

**The death of a man at HMP Ashwell  
on 17 September 2005**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2006**

This is the report of an investigation into the circumstances surrounding the death of a man on 17 September 2005. He was 67 and in the 32<sup>nd</sup> year of a life sentence, died in hospital at approximately 7.10am. At the time of his death, he was serving his life sentence at HMP Ashwell.

A post mortem examination carried out on 20 September in hospital revealed that the immediate cause of death had been occlusion of the pulmonary trunk by a thromboembolism. This was caused by a deep vein thrombosis in the legs, the origin of which was an earlier stroke.

I offer my sympathy and condolences to the friends of the man. Sadly, no relatives of his have yet been identified.

The investigation was carried out on my behalf by a colleague. As part of the investigation, a review by the Melton, Rutland and Harborough Primary Care Trust into the clinical management of the man was commissioned.

My thanks go to the Governor and staff at Ashwell. I appreciate their willing co-operation with my investigation.

Although it is not entirely clear what occurred, not everything revealed of the actions of staff following the discovery of the man collapsed in his cell makes for comfortable reading. I make five recommendations and identify one example of good practice.

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

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

**July 2006**

## **Contents**

Summary

The investigation process

Ashwell prison

Events leading to and following the death of the man

Issues considered during the investigation

- Medical procedures at Ashwell

- Observation Book entries

- The discovery of the man on 13 September

- Escort arrangements at the hospital

List of recommendations

## Summary

1. This is the report of an investigation into the death on 17 September 2005 of a man. He was serving a life sentence at HMP Ashwell at the time of his death.
2. The man was a Hungarian national, aged 67, who had been in prison for 32 years. He had come to Britain in the mid-1950s following the uprising in his home country. The man had been sentenced to life imprisonment with a deportation order at Sheffield Crown Court 1973.
3. The man had been in custody at Ashwell since 7 March 2005. He was being treated for hypertension, a condition that he had suffered from for some time.
4. On 30 August, he became unwell with dizziness and headache and was attended by nursing staff on the wing. On 5 September, it was reported by wing staff that he had a shuffling gait, and he was again seen by healthcare personnel.
5. In the early hours of 13 September, the man was found on the floor of his cell by another prisoner. The Operational Support Grade (OSG) on nights was alerted and attended. As he was dizzy and appeared weak, the man was helped back into bed by the OSG. Other night staff attended and it was decided to observe the man hourly for the rest of the night. He remained disoriented and was unable to walk to the cell toilet area later on during the night. He also fell again in his cell. No medical advice was sought and no consideration given to taking the man to hospital.
6. When the day staff came on duty, he was taken to hospital where he was diagnosed as having suffered a stroke. He remained unwell and died four days later.
7. This report considers the medical care that the man received in the time he was in prison custody. It also describes the actions taken by staff following the discovery of his collapse on 13 September. I have found that the system in place to deal with night time medical emergencies was not adhered to by staff.
8. There has been great difficulty in identifying the man's next of kin. Records indicate that he has a brother and sister. While the man seems to have had some contact with them much earlier in his sentence, he had not seen them since 1955. Ashwell have managed to make contact with the man's family in Hungary, via the Hungarian embassy. It has been established that the family wish his ashes to remain in Britain and a few personal items are being returned to them. I commend the management team at Ashwell for their efforts to find the man's family.
9. While it would appear that his death could not have been prevented, I was concerned about the incident management on the night of 13 September 2005.

The Prison Service commissioned an inquiry into the circumstances of the man's care on the night he fell ill, as it was apparent from the reports received that the night time procedure for medical emergencies had not been followed.

## **The investigation process**

10. The investigation was opened on 26 September 2005. One of my contract staff, met with the Governor and other senior staff. He was given a comprehensive and helpful briefing by the head of operations on the events leading up to and after the man's death. Ombudsman's notices were issued to staff and prisoners, identifying the scope of the investigation and inviting anyone who wished to see my colleague to make themselves known. No-one came forward in response to these notices.
11. A representative of the local branch of the Prison Officers' Association, was briefed by my colleague on 26 September. He was helpful and offered constructive comment and advice. My colleague also spoke with an IMB member, on the same day and found her assistance to be of considerable value to the investigation.
12. In the company of the head of operations, my colleague visited the man's cell which had been sealed since 13 September. He also took the opportunity to view the residential accommodation on the wing and in the rest of the prison.
13. The Coroner's office was contacted and staff there provided additional information. An independent clinical review was commissioned from the Melton, Rutland & Harborough Primary Care Trust. I am very grateful to a doctor for her review into the clinical care and treatment the man received whilst he was in Ashwell.

14..

