

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Mark Elsworth, a prisoner at HMP Humber, on 13 August 2021**

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

## OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

## WHAT WE DO



## WHAT WE VALUE



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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mark Elsworth died on 13 August 2021, at HMP Humber. His cause of death was a myocardial infarction (a heart attack) and coronary artery atherosclerosis and stenosis (narrowing of the coronary artery restricting the blood flowing through it). He also had extensive old myocardial infarction (dead tissue within heart caused by blocked blood vessels), which contributed to but did not cause his death. Mr Elsworth was 55 years old. I offer my condolences to Mr Elsworth's family and friends.

The clinical reviewer concluded that the clinical care that Mr Elsworth received at HMP Humber was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community. She was concerned with elements of the reception screen process and that a referral had not been made to the long-term condition clinic for his asthma. The clinical reviewer has made five recommendations that the Head of Healthcare will need to address.

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

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**July 2023**

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# Summary

## Events

1. Mr Mark Elsworth was transferred to HMP Humber on 30 July 2021. He had no known history of heart problems but did have asthma and hypertension (high blood pressure).
2. At approximately 9.00am on 13 August 2021, a member of staff unlocked Mr Elsworth's cell and called out to him. Mr Elsworth did not respond and so the officer went into the cell and touched his arm, which was cold. The member of staff raised the alarm.
3. At approximately 9.03am, a nurse arrived and examined Mr Elsworth. She concluded that he had been dead for some time and that any resuscitation attempts would be futile.
4. A family liaison officer was appointed the same day. Mr Elsworth's next of kin were notified of his death on 16 August.

## The Investigation Process

5. We were notified of the death of Mr Elsworth on 13 August 2021.
6. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Elsworth's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Elsworth's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff via Microsoft Teams on 17 November 2021.
9. We informed HM Coroner for Hull and East Riding of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr Elsworth's sister to explain the investigation and to ask if she had any matters they wanted us to consider. She did not have any questions.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

## Background Information

### HMP Humber

12. HMP Humber is a Category C resettlement prison for adult men with 14 residential wings. The prison was formed in 2013, following the amalgamation of two former prisons, HMP Wolds and HMP Everthorpe, and it can hold approximately 1,000 men.
13. At the time of Mr Elsworth's death healthcare services were provided by City Health Care Partnership.

### HM Inspectorate of Prisons

14. The most recent inspection of HMP Humber was in November 2020 at which time the prison was still in a period of recovery following the COVID-19 pandemic. Inspectors concluded that managers, staff and prisoners had responded well to the pandemic and were continuing to work hard to maintain an environment safe from COVID-19.

### Independent Monitoring Board

15. 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 December 2021, the IMB reported that HMP Humber had been managed extremely well throughout 2021, within the circumstances of the pandemic and that prisoners were treated fairly and humanely.

### Previous deaths at HMP Humber

16. Mr Elsworth was the 12<sup>th</sup> prisoner to die at HMP Humber since August 2018. Of the previous 11 deaths, five were from natural causes, three were drug-related and three were self-inflicted. Since Mr Elsworth's death, there have been two natural causes deaths and one self-inflicted. There are no similarities between our findings in the investigation into Mr Elsworth's death and our investigation findings for the previous deaths.

## Key Events

17. On 2 February 2021, Mr Mark Elsworth was sentenced to 18 months imprisonment for harassment offences. Due to the time served on remand, Mr Elsworth was released on licence on 3 February.
18. His licence was subsequently revoked on 9 June and Mr Elsworth was transferred to HMP Humber on 30 July 2021.
19. Mr Elsworth had a number of physical conditions, including, but not limited to, asthma and hypertension (high blood pressure) and mental health conditions. He had no known history of heart problems.
20. At approximately 6.25pm, on 12 August 2021 Mr Elsworth was locked in his cell by an officer.

