Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Bernard Meason, a prisoner at HMP Ashfield, on 2 November 2022

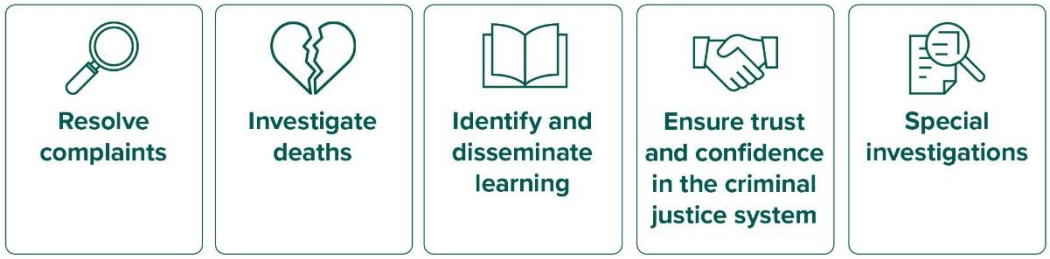
## A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T l 020 7633 4100

## 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

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 Bernard Meason died in hospital from a spontaneous intracerebral haemorrhage (bleeding into the brain) as a result of high blood pressure on 2 November 2022 while a prisoner at HMP Ashfield. He had also had an aortic valve replacement (a type of open-heart surgery) which contributed to but did not cause his death. He was 65 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the care that Mr Meason received at Ashfield when he had symptoms consistent with a stroke on 31 October was not equivalent to that which he could have expected to receive in the community.

We are concerned that there were missed opportunities and delays in ensuring that Mr Meason's clinical care was appropriately escalated. We are also concerned that when prison staff first called the ambulance service, they failed to tell them that Mr Meason might have had a stroke. This resulted in the ambulance service not providing the most urgent level of emergency response.

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

**Kimberley Bingham**
**Acting Prisons and Probation Ombudsman** **December 2023**

# Contents

# Summary

## Events

1. In September 2017, Mr Bernard Meason was remanded to HMP Woodhill. On 13 November, he was sentenced to eight years in prison for sex offences. On 6 March 2019, he was transferred to HMP Ashfield.

2. Mr Meason had a history of aortic stenosis (heart valve disease) and had a mechanical aortic valve replacement in 2014, left ventricular diastolic dysfunction (difficulty in filling the heart chamber with blood) and hypertension (high blood pressure).

3. At about 9.45am on 31 October 2022, Mr Meason went to the healthcare unit. He stumbled into the room and told a healthcare assistant that he felt unwell. The healthcare assistant recorded a National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) of zero (which indicated a low clinical risk). She noted that Mr Meason had no obvious signs of a stroke (a serious life-threatening condition when the blood supply to part of the brain is cut off).

4. At about 10.30am, when Mr Meason returned to his cell, two prison officers visited him as they had seen that he was unsteady on his feet when he returned to the wing. They found him sitting on his chair and so left. When a prison buddy (a prisoner who provides help and support to another prisoner) told them that Mr Meason did not look well, they returned to the cell and agreed. An officer telephoned the healthcare unit and spoke to a nurse who told her that Mr Meason's observations had been normal that morning. She asked the officer to keep an eye on him and call her, if necessary. She agreed to see Mr Meason later that day to complete more observations.

5. At about 11.15am, the officers checked on Mr Meason who was slouched in his chair. His speech was slurred. One of them telephoned the nurse who came to see him. She noted that he did not display any symptoms consistent with a stroke. She recorded a NEWS2 score of zero and told Mr Meason that she would ask a prison GP to review him.

6. At about 1.00pm, the nurse telephoned an officer to find out how Mr Meason was. The officer said that he had eaten his lunch but that his presentation had not changed.

7. At about 2.00pm, an officer received a telephone call from healthcare staff, asking her to bring Mr Meason to them. She went to Mr Meason's cell with a prison buddy, and saw that Mr Meason was half on the floor and half on his chair and had urinated and vomited. She radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing).

8. An operational support grade in the control room telephoned the ambulance service and told them that Mr Meason was conscious, breathing and had fallen because he was dizzy. She told them that Mr Meason was semi-alert, very pale, clammy and unresponsive. On the basis of the information provided, the ambulance service operator classified the call as a category two emergency (a second level priority

category which indicates a potentially serious condition that may require rapid assessment and urgent intervention). She agreed to send the next available ambulance.

9. Two nurses went to Mr Meason's cell. They recorded a NEWS2 score of four (which indicated a medium clinical risk). Mr Meason vomited, and the nurses placed him in the recovery position.

