Investigation into the circumstances surrounding the death of a man at HMP Leeds in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

December 2008

This is the report of an investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Leeds. The man died in May 2007 in Leeds General Infirmary after an emergency admission to the hospital for bleeding gastric ulcers. The post mortem report indicates that he died from a massive gastrointestinal tract haemorrhage due to a benign gastric ulcer with cirrhosis of the liver. He was 34 years of age when he died.

I would like to extend my personal condolences to the man's family and friends for their loss. The loss of a loved one at any time is difficult, but especially so when they are relatively young, die suddenly and are in custody.

This investigation was carried out by a colleague of mine. A clinical review (for which I am most grateful) was undertaken by a doctor on behalf of Leeds Primary Care Trust (PCT). The Trust's Clinical Director reviewed the report and interviewed prison doctors and researched the conditions that led to the man's death, to help give greater clarity to my report. I would also like to thank the Governor of HMP Leeds, and his staff for their help and co-operation during this investigation.

This report has taken a long time to complete, for which I apologise. There are four recommendations made within this report.

Jane Webb
Deputy Prisons and Probation Ombudsman **December 2008**

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SUMMARY

The man was first remanded in custody on 31 July 2006. He was sentenced to life imprisonment on 13 December 2006, and died five months later in the early hours of 3 May 2007.

The man arrived in prison with a known medical history of Hepatitis C and alcohol problems. He received treatment for his alcohol withdrawal and his previous medication was continued except for a drug called Propranolol. Propranolol is sometimes used as a preventative measure against varices as it lowers the blood pressure. (Varices is a condition of enlarged veins that can rupture under certain circumstances, particularly in people with chronic liver problems such as long-term alcoholics or Hepatitis sufferers.)

On 21 April 2007, the man was admitted to Leeds General Infirmary as an emergency as he was suffering from gastric varices. He was treated with a series of injections to the site of the bleeding and discharged back to prison on 26 April with a prescription for Propranolol.

On 2 May, at approximately 11.45pm nursing staff were called to see the man who was complaining of coughing up blood. The nurse recorded his blood pressure and pulse and these gave her no cause for concern. On examination, the nurse decided that because she saw no evidence that he had coughed up blood and his cellmate seemed more distressed than the man was, the man would be alright until the morning.

At approximately 2.10am on 3 May 2007, the man suffered a serious haemorrhage from his gastric ulcers. Despite the best efforts of paramedic staff who arrived on the scene within seven minutes, he died in hospital at 3.31am.

The clinical review does not seek to blame any individual, but points out that complex medical conditions such as the man's should be the subject of comprehensive care plans that enable staff taking responsibility for patients to have the best possible information and guidance.

THE INVESTIGATION PROCESS

1. My colleague visited HMP Leeds on 17 May 2007 to review and collect papers from the prison. Whilst there he ensured that Notices to Prisoners and Staff were prominently displayed. These notices invited people to contact him if they wanted to bring any matters to his attention.

2. My colleague also met with members of the Independent Monitoring Board and the Prison Officers' Association. He was shown around the prison and saw the unit where the man was located at the time of his death. My colleague met several members of the prison staff, including nursing staff.

3. One of our Family Liaison Officers (FLO), made contact with the man's mother on 30 May to explain the purpose of the investigation and invite the family to raise any concerns they wished to be considered and addressed as part of the investigation. The family will receive a copy of this report. The mother asked our FLO about her son's medication. She wanted to know why he had not received the correct medication for the nine months prior to his death; a matter I deal with in this report. I hope it helps the family better understand what happened to the man in the time leading up to his death.

4. The man's cell mate had been discharged before my colleague could interview him but his police interview statement taken on the night the man died was available. My colleague has also been in regular contact with the West Yorkshire Police over their continued investigation into matters relating to his death. As with all deaths in custodial settings, the police undertake their own investigation into matters relating to that death. In respect of the man's death, these investigations were protracted which has resulted in a delay to this report being issued.

5. Leeds Primary Care Trust was asked to undertake a clinical review of the care the man received while he was in custody. A doctor undertook this review and this was supplemented by a further report from another doctor, who is Clinical Director for Leeds Primary Care Trust at the prison.