## **HMP Ashwell**

15. HMP Ashwell is an accredited stage one resettlement prison and is situated near Oakham in Rutland. It is an adult male category C establishment and has an operational capacity of 545. Ashwell runs an open regime in six residential units with a commitment to sentence planning, throughcare and purposeful activity. There is unsupervised access to the prison grounds for prisoners and free movement during the day. Prisoners have keys to their own rooms and there is access to the grounds at night.
16. The establishment was visited by HM Prisons Inspectorate earlier during 2005. The inspection team found that some prisoners felt vulnerable and that too much prisoner activity lacked purpose. However, it was thought that Ashwell offered a generally safe environment. The Chief Inspector said that any weaknesses could be remedied by vigorous management attention and a clear sense of strategic direction.
17. The healthcare centre at Ashwell does not provide a 24 hour service. A system of duty GP covers the daytime period. The out of hours arrangements include the use of an on call nurse, and the 999 emergency system. Patients who need hospital care are taken to the local NHS hospital.

## **Events leading to and following the death of the man**

18. The man was received into Ashwell on 7 March 2005, having been transferred from Sudbury prison following the issue of a Home Office order for his deportation from Britain. It was deemed that under these circumstances more secure conditions were necessary. After beginning his sentence at Wakefield, the man had moved to a number of establishments, including more recently Birmingham, Channings Wood, Lindholme and Sudbury.
19. Earlier in his sentence, the man was thought to be a rather isolated person due to his cultural differences. He also seemed at times to be somewhat obsessional, especially in some dealings with female members of staff. This apart, he was well behaved and received good work reports. Reports on the man made by prison staff in the 1980s said that they had found him helpful, co-operative and with a sense of humour.
20. On arrival at Ashwell, he went onto the induction wing where he underwent the standard reception and induction procedures. It was noted that he was hypertensive, and he was referred to the GP who saw him the same day. The man said that he suffered chest pain and this was noted, as was the fact that he said that his father had had a stroke when he was in his 50s. His blood pressure was found to be within normal range and he was kept on the medication that had been prescribed at his previous establishment. This was Lisinopril, Bendrofluozide and Adalat, which are treatments for the symptoms of hypertension.
21. The man gave his next of kin as a pen friend who lived in the south west of England.
22. On 14 July, he was allocated to the ground floor (L1-14) of Langham unit which is one of Ashwell's general residential wings. It would appear that the man lived on Langham unit without incident until 15 August when he slipped and fell while in his cell. He was referred for review by the GP the same day and his Adalat dosage was increased. He was checked again later that day. At a further check on 18 August, the nurse confirmed that he should continue with his medication. No F213 (a form used to record injuries to prisoners) was raised to record the fall.
23. Wing staff became concerned on 30 August when the man complained of dizziness and a headache over his right eye. As he was too poorly to attend healthcare, a nurse saw him in his cell. There are contradictory notes about these events. In his medical record and in reports, it is noted that nursing staff visited him, while the wing observation book says this did not occur.
24. The man was referred to the doctor and seen the next day. Meanwhile, he was to continue with his medication and wing staff were reminded of the night call out procedure for medical assistance if it was needed. On 31 August, the man was

prescribed an increased dose of Adalat by the doctor in order to better control his condition. On 5 September, wing staff called for healthcare to assess him as they were concerned that he was shuffling around on the wing. When speaking to the staff nurse, the man had no additional complaints apart from reporting that he had lost confidence following his earlier fall. The staff nurse did not think that tests were necessary, and it was decided to leave him on normal location.

25. At approximately 2.15am on 13 September, a prisoner resident on Langham unit heard cries from L1-14. He went to investigate the noise and alerted the night staff, an OSG. The man was lying on the floor, having apparently fallen out of bed. After returning the man to bed, the OSG called the night orderly officer, SO. He arrived with an officer at approximately 2.40am. The man was said to be disoriented and complained of a headache, but had no apparent injuries from his fall. It was decided by the night orderly officer that the OSG would check on the man hourly through the rest of the night. No analgesic was available. The OSG stated that he heard the officer twice speculate that the man might have had a stroke. This is not included in her written statement to the Governor. Other staff arrived on the wing, including a second officer. The OSG said he heard the second officer suggesting that the first officer did not say that she thought that the man had had a stroke.
26. The OSG began to check the man hourly. At 4.10am, it was noted that it took the man 15 minutes to turn over to his right side and that he had no use of his left arm. At approximately 5.10am, the man said he wanted to use the toilet in his cell. He was unable to get out of bed and take the short steps necessary to get there, so assistance was called for. Because the man was a heavily built man, it was not possible to lift him to the toilet so he was offered a bucket by his bed.
27. In his written statement, the OSG reported that at approximately 7.00am he received a phone call from the second officer saying, "If he has died, leave him for the day staff." At approximately 7.20am, the L1-14 cell alarm was activated. The OSG attended and found the man again on the floor of his cell. Helped by two prisoners, the OSG put the man back on his bed.
28. At 7.30am the cell alarm was again activated and the OSG found the man on his bed covered and shivering after having again fallen. By this time, a member of day staff, an officer, had arrived and the orderly officer was called to arrange medical assistance. The night orderly officer handed over to a principal officer (PO) and asked him to arrange for a healthcare check on the man.
29. At approximately 7.55am, the clinical nurse manager arrived. The man was lying on his bed without sheets and with an uncovered duvet over him. The nurse manager found left sided facial weakness and weakness to the man's left limbs. These symptoms were indicative of him having suffered a stroke. An ambulance was called and oxygen was administered. The ambulance arrived at Langham