10. The operational support grade telephoned the ambulance service again and said that Mr Meason's condition had changed, that he was unconscious and that it looked like he was having a stroke. By this time, the ambulance service estimated that an ambulance was 13 minutes away and the priority level was therefore not changed.

11. A prison GP went to Mr Meason's cell and concluded that Mr Meason had an intracranial bleed (a burst blood vessel in the brain).

12. At 2.39pm, ambulance paramedics were at Mr Meason's side and at 3.26pm, took him to hospital. Hospital staff confirmed that he had had an intercranial bleed.

13. On 2 November, Mr Meason died in hospital.

## Findings

14. The clinical reviewer found that the clinical care that Mr Meason received on 31 October was not equivalent to that which he could have expected to receive in the community. She said that there were missed opportunities and delays in ensuring that Mr Meason's clinical care was appropriately escalated when he displayed symptoms consistent with a stroke.

15. In the first call to the ambulance service that day, the operational support grade did not tell them that they thought that Mr Meason was having a stroke. This meant that the call was not graded as the highest level of emergency response as it should have been and in turn meant the ambulance took longer to arrive than it otherwise might have.

## Recommendations

- The Head of Healthcare should ensure that healthcare staff complete neurological observations, including the use of the Glasgow Coma scale, when assessing prisoners displaying symptoms consistent with a stroke.

- The Head of Healthcare should ensure that healthcare staff conduct full clinical observations, including all the observations required for an accurate NEWS2 score, and that care is escalated appropriately and in a timely manner.

- The Governor and Head of Healthcare should ensure that relevant, full and accurate information about the condition of a prisoner is provided to the ambulance service.

## The Investigation Process

16. 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.

17. The investigator obtained copies of relevant extracts from Mr Meason's prison and medical records.

18. NHS England commissioned a clinical reviewer to review Mr Meason's clinical care at the prison.

19. We informed HM Coroner for Avon of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer wrote to Mr Meason's wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

21. We shared the initial report with the Prison Service. There were no factual inaccuracies.

# Background Information

## HMP Ashfield

22. HMP Ashfield is a Category C prison, operated by Serco and holding approximately 400 men who have been convicted of sexual offences. Oxleas NHS Foundation Trust provide physical healthcare services.

## HM Inspectorate of Prisons

23. 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 that 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

24. 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 June 2022, the IMB reported that they were concerned with healthcare staff shortages which could present a risk to the long-term health and wellbeing of prisoners although access to routine healthcare services was generally assessed as being equal to that provided in the community.

## Previous deaths at HMP Ashfield

25. In the two years before Mr Meason's death, four prisoners died from natural causes at Ashfield. There are no significant similarities between our findings in this investigation and those of the other deaths.

# Key Events

26. On 8 September 2017, Mr Bernard Meason was remanded to HMP Woodhill. On 13 November, he was sentenced to eight years in prison for sex offences. On 6 March 2019, Mr Meason was transferred to HMP Ashfield.

27. Mr Meason had a history of aortic stenosis (heart valve disease) and had a mechanical aortic valve replacement in 2014, left ventricular diastolic dysfunction (difficulty in filling the heart chamber with blood) and hypertension (high blood pressure).

28. On 26 May 2022, a nurse reviewed Mr Meason because he said that he was short of breath on exertion. Mr Meason's blood pressure was slightly raised. She carried out an electrocardiogram (ECG, a test of the heart's rhythm), which was normal. An advanced clinical practitioner said that a prison GP should see Mr Meason.

29. On 31 May, a prison GP saw Mr Meason who said that he had pain on his right side. He noted that Mr Meason appeared 'stiff'. He arranged for Mr Meason to have chest and lower back x-rays and blood tests (the results of which were normal) and referred him for physiotherapy. Until May 2021, Mr Meason was referred to cardiology services.

30. On 12 July, Mr Meason had x-rays which showed some mild degenerative changes (osteoarthritis) in the spine.

31. On 27 July, a nurse carried out a review of Mr Meason's long-term conditions, including his hypertension. His blood pressure was stable. Mr Meason told her that he was no longer able to exercise due to pain in his knees.

## Events of 31 October

32. At about 9.45am on 31 October, a PCO saw Mr Meason when he left the wing to go to a healthcare appointment because he felt unwell.

33. At the healthcare appointment, a Healthcare Assistant (HCA) noted that Mr Meason stumbled when he came into the room. He told her that he had felt unwell for the last few hours. She recorded a NEWS2 score of zero. A nurse advised her to test Mr Meason's urine. It was found to contain blood. The HCA noted that healthcare staff would see Mr Meason again that afternoon.

