Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Lee, a prisoner at HMP Preston, on 19 October 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 Steven Lee died in hospital of acute subdural haemorrhage (bleeding on the surface of the brain) on 19 October 2023, while a prisoner at HMP Preston. He also had chronic kidney disease, ischemic heart disease (caused by narrow arteries), a stroke, and Type 2 diabetes which contributed to but did not cause his death. He was 60 years old. We offer our condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Lee received at Preston for his long-term conditions was equivalent to that which he would have received in the community.

However, when Mr Lee was found unresponsive, staff did not radio an emergency medical code for 21 minutes. This represented an unacceptable delay in assessing the severity of the situation, causing delays going into the cell, treating Mr Lee and requesting an ambulance.

It was also completely unacceptable that Mr Lee was restrained when he went to hospital, despite being in a coma.

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 **July 2024**

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Summary

Events

1. In December 2022, Mr Steven Lee was remanded to custody and taken to HMP Forest Bank, charged with fraud. On 1 September 2023, he transferred to HMP Preston.

2. At his initial health screen, Mr Lee told a nurse that he had chest pains. The nurse sent him to hospital, and it was later confirmed that Mr Lee had had a heart attack. On 15 September, Mr Lee returned to Preston and lived in the healthcare wing for a period of enhanced observations.

3. At 3.37pm on 19 October, a Healthcare Support Worker (HSW) went to Mr Lee's cell to give him his medication. The HSW was unable to rouse him. A nearby nurse telephoned for an officer to open the cell door. The nurse and HSW thought that Mr Lee was in a deep sleep. At 3.48pm, an officer opened the cell door. They tried to rouse Mr Lee but were unable to do so. Seven minutes later, the nurse asked a GP and another nurse to attend.

4. At 3.57pm, a GP arrived, examined Mr Lee, and asked the nurse to call an ambulance. Another nurse arrived and recorded Mr Lee had a Glasgow Coma Scale score of 4, which indicated that Mr Lee was in a coma. She inserted an airway.

5. At 4.14pm, ambulance paramedics arrived and took over Mr Lee's treatment. At 4.59pm, they took him to hospital. Two officers escorted Mr Lee, who was restrained with an escort chain. At 5.55pm, hospital staff told the officers with Mr Lee that he would be placed on end-of-life care. At 6.05pm, the officers removed the restraint. Mr Lee died later that evening.

Findings

Emergency response

6. There was a delay of eleven minutes opening Mr Lee's cell door after staff found him unresponsive. There was a further nine-minute delay before staff requested an ambulance and a minute after that they radioed an emergency medical code.

Restraints, security and escorts

7. Mr Lee was inappropriately restrained when he was taken to hospital in a coma.

Recommendations

- The Head of Healthcare should ensure that where there are serious concerns about the health of a prisoner, staff use an emergency code to summon assistance and alert control room staff to call an ambulance immediately, in line with Prison Service Instruction (PSI) 03/2013.

- The Governor and Head of Healthcare should ensure that staff accurately reflect their professional opinion on restraint risk assessment forms, that there are clear and considered conversations between healthcare and prison staff about a prisoner's risk where necessary and that these conversations are routinely documented.

The Investigation Process

8. On 19 October 2023, the PPO was informed of Mr Lee's death.

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

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

11. The investigator interviewed two members of staff by video call on 15 November and 22 November 2023.

12. NHS England commissioned a clinical reviewer to review Mr Lee's clinical care at the prison.

13. We informed HM Coroner for Lancashire of the investigation. He gave us Mr Lee's cause of death. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer wrote to Mr Lee's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

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

Background Information

HMP Preston

16. HMP Preston is a Category B local prison serving the courts in Lancashire and Cumbria. It holds up to 680 adult male prisoners. Spectrum Community Health CIC provides community healthcare services 24 hours a day, seven days a week, as well as substance misuse services. Tees Esk and Wyre Valleys NHS Foundation Trust provides mental health services at Preston.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Preston was in June 2023. Inspectors reported that health care was very well led, and the Governor understood the importance of these services for such a complex and vulnerable population, appointing extra staff to support the work.

Independent Monitoring Board

18. 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 March 2023, the IMB reported that the prison had a well-staffed regional enhanced care unit with services in place to oversee long-term conditions and chronic disease.

Previous deaths at HMP Preston

19. In the three years before Mr Lee's death, there were seven deaths from natural causes and two self-inflicted deaths at Preston. Up until the end of January 2024 there has been one self-inflicted death since Mr Lee's death. There are no similarities between our findings in the investigation into Mr Lee's death and previous investigations.