unit at 8.20am and left at 8.35am to take the man to hospital where it was confirmed that he had in fact had a stroke.

30. The escort arrangements were swiftly reviewed by the head of operations, and the man was accompanied by an escort strength of one officer for the duration of his stay at the hospital. Restraints were not used.
31. After a period in A&E, he was moved to Ward 1. His condition did not improve and he was described on 16 September as "quite flat" and having difficulty in swallowing. After having an unsettled night, the man requested a drink on 17 September. At 6.40am, nursing staff came to wash him and an escorting officer was asked to leave the room. Soon afterward, one of the nurses told him that a doctor had been called as the man was having a seizure. At 7.10am, a doctor informed the officer that the man had died.
32. Notices to staff and prisoners were issued at Ashwell that morning informing them of the man's death. They included reference points for help and counselling. A memorial service was held in the prison chapel on 18 September.
33. Efforts were made to find the man's next of kin but the most recent name he had given was that of a pen friend who did not wish to be involved in any arrangements following his death. Following receipt of a Christmas card, addressed to the man, written in Hungarian, Ashwell arranged for it to be translated.
34. The Head of Operations at Ashwell, made contact with the Hungarian Embassy. Embassy staff made contact with the family and it was agreed that they wished the ashes to remain in Britain. The family asked for some of the man's smaller possessions to be returned to them. Arrangements have been made locally to accommodate their wishes.
35. A post mortem found that blood clots had travelled from the man's veins to his vital organs, and that this was the immediate cause of death. The formation of such clots was a consequence of his stroke.

## Issues considered during the investigation

- **Medical procedures at Ashwell**

36. The Clinical Review undertaken by Melton, Rutland and Harborough PCT, found that the man's death was sudden and unexpected. In the view of the consultant in charge of his care, earlier admission to hospital would probably not have altered the outcome.

37. The man was intermittently reviewed for his hypertension whilst in Ashwell. The clinical reviewer felt that his health care in this respect was opportunistic in nature, but of reasonable quality.

38. He was an elderly man with health problems for which he was receiving medical care at Ashwell. There are concerns about how this function is managed at Ashwell. Not all National Service Frameworks (NSFs) have been implemented and medical audit trails need to be established. F213s are not routinely raised when prisoners have accidents. When the man fell on 15 August, an F213 should have been raised and placed in the IMR. Staff should be reminded of the importance of recording all injuries to prisoners and accidents properly, and the need for a subsequent medical examination.

**The Primary Care Trust and the Governor should work together to ensure all existing National Service Frameworks (NSFs) are implemented within the prison, as in the NHS. As part of the NSF for Coronary Heart Disease and the NSF for Diabetes, chronic disease management registers need to be established, to facilitate regular review and improved care of patients. Clinical IT systems are an essential requirement for the effective implementation of chronic disease management registers.**

**The PCT and Governor should work together to ensure that patients requiring chronic disease management are identified during reception screening, referred to appropriate clinics and an appropriate audit trail established.**

**The PCT and Governor should review the systems in place to ensure that, whenever a prisoner has an accident, an F213 is raised regardless of whether any injury is apparent.**

- **Observation Book Entries**

39. The contradictions in the recording of the events of 30 August may be explained by an early entry by wing staff in the observation book that no one from healthcare had attended to the man immediately after his fall. After healthcare had later attended, as was clearly noted both in his medical record and in staff reports, wing staff did not make a fresh entry to reflect this. There were other anomalies found in the maintaining of the wing observation book that suggest

more care should be taken when making entries. The wing observation book seems not to have been used systematically, and this can lead to confusion as to what has and has not happened.