34. At 10.00am, the HCA sent an electronic message to a prison GP (because prison GPs were not at Ashfield until the afternoon), stating that Mr Meason was dizzy. A prison GP responded to advise that he should be monitored throughout the day.

35. At about 10.30am, Mr Meason returned to the wing. Two PCOs saw that he appeared unsteady on his feet on his way to his cell. They went to his cell and found him sitting in a chair. A short while after they left, a prison buddy told the officers that Mr Meason did not look good. They returned to Mr Meason's cell and agreed that he looked unwell. A PCO telephoned the healthcare unit and spoke to a nurse, who told her that Mr Meason's results were clear. She asked them to keep

an eye on him and call her back, if necessary. The nurse also told the PCO that she would see Mr Meason after lunch to carry out more observations.

36. At 10.51am, the HCA noted in Mr Meason's medical records that he had no obvious signs of a stroke.

37. At about 11.15am, both PCOs went back to Mr Meason's cell and saw him slouched in his chair. Mr Meason's speech was slurred. A PCO telephoned a nurse and told her what she had seen.

38. At about 11.30am, the nurse saw Mr Meason in his cell. She noted that he was not displaying any symptoms consistent with a stroke. She noted that he was mumbling but that his speech was coherent and logical, with no evidence of confusion. Mr Meason told her that his right arm was weak, and she noted that he was able to lift his arm to shoulder height. Mr Meason was unable to grip her hands but was able to resist her attempt to move his arm. He told her that he thought that his mouth was drooping, and she noted that this was visible on his left-hand side, but he was able to smile and stick his tongue out when asked. Mr Meason told her that he was unsteady on his feet and that he had reduced movement in his right leg. She noted that he was able to elevate and bend his legs. She took his observations, which were within an acceptable range, apart from his blood pressure which was raised. She recorded a NEWS2 score of zero. She told Mr Meason that she would ask a prison GP to review him. Mr Meason told her that he could no longer see out of one eye, but she noted that that he was still able to make eye contact. She noted that Mr Meason's health was progressively worse since earlier that morning but did not present with symptoms consistent with a stroke.

39. A buddy collected Mr Meason's lunch which PCO Bill saw Mr Meason eat in his cell. Mr Meason put his hand up to thank her.

40. At about 1.00pm, the nurse telephoned a PCO to ask how Mr Meason was getting on. Two PCOs went to Mr Meason's cell and found that he had eaten his lunch, and that his presentation had not changed. The PCO telephoned the nurse, who told her that she would arrange a welfare check for Mr Meason and that a prison GP would see him after lunch.

41. At about 1.15pm, a PCO saw Mr Meason and recorded that he was sitting, slouched in his chair.

42. At about 2.00pm, the PCO received a telephone call from healthcare staff who asked her to bring Mr Meason to them. She went to Mr Meason's cell with a prison buddy and a wheelchair. She saw Mr Meason half on the floor and half on his chair, and that he had urinated. The buddy went into the cell and saw that Mr Meason had also vomited. She radioed a medical emergency code blue.

43. At 2.13pm, an OSG telephoned the Ambulance Service from the control room. She received a telephone call from the wing who told her that Mr Meason was conscious and breathing and that he had fallen over as a result of dizziness. She relayed this information to the Ambulance Service operator. She then told the Ambulance Service operator that Mr Meason was semi-alert, was very pale and clammy and unresponsive. The Ambulance Service operator told her that she classified the call

as a category two emergency response (a second level priority response) and that she would send the next available ambulance.

44. Two nurses went to Mr Meason's cell. They took Mr Meason's clinical observations and recorded a NEWS2 score of four (which should trigger a prompt assessment by a nurse to decide if escalation of clinical care is needed). Mr Meason vomited, and the nurses placed him in the recovery position. One nurse noted that Mr Meason had right-sided weakness, aphasia (difficulty with language and speech) and was unable fully to understand commands.

45. The OSG telephoned the Ambulance Service again and told the operator that Mr Meason's condition had changed, and it looked like he was having a stroke and was no longer conscious. The Ambulance Service operator said that their estimated time of arrival was thirteen minutes.

46. A prison GP went to Mr Meason's cell and concluded that Mr Meason was having an intracranial bleed (a burst blood vessel in the brain). He was concerned that because Mr Meason was prescribed warfarin (used to treat blood clots), there was an increased risk of excessive bleeding. He asked for the ambulance response to be upgraded.

