Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lawrence Dugbazah, a prisoner at HMP Littlehey, on 6 January 2023

A report by the Prisons and Probation Ombudsman

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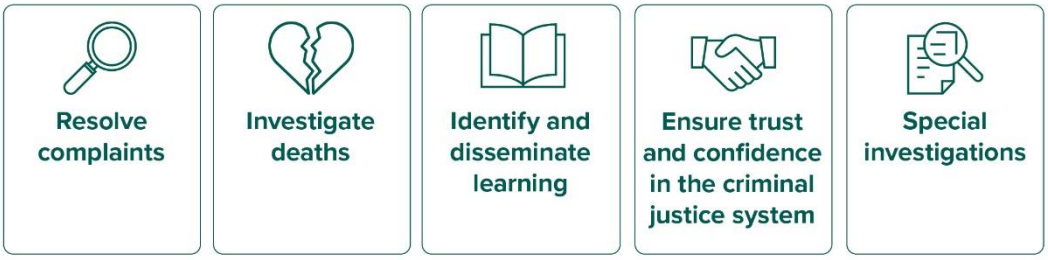
OUR VISION

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 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 Lawrence Dugbazah died of heart disease on 6 January 2023, following seven weeks of food refusal at HMP Littlehey. He had told staff that he saw no point in living and wanted to die. He was the third man to take his life at Littlehey in three years. Mr Dugbazah was 38 years old. I offer my condolences to his family and friends.

Mr Dugbazah refused food from the moment he arrived at Littlehey on 18 November 2022. He lost 30kg, a third of his body weight, over the next seven weeks. Staff managed him using suicide and self-harm prevention procedures (known as ACCT) but he refused to engage with the process.

Healthcare staff monitored Mr Dugbazah regularly and there was evidence that they treated him with care and compassion in difficult circumstances. However, there was a long delay in putting a food refusal care plan in place and then healthcare staff did not always follow it which meant that important actions were missed.

Not enough was done to address whether Mr Dugbazah had underlying mental health issues. A psychiatrist referral should have been done by day ten of food refusal but it was not done until day 45. Mr Dugbazah died on the day the psychiatrist appointment was due to take place and was never assessed. This was a missed opportunity.

Prolonged food refusal is fortunately rare. While many staff were trying their best to care for Mr Dugbazah in very challenging circumstances, it was clear that they were unaware of the policies and processes to manage food refusal in custody. Littlehey needs a much more robust food and fluid refusal policy to ensure that staff are clear about how they should care for prisoners in these circumstances, including assessing underlying mental health needs and mental capacity.

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 **March 2024**

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Summary

Events

1. In June 2010, Mr Lawrence Dugbazah was given an Imprisonment for Public Protection (IPP) sentence for sexual offences. He was released ten years later but was recalled to prison on 31 March 2022, following allegations of further sexual offences.

2. On 2 April, Mr Dugbazah was moved to HMP Thameside. Later that month, he stopped eating. He said he was feeling low and did not understand why he was back in prison.

3. On 23 May, staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Dugbazah as he was still not eating and said he did not care if he died. A few days later, he told staff that he had a special diet outside prison (due to his Irritable Bowel Syndrome) and that he was prepared to start eating again if he was given an appropriate diet. Healthcare staff arranged this with the kitchen and Mr Dugbazah resumed eating. Staff stopped ACCT monitoring on 6 June.

4. On 18 November, Mr Dugbazah was moved to HMP Littlehey. He told reception staff that his mental health was poor anyway and it had got worse when he found out he was being moved as it had unsettled him. He said he was facing a life sentence, saw no point in living and would refuse all food and drink. Staff started ACCT procedures and placed Mr Dugbazah under constant supervision (subsequently reduced to one observation an hour).

5. When he arrived, Mr Dugbazah weighed just under 90kg (in the overweight range). The reception nurse noted that he had high blood pressure.

6. On 21 November, the ACCT case coordinator invited the mental health team to attend the second case review, but they had no record that Mr Dugbazah had been referred to them. A mental health referral was made that day. However, Mr Dugbazah refused to engage when a mental health nurse visited him on 23 November. He also refused to engage with the ACCT case reviews.