6. My colleague contacted Her Majesty's Coroner to inform him of the nature and scope of our investigation and to request a copy of the Post Mortem report. Upon completion, a copy of this report will be sent to the Coroner to assist him in his enquiries into the man's death.

HMP LEEDS

7. Leeds is a category B local prison that generally accepts adult male prisoners from West Yorkshire. It was built in 1847, but has had additional wings added in 1994 and a new gate lodge complex built in 2002. It can accommodate 1,254 prisoners in 680 cells, which means that most prisoners share a cell with at least one other person.

8. Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, undertook an unannounced inspection of Leeds between 22 and 26 August 2005. The report commented that Leeds presented as a typically overcrowded and pressurised local prison 'It exhibits, in acute form, some of the problems associated with our overcrowded prisons'. There were no observations or recommendations of particular relevance to the man's death in that inspection report.

9. The Independent Monitoring Board's (IMB) latest annual report says that 'HMP Leeds is a rapidly improving establishment with a committed and competent management and staff'. The report points out that 2007 – 2008 saw a reduction in the numbers of deaths occurring within the prison (down from 11 the previous year to just four in this reporting period).

10. However, this is still one of 29 deaths the Ombudsman's office has investigated at Leeds since April 2004. Several of those investigations are ongoing and a number of reports have yet to be published. However, the issue of care plans and record keeping is a factor in at least one other investigation already completed, and features in recommendations here and another report yet to be published.

11. The move to wing based nursing should, when coupled with the recommendations in this report for comprehensive care plans, ensure that higher standards of care are delivered to prisoners who are patients at Leeds.

KEY FINDINGS

12. On his initial reception into HMP Leeds on 31 July 2006, a first reception health screen was undertaken on the man. This revealed that he was a heavy drinker and so he was referred to the doctor for further investigations. When he was seen later that evening for his secondary health screening he told the nurse that he had Hepatitis C which is a viral infection that leads to chronic liver disease.

13. The man then saw a doctor and told him that he had been prescribed medication in the community. He said that he took Thiamine, Vitamin B Compound, Spironalactone, Ciproflaxacin, Propanolol and Dihydracodiene. He also told the doctor that he suffered from depression and paranoia. The man was started on an alcohol detoxification programme on the evening of 31 July with a reducing dose of Chlordiazepoxide. This is a standard detoxification regime used in prisons for alcohol withdrawal.

14. The prison contacted the man's doctor by fax the following day to ascertain information about his medical history. The GP responded the same day confirming all of the medication, except the Propanolol. The GP also told the prison that the man had been assessed by a professor at St James' Hospital, Leeds Liver Unit, and diagnosed with alcoholism and Hepatitis C. The man had undergone a period of residential alcohol detoxification at St Anne's clinic (part of the community services in Leeds) in early March 2006. The GP made the point that the man was a newly registered patient and he therefore did not know if he was prescribed any other medication.

15. On 16 August, the man was seen by a prison doctor and prescribed all the medication listed by the GP. This did not include any Propanolol as it was not listed as being prescribed by the GP. The delay in the man receiving his medication is reported to be because the doctors did not know the fax from his GP had arrived with confirmation of the man's medication. The man was also given an appointment to attend a clinic for blood tests to be done the following day. He failed to keep this appointment.

16. The man was treated for a dental abscess on 10 October and referred to the visiting dentist. It had been noted on his reception health screening that he had had surgery to his jaw, and it was thought that the infection might be related to that.

17. The man was seen by a counsellor on 30 October because of the stress and anxiety generated by his impending trial. The counsellor saw the man on a number of occasions throughout the following months, until 6 February 2007.

18. The man was convicted of murder on 11 December. He was seen that day in reception by the nurse who assessed him as being depressed and in a state of shock following his return from court. The nurse referred the man to the doctor for some sleeping tablets and opened an Assessment, Care in Custody and Teamwork document (ACCT). (ACCT is a flexible, prisoner-centred

assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment.) The ACCT was closed on 19 December.

19. Although the visiting doctor did not see the man on 11 December, he did prescribe sleeping tablets for the next five nights (10 milligrams Nitrazepam).