47. At 2.39pm, ambulance paramedics were at his side and at 3.26pm, they took Mr Meason to hospital. Hospital staff confirmed that Mr Meason had had an intercranial bleed.

48. On 2 November, Mr Meason died in hospital.

## Contact with Mr Meason's family

49. On 31 October, a Custodial Operations Manager (COM) appointed a PCO as the family liaison officer and a chaplain as the deputy family liaison officer. After Mr Meason was admitted to hospital, the chaplain telephoned Mr Meason's next of kin, but the number was no longer in use. At 1.24am on 1 November, the PCO telephoned Mr Meason's ex-wife and explained that Mr Meason was very unwell. He updated her about his condition throughout the day. After Mr Meason died, the PCO telephoned Mr Meason's ex-wife, informed her that he had died and offered his condolences. Mr Meason's funeral took place on 30 November. The prison contributed to its cost in line with national instructions.

## Support for prisoners and staff

50. After Mr Meason's death, the Head of Security debriefed the staff who were at the hospital when Mr Meason died to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The Director posted notices informing prisoners of Mr Meason's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Meason's death.

## Post-mortem report

52. The Coroner told us that an intensive care consultant at the hospital concluded that Mr Meason had died from a spontaneous intracerebral haemorrhage (bleeding into the brain) as a result of hypertension (high blood pressure). He had also had an aortic valve replacement which contributed to but did not cause his death. There was no post-mortem examination.

## Inquest

53. At the inquest held on 4 October 2023, the Coroner concluded that Mr Meason died from natural causes.

# Findings

## Clinical care

54. The clinical reviewer concluded that the clinical care that Mr Meason received at Ashfield before 31 October 2022 was of a good standard and equivalent to that which he could have expected to receive in the community. However, she found that the clinical care that Mr Meason received on 31 October was not equivalent.

55. The clinical reviewer found that there were missed opportunities and delays in ensuring that Mr Meason's clinical care was appropriately escalated when he displayed symptoms consistent with a stroke.

56. At 9.54am, when a healthcare assistant saw Mr Meason, there were no obvious signs that he was having a stroke. The healthcare assistant tried to book an appointment for a prison GP, but they were not at Ashfield until the afternoon.

57. At 11.30am, when a nurse saw Mr Meason, the clinical reviewer found that there were obvious warning signs that Mr Meason was having a stroke. She noted that the nurse did not complete neurological observations, including the use of the Glasgow Coma Scale (a clinical assessment scale to measure a patient's level of consciousness) in line with National Institute for Health and Care Excellence (NICE) guidelines for diagnosing and managing strokes. Although the nurse completed a NEWS2 score (which was zero) and recorded Mr Meason's blood pressure, she did not consider his other symptoms such as vision loss, limb weakness and facial droop, all signs of a stroke. We are also concerned that she reported to a PCO that Mr Meason's test results were clear when his urine tested positive for blood. The clinical reviewer concluded that Mr Meason's care should have been escalated sooner and an ambulance should have been called at 11.30am. The clinical reviewer said that the nurse's delay in asking a prison GP to review Mr Meason at 2.00pm was not acceptable as there was a risk that Mr Meason was having a stroke. We make the following recommendations:

    **The Head of Healthcare should ensure that healthcare staff complete neurological observations, including the use of the Glasgow Coma scale, when assessing prisoners displaying symptoms consistent with a stroke.**

    **The Head of Healthcare should ensure that healthcare staff conduct full clinical observations, including all the observations required for an accurate NEWS2 score, and that care is escalated appropriately and in a timely manner.**

58. When an officer radioed a medical emergency code blue, an OSG in the control room telephoned the Ambulance Service. We are concerned that the OSG initially told the Ambulance Service operator that Mr Meason had had a fall because he was dizzy. If the OSG had been told that Mr Meason had symptoms consistent with a stroke, the Ambulance Service might have escalated the response to the highest level of priority. The clinical reviewer said that it was not within her clinical expertise to determine if the outcome for Mr Meason would have been different if he had received timely and appropriate medical attention. However, she concluded that the response was not in line with the NICE guidance for the diagnosis and initial

management of a stroke and transient ischaemic attack. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that relevant, full and accurate information about a prisoner's condition is provided to the ambulance service.**

59. The Head of Healthcare has addressed the concerns about the care the nurse provided. The clinical reviewer has seen evidence that she has been supported with supervision, additional training and a supervisory action plan to ensure competency and safety in her future clinical practice.

60. The clinical reviewer has also seen evidence that healthcare staff have received comprehensive stroke awareness training.

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