7. Mr Dugbazah was provided with foods in line with his requested diet, but he refused to eat them.

8. Healthcare staff visited Mr Dugbazah regularly to carry out welfare checks. However, he sometimes refused to have his clinical observations taken and to give blood and urine samples.

9. On 15 December, healthcare staff put a food refusal care plan in place. It said that daily GP visits should take place after day 3 of food refusal, that a psychiatrist referral should be made by day 10 and that an urgent review should take place if weight loss was greater than 10%. No psychiatrist referral was made, and no urgent review took place (this was day 27 and Mr Dugbazah had lost almost 20% of his body weight).

10. Around a week later, Mr Dugbazah said he wanted some fizzy drinks to give him some energy. Staff ordered several cans for him. However, he said he had vomited when he had drunk one.

11. On 3 January 2023, a palliative care consultant and a palliative care nurse visited Mr Dugbazah to discuss his end of life wishes. They put a Do Not Resuscitate order in place for Mr Dugbazah in line with his wishes. The same day, healthcare staff made a psychiatrist appointment for 6 January.

12. Shortly after lunchtime on 6 January, while staff were locking prisoners back in their cells, staff noticed that Mr Dugbazah was on the toilet. An officer thought it seemed strange and went back to check on him a few minutes later. When he asked Mr Dugbazah if he was alright, he saw that he was slumped against the wall and appeared vacant. He called a medical emergency code. Control room staff called for an ambulance but were told there would be a long delay. Staff did not start CPR in line with the DNR.

13. At around 1.35pm, a GP at Littlehey arrived at Mr Dugbazah's cell and assessed that he was showing no signs of life. Paramedics arrived around ten minutes later and pronounced that Mr Dugbazah had died.

14. The post-mortem report concluded that Mr Dugbazah died from heart disease. Weight loss was listed as a contributory factor.

Findings

15. Reception staff correctly started ACCT procedures when Mr Dugbazah arrived at Littlehey, but they failed to refer him for a mental health assessment as they should have done.

16. There was a long delay in healthcare staff starting a food refusal care plan and important actions were not taken in line with the plan. There was a 35-day delay in making a psychiatrist referral which meant Mr Dugbazah was not assessed before he died.

17. There was limited input by the GP and no involvement by the safeguarding team. Also, healthcare staff were unaware of the risks of refeeding syndrome (potentially dangerous symptoms that can arise when a malnourished person starts eating again).

18. Healthcare staff thought that Mr Dugbazah had the mental capacity to make decisions about his food refusal, but no formal assessments were undertaken.

Recommendations

- The Head of Healthcare should ensure that reception staff make an urgent mental health referral when a prisoner presents as hopeless or expresses thoughts of suicide or self-harm.

- The Head of Healthcare should develop a food and fluid refusal policy to ensure that staff understand how they should manage prisoners who refuse food and fluids and that:

    - a food and fluid refusal care plan is initiated promptly and actions followed;

    - the appropriate multidisciplinary team members are involved, including the safeguarding team;

    - the prisoner has at least daily contact that involves the offer of healthcare provision including physical observations and meaningful conversation;

    - a GP assesses the prisoner after three days of food refusal, specifies regular review intervals and attends all multidisciplinary team reviews; and

    - advice is sought from a specialist healthcare professional on the implications of refeeding syndrome.

- The Head of Healthcare should ensure that all staff receive training in two stage mental capacity assessments.

The Investigation Process

19. HMPPS notified us of Mr Dugbazah's death on 6 January 2023.

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

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

22. NHS England commissioned two clinical reviewers to review Mr Dugbazah's clinical care at the prison. The investigator and one clinical reviewer jointly conducted 12 interviews between 21 February and 30 March. The other clinical reviewer and another investigator conducted additional interviews on 6 July.

23. We informed HM Coroner for Cambridgeshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

24. The Ombudsman's family liaison officer contacted Mr Dugbazah's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

25. We shared our initial report with HMPPS and the healthcare provider at Littlehey. They pointed out some factual inaccuracies, which have been amended in this report. We also amended one of the recommendations following feedback. The healthcare provider provided an action plan which is annexed to this report.

