Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Isaac Ayeni, a prisoner at HMP Aylesbury, on 16 May 2022

## A report by the Prisons and Probation Ombudsman

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## 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.

If my office is to best assist HMPPS in ensuring the standard of care received by those within service in remit is appropriate then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Isaac Ayeni died in hospital on 16 May 2022, after being found unresponsive in his cell at HMP Aylesbury just over an hour earlier. He was 23 years old. A post-mortem concluded that Mr Ayeni died from natural causes, but the exact cause could not be ascertained. I offer my condolences to Mr Ayeni's family and friends.

Establishing Mr Ayeni's cause of death was a complex process that took around a year and a half, and my investigation was significantly delayed as a result.

Mr Ayeni was a young man who appeared to be in relatively good physical health, and his death was unexpected. The clinical reviewer concluded that the healthcare provided to Mr Ayeni at Aylesbury was equivalent to that which he could have expected to receive in the community.

The investigation identified issues with the management of the emergency response. Staff on the scene of the incident did not provide full information to their colleagues in the control room. There was a significant delay in escorting the ambulance through the prison to Mr Ayeni's wing, seemingly caused by some confusion about how to manage the escort during prisoner movements.

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** **April 2024**

# Contents

# Summary

## Events

1. On 23 August 2021, Mr Isaac Ayeni was remanded in custody for drug offences. He was also required to serve a 28-day fixed term recall as he had breached an earlier release licence. Mr Ayeni spent time at HMP Pentonville and HMP Thameside before he transferred to HMP Aylesbury on 27 April 2022.

2. Mr Ayeni had asthma and was prescribed his usual medications in prison.

3. At around 1.53pm on 16 May 2023, prisoners saw Mr Ayeni lying awkwardly and unresponsive on his bed, so they alerted staff. An officer radioed a medical emergency code and healthcare staff started cardiopulmonary resuscitation (CPR). Paramedics continued resuscitation and Mr Ayeni was taken to hospital. At 3.14pm, hospital staff declared that Mr Ayeni had died.

## Findings

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

5. When Mr Ayeni was discovered, the control room staff called for an ambulance immediately. However, despite repeated requests, staff at the scene did not provide them with updates on Mr Ayeni's condition. When paramedics arrived there was an 18-minute delay before they reached Mr Ayeni.

## Recommendations

- The Governor should review the Local Operating Policy for Emergency Response to include guidance for escorting an emergency ambulance during movements.

- The Governor should ensure that all staff are aware of and understand their responsibilities during a medical emergency, including that information about the prisoner's medical condition is provided to the control room in a timely manner.

# The Investigation Process

6. We were informed of Mr Ayeni's death on 16 May 2022.

7. The investigator issued notices to staff and prisoners at HMP Aylesbury informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator visited Aylesbury on 25 May, and obtained copies of relevant extracts from Mr Ayeni's prison and medical records. She also visited the wing where Mr Ayeni lived and briefly spoke to three prisoners who had alerted staff on the day he died. The investigator also interviewed two prison staff who were on duty in the communications room.

9. NHS England commissioned the clinical reviewer to review Mr Ayeni's clinical care at the prison. The investigator, together with the clinical reviewer, interviewed 12 healthcare and prison staff in July 2022. The investigator also interviewed a custodial manager, prison officer and nurse in August 2022. The three prisoners who alerted staff to check on Mr Ayeni declined to be interviewed but did provide statements to the police on the day he died, which were shared with the investigator.

10. We suspended our investigation between May 2022 and October 2023, awaiting confirmation of the cause of Mr Ayeni's death.

11. We informed HM Coroner for Buckinghamshire of the investigation, who provided information about the cause of death. We have sent the Coroner a copy of this report.

12. The PPO's family liaison officer contacted Mr Ayeni's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Ayeni's family wanted to know the sequence of events on the day he died, how he was discovered, who alerted staff and if he was unconscious. Mr Ayeni's family asked a question which we have addressed in separate correspondence. Mr Ayeni's family also asked some questions about the care provided by paramedics, which is outside the remit of our investigation.

