

**Prisons &
Probation**

Ombudsman
Independent Investigations

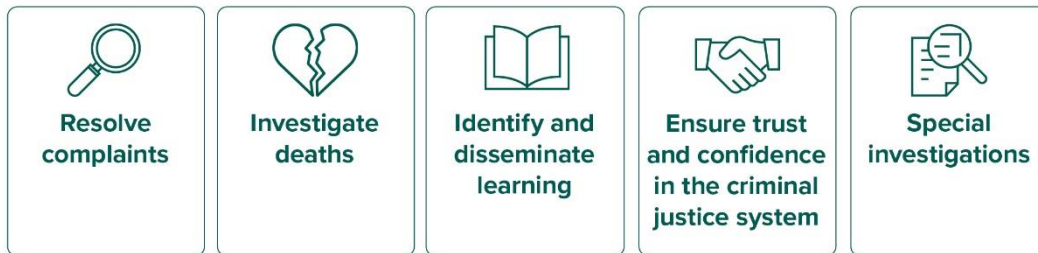
Independent investigation into the death of Mr Robert Ewing, a prisoner at HMP Long Lartin, on 4 November 2022

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 HM 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 Robert Ewing died of heart disease on 4 November 2022 at HMP Long Lartin. He was 68 years old. I offer my condolences to Mr Ewing's family and friends.

The clinical reviewer concluded that the clinical care provided to Mr Ewing was equivalent to that which he could have expected to receive in the community.

We found that Long Lartin did not have a local procedure for checking prisoners' welfare when they were unlocked from their cells in the morning, despite a national requirement to do so. This should be addressed by the Governor, to ensure any concerns are identified and to ensure decency in the event that a prisoner has died of natural causes overnight.

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

September 2023

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Summary

Events

1. On 25 September 2014, Mr Robert Ewing was remanded to HMP Preston. He was given a life sentence on 28 July 2015 for murder and perverting the course of justice. On 25 November, Mr Ewing transferred to HMP Long Lartin.
2. At the initial healthcare screening, healthcare staff recorded that Mr Ewing had a BMI (Body Mass Index) rating of obese and was on medication for high cholesterol, and high blood pressure. Mr Ewing was also prescribed antidepressants.
3. On 20 January 2022, a GP at Long Lartin reviewed Mr Ewing and noted that his blood pressure was too high. The GP increased Mr Ewing's blood pressure medication and encouraged him to lose weight.
4. At approximately 8.28am on 4 November, another prisoner told officers that Mr Ewing had not come out of his cell. The officers went to Mr Ewing's cell and found that he had died.
5. At 1.40pm, a prison GP confirmed Mr Ewing's death.

Findings

6. Long Lartin does not have a local policy that details how or when staff should satisfy themselves about prisoners' wellbeing each day despite this being a national policy requirement contained within *Prison Service Instruction (PSI) 75/2011: Residential Services*.
7. On 4 November, Mr Ewing did not come out of his cell during the morning unlock. Another prisoner alerted officers to a change in Mr Ewing's behaviour.
8. This had no bearing on Mr Ewing's death as he had been dead for some time when officers found him. However, checking prisoners' wellbeing around the time of unlock could prevent deaths in the future by ensuring timely access to emergency healthcare.

Recommendations

- The Governor should implement a process for checking on prisoner welfare around the time of unlock, in line with PSI 75/2011: Residential Services.

The Investigation Process

9. We were notified of Mr Ewing's death on 4 November 2022.
10. The investigator issued notices to staff and prisoners at HMP Long Lartin 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 Ewing's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Ewing's clinical care at the prison.
13. We informed HM Coroner for Worcestershire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer contacted Mr Ewing's family to explain the investigation and to ask if they had any matters they wanted us to consider. We did not receive a response.

Background Information

HMP Long Lartin

15. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Practice Plus Group, with mental healthcare provided by Midlands Partnership Foundation Trust.

HM Inspectorate of Prisons

16. The most recent inspection of Long Lartin was in February 2021. Inspectors reported that healthcare waiting times for routine appointments were long, with one prisoner waiting 428 days to see a GP. There was inconsistency in the process of transferring prisoners' healthcare applications to waiting lists and then to clinics, which meant that prisoners with similar ailments were treated with different levels of urgency. Nurses continued to provide urgent care despite the strain.

Independent Monitoring Board

17. 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 2021, the IMB reported that Long Lartin was an orderly and disciplined prison. However, Covid-19 measures, staff shortages and a lack of hospital appointments had negatively affected all aspects of the delivery of healthcare. However, staff had worked hard to overcome these limitations and prisoners were understanding.

Previous deaths at HMP Long Lartin

18. Mr Ewing was the 10th prisoner to die at Long Lartin since November 2019. Of the previous deaths, seven were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation into Mr Ewing's death and our investigation findings for the previous deaths.