Background Information

HMP Littlehey

26. HMP Littlehey is a category C training prison for men convicted of sexual offences. It holds approximately 1,200 men.

27. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

28. The most recent inspection of HMP Littlehey was in 2019. Inspectors reported the prison was overwhelmingly safe, and while the number of suicide and self-harm procedures started had increased, the quality was good and improving. Inspectors noted that there was positive input from healthcare staff where appropriate.

29. Inspectors reported that the number of deaths at Littlehey was likely a result of the large population of older prisoners. They noted that palliative care at the prison was highly developed, with a specialist nurse and end of life staff employed in dedicated roles. HMIP identified this as an area of good practice, with well-integrated strategies for the care of older prisoners and patients with terminal conditions.

Independent Monitoring Board

30. 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 31 January 2022, the IMB reported that the healthcare team worked well with prison staff to respond rapidly to keep prisoners as safe as possible throughout the changing pandemic requirements. They ensured prisoners continued to receive their medications and access to medical consultations and treatments, which included the reintroduction of on-wing deliveries and consultations when needed.

31. Between April 2021 and January 2022, healthcare staff saw 403 prisoners transferred to Littlehey and attended 483 ACCT reviews, both an increase of almost 27% compared to the previous period.

Previous deaths at HMP Littlehey

32. Mr Dugbazah was the 44th prisoner to die at Littlehey since January 2020. Of the previous deaths, 42 were from natural causes and two were self-inflicted. There were no similarities between the findings from our investigation into Mr Dugbazah's death and the findings from our investigations into the previous deaths.

Key Events

33. On 10 June 2010, Mr Lawrence Dugbazah was given an Imprisonment for Public Protection (IPP) sentence for sexual offences. He was released in June 2020.

34. On 31 March 2022, Mr Dugbazah was recalled to prison following allegations of further sexual offences.

35. Mr Dugbazah was prescribed medication for Irritable Bowel Syndrome (IBS), asthma and eczema.

HMP Thameside

36. On 2 April, Mr Dugbazah was moved to HMP Thameside. Later that month, Mr Dugbazah stopped eating. He said he was feeling low and did not understand why he was back in prison. He told staff he wanted a single cell because he did not like using the toilet in a shared cell due to his IBS. He said that one of the reasons he had stopped eating was to reduce his need to use the toilet.

37. On 23 May, staff started suicide and self-harm prevention procedures (known as ACCT) because he was still not eating and refused to engage with healthcare staff. He said he would not eat until he was released from prison and did not care if he died.

38. On 26 May, Mr Dugbazah was admitted to the prison's inpatient unit (to a single cell) as staff were concerned about his physical health as he was very weak. Around a week later, he told staff that he ate a gluten-free, lactose-free and caffeine-free diet outside prison and that he was ready to start eating again if he was given the right diet. He started eating and drinking again once he was given appropriate food and drinks.

39. At the case review on 6 June, staff noted that Mr Dugbazah had been eating two to three meals a day after healthcare staff had arranged the appropriate diet. Mr Dugbazah said he had been willing to engage more as he had felt listened to. He asked for a single cell when he was moved back to a standard wing, but staff said that he did not meet the criteria. (Mr Dugbazah was assessed as standard risk for cell sharing so he was expected to share a cell and his health condition was not one that required a single cell.) Staff stopped ACCT monitoring.

40. On 13 June, healthcare staff diagnosed Mr Dugbazah with mixed anxiety and depressive disorder. A GP prescribed sertraline (an antidepressant).

41. Mr Dugbazah was moved back to a shared cell on a standard wing on 15 June. He was initially unhappy but then appeared to settle. He got a job as a wing cleaner and then in the kitchen. He continued to eat, though sometimes complained that he was not getting the correct diet. He had regular meetings with his key worker and his engagement was broadly positive. His main concerns were about getting his special diet and delays with his court case.

HMP Littlehey

42. On 18 November, Mr Dugbazah was moved to HMP Littlehey. He told reception staff that his mental health was not good anyway and had got worse when he found out he was being transferred as it had unsettled him. When asked if he felt suicidal, he said he could not guarantee that he would not try to kill himself. He said he was facing a life sentence, saw no point in living and would refuse all food and drink. Prison staff started ACCT procedures and placed Mr Dugbazah under constant supervision. They also started a prison food refusal log.