Key Events

20. On 24 December 2022, Mr Steven Lee was remanded to HMP Forest Bank for fraud. In January 2023, Mr Lee transferred to HMP Liverpool. He had a number of health conditions notably Type 2 diabetes, chronic kidney disease stage 3 (a long-term disease where the kidneys do not work as well as they should), unstable angina (a condition where the heart does not get enough blood flow and oxygen) and high blood pressure and was sent to hospital on a number of occasions with chest pains.

21. On 1 September, Mr Lee was transferred to HMP Preston. That day during his initial health screen, he told an Associate Nurse Practitioner (ANP) that he had chest pains. The ANP thought that he was having a heart attack and sent him to hospital. The hospital later confirmed that Mr Lee had had a heart attack.

22. On 15 September, Mr Lee returned to Preston and went to the healthcare wing for a period of enhanced observations. He was scheduled to have a cardiology follow up appointment in three months, but he died before the appointment.

23. At 10.13am on 22 September, a nurse found Mr Lee on the floor in his cell. He told her that he had lost his footing on the way back from the toilet. Mr Lee was not injured. She completed a falls risk assessment and offered him a walking frame which he refused, preferring his stick.

Events of 19 October 2023

24. On 19 October at 11.17am, as part of the daily routine observations, a HSW saw Mr Lee in his cell. She completed his physical observations and noted that his National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was zero, which indicated no clinical risk. At 2.30pm, she saw Mr Lee in his cell. He was resting on his bed, and she had no concerns about him.

25. At 3.37pm, the HSW went to Mr Lee's cell to give him his medication (due to Mr Lee being unstable on his feet he received his medication through the cell door hatch). She called to him through the observation panel and thought he was snoring and appeared to be in a deep sleep.

26. A nurse told the HSW to bang harder on the door and shout to Mr Lee, as she said he was a deep sleeper. The HSW was unable to rouse Mr Lee. Believing him to be in a deep sleep, the nurse telephoned for an officer to attend the healthcare wing to open the cell door (nurses to do not carry cell keys). She spoke to a member of staff and told them that they could not wake up Mr Lee and needed to go into his cell to give him his medication. Five minutes later, after no one came, she telephoned again for an officer.

27. At 3.48pm, an officer got to Mr Lee's cell and opened the door. He and the HSW tried to rouse him. (For medical reasons, the nurse was not having face to face contact with prisoners at the time, so she did not go into the cell.) At 3.55pm, the nurse telephoned a GP and another nurse to come and assess Mr Lee. The GP said that the nurse told him that Mr Lee was "unconscious and unresponsive". He went straight to Mr Lee's cell and got there at 3.57pm. He told the nurse to call an ambulance.

28. The nurse radioed a code blue (an emergency code when a prisoner is having difficulty or not breathing) which triggers staff in the control room to call an ambulance. Another nurse got to Mr Lee's cell at 4.00pm. She recorded a Glasgow Coma Scale (a clinical assessment scale to measure a patient's level of consciousness) of 4 (the highest score is 15, and the lowest is 3. A score of 15 indicates fully awake and a score of 8 or fewer indicates a coma). The nurse inserted an airway. At 4.14pm, paramedics arrived and took over Mr Lee's care. At 4.59pm, they took him to hospital.

29. Before Mr Lee went to hospital, prison staff completed an escort risk assessment. A nurse told the investigator that she spoke to a Custodial Manager (CM) and said that Mr Lee did not need to be restrained as he was unresponsive. The CM then telephoned the Head of Security and told him that the nurse did not think Mr Lee needed to be restrained. The Head asked if Mr Lee would need to be shocked through the use of a defibrillator. The nurse said that there was only a slight possibility of a defibrillator being used. Therefore, the Head said that Mr Lee needed to be restrained due to concerns about previous hospital visits. The paramedics present shared the nurse's concerns about Mr Lee being restrained. However, the nurse completed the medical section of the escort risk assessment noting that she did not object to the use of restraints. In the section where she recorded the prisoner's current medical condition, she wrote, "unstable comorbidities". She said that she did not feel empowered to object to the use of restraints on the form.

