

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Barry Fisher, a prisoner at HMP Ashfield, on 7 October 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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Barry Fisher died from heart failure on 7 October 2021 at HMP Ashfield. He was 74 years old. I offer my condolences to Mr Fisher's family and friends.

Mr Fisher had several long-term conditions when he arrived in prison, including heart disease, diabetes and lung disease. The clinical reviewer found that Mr Fisher's clinical care was equivalent to that he could have expected to receive in the community. However, he found that staff had not put formal care plans in place.

Mr Fisher was found unresponsive on the floor of his cell in the early hours of 7 October. I am concerned that prison staff started CPR despite Mr Fisher having signed an order saying that he did not want to be resuscitated if his heart or breathing stopped. It is important that prison staff are aware of, and respect, a prisoner's wishes.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**July 2022**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	8

# Summary

## Events

1. In February 2020, Mr Barry Fisher was sentenced to 11 years imprisonment for sexual offences.
2. Mr Fisher had already been diagnosed with heart disease and had experienced multiple heart attacks before entering prison. He also had several serious physical health conditions including type 2 diabetes, chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases) and chronic kidney disease.
3. In April 2020, after being admitted to hospital with heart failure, Mr Fisher signed a Do Not Resuscitate (DNR) order saying he did not want to be resuscitated if his heart or breathing stopped. He was discharged back to prison when his condition stabilised.
4. On 21 April 2021, Mr Fisher was moved to HMP Ashfield.
5. At around 2.20am on 7 October, an officer saw that Mr Fisher's cell light was on and went to check on him. He noticed that Mr Fisher was on the floor. He fetched two colleagues who looked through the cell hatch. They could not get a response from Mr Fisher and thought he was not breathing. They radioed for the Night Orderly Officer (the senior officer in charge) to attend and then they called a medical emergency code. When the Night Orderly Officer arrived, she told them to start CPR.
6. At 2.37am, the Night Orderly Officer spoke to the Duty Director by telephone and said that Mr Fisher was cold and she thought he had been dead for some time. The Duty Director told her to stop CPR.
7. At 2.47am, ambulance paramedics arrived. They pronounced Mr Fisher dead at 3.05am.
8. The post-mortem report concluded that Mr Fisher died from heart failure caused by heart disease and COPD

## Findings

9. The clinical reviewer found that the care Mr Fisher received at Ashfield was of a reasonable/good standard and was equivalent to that which he could have expected to receive in the community.
10. However, he found that staff had not held reviews of Mr Fisher's heart disease while at Ashfield and had not put a formal care plan in place. He also found that although staff had held comprehensive reviews for Mr Fisher's COPD and diabetes, they had not put formal care plans in place. He also highlighted issues with the use of the National Early Warning Score tool (NEWS2 - used to assess clinical deterioration).
11. We are concerned that prison staff were unaware that Mr Fisher had a DNR order in place and started CPR against his wishes. They also started CPR when it was clear that Mr Fisher was already dead, which is distressing for staff and undignified for the deceased.

12. We also found that prison staff seemed unclear about how a defibrillator works and gave misleading information to the ambulance dispatcher, which indicated that Mr Fisher may still be alive and led to the dispatcher telling prison staff to continue CPR

## Recommendations

- The Head of Healthcare should ensure that a formal care plan approach is adopted for all prisoners with long-term conditions and that the plan is discussed and agreed with them.
- The Head of Healthcare should ensure that staff:
  - use the NEWS2 tool correctly and escalate scores as and when required; and
  - complete follow-up assessments as agreed.
- The Director and Head of Healthcare should ensure that:
  - healthcare staff provide prison staff with details of all prisoners with DNR orders in place and this is communicated to relevant wing staff; and
  - all staff are aware of what a DNR order means and do not attempt resuscitation against a prisoner's wishes.
- The Director should ensure that staff are aware of the circumstances in which resuscitation is inappropriate in line with *Guidance to support the decision making process of when not to perform Cardiopulmonary Resuscitation in prisons (2016)*.
- The Director should ensure that prison staff know how to use a defibrillator and can clearly communicate to the ambulance service what the defibrillator is indicating.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Fisher's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Fisher's clinical care at the prison.
16. The investigator, accompanied by, the Ombudsman's family liaison officer (FLO), interviewed four members of staff at HMP Ashfield on 17 November 2021.
17. We informed HM Coroner for Avon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The FLO contacted Mr Fisher's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

## **Background Information**

### **HMP Ashfield**

20. HMP Ashfield is a Category C prison, operated by Serco and holding approximately 400 men who have been convicted of sexual offences. Hanham Secure Health provide healthcare services. Nurses are on duty at Ashfield Monday to Sunday, 7.30am to 6.00pm, including bank holidays.

### **HM Inspectorate of Prisons**

21. The most recent inspection of HMP Ashfield was in March 2019. Inspectors reported the health and social care provisions were of a good standard and most prisoners were satisfied with the quality of healthcare received. The inspection found not all prisoners with long-term health conditions had care plans in place and made a recommendation for this to be implemented. The prison agreed to the recommendation.