13. Mr Ayeni's family received a copy of the initial report. They did not identify any factual inaccuracies. However, they raised a number of points which we have answered in separate correspondence. Mr Ayeni's family disagreed with the clinical reviewer's findings that his care was equitable to that which he could have expected to receive in the community.

14. The prison also received a copy of the report. They did not identify any factual inaccuracies.

# Background Information

## HMP Aylesbury

15. HMP Aylesbury, when fully operational, can hold 402 prisoners. All the cells are designed for single occupancy. In February 2019, the prison was put into 'special measures' by Her Majesty's Prison and Probation Service (HMPPS), due to serious concerns about safety, and operated at a reduced capacity. By May 2021, Aylesbury was out of special measures and had started to increase the number of prisoners held. At the time Mr Ayeni was at Aylesbury, they accepted men aged between 18-27 and although the number of prisoners had increased, they were not yet up to full capacity. Since 1 October 2022, Aylesbury now accepts Category C adult males.

16. Practice Plus Group provide physical health services and Barnet, Enfield and Haringey Mental Health Trust provide mental health and substance misuse services.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Aylesbury was in November/December 2022.

18. Inspectors had been consistently critical of Aylesbury prison over many years and this inspection was no different. Inspectors found that the prison was short of about 50 officers. They reported that the healthcare situation was so dire that it had been determined that it was an unacceptable risk to send prisoners over the age of 40 to the prison. They found that emergency bags were regularly checked and adequately supplied, but that ambulances were not automatically called in medical emergencies.

19. In August 2023, inspectors returned to Aylesbury to review progress. They commended the positive change since their last inspection. Staff vacancies had halved. The prison had made good progress in the management of long-term health conditions and all prisoners who required them had care plans.

## Independent Monitoring Board

20. 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 most recent annual report for the year to 31 March 2023 the IMB noted that the senior management team stayed stable through the year but staffing at other levels did not. Throughout the year the shortage of officers in all grades impacted negatively on the regime in the prison and as a consequence on the lives of all the prisoners. The preparation for the prison to change from a young offenders institution (YOI) to a category C prison was found to be seriously inadequate. The staff had minimal opportunity to retrain to deal with this different cohort.

21. The IMB reported that there were significant staff shortages in healthcare and a heavy reliance on agency staff. These shortages, combined with significant IT problems, impacted service delivery, which the IMB found was unsafe at times. They found that provision had improved by the end of the reporting year, with a new

Head of Healthcare and several initiatives to better explain healthcare services to prisoners.

## Previous deaths at HMP Aylesbury

22. Mr Ayeni was the third prisoner to die at Aylesbury since May 2019. The previous deaths were both from suicide. There have been three deaths since; two drug related deaths and one not yet ascertained. There are no significant similarities with this death.

# Key Events

23. On 23 August 2021, Mr Isaac Ayeni was remanded to prison custody charged with drug offences and taken to HMP Pentonville. He had breached the terms of a previous licence and also had to serve a fixed term recall of 28 days.

24. At his initial healthscreen, Mr Ayeni disclosed that he had asthma and was prescribed an inhaler, which he said he rarely needed to use. He said that he had no physical health concerns, and his clinical observations were all within a normal range.

25. On 13 October, Mr Ayeni appeared in court and was taken from court directly to HMP Thameside.

26. On 28 January 2022, Mr Ayeni was sentenced to five years and eight months in prison.

## HMP Aylesbury

27. On 27 April, Mr Ayeni moved to HMP Aylesbury as part of his sentence progression.

28. At the initial healthscreen, the reception nurse noted that Mr Ayeni did not have any physical health concerns, and his clinical observations were within a normal range. Mr Ayeni was assessed as being medically fit to attend the gym.

29. On 3 May, a nurse completed Mr Ayeni's secondary healthscreen. He did not disclose any significant family history of physical health concerns, and he stated he did not have any long-term conditions other than asthma. Mr Ayeni's clinical observations were not taken.

