Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leon Cadman, a prisoner at HMP Peterborough, on 12 July 2022

A report by the Prisons and Probation Ombudsman

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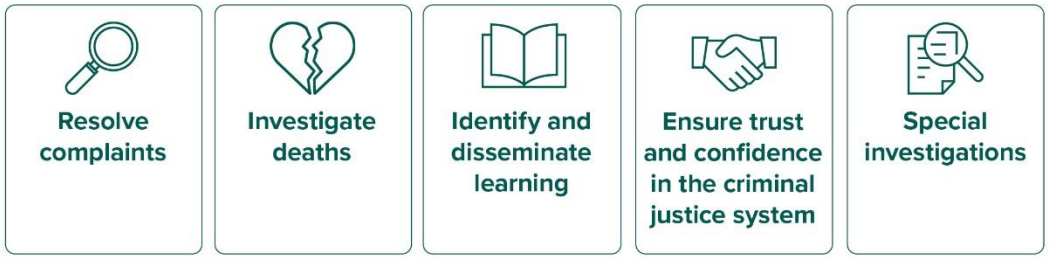
OUR VISION

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

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Leon Cadman died in hospital of cirrhosis of the liver on 12 July 2022, while a prisoner at HMP Peterborough. This was caused by alcohol and hepatitis C infection (liver failure). He also had previous intravenous opiate drug dependency which contributed to but did not cause his death. He was 51 years old. We offer our condolences to Mr Cadman's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Cadman received at Peterborough was mostly of the required standard and partially equivalent to that which he could have expected to receive in the community. She was concerned that there was no timely escalation when Mr Cadman's health deteriorated on 12 July 2022, National Early Warning Scores (NEWS2, a clinical tool to identify and address clinical deterioration) were not calculated correctly and healthcare staff were not offered appropriate support after his death.

5. We are concerned that the early compassionate release process was not managed effectively or efficiently. We saw no evidence that an application was completed after 27 June 2022, as it should have been.

6. We were also concerned that, despite requests, Peterborough did not provide the investigator with all the documentation about the use of restraints when Mr Cadman went to hospital. This meant that we could not determine whether the decision to restrain Mr Cadman on 24 June 2022 was appropriate.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
    - are fully competent in using the National Early Warning Score (NEWS2) effectively;
    - complete full and accurate clinical observations;
    - follow protocols for clinical escalation in line with NEWS2 and sepsis pathways; and
    - make accurate, timely and contemporaneous notes in prisoners' medical records, in line with the Nursing and Midwifery Council's guidance.

- The Governor at HMP Peterborough should ensure that a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend, in line with PSI 64/2011.

- The Governor and Head of Healthcare should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised, and that a record is kept of action taken.

- The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Cadman's clinical care at Peterborough.

8. The PPO investigator investigated the non-clinical issues relating to Mr Cadman's care, including Mr Cadman's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Cadman's next of kin, his wife, to explain the investigation. She did not respond to our letter.

10. The solicitor representing Mrs Cadman, received a copy of the initial report. They wrote to us raising a number of issues that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Peterborough

12. Mr Cadman was the sixth prisoner to die at Peterborough since July 2020. The majority of the previous deaths were from natural causes, and one was drug-related. There have been ten deaths since.

13. Following a death in April 2022, our investigation found that although clinical observations were taken, NEWS2 scores were not always assessed at Peterborough. HM Prison and Probation Service's (HMPPS) action plan following our investigation report had not been completed at the time of this report.

Key Events

14. On 26 July 2021, Mr Leon Cadman was sentenced to seven years in prison for drug offences. He was sent to HMP Lincoln and transferred to HMP Stocken the following day.

15. On 3 August, Mr Cadman was sent to hospital, where he was treated for alcohol-related liver disease, ascites (a build-up of fluid in the abdomen, often due to severe liver disease), bilateral pleural effusions (an excessive build-up of fluid in the space between the lungs and chest cavity), sepsis (an infection of the blood stream) and resolved hepatic encephalopathy (a loss of brain function as a result of toxins not being removed from the blood due to liver damage).

16. On 2 November, Mr Cadman was discharged from hospital to HMP Peterborough to access twenty-four-hour healthcare. He was located on the prison healthcare wing.

17. On 4 November, a nurse noted that he had turned down a liver transplant and was on a palliative care pathway. Appropriate palliative care plans were put in place.

18. On 11 November, Mr Cadman said he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect.

19. On 12 November, the Head of Safety appointed a Senior Officer as Mr Cadman's family liaison officer (FLO). The FLO agreed with the Head of Safety, that she would not contact the family until after an upcoming palliative care meeting.

20. On 1 December, the FLO telephoned Mr Cadman's wife to introduce herself to the family and talk about Mr Cadman's health.

21. On 22 December, Mr Cadman was released on temporary licence to continue medical treatment in hospital without escorting prison officers by his side.