43. At his reception health screen, the nurse recorded Mr Dugbazah's weight as 89.8kg which gave a body mass index (BMI) of 29.73kg/m^2 (in the overweight range). The nurse took Mr Dugbazah's clinical observations which were all normal apart from his blood pressure which was high. There was no repeated blood pressure reading recorded.

44. On 19 November, staff held the first ACCT case review. Mr Dugbazah refused to engage and so staff held the review in his absence. The case review team noted that Mr Dugbazah had appeared settled at Thameside and there was no evidence he had ever self-harmed. They noted that his dietary requirements were being met by the kitchen. They agreed to stop constant supervision and set observations at three an hour. Mr Dugbazah was placed in a double cell on E Wing, but with no cellmate.

45. Staff held the second case review on 21 November. The ACCT case coordinator invited the mental health team to attend but they said that they had no record of Mr Dugbazah as he had not been referred to them. Staff made a mental health referral that day and the ACCT case coordinator noted that the mental health team would attend the next review. The case review team reduced observations to two an hour.

46. On 23 November, a nurse from the mental health team visited Mr Dugbazah to carry out a mental health assessment but he refused to engage and said he had nothing to say.

47. The nurse attended the third case review later that morning, but Mr Dugbazah refused to engage. The case review team reduced observations to one an hour.

48. That afternoon, a nurse visited Mr Dugbazah to carry out his secondary health screen. He refused to engage and failed to attend the appointment rescheduled for 25 November. He had not collected his medications since he had arrived at Littlehey (as he was on an ACCT, he was not allowed to keep his medication in his possession and had to collect it from the medications hatch).

49. On 24 November, an officer recorded that he had put Mr Dugbazah's gluten-free box of food in his cell, but Mr Dugbazah had put it out on the landing and said he did not want it. He continued to drink water. By this date, it was clear Mr Dugbazah was not eating, but there is no evidence that anyone from healthcare considered beginning a food refusal care plan.

50. Staff held the next case review on 28 November and then held weekly multidisciplinary case reviews thereafter. Mr Dugbazah continued to refuse to engage. Staff kept observations at one an hour.

51. On 2 December, a nurse called the wing to ask if Mr Dugbazah would go to the healthcare unit for a welfare check. The nurse then went over to the wing to see him. He told her that he had not eaten anything since he had arrived. The nurse noted that he had cups of water in his cell. He refused to let the nurse take clinical observations. Wing staff recorded that they had tried to engage him in conversation, but he was unwilling to engage, though remained polite.

52. On 7 December, Mr Dugbazah was due to attend court, but he refused to attend.

53. The same day, staff held a multidisciplinary team meeting (MDT) to discuss how to care for Mr Dugbazah given his food refusal. Prison staff, safer custody staff, the offender management unit and the mental health team attended. Staff agreed to move Mr Dugbazah to a single cell on K Wing (this was actioned later that day).

54. On 8 December, healthcare staff called the wing to ask if Mr Dugbazah would go to the healthcare unit for a welfare check but he refused. A healthcare assistant (HCA) in the mental health team visited Mr Dugbazah in his cell. He refused to engage. He told the HCA that he was not eating and would not eat 'today, tomorrow or the day after' and he wanted to be taken out of prison in a body bag.

55. On 8, 9 and 10 December, healthcare staff contacted the wing to see if Mr Dugbazah would attend the healthcare unit for a welfare check but he refused. On 11 December, a nurse visited Mr Dugbazah in his cell, but he refused to have his clinical observations taken.

56. On 12 December, wing staff contacted healthcare staff to report that Mr Dugbazah was feeling dizzy. He refused to attend the healthcare unit. He declined the next day too.

57. On 14 December, the Deputy Head of Healthcare and a palliative care nurse visited Mr Dugbazah in his cell. He was happy to engage with them. The Deputy Head of Healthcare asked Mr Dugbazah if there was anything she could do to encourage him to eat but he said there was not. He agreed to have his clinical observations taken if nurses came to his cell. When they left the cell, a prisoner told them that Mr Dugbazah was eating fruit, so the Deputy Head of Healthcare noted that she would email the kitchen to ask for more fruit to be sent to Mr Dugbazah.