30. On 6 May, Mr Ayeni did not attend an asthma clinic appointment or for a first Hepatitis B vaccination and it was documented that this would be rebooked.

31. On 15 May, Mr Ayeni received very positive feedback from prison staff. They recorded in his prison record that he helped deescalate a violent situation on the wing by moving other prisoners away from the incident and encouraging them not to get involved. Officers described Mr Ayeni as showing a high level of maturity. This is the last entry in Mr Ayeni's prison record.

32. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to some of the calls Mr Ayeni made to several friends in the week before he died. There was nothing in these phone calls to suggest that Mr Ayeni was having any difficulties with his physical or mental health.

## Events on 16 May

33. At 8.00am on 16 May, Closed Circuit Television (CCTV) shows that a Supervising Officer (SO) unlocked Mr Ayeni's cell. Around 30 minutes later, Mr Ayeni left the wing with other prisoners to attend the gym. The Physical Education Instructor (PEI) said that Mr Ayeni completed his induction, used the weights room, and asked if he could be considered for a gym orderly role before he left. The PEI said that Mr

Ayeni was obviously used to exercising and he had no concerns about him during the session. Mr Ayeni returned to the wing at around 10.00am and was locked in his cell.

34. At 11.50am, Mr Ayeni was unlocked to collect his lunch and he spoke briefly with the SO at the servery. At around 12.00pm, an officer locked Mr Ayeni back in his cell. Mr Ayeni did not raise any concerns and prison staff did not observe anything unusual.

35. At around 1.50pm, some prisoners were unlocked to attend activities. Three prisoners told the police that they went to Mr Ayeni's cell as they were all going to attend the chapel. They looked through the observation panel in his cell and saw him in an unusual position lying on his bed, and alerted an officer that they thought something was wrong. The officer opened Mr Ayeni's door and, when he did not get a response, radioed a medical emergency. (The officer initially incorrectly called a code red, significant blood loss, but changed this a short while later to a code blue, when someone is not breathing or unresponsive. This did not alter the response by prison and healthcare staff as the response to a medical emergency is the same for either code.)

36. The officer found Mr Ayeni was laid on his bed with his legs hanging over the end. Officers moved Mr Ayeni to the floor of his cell and placed him in the recovery position, as they believed they could feel a pulse. Two nurses responded to the emergency. A nurse assessed Mr Ayeni and did not feel a pulse so started cardiopulmonary resuscitation (CPR). A defibrillator was attached to Mr Ayeni, which advised he had no shockable rhythm, and staff continued CPR until paramedics arrived.

37. Control room staff telephoned for an ambulance immediately on receipt of the radio message of a medical emergency. They made several requests for staff on the scene to update them of Mr Ayeni's condition, in order to provide accurate, detailed information to the ambulance service, but this was not provided (this did not delay the dispatching of the ambulance).

38. South Central Ambulance Service records show an ambulance was requested at 1.55pm. Paramedics arrived at Aylesbury at 2.02pm, followed by two more ambulances. Paramedics did not reach Mr Ayeni's cell until 2.20pm. The delay was caused because officers were not immediately made available to escort the ambulance and because it was prisoner movements (when prisoners move from wings to education or workshops) and staff were uncertain of the procedures to open internal gates to allow the ambulance through.

39. On their arrival at the cell, paramedics continued resuscitation attempts, and took Mr Ayeni to Stoke Mandeville Hospital, escorted by two officers. He arrived at the hospital at 3.04pm. At 3.14pm, doctors declared that he had died.

## Contact with Mr Ayeni's family

40. Aylesbury appointed the prison manager as the family liaison officer (FLO). She phoned Mr Ayeni's sister to inform her that he had been taken to hospital as this was the quickest way to tell her that he was seriously ill. Aware that Mr Ayeni's sister was on her way to the hospital, the FLO contacted her a short while later, again by phone, to inform her that he had died. She offered her condolences and

ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Ayeni's funeral, which was held on 28 July 2022.