22. That day, the FLO told Mr Cadman's wife that the Director of Peterborough had approved Mr Cadman's early compassionate release application and that it would be submitted that week. She told her that the application may take six to eight weeks to progress.

23. On 3 February 2022, the FLO told Mr Cadman's wife that there were no updates about the compassionate release application as the prison was still waiting for a hospital consultant's letter about Mr Cadman's prognosis.

24. On 10 February, Mr Cadman retracted his decision not to be resuscitated if his heart or breathing stopped. He asked to be added to the waiting list for a liver transplant. The Operational Healthcare Manager told him that he would not be eligible for early compassionate release if he was seeking active treatment. Mr Cadman confirmed that he still wanted a transplant.

25. On 20 May, Mr Cadman said he did not want to be resuscitated if his heart or breathing stopped and signed a new order to that effect.

26. On 31 May, the FLO met Mr Cadman's wife when she visited Mr Cadman at Peterborough. Mr Cadman's wife asked her about early compassionate release and

the FLO said a new application would be needed and she would ask if it was an option.

27. On 24 June, Mr Cadman attended the local hospital for a planned blood test and to have the swelling in his legs drained. No documentation was provided to the investigator about the arrangements for this escort, so we do not know whether any restraints were applied.

28. On 27 June, a nurse noted that both Peterborough and Leeds hospitals had confirmed that Mr Cadman was not a candidate for a liver transplant. She emailed the liver specialist nurse at the local hospital to ask for a letter from the hospital consultant to establish Mr Cadman's prognosis to support an early compassionate release application.

Events of 12 July 2022

29. At 9.34am, a Healthcare Assistant (HCA) attended Mr Cadman's cell to carry out physical observations. She recorded that his blood pressure was low (at 77/52mmHg) and that his heart rate was high (at 130bpm). His temperature and oxygen saturation levels were within normal range. She did not complete a NEWS2 score. (A clinical tool to identify and address clinical deterioration. A score above seven indicates the need for an emergency response.) If she had calculated a NEWS2 score using the recorded observations, it would have been at least nine. There is no record of the abnormal observation results being escalated or further action being taken.

30. At 10.07am, the HCA left Mr Cadman to continue with her ward observations. She walked into the corridor past, a prison GP, who was carrying out the weekly ward round, but did not mention the abnormal observations. The GP noted that she had seen Mr Cadman for the weekly ward round in the healthcare unit. She said that Mr Cadman was tearful and said he felt better when he had company.

31. The HCA told the investigator at interview that at approximately 10.30am she completed her ward observations and recorded them on the computer. She said she then told a senior nurse about the low blood pressure result but not the heart rate result. There is no clinical record about this. The nurse said that she did not recall anyone escalating Mr Cadman's observations to her.

32. At 10.34am, two nurses saw Mr Cadman because an officer reported to them that Mr Cadman was uncomfortable. They attended to his legs as they were leaking fluid and made him comfortable. This was reported at interview but was not documented in the medical records.

33. At 12.50pm, a nurse saw Mr Cadman to give him his medication. She noted that he had visibly deteriorated physically and noted that his observations were 'abnormal'. She did not calculate a NEWS2 score and did not call a medical emergency code.

34. At 1.15pm, the nurse repeated the physical observations and noted a NEWS2 score of 11. She asked an officer to request an emergency ambulance.

35. At 1.19pm, the officer telephoned to request an emergency ambulance and ambulance paramedics arrived at 1.42pm. The ambulance left at 2.27pm to take Mr

Cadman to hospital. Prison staff did not apply restraints to Mr Cadman when they escorted him to hospital.

36. At approximately 2.45pm, the deputy FLO telephoned Mr Cadman's wife to inform her that Mr Cadman was in a critical condition. She agreed to meet her at the hospital.

37. At 4.51pm, Mr Cadman died with his family by his side.

38. The following day, a debrief meeting was held with the two officers who escorted Mr Cadman to hospital. There are no records of whether anyone else was invited to attend this meeting.

Post-mortem report

39. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Cadman's cause of death as cirrhosis of the liver. This was caused by alcohol and hepatitis C infection. He also had previous intravenous opiate drug dependency which contributed to but did not cause his death.

Inquest into Mr Cadman's death

40. The inquest into Mr Cadman's death was concluded on 18 March 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Cadman's death was due to acute chronic liver failure, sepsis of an unknown cause and alcohol and hepatitis C virus related liver cirrhosis. He also had previous intravenous drug use and opioid dependency.

Clinical Findings

Clinical care

41. The clinical reviewer concluded that the clinical care Mr Cadman received at Peterborough was mostly of the required standard and partially equivalent to that which he could have expected to receive in the community. She said there was evidence of appropriate care planning, timely transfers to hospital when required and ongoing monitoring of his health needs. However, she was concerned that there was no timely escalation when Mr Cadman's health deteriorated on 12 July 2022, NEWS2 scores were not calculated correctly, and healthcare staff were not offered appropriate support after his death.

