with him.

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