### **Independent Monitoring Board**

22. 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 30 June 2021, the IMB reported that Ashfield was a well-managed prison. They said that healthcare services were equal to those provided in the community. The IMB assessed that the prison was a safe environment and that prisoners were treated humanely.

### **Previous deaths at HMP Ashfield**

23. Mr Fisher was the fourth prisoner to die at Ashfield since October 2019. All deaths were from natural causes. We have previously raised concern about the use of the NEWS2 assessment tool.

## Key Events

1. In February 2020, Mr Barry Fisher was sentenced to 11 years imprisonment for sexual offences. He was sent to HMP Bristol.
2. Mr Fisher had already been diagnosed with heart disease and had experienced multiple heart attacks before entering prison. He also had several serious physical health conditions including type 2 diabetes, chronic obstructive pulmonary disease (COPD – the term for a group of serious lung diseases) and chronic kidney disease.
3. On 22 April, Mr Fisher was admitted to hospital with heart failure. While he was in hospital, staff discussed a Do Not Resuscitate (DNR) order with him. He agreed that he did not want anyone to resuscitate him if his heart or breathing stopped and signed the DNR order to that effect. He was discharged on 27 April when his condition stabilised.
4. On 21 April 2021, Mr Fisher was moved to HMP Ashfield.
5. On 4 October, Mr Fisher complained of a painful, swollen knee. A nurse assessed him and thought it could be a flare up of gout (a type of arthritis). She found Mr Fisher had low blood pressure (which was not unusual for him) and calculated a National Early Warning Score (NEWS2) of 2. (NEWS2 is a tool used to assess clinical deterioration. The in-house protocol says that a score of 1-2 should prompt the practitioner to inform a senior clinician.) The nurse encouraged Mr Fisher to eat and drink more. A prison GP prescribed medication for gout.
6. A healthcare assistant checked Mr Fisher's blood pressure again the next day and it was still low. She calculated a NEWS2 score of 3 (in-house protocol states a score of 3-6 should prompt a sepsis [the body's extreme response to an infection] screening). She told him to drink plenty of water and she would check him again the next day.
7. At approximately 7.00pm that evening, Mr Fisher fell off his mobility scooter and soiled himself. Officers helped to clean him up. Mr Fisher did not appear to have injured himself.
8. There is no record that healthcare staff saw Mr Fisher on 6 October.
9. At approximately 8.00pm that evening, staff completed a roll check (count of prisoners). They raised no concerns about Mr Fisher.
10. At approximately 2.20am on 7 October, a Prison Custody Officer (PCO) went to check on Mr Fisher as he saw his cell light was on and knew he had fallen the day before. He saw that Mr Fisher was on the floor with his eyes open. He thought he had fallen and needed someone to help him up. The PCO went to get colleagues to access the cell and promptly returned with two other PCOs who looked through the cell hatch. They could not get a response from Mr Fisher and thought he was not breathing.
11. At 2.24am, one of the PCOs radioed for the Night Orderly Officer (the senior officer in charge), a Custodial Operations Manager (COM), to attend and then called a code blue (a medical emergency code used when a prisoner is unconscious or

having breathing difficulties.) Staff in the prison's control room called for an ambulance.

12. The PCOs unlocked Mr Fisher's cell and entered. They found that he was cold to touch, had no pulse, was not breathing and his pupils were not responsive, indicating he was dead.
13. At approximately 2.25am, the COM arrived. The PCOs told her they thought Mr Fisher had been dead for some time. The COM instructed staff to collect the defibrillator and start CPR. A PCO collected the defibrillator and the two other PCOs started CPR. A PCO then went to the wing office to speak with the ambulance dispatcher on the phone.
14. Soon afterwards, the COM also went to the office to provide an update. She said to the dispatcher, "He's quite clearly been dead for some time, he's cold, it looks as though he's fell over and cracked his head open. There's blood on the floor, it looks as though he's been trying to get off the toilet and he's fell. He's cold, we're doing CPR."
15. The dispatcher asked what the state of Mr Fisher's body was when staff tried to move him. The COM said he was "still". She went on to say that they were currently doing CPR and had "used the defibrillator once so far". The COM then left to return to Mr Fisher's cell.
16. A PCO returned to the phone and the dispatcher asked him to confirm that CPR was still being done and that the defibrillator had shocked once. The PCO said he did not think the defibrillator had shocked Mr Fisher and asked, "Would you recommend going to the shock?". The dispatcher said that the COM had told him that the defibrillator had shocked him once. The dispatcher explained that as there had been a shock administered, he could not instruct them to stop CPR as this suggested a chance Mr Fisher could be revived.
17. At 2.37am, the COM briefed the Duty Director, by telephone. He instructed officers to stop CPR due to signs of rigor mortis and indications that Mr Fisher had been dead for some time.
18. At 2.47am, ambulance paramedics arrived. They pronounced Mr Fisher dead at 3.05am

### **Contact with Mr Fisher's family**

19. The prison appointed a PCO as the family liaison officer (FLO). At 7.45am on 7 October 2021, he arrived at Mr Fisher's daughter's address, and told her that Mr Fisher had died.
20. The prison contributed financially to Mr Fisher's funeral in line with national guidance.