## Events of 13 August 2021

21. At around 5.30am, two Operational Support Grades (OSG) commenced the early morning roll check.
22. At approximately 5.40am, OSG A went to Mr Elsworth's cell and opened the observation flap. He said that there were no curtains, so he was able to see into the cell clearly. He observed that Mr Elsworth was sat on his bed with his right leg out of bed and his left leg under the bed covers, and his hands were on his groin area. He said that he thought he saw Mr Elsworth move when he rattled the observation flap. He said he asked his colleague, OSG B, to take a look due to Mr Elsworth's position on the bed. He explained that he did not seek a verbal response as Mr Elsworth appeared to be sleeping.
23. The CCTV footage shows that OSG A looked through the observation panel and through the crack between the wall and the hinge side of the door before looking through the observation panel again.
24. OSG B said that OSG A asked him to look into Mr Elsworth's cell because he was lying in a strange position. He said it was daylight at the time, so he was able to see him clearly and he thought that he saw Mr Elsworth's chest move. He stated that Mr Elsworth was laid on his back with his shoulders against the wall and his eyes were closed. He said that he did not seek to obtain a verbal response because he was satisfied that he had seen movement.
25. The CCTV shows that around 7.17am, an officer checked that Mr Elsworth's cell door was locked by trying the door handle.
26. At approximately 8.58am, Officer A opened the door to Mr Elsworth's cell. He said that Mr Elsworth was laid in bed with his head against the wall. He recorded that he called out to Mr Elsworth a couple of times and because there was no response, he entered the cell and shook his right arm to rouse him. Mr Elsworth did not respond and was cold to touch.

27. Officer A went to the wing office to get help and to call a medical code blue (used when a prisoner is unconscious or having trouble breathing, and automatically leading control room staff to call an ambulance). On his way to the wing office, he told Officer B that he was concerned that Mr Elsworth was either under the influence or dead.
28. At approximately 8.59am, Officer B radioed a medical code blue and then entered Mr Elsworth's cell. She noted that Mr Elsworth was sat up in bed and was blue in colour. She took hold of his hand which she said was cold and stiff.
29. Staff in the control room called an ambulance at 8.59am.
30. At approximately 9.01am, a nurse entered Mr Elsworth's cell. She noted that Mr Elsworth was unresponsive, cold to touch and there were signs of lividity (bluish-purple discoloration of the skin). She concluded that Mr Elsworth had been dead for some time.
31. Staff tried to move Mr Elsworth, but this was not possible due to rigor mortis and at 9.04am. The nurse decided not to attempt cardiopulmonary resuscitation (CPR) on the basis that it was futile and undignified as Mr Elsworth was clearly dead.
32. The ambulance arrived at the prison at approximately 9.10am and paramedics confirmed his death.
33. At 9.22am, the Managing Chaplain was appointed as the Family Liaison Officer. There were no next of kin details recorded in Mr Elsworth's file. Following a number of enquiries, a next of kin, Mr Elsworth's sister, was notified of his death on 16 August.
34. Mr Elsworth's funeral took place on 26 August 2021. HMP Humber contributed to the cost, in line with national instructions.

## **Support for prisoners and staff**

35. After being notified of Mr Elsworth's death, the Head of Reduce Reoffending arranged for the immediate deployment of the staff care team to support the officers who had been affected by the death. She chaired a staff debrief later that day.
36. The prison posted notices informing other prisoners of Mr Elsworth'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 Elsworth's death.

## **Post-mortem report**

37. A post-mortem examination established that Mr Elsworth died of recent myocardial infarction (a heart attack – when the supply of blood to the heart is suddenly blocked) and coronary artery atherosclerosis and stenosis (narrowing of the coronary artery restricting the blood flowing through it). He also had extensive old myocardial infarct (damaged heart tissue from a previous blockage), which contributed to but did not cause his death.

## **Inquest**

38. The inquest into Mr Elsworth's death was held on 25 September 2023 and a verdict of natural causes was recorded.
39. The coroner concluded that Mr Elsworth's death was due to a recent myocardial infarct caused by coronary artery atherosclerosis and stenosis. An extensive old myocardial infarct contributed to but did not cause his death.

# Findings

## Clinical care

40. The clinical reviewer concluded that the clinical care that Mr Elsworth received at HMP Humber was not of the required standard and therefore not equivalent to that which he would have received in the wider community. She said that the care, in relation to his asthma and mental health conditions, was not delivered in line with NICE (National Institute for Health and Care Excellence) guidelines. The clinical reviewer has made five recommendations, which are not related to Mr Elsworth's death, which will need to be addressed by the Head of Healthcare at HMP Humber.
41. Within their report the clinical reviewer also identified some good practice in regard to the management of Mr Elsworth following the code blue. She stated that the attending nurse had clearly documented her rationale for not commencing CPR.

## Discovering Mr Elsworth

42. We cannot be sure if Mr Elsworth was alive or dead at the time of the roll check.
43. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. On 13 August 2021, staff conducted the first roll check of the day at around 5.30am. It is reasonable that staff do not wake prisoners up to obtain a verbal response at that time of the morning.
44. Although concerned that Mr Elsworth was lying in an unusual position, both OSGs told us that they had seen movement and were assured that Mr Elsworth was alive.
45. We are satisfied that at the point at which it became clear that Mr Elsworth was unresponsive, prison staff acted swiftly and in accordance with prison policy.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**July 2023**

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