## Support for prisoners and staff

41. After Mr Ayeni's death there was not a collective debrief. The Deputy Governor spoke individually to most prison staff involved in the emergency response but this did not include the operational manager or healthcare staff.

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

## Post-mortem report

43. The pathologist concluded that Mr Ayeni died from unascertained other natural causes. Toxicology tests showed that Mr Ayeni had not used any illicit substances prior to his death.

# Findings

## Clinical Care

44. The clinical reviewer concluded that the care Mr Ayeni received was equivalent to that which he could have expected to receive in the community. The clinical reviewer made some recommendations not directly related to Mr Ayeni's death that the Head of Healthcare will wish to address.

## Emergency response

45. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. Two distinct codes are used; code blue if a person is unresponsive or not breathing, and code red if there is significant blood loss or burns. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident, that there are no delays in calling an ambulance and must prevent any unnecessary delay in escorting ambulances and paramedics to the patient. PSI 03/2013 was amended in Sept 2021 to include requirement for staff at the scene of an emergency to provide relevant information to the control room as soon as possible.

46. We found, in respect of communication, the emergency response was poorly co-ordinated. Staff radioed a medical emergency response, and the communications room contacted the ambulance service immediately. However, information on Mr Ayeni's condition was not provided to the communications room. Despite Mr Ayeni being unconscious, a custodial manager said over the radio that she had to wait for healthcare staff to confirm his medical condition so that she could provide accurate information to the ambulance service. Nobody provided the communications room with an update on Mr Ayeni's condition, despite numerous requests by staff in the control room.

47. A custodial manager (CM) who was at the scene and who assisted with the resuscitation attempt, said that she was unaware that the ambulance service needed to be updated on Mr Ayeni's condition or how they prioritised the ambulance response, as she was just focussed on helping him.

48. It is important that staff provide clear, up to date information to the control room as this will help them to ensure that an ambulance is despatched with appropriate priority. Healthcare staff should not normally be required to be present before basic information about whether a patient is conscious or breathing is provided.

49. Aylesbury's Local Operating Policy (LOP) for Emergency Response states that: "The Orderly Officer [senior officer in charge] will manage the incident, ensuring that staff are available to escort the ambulance to incident location". This did not happen. Movement of prisoners had been allowed to continue, and there was a delay detailing a member of staff to escort the ambulance. It took 18 minutes before paramedics reached Mr Ayeni. Staff in the communications room spoke of their frustration trying to obtain information about Mr Ayeni's condition and that they felt responsible for finding staff to escort ambulances when this should have been the responsibility of the orderly officer.

50. A CM, who was the orderly officer, said that stopping movements would have been more time consuming and she would have expected Gate staff to have made an officer available to escort the ambulance to Mr Ayeni's wing.

51. Local guidance does not explain to staff what they should do to ensure that ambulances are able to move through the prison quickly during movements. This is a busy time as there are prisoners moving to different parts of the prison and prison staff will naturally be cautious about opening internal gates to allow the ambulance to pass. It is understandable that duty managers might be unsure about the best way to allow the ambulance access while maintaining security, and local policy should be amended to provide clear guidance. We make the following recommendations:

**The Governor should review the Local Operating Policy for Emergency Response to include guidance for escorting an emergency ambulance during movements.**

**The Governor should ensure that all staff are aware of and understand their responsibilities during a medical emergency, including that information about the prisoner's medical condition is provided to the control room in a timely manner.**

# Governor to note

## Staff Support

52. The Incident Management Manual, dated 2 May 2022, sets out that there should be a debrief for all staff involved following a serious incident. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be immediately addressed. It also provides those directly involved with an opportunity to process events and for managers to signpost sources of support. Although most prison staff involved in the emergency response were spoken to individually by the Deputy Governor, there was not a collective debrief as there should have been, which we bring to the attention of the Governor.

### Inquest

53. The inquest into Mr Ayeni's death concluded in July 2025. The jury returned a verdict of natural causes. The medical cause of death was unascertained, but was likely to have been contributed to by unforeseeable idiopathic cardiac arrhythmia.

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