Key Events

Background

19. On 25 September 2014, Mr Robert Ewing was remanded to HMP Preston. On 28 July 2015, he was given a life sentence for murder and a determinate sentence for perverting the course of justice. On 25 November, Mr Ewing transferred to HMP Long Lartin.
20. At the initial healthcare screening, healthcare staff recorded that Mr Ewing had a BMI (Body Mass Index) rating of obese and was on medication for high cholesterol, high blood pressure and depression. They also noted that Mr Ewing had recently had an angiogram (an X-ray of the blood vessels) in the community, which found a blocked artery. Mr Ewing had been prescribed medication to manage the blockage.
21. Healthcare created a care plan to manage Mr Ewing's high blood pressure, which was regularly reviewed. A referral was made to the cardiology specialist at the local hospital and Mr Ewing attended a review on 7 April 2016. There was a delay in receiving Mr Ewing's discharge letter, which was sent to the prison over three months later, however his blood pressure was appropriately checked.
22. On 20 January 2022, a GP at Long Lartin found that Mr Ewing's blood pressure was too high. His medication was increased and he was encouraged to lose weight.

Events of 3 - 4 November 2022

23. On 3 November, a pharmacist reviewed Mr Ewing's blood pressure medication. Mr Ewing told the pharmacist that he occasionally felt dizzy. The pharmacist scheduled weekly blood pressure checks.
24. At 4.20pm, CCTV shows Mr Ewing walking into his cell. At 7.08pm, Mr Ewing sent a request for his door to be opened. (At night, cell doors at Long Lartin are opened electronically on request so that prisoners can use the toilet.) His request was put in the queue. At 9.41pm, Mr Ewing's door was electronically opened. CCTV shows Mr Ewing walking along the corridor brushing his teeth and then returning to his cell at 9.49pm. He was walking at a reasonable pace and showed no obvious signs of concern.
25. At approximately 6.24am and 8.00am on 4 November, officers conducted a routine check on Mr Ewing's wing. They reported no issues.
26. At approximately 8.20am, cells were unlocked and prisoners began to come out for association. CCTV footage shows two officers standing together nearby.
27. At approximately 8.28am, a prisoner told officers that Mr Ewing had not come out of his cell. The officers went to Mr Ewing's cell and looked through the observation hatch. Officer A recorded in her statement that Mr Ewing was in bed with his face down, in a sleeping position. She called his name and knocked on the door, but he did not reply.

28. The officers entered the cell and Officer B shook Mr Ewing's shoulder. He did not respond. Officer A noticed Mr Ewing's hands were grey and radioed a code blue emergency (indicating that a prisoner is unconscious or not breathing). The officers turned Mr Ewing over to start cardiopulmonary resuscitation (CPR) but noticed that he was stiff. They presumed he was dead and did not start CPR.
29. Healthcare staff arrived very shortly afterwards and recorded that rigor mortis (the stiffening of the body that occurs naturally after death) had set in, so CPR was inappropriate.
30. At 1.40pm, a GP confirmed Mr Ewing's death.

Contact with Mr Ewing's family

31. Long Lartin appointed a Family Liaison Officer (FLO) immediately after Mr Ewing's death. The FLO travelled to the home of Mr Ewing's next of kin and informed them of his death.
32. Long Lartin offered to contribute towards Mr Ewing's funeral expenses, in line with national policy.

Support for prisoners and staff

33. After Mr Ewing's death, the duty governor 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.
34. The prison posted notices informing other prisoners of Mr Ewing'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 Ewing's death.

Post-mortem report

35. The post-mortem concluded that Mr Ewing died of ischaemic heart disease caused by hypertension (high blood pressure).

Findings

Clinical Findings

36. The clinical reviewer concluded that the clinical care provided to Mr Ewing was equivalent to that which he could have expected to receive in the community. She makes some recommendations for the Head of Healthcare on issues not related to Mr Ewing's death.

Non- Clinical Findings

37. Prison Service Instruction (PSI) 75/2011: Residential Services requires prisons to have local systems in place to assure staff about prisoners' wellbeing during, or soon after, the unlock process. This was written in response to repeated cases of prisoners dying of natural causes overnight and not being discovered by staff in the morning. Long Lartin does not have a local policy that details how or when staff should satisfy themselves of prisoners' wellbeing.
38. On 4 November, Mr Ewing did not come out of his cell during the morning unlock. Officers did not check on Mr Ewing's wellbeing around the time of unlock and a prisoner alerted them to his change in behaviour.
39. This had no bearing on the outcome for Mr Ewing who had been dead for some time when officers found him. However, checking prisoners' wellbeing around the time of unlock could prevent further deaths by ensuring timely access to emergency healthcare. It would also ensure decency for those who have died overnight, allowing their body to be discovered and removed from the wing as soon as possible. We make the following recommendation:

The Governor should implement a process for checking prisoner welfare around the time of unlock, in line with *PSI 75/2011: Residential Services*

Adrian Usher
Prisons and Probation Ombudsman

July 2023

Inquest

The inquest, held on 25 August 2023, concluded that Mr Ewing died from natural causes.

**Prisons &
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