20. On 13 December, at Leeds Crown Court, the man was sentenced to life imprisonment with a tariff of 18 years imprisonment. The same day that he was sentenced, the visiting doctor changed the Nitrazepam prescription for one of 7.5 milligrams of Zopiclone for five nights.

21. The man was seen again by the counsellor on 19 December and was described as still in a state of shock with symptoms akin to that of Post Traumatic Stress Disorder (PTSD). The counsellor went on to say that the man gave an essentially honest account of himself, was direct and was not someone who was trying to get more medication, the inference being he genuinely needed help. The counsellor made the point that the man was, nevertheless, showing positive signs in that he was making plans for the future. The man thought he might like to become a Listener if he were to be accepted for the training, and also to undertake some sort of self development course. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)

22. The man was seen by the Lifer Management unit at Leeds on 22 December and a plan for his immediate custodial needs was drawn up. This included ongoing support from the counsellor to help him come to terms with his long sentence. Although he was expecting a life sentence if he was found guilty, it had still come as a shock to him when that happened. The man was also allocated, as a first stage lifer prisoner, to HMP Wakefield or HMP Gartree.

23. On 3 January 2007, another visiting doctor, saw the man in his morning surgery at the prison. He found that the man was suffering from depression and prescribed Mirtazepine (an anti-depressant) for a month, to be reviewed on 3 February. The visiting doctor did not think that the man was suicidal, although he did say that he was not sleeping properly and did not have any interest in things generally.

24. When the visiting doctor saw the man two days later, he was sleeping better thanks to the Mirtazepine, but had feelings of anxiety. The man requested a prescription for Diazepam, but the visiting doctor was not in favour and instead prescribed a low dose of Haloperidol for his anxiety.

25. The prison doctor saw the man on 18 January and stopped the Haloperidol because the man said it was not having any effect. He prescribed a short course of Zopiclone again.

26. On 25 January, the prison doctor changed the Zopiclone for Nitrazepam to help the man with his insomnia. The prison doctor saw the man the following day, when he complained of a pain in his right thumb which had lasted for two

or three weeks. The prison doctor diagnosed De Quervain's disease and prescribed a cream to be rubbed in to the affected area.

27. The man went to see the prison doctor on 29 January complaining of a rash on his body. It was thought he had scabies, and he was given some cream to treat this. He was seen again on 15 February with the same problem and re-treated.

28. The counsellor recorded in the medical notes on 6 February that he had seen the man in passing on the wing. The man asked to be taken off the list for counselling which the counsellor agreed.

29. A Month later on 5 March, the man was seen by the prison doctor because he was depressed. The prison doctor recognised that the man had been on Mirtazepine for two months, and that this was not working. He therefore changed the prescription of Mirtazepine to one of Trazodone 100mgs, to be reviewed after one month.

30. A doctor saw the man on 2 April and recorded in the clinical notes that the man was still not sleeping well. He was feeling angry all the time and getting into fights. The man told the doctor that he was getting no benefit from the Trazodone. The doctor stopped the medication and asked that the man be reviewed in one week's time. The man did not visit a doctor because of depression again.

31. A nurse saw the man on 21 April because he was not feeling well. He told the nurse that he had abdominal pain, had been vomiting since the previous day and had dark coloured stools for two days. Whilst she was assessing him, he vomited dark coloured blood. An ambulance was called and the man was admitted to Leeds General Infirmary.

32. The man was at Leeds General Infirmary for five days until 26 April undergoing treatment for gastric and oesophageal varices (in this instance the enlarged veins were within the oesophageal wall or the lining of the stomach). The man was prescribed Propranolol by the hospital doctors when he was discharged from the infirmary.

33. When the man returned to the prison on 26 April, he was seen by another doctor who recorded in the clinical notes that the man stated he had repeatedly requested his Propranolol. The man said that it had not been prescribed at his initial reception because he had not been able to cite the dose. The doctor also reviewed the notes and was unable to find any reference to the man previously having any signs of oesophageal varices.

34. At approximately 11.45pm on 2 May, the man saw a nurse in his cell on C4 landing, because he had told the night orderly officer that he was coughing up blood. When the nurse arrived she took his blood pressure (blood pressure 92/60 which is slightly low, pulse 50 which is quite slow) and pulse. The man seemed to be alright to the nurse and he did not appear too concerned about his condition, so she advised that he should see the wing nurse the following

day if he felt no better. The man told the nurse that he was prescribed Propranolol (which lowers blood pressure), and she could see no evidence of his having coughed up any blood. She said in interview that it was the man's cell mate, who was most concerned about his condition, not the man himself.