58. Nurses visited Mr Dugbazah later that day and took his observations. They recorded that Mr Dugbazah had lost 17.6kg (almost 20% of his body weight) during his four weeks at Littlehey. Nurses tried to take a blood sample but struggled as Mr Dugbazah was dehydrated. He refused to let them have a second try as he said he was scared of needles.

59. On 15 December, healthcare staff started a food refusal care plan, which said that after day three of food refusal, the following should be carried out:

- Daily nursing interventions blood pressure and pulse check.
- Weekly (then daily) weight and urinalysis by nursing staff.
- After day three, daily visit/consultation by GP, apart from weekend until point of deterioration.
- MHIRT referral day four and to be seen within the first week.

- MHIRT to refer to Psychiatrist who needs to see prisoner before day ten of food refusal.
- All clinical details to be recorded on SystmOne.
- Prison GP to consider prescribing supplements should BMI fall below 18.
- Bloods to be taken for U&E and renal function, repeated as needed.
- Ask patient to drink 1.5 litres of water daily with a teaspoon of salt added.
- If weight loss greater than 10%, urgent review required.
- Visit every day.

When the care plan was started, Mr Dugbazah had been refusing food for 27 days and had lost almost 20% of his body weight. There is no record of a psychiatrist referral (which should have been done by day ten of food refusal) or of an urgent review (which should have been done when weight loss was greater than 10%).

60. On 16 December, healthcare staff took Mr Dugbazah's clinical observations, but he refused to have blood tests or provide a urine sample.

61. Later that day, a Custodial Manager (CM) held a key worker session with Mr Dugbazah. Mr Dugbazah told him that he was in pain and wanted to die. The CM had also been appointed as family liaison officer and asked Mr Dugbazah for permission to contact his next of kin, but he refused. Mr Dugbazah received regular key work sessions with the CM.

62. On 17 December, prison staff opened a self-isolator log for Mr Dugbazah, following concerns about his refusal to engage with staff. Staff made regular entries. (Opening a self-isolator log does not lead to any specific actions but encourages staff to monitor the prisoner's engagement with staff, other prisoners and the regime.)

63. On 17 and 18 December, Mr Dugbazah refused to have his clinical observations taken. He agreed on 19 December but refused to have blood glucose levels measured or provide a urine sample.

64. On 20 December, Mr Dugbazah refused to attend court because he felt unwell. He agreed to have a blood sample taken. Healthcare staff did not see him on 21 December. The reason is unclear.

65. On 22 December, Mr Dugbazah asked staff if they could get him some cans of fizzy drink (Irn Bru) to give him some energy. Staff gave him several cans.

66. The same day, healthcare staff took Mr Dugbazah's clinical observations and noted he had high blood pressure and a high pulse rate. Mr Dugbazah said he felt unwell and had vomited after drinking a fizzy drink. A GP at Littlehey reviewed the blood test results, which were abnormal, so he made an appointment to see Mr Dugbazah.

67. On 23 December, staff held a multidisciplinary team meeting to discuss Mr Dugbazah. Staff attempted to engage him in the process and gain consent to contact his next of kin, but he refused. Mr Dugbazah was not receiving visits from family or friends and did not make phone calls while at Littlehey.

68. Later that day, the palliative care nurse saw Mr Dugbazah and tried to discuss an advanced care plan (for end of life planning) with him, but he refused. A prison GP also visited Mr Dugbazah that day and prescribed an iron supplement for anaemia. He recorded that Mr Dugbazah said he wanted to be left to die. He recorded that there should continue to be welfare checks, weekly weight checks and a mental health review. Mr Dugbazah agreed for the GP to visit again the following week.

69. On 29 December, a nurse saw Mr Dugbazah on the wing. She recorded that he appeared to understand the consequences of his food refusal and gave coherent answers about his decision.

70. On 30 December, the palliative care nurse completed an advanced care plan which included a discussion about Mr Dugbazah's preferred place of death. She noted that Mr Dugbazah was happy to have this conversation, and she had no reason to doubt his capacity. She noted that Mr Dugbazah had lost 26.9kg since arriving at Littlehey, almost 30% of his body weight. Later that day, a prison GP saw Mr Dugbazah and prescribed Fortisip, a nutritional supplement for malnutrition.