30. The Head of Security authorised that Mr Lee be accompanied by two officers and be restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He said normally unsentenced prisoners were accompanied by two officers and double cuffed (double cuffing is when the prisoner's hands are handcuffed in front of them, and one wrist is attached to a prison officer by an additional set of handcuffs). He said that on previous hospital visits, Mr Lee's family had attended in large numbers, and it had been difficult to manage. He told the investigator that he was not aware that Mr Lee's condition was life-threatening. He considered his prior knowledge of Mr Lee, that he was unwell and being taken to hospital by ambulance and decided that the use of the escort chain was appropriate.

31. In hospital, Mr Lee had a CT scan, which showed that he had suffered a large brain haemorrhage. Hospital staff said that he should be placed on end-of-life care. At 6.05pm, an officer contacted the Head of Security, who authorised that the restraint could be removed. Mr Lee died at 9.50pm.

Contact with Mr Lee's family

32. On 19 October, a prison chaplain was appointed as the family liaison officer. At 6.17pm, she telephoned Mr Lee's wife and told her that Mr Lee was seriously ill in hospital. The chaplain went to the hospital, where she met Mr Lee's family, who were with him when he died. The prison contributed to the cost of Mr Lee's funeral in line with national instructions.

Support for prisoners and staff

33. After Mr Lee's death, the Head of Security debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. He arranged for the staff care team to offer ongoing support.

34. The prison posted notices informing other prisoners of Mr Lee'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 Lee's death.

Post-mortem report

35. A hospital doctor established that Mr Lee died from acute subdural haemorrhage (spontaneous bleeding on the surface of the brain). He also had chronic kidney disease, ischemic heart disease, a stroke and Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

36. The clinical reviewer found that the clinical care that Mr Lee received at Preston was of a mixed standard. She was satisfied that the care of Mr Lee's long-term conditions was equivalent to that which he would have received in the community. He was appropriately located in the healthcare wing to allow him to be monitored.

37. However, she was concerned about the emergency response and delay in radioing a code blue. This is discussed further below.

38. The clinical reviewer also made a recommendation about the transfer of medication between prisons which was not relevant to Mr Lee's death, but which the Heads of Healthcare at Liverpool and Preston will want to address.

Emergency response

39. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes* and Preston's local protocol, *Medical Emergency Response Codes* sets out the actions staff should take in a medical emergency. Both instructions state that if a person is found unresponsive then staff should radio an emergency code which means staff will respond and an ambulance will immediately be requested. The PSI says that local procedures must ensure that staff understand they should not delay summoning emergency assistance. It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed.

40. At 3.37pm, a HSW found Mr Lee unresponsive in his cell and thought he was in a deep sleep. A nurse was also present. Healthcare staff made a non-urgent request for an officer to open the cell door. An officer opened the cell door 11 minutes later. Seven minutes later, the nurse asked a nurse and GP to attend as Mr Lee was still unresponsive. At 3.57pm, after a GP went to the cell, he asked the nurse to request an ambulance. She did so immediately. This was 21 minutes after staff first found Mr Lee unresponsive. This was an unacceptable delay. It is extremely concerning that two members of healthcare staff did not recognise the severity of the situation or radio a code blue when they first discovered Mr Lee unresponsive. It delayed staff going into the cell, his treatment and an ambulance being requested. We make the following recommendation:

    The Head of Healthcare should ensure that where there are serious concerns about the health of a prisoner, staff should use an emergency code to summon staff and alert control room staff to call an ambulance immediately, in line with Prison Service Instruction (PSI) 03/2013.

Restraints, security and escorts

41. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

42. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. We have identified a number of significant concerns about the use of restraints on Mr Lee.

43. On 19 October, staff found Mr Lee unresponsive in his cell and subsequently assessed him as being in a coma. The nurse did not include this information in the medical section of the escort risk assessment form and noted that she did not object to the use of restraints. She said that she objected verbally to the use of restraints but did not feel able to write this on the form once the Head of Security told another member of staff that Mr Lee would be restrained. She told the investigator that she would not feel pressured into changing her opinion again and if she objected to the use of restraints, she would note this on the form regardless of what the final decision was.

44. The Head of Security said he was unaware that Mr Lee's condition was life-threatening and authorised restraint with an escort chain. We accept that in hospital, when officers updated him on Mr Lee's condition, he authorised the restraint to be removed. However, Mr Lee was in a coma and should never have been restrained.

45. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff accurately reflect their professional opinion on restraint risk assessment forms, that there are clear and considered conversations between healthcare and prison staff about a prisoner's risk where necessary and that these conversations are routinely documented.

Inquest

46. The inquest into Mr Lee's death concluded in May 2025 and found that he died of natural causes.

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