**The Governor should remind wing staff of the importance of timely and comprehensive entries in wing observation books.**

- **The discovery of the man on 13 September**

40. On 13 September, the man became ill during the night and was attended by the duty staff including the night orderly officer (NOO). No medical assistance was sought until a new shift began. This was some five hours after he appeared to have had a collapse of some kind. This judgement is difficult to understand given the circumstances of that night. The man was plainly unwell, not even able to step into the toilet area of his cell. Local orders detailing the procedures for calling for advice or assistance were not used.
41. Ashwell's local Notice to Staff (NTS) 55/05 about night emergency cover became effective on 9 September 2005. The required actions are very clearly set out. If there is a non-minor healthcare issue about a prisoner, the night orderly officer is to contact the duty nurse after having completed an assessment pro forma. If a prisoner is collapsed or in severe pain then the 999 system is to be used to get an ambulance. The man's condition did not fall into the category of "minor ailments". While he complained of a headache, which is described in the order as a minor condition that does not need additional help, he had also fallen and appeared confused. At least one member of staff on duty, the OSG could see other worrying symptoms, and he suggested that another member of staff did too. The responsibilities of the night orderly officer are spelled out very clearly in the notice. If it was thought that the man had collapsed, then this was an "acute emergency" requiring the use of the 999 service. If the full gravity of the situation had not been clear, then the on call nurse should have been contacted, and he or she would advise from that point. In the event, neither course was taken.
42. The Governor commissioned a formal investigation of the circumstances of the night of 13 September. That investigation found there were issues arising from how the man was dealt with. The investigation addressed the allegations of inappropriate staff actions during the night, and negligence on the part of managers. It found that the management of the incident by the night orderly officer did not follow laid down guidelines with regard to call out procedures as per NTS 55/05. The Governor's investigation did not discover any further information to support the OSG's allegation that one of the officers had made an inappropriate comment about leaving the man for the day staff if he had died. There was, therefore, no recommendation to the Governor in relation to this claim.

**The Governor should remind all staff of the procedures to follow in the event of a potential night time medical emergency.**

- **Escort arrangements at the hospital**

43. Soon after the man was taken out of the establishment to be taken to hospital, his escort needs were quickly assessed and determined to be minimal. This meant there was no need for handcuffs. This was good practice.

44. One officer remained with the man during his time in hospital. It is understood that the bed watch was conducted in a professional and sensitive manner.

## List of Recommendations

### Healthcare

**The Primary Care Trust and the Governor should work together to ensure all existing National Service Frameworks (NSFs) are implemented within the prison, as in the NHS. As part of the NSF for Coronary Heart Disease and the NSF for Diabetes, chronic disease management registers need to be established, to facilitate regular review and improved care of patients. Clinical IT systems are an essential requirement for the effective implementation of chronic disease management registers.**

*Accepted: Operational policies ensuring that NSF frameworks are implemented, have been drafted for Coronary Hear Disease, Diabetes, Asthma and other chronic diseases. They will be in use by May 2006.*

*Currently there are written registers for all chronic diseases and disability. IT cabling has been completed during March 2006. Full IT facilities including appropriate clinical software and training for staff will be completed by September 30<sup>th</sup> 2006.*

**The PCT and Governor should work together to ensure that patients requiring chronic disease management are identified during reception screening, referred to appropriate clinics and an appropriate audit trail established.**

*Accepted: On Reception all prisoners are seen by a nurse who refers any health issue to the appropriate clinic.*

*A review has taken place of the Reception screening tool. Since the mans' reception, staff development has enabled us to provide a range of clinics, to address chronic disease management.*

*The audit trail is to be brought up to desired standards with the introduction of the IT System. September 30<sup>th</sup> 2006.*

**The PCT and Governor should review the systems in place to ensure that, whenever a prisoner has an accident, an F213 is raised regardless of whether any injury is apparent.**

*Accepted: Governors Order to be issued emphasising the importance of correct accident/incident reporting regardless of whether an injury is sustained or not. To support this an accident/incident "pack" to be issued to each wing, which contains all relevant documentation and a summary of all actions required. The pack and Governors Order to be issued week ending 7<sup>th</sup> April 06.*

### **Operational**

**The Governor should remind staff of the importance of timely and comprehensive entries in Wing Observation Books.**

*Accepted: Governors Order to be issued reminding staff of the importance of recording all significant custodial events.*

**The Governor should remind all staff of the procedures to follow in the event of a potential night time medical emergency.**

*Accepted: A notice to staff revised for absolute clarity was issued on 18<sup>th</sup> October 2005*

### **Good practice**

**Soon after the man was taken out of the establishment to be taken to hospital, his escort needs were quickly assessed and determined to be minimal. This meant there was no need for handcuffs.**