71. On 3 January 2023, a palliative care consultant and the palliative care nurse saw Mr Dugbazah and discussed his food refusal with him. They recorded that he was clear in his intention to die and did not want to be resuscitated. They completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form in line with Mr Dugbazah's wishes. Staff placed this on the noticeboard in Mr Dugbazah's cell.

72. The same day, staff made a psychiatrist appointment for Mr Dugbazah, which was scheduled for 6 January. (He died before this appointment took place.)

73. On 4 January, the CM held a key work session with Mr Dugbazah. He noted that he was unwilling to engage until the CM wanted to discuss plans for what would happen if Mr Dugbazah died in Littlehey. Mr Dugbazah told the CM that he wanted to be cremated and his brother to inherit his possessions. The CM asked Mr Dugbazah if he could contact his brother, but he did not answer.

74. A nurse recorded Mr Dugbazah's weight on 4 January as 59kg. He had lost 30kg, a third of his body weight, since he had arrived at Littlehey.

Events of 6 January 2023

75. On 6 January, staff held an ACCT case review, but Mr Dugbazah refused to engage. Staff noted that he had an upcoming psychiatric appointment to assess his mental capacity.

76. At 12.15pm, Officer A and Officer B were locking prisoners in their cells. When they got to Mr Dugbazah's cell, they saw he was sitting on the toilet. Officer A asked Mr Dugbazah if he was alright, and he raised his hand to acknowledge them. Officer A went back to the office and thought something was odd about Mr Dugbazah being on the toilet so went back to check on him.

77. When Officer A checked on Mr Dugbazah again, he was still on the toilet, leaning against the wall. He said he asked Mr Dugbazah if he was alright, and he seemed vacant.

78. At 12.31pm, Officer A called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff responded, including Officer B. Control room staff called an ambulance at 12.34pm and updated the ambulance five minutes later with Mr Dugbazah's condition. The ambulance service advised that it could be an hour wait.

79. Officer B said during interview that she tried to get a response from Mr Dugbazah and his eyes were moving and he was struggling to breathe, but he was unable to respond. Staff did not attempt resuscitation, in line with Mr Dugbazah's wishes.

80. At around 1.35pm, a GP returned from a meeting and was told to attend Mr Dugbazah's cell. When he arrived, he checked for a heartbeat but could not find one.

81. At 1.42pm, ambulance staff arrived at Mr Dugbazah's cell. Paramedics initially believed Mr Dugbazah to be showing signs of life, but he was pronounced dead at 1.52pm.

Contact with Mr Dugbazah's family

82. On 6 January at 2.15pm, the family liaison officer (FLO) contacted HMP Lancaster Farms to ask them to notify Mr Dugbazah's listed next of kin, his brother, of his death as the address was in Lancashire, over three hours travel from Littlehey. Lancaster Farms sent two FLOs to the address, but Mr Dugbazah's brother was not there. The FLO at Littlehey contacted the police who were also unable to verify an address.

83. The FLO tried contacting Mr Dugbazah's other siblings, after finding some old contact details in prison records. He spoke to one of Mr Dugbazah's brothers and broke the news of his death and offered his condolences. Mr Dugbazah's listed next of kin contacted the FLO shortly after. The FLO explained the circumstances, offered condolences and said the prison would contribute toward the funeral costs.

Support for prisoners and staff

84. After Mr Dugbazah's death, a prison manager 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.

85. The prison posted notices informing other prisoners of Mr Dugbazah'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 Dugbazah's death.

Post-mortem report

86. The post-mortem report found that Mr Dugbazah died from ischaemic heart disease. The report found that on balance, Mr Dugbazah's weight loss was likely to have been a contributory factor.

Findings

Reception

87. Staff correctly started ACCT procedures when Mr Dugbazah arrived at Littlehey. Mr Dugbazah had been under the care of the mental health team at Thameside, his previous prison, and he had expressed thoughts of suicide when he arrived at Littlehey. According to National Institute for Health and Clinical Excellence (NICE) guidelines, this should have triggered a mental health referral. The mental health referral was not done until three days later, when the ACCT case review team realised that one had not been done. We recommend:

The Head of Healthcare should ensure that reception staff make an urgent mental health referral when a prisoner presents as hopeless or expresses thoughts of suicide or self-harm.