35. At 2.10am on 3 May 2007, the man collapsed in his cell and his cell mate summoned staff assistance. The nurse was in the vicinity of the prison centre at the time and joined staff in the emergency call. She discovered the man lying on the floor with signs that he had vomited a large amount of blood. An ambulance was called and arrived at 2.17am. Paramedics took the man to hospital, but despite all their efforts, the man died at 3.31am.

ISSUES

36. The clinical review says that Propranolol is used in the first place to reduce the incidence of bleeding from varices, as well as the chance of a re-bleed. The man was not prescribed Propranolol at his initial reception, neither was there any follow up of his chronic liver disease. The Clinical Reviewer points to research that shows that the risk of initial variceal bleeding in some patients can reduce from 45 per cent to 22 per cent if Propranolol is prescribed. The Clinical Reviewer therefore concluded that the 'lack of use of Propranolol may have contributed to his first GI [gastro intestinal] bleed in prison'.

37. The Clinical Director for Leeds Primary Care Trust at Leeds prison has added some additional thoughts and comments to the clinical review undertaken by the Clinical Reviewer. The Clinical Director picked up on the Clinical Reviewers point that the man had not been prescribed Propranolol at his first reception. The Clinical Director discussed the matter with a Consultant Hepatologist at St James's University Hospital, who also reviewed the man's medical notes. The Consultant referred to emerging evidence that prescribing Propranolol in situations where oesophageal varices might occur is proving effective. The Clinical Director goes on to say in his report that, in the man's case, the omission of Propranolol medication was not a factor as he died as a result of an acute gastric ulcer bleed. There was no evidence at post mortem of any oesophageal varices.

38. The Clinical Reviewer did not conclude that the man's final illness was attributable to the lack of Propranolol. He confirms that the man died from a ruptured gastric ulcer. However, the Clinical Reviewer says that there are case studies to suggest that treating varices with injections carries its own risks of further bleeding at the site of treatment. He suggests that it is plausible that all these factors are interlinked, and he says that varices can be difficult to detect after death.

39. It would therefore seem unfair to conclude that the omission of Propranolol at the man's first reception was a specific cause of his death. It would be fair though to say that emerging good practice for chronic liver disease management should include consideration of Propranolol.

40. The Clinical Director made some useful observations on the prescribing of medication for people entering prison for the first time. He observed that the man gave a good account of medication prescribed by his own doctor. The Clinical Director noted that reasonable attempts were subsequently made to verify those prescriptions. The Clinical Reviewer points out that the fax containing confirmation of the detail of the man's medication appears to have taken two weeks to be filed – and that this is unacceptable.

41. The Clinical Director lays out a pragmatic solution to prescribing problems for new arrivals in prison:

> 'Where patients present with boxes or lists of medication with a clearly defined dose, then this information will be taken at face value and the

medication prescribed to the patient. Similarly, where the patient does not have the medication or a list, but is clearly able to report the dose of the medication, then this information will be taken at face value and prescribed. The exception to this would be medication that has an abuse potential, which includes benzodiazepines, opiates (typically methadone, buprenorphine or dihydrcodeine) or where medication is toxic in overdose e.g. tricyclics and antidepressants. However, in all the above cases, confirmation would still be sought from the GP. Where the patient is unable to recall the dose and there is no confirmation, then the medication will not be written up, but confirmation will be sought urgently from the GP.'

The healthcare manager should develop a system to confirm a prisoner's medication on reception into the prison.

42. Both the Clinical Reviewer and the Clinical Director also recognised that Hepatitis C is a major health concern within the prison population. Whilst most patients who have liver disease who come into prison will not have any symptoms, they recommend that there should be an improvement in the uptake of anti-retroviral treatment (treatment that slows the effects of a virus like Hepatitis).

The healthcare manager should review the needs of patients with Hepatitis C and liver disease. They should develop a clinical policy for chronic liver disease to improve the delivery of anti-retroviral treatment, including staff education and training.