Events of 12 July 2022

42. The clinical reviewer was concerned about the events of 12 July and the different reports of how and when healthcare staff escalated concerns. There were no records of escalation documented in Mr Cadman's medical records, other than those of a nurse, who requested an emergency ambulance at 1.15pm.

43. The HCA completed her observations at 9.34am. She recorded Mr Cadman's low blood pressure and high heart rate. The clinical reviewer reported that the observations and open leg wounds were high-risk factors for sepsis. There was no indication in the medical records that sepsis was considered. The HCA did not complete a NEWS2 score.

44. The clinical reviewer found that Mr Cadman's physical observations were monitored regularly during his time at Peterborough. However, NEWS2 scores were often not calculated. At interview, the Head of Healthcare reported that all staff had received NEWS2 training in November 2020, and that scores should be recorded either manually on a scoring sheet or in the medical records. The HCA reported at interview that she had only been trained on NEWS2 in August 2022 after Mr Cadman's death. Training records suggest she attended training in December 2019. It is clear that NEWS2 scoring was not embedded in practice at Peterborough at the time of Mr Cadman's death.

45. Following a death in April 2022, our investigation found that although clinical observations were taken, NEWS2 scores were not always assessed at Peterborough. We await HM Prison and Probation Service's action plan at the time of issuing this report.

46. After the HCA completed the observations on 12 July, she walked out of Mr Cadman's room and past a prison GP, who was completing a ward round on the wing. She did not tell the GP about Mr Cadman's abnormal observation results. The GP said at interview that she did not require observation results for the ward round. However, in the case of a deteriorating patient, we would expect to see an immediate escalation to senior healthcare staff or the use of a medical emergency code to call for help.

47. The HCA said at interview that she did not notice Mr Cadman's high heart rate. Had she completed the NEWS2 scoring template, it would have highlighted to her that

Mr Cadman's health was deteriorating. She said she passed on the information about Mr Cadman's low blood pressure to a senior nurse at approximately 10.30am. There is no record of this escalation within the records and no record of any action taken. The nurse said in a statement that she did not recall any observations escalated to her. She was on extended leave from the prison and was unavailable for interview.

48. We are unable to say whether the observations were escalated by the HCA to the senior nurse. However, we know that there is no record of escalation and no clear actions taken. There were a number of opportunities to escalate these results. While we cannot say that escalation would have changed the outcome for Mr Cadman, it is possible that he would have been sent to hospital for treatment sooner and in other emergencies, it could be critical. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **are fully competent in using the National Early Warning Score (NEWS2) effectively;**
- **complete full and accurate clinical observations;**
- **follow protocols for clinical escalation in line with NEWS2 and sepsis pathways; and**
- **make accurate, timely and contemporaneous notes in prisoners' medical records, in line with the Nursing and Midwifery Council's guidance.**

Staff support

49. PSI 64/2011 sets out the actions that should be taken following a death in custody. This includes holding a hot debrief immediately after a death in custody and inviting all staff directly involved in the incident, including healthcare staff, to attend.

50. A hot debrief took place the day after Mr Cadman's death. It was attended by two officers who had escorted Mr Cadman to hospital, however there is no record that any of the other staff involved in the incident, including healthcare staff were invited to attend. During interview, a nurse, who was involved in the emergency response, reported that she did not receive any support and that she was not invited to the hot debrief. We are concerned that healthcare staff involved were given no opportunity to discuss any concerns that arose and were not offered support services. We make the following recommendation:

The Governor at HMP Peterborough should ensure that a manager holds a hot debrief promptly after a death in custody and that all those involved in the incident, including healthcare staff, are invited to attend, in line with PSI 64/2011.

Non-Clinical Findings

Compassionate release

51. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from prison before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds (ERCG) Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service.

52. In December 2021, the prison approved an application for early compassionate release for Mr Cadman. This was appropriately withdrawn when Mr Cadman subsequently decided to seek active treatment and to apply to go on the liver transplant waiting list.

53. On 27 June 2022, a nurse emailed the hospital consultant for a letter to confirm Mr Cadman's prognosis to support a compassionate release application. This was because the hospital had confirmed Mr Cadman was not a suitable candidate for a liver transplant. However, there is no evidence that the compassionate release process was followed up or that the application was started, and the investigator was unable to identify why this did not progress.

54. Mr Cadman died fifteen days later. While the ERCG Policy Framework gives no specific timescales for making an application, it states that it is imperative that applications are expedited as far as possible. We are concerned that the compassionate release process was not managed efficiently. We have seen no evidence that the compassionate release application was completed after 27 June, and we are concerned that no prison manager took effective control of the process. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised, and that a record is kept of action taken.

Providing the PPO with relevant documents

55. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Peterborough did not give us all the escort risk assessment documentation. This adversely affected our investigation and meant that we could not determine whether the decision-making process when Mr Cadman was escorted to hospital on 24 June 2022 was appropriate. We make the following recommendation:

The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

Kimberley Bingham
Deputy Prisons and Probation Ombudsman **May 2024**

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