ACCT management

88. It was good practice to open an ACCT for Mr Dugbazah as soon as he arrived at Littlehey. Staff held regular, multidisciplinary ACCT reviews. The management of the ACCT was complicated by the fact that Mr Dugbazah refused to engage throughout. We consider that staff managed it appropriately in the circumstances.

Clinical care

Food refusal

89. The clinical reviewer found that there were many examples of caring, compassionate nursing care with daily welfare checks undertaken to try to establish rapport and engagement with Mr Dugbazah. However, she found that there were many missed opportunities to start a healthcare directed food and fluid refusal care plan and invite key multidisciplinary team members to assess Mr Dugbazah for an underlying mental health disorder.

90. A food refusal care plan was not started until 15 December 2022 and by then, Mr Dugbazah had been refusing food for 27 days and had already lost almost 20% of his body weight. The care plan said that if Mr Dugbazah lost 10% of his body weight, the primary care team should carry out an urgent review. This did not happen. By 30 December, Mr Dugbazah had lost almost 30% of his body weight and still there was no urgent review. The care plan also said that a psychiatric assessment should be carried out by day ten of food refusal. Healthcare staff did not make the psychiatrist appointment until 3 January (day 45), and the appointment was for 6 January, the day Mr Dugbazah died, so he was never assessed.

91. The care plan said that after day three of food refusal, there should be a daily visit by a GP apart from at the weekend. There was very limited input from a GP at Littlehey, who only worked two sessions a week on Thursdays and Fridays.

92. Throughout Mr Dugbazah's time at Littlehey, there was no involvement of the safeguarding team or external support sought with regards to refeeding syndrome (metabolic abnormalities that occur when a malnourished person starts feeding). Guidelines say that extreme caution should be taken with recommencing food and fluids as patients are at risk of refeeding syndrome. Specialist advice should have been sought. It is possible that staff's unfamiliarity with the process when a prisoner refuses food was exacerbated by the lack of a food and fluid refusal policy at Littlehey.

93. We recommend:

The Head of Healthcare should develop a food and fluid refusal policy to ensure that staff understand how they should manage prisoners who refuse food and fluids and that:

- **a food and fluid refusal care plan is initiated promptly and actions followed;**
- **the appropriate multidisciplinary team members are involved, including the safeguarding team;**
- **the prisoner has at least daily contact that involves the offer of healthcare provision including physical observations and meaningful conversation;**
- **a GP assesses the prisoner after three days of food refusal, specifies regular review intervals and attends all multidisciplinary team reviews; and**
- **advice is sought from a specialist healthcare professional on the implications of refeeding syndrome.**

Mental capacity

94. Although it was accepted that Mr Dugbazah had the mental capacity to make decisions about his food refusal, no formal two stage mental capacity assessments were documented.

95. Mental capacity can fluctuate from day to day and as Mr Dugbazah became frailer and more unwell from his food and fluid refusal there should have been consideration of formal two stage mental capacity assessments.

96. We recommend:

The Head of Healthcare should ensure that all staff receive training in two stage mental capacity assessments.

Head of Healthcare to note

Blood pressure

97. When Mr Dugbazah arrived at Littlehey, the reception nurse noted that his blood pressure reading was high but there was no record that she repeated the reading as she should have done. The Head of Healthcare should remind staff of the correct process for high blood pressure readings.

Areas of good practice

98. The clinical reviewer found evidence of sensitive and open communication with Mr Dugbazah about his impending death and also in relation to Advance Care Planning. Mr Dugbazah was reluctant to engage with staff and services in the prison, but it is evident from the records that the Deputy Head of Healthcare and the palliative care nurse made a concerted effort to communicate with him in order to gain his trust.

Inquest

99. The inquest was held from 12 to 14 August 2024. The jury concluded that Mr Dugbazah died from natural causes contributed to by self-neglect.

Prisons & Probation Ombudsman
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