43. When the nurse took the man's pulse and blood pressure on 2 May, they showed that he had a pulse of 50 with a blood pressure of 92/60. The blood pressure readings are described by the Clinical Director as 'borderline low' and both the Clinical Reviewer and Clinical Director are of the opinion that this should have prompted further observations with a view to calling the emergency doctor. The Clinical Reviewer remarked in his clinical review that when the nurse did access the man's medical notes no comparative blood pressure readings were available as his blood pressure had not been recorded since his arrival at the prison.

44. In interview the Nurse was uncertain how she became aware that the man was prescribed Propranolol. Initially she thought she had consulted the man's medical notes to gain this information before she made her first visit to him at 11.45pm. Subsequently she is unsure whether she saw it on his medical record after she saw him, or whether he told her he received Propranolol. This is significant because low blood pressure readings with fast pulse readings are an indication of internal bleeding. The man's low blood pressure reading was not accompanied by a fast pulse, and it was actually quite slow, which is at variance with internal bleeding.

45. The Clinical Reviewer says that Propranolol could slow the heart rate and consequently mask a rapid heart rate that would be an indicator of further bleeding. The Clinical Director considers that the nurse should have

recognised the risk of further bleeding, given that she was presented with a patient with low blood pressure who had disclosed he was coughing up blood and who had recently been in hospital with oesophageal varices.

46. Rather than singling out an individual, the Clinical Reviewer is inclined to look at ways of changing the system under which nurses are expected to work when they are making autonomous decisions. He makes the point in his clinical review that there is no care plan system for complex clinical problems, and that one should be developed. There was no system for handing over care for patients who had these complex clinical needs between shifts or within various locations within the prison.

The healthcare manager should develop a system of care plans for complex medical cases, including a handover between clinical teams.

47. One area where the Clinical Reviewer was critical of the nurse was in her initial handling of the man's acute emergency at 2.10am on 3 May. Although the initial response was swift, and the ambulance arrived just seven minutes after the alarm was raised, the nurse apparently made no attempt to record any vital signs.

48. In her interview with the investigator on 12 September 2007, the nurse said she was accompanied by her nursing colleague, at the medical emergency timed at 2.10am. The nurse believes they tried to obtain vital signs from the man, but they were unable to get any due to his weakness. In any event, no record of this attempt was made.

49. In the investigators interview with the nurse of 22 January 2008, the nurse gave a description of the typical workload expected of a nurse working nights. It is clear from this description that nursing staff do not have access to clinical systems at the time of consultation, nor is it always easy to make written records of their interactions with patients soon afterwards. This is not acceptable. Managers should remind staff of the importance of making notes at the same time as patient consultations, and provide the necessary resources to enable this to happen.

The healthcare manager should develop a means of recording patient consultations in the clinical record in a timely manner.

RECOMMENDATIONS

1. The healthcare manager should develop a system to confirm a prisoner's medication on reception into the prison.

   The Prison Service accepted this recommendation in full and said:

   Clinical Director and Senior Medical Officer will devise a protocol of conditions that need next day reception telephone confirmation. A procedure will be piloted for non-clinicians (admin staff) to contact practices about clinical information. The pilot will be monitored, staff trained as required and pathway rolled out in April 2009.

2. The healthcare manager should review the needs of patients with Hepatitis C and liver disease. They should develop a clinical policy for chronic liver disease to improve the delivery of anti-retroviral treatment, including staff education and training.

   The Prison Service accepted this recommendation in full and said:

   HMP Leeds has been offering in-house Consultant-led Hepatitis C clinics and treatments since February 2008. HMP Leeds is involved in regional planning of services and are involved in the development of a national training package with the Royal College of General Practitioners (RCGP).

3. The healthcare manager should develop a system of care plans for complex medical cases, including a handover between clinical teams.

   The Prison Service accepted this recommendation in full and said:

   Everyone returning from a bedwatch with a chronic disease to have a care plan upon reception back into prison that is reviewed regularly with ongoing handover between nursing staff at the end of shifts. This is to be implemented by January 2009.

4. The healthcare manager should develop a means of recording patient consultations in the clinical record in a timely manner.

   The Prison Service accepted this recommendation in full and said:

   System One medical records system due to be implemented November 2008.