## **Support for prisoners and staff**

21. After Mr Fisher's death, the Duty Director 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.
22. The prison posted notices informing other prisoners of Mr Fisher's death and offering support.

## **Post-mortem report**

23. The post-mortem report concluded that Mr Fisher died of congestive cardiac (heart) failure caused by ischaemic heart disease (lack of blood supply to the heart caused by a build-up of fatty substances in the coronary arteries) and COPD

# Findings

## Clinical care

24. The clinical reviewer concluded that the care Mr Fisher received was of a reasonable/good standard and was at least equivalent to that which he could have expected to receive in the community.
25. However, the clinical reviewer found that although staff held comprehensive reviews of Mr Fisher's diabetes and COPD, they did not create formal care plans for these conditions. He also found that although reviews had been scheduled for Mr Fisher's heart disease (for after his death), he did not have any reviews while at Ashfield and again, staff had not put a formal care plan in place. We recommend:

**The Head of Healthcare should ensure that a formal care plan approach is adopted for all prisoners with long-term conditions and that the plan is discussed and agreed with them.**

26. The reviewer also found that in the days leading up to Mr Fisher's death, the in-house protocol for escalating NEWS2 scores was not followed and that a follow-up assessment was not completed.
27. On 4 October, a nurse calculated a NEWS2 score of 2. She did not escalate this to a senior clinician as advised by the in-house protocol.
28. On 5 October, a healthcare assistant calculated a NEWS2 score of 3. She did not complete a sepsis screening as advised by the in-house protocol. She noted that Mr Fisher's blood pressure would be checked again the next day but there is no record that healthcare staff saw him on 6 October.
29. We recommend:

**The Head of Healthcare should ensure that staff:**

- **use the NEWS2 tool correctly and escalate scores as and when required; and**
- **complete follow-up assessments as agreed.**

## Attempted resuscitation of Mr Fisher

30. Mr Fisher signed a Do Not Resuscitate (DNR) order in April 2020. Medical records show that healthcare staff at Ashfield discussed the DNR order with Mr Fisher on several occasions. However, there is no evidence to show that this information was shared with prison staff.
31. During interview, prison staff said they were unaware of Mr Fisher's DNR order. Most were also unsure about how they would be made aware of prisoners with DNR orders in place. The COM said that prisoners with DNR orders in place would be read out at the daily morning briefing but there was no briefing for night staff. Night staff were expected to read the daily briefing sheet themselves. However, Mr Fisher was not listed on the daily briefing sheet. We recommend:

**The Director and Head of Healthcare should ensure that:**

- **healthcare staff provide prison staff with details of all prisoners with DNR orders in place and this is communicated to relevant wing staff; and**
- **all staff are aware of what a DNR order means and do not attempt resuscitation against a prisoner's wishes.**

32. All the staff who saw Mr Fisher when he was found lying on his cell floor thought he was dead as he was cold to touch, was not responding or breathing and his head/neck were not in a natural position. This included the COM, who thought Mr Fisher had been dead for some time.
33. Despite this, the COM instructed staff to start CPR. When interviewed, she said her understanding was that CPR should always be started until staff were told to stop by paramedics.
34. However, resuscitation should not be started where it is clear that a person is already dead. This is distressing for staff and undignified for the deceased. This is made clear in *Guidance to support the decision making process of when not to perform Cardiopulmonary Resuscitation in prisons* (published in March 2016 and based on the European Resuscitation Council *Guidelines for Resuscitation 2015*). We recommend:
35. **The Director should ensure that staff are aware of the circumstances in which resuscitation is inappropriate in line with *Guidance to support the decision making process of when not to perform Cardiopulmonary Resuscitation in prisons (2016)*.**

**Liaison with the ambulance dispatcher**

36. The investigator listened to the recording of the 999-call made by prison staff.
37. During the call, the COM told the dispatcher that she thought Mr Fisher had been dead for some time but that they had started CPR. She said that they had “used the defibrillator once so far”.
38. When the investigator asked the COM what was meant by “used the defibrillator once so far”, she replied, “They were using it as in had wired it up to him etc. but there had been no shocks when I left. I do remember hearing it counting down which is maybe why I said, ‘used it once’.”
39. The investigator has verified with officers on scene that no shocks were administered by the defibrillator. However, the ambulance dispatcher understood that a shock had been given based on the COM saying the defibrillator had “been used once so far”. We consider that this miscommunication impacted the dispatcher’s decision to tell prison staff to continue CPR.
40. During the call, a PCO asked the dispatcher, “Would you recommend going to the shock?”. This would indicate that the PCO was unclear on how a defibrillator works, as the defibrillator will deliver a shock to the patient if it detects a pulse; the user cannot decide when a shock should be delivered. We recommend:

**The Director should ensure that prison staff know how to use a defibrillator and can clearly communicate to the ambulance service what the defibrillator is indicating.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100