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

Report by the Prisons and Probation Ombudsman for England and Wales

August 2009

This is the report of an investigation into the death of a man, who died from a stomach haemorrhage in June 2007 in HMP Leeds.

I would like to offer my sincere personal condolences to the man's family.

This investigation was undertaken by my colleague. Both he and I would like to thank the Governor of HMP Leeds and his staff for their participation. A doctor was asked by the local Primary Care Trust to undertake a review of the man's clinical care, and I also appreciate his assistance.

My investigation was held up for some considerable time whilst the police carried out their own enquiries into the man's death. I know that this must have been very stressful for his family and friends, and I apologise for the delay that has resulted. I hope my report now answers any outstanding questions they may have.

As is the case in many of my investigations following a death from natural causes, I am necessarily highly influenced by the findings of the clinical review. In this report, the review identifies some concerns about care-planning and record-keeping for prisoners who are receiving medical care in HMP Leeds.

I make three recommendations to the Head of Healthcare, and I am pleased to note that all the recommendations have been accepted.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2009**

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SUMMARY

The man was received into HMP Leeds in June 2007. He was identified as a drug user and prescribed a standard daily dosage of methadone to aid his withdrawal. His community Drug Intervention Programme worker and his doctor were contacted to clarify the amount of methadone he would require. A reply was received from the community drug worker on 7 June, but this was not noted in his records until 11 June.

When the man went to collect his daily prescription on 9 June, the dispensing nurse was sufficiently concerned by his appearance to withhold the medication until he had seen a doctor. The doctor examined him and raised the dosage. He reassessed the man and he was feeling a little better. The doctor asked to see him again after lunch. This further assessment did not happen.

On the morning of 12 June, a prison officer was checking on his cellmate when she noticed that the man looked unwell. She had had first aid training, and asked him about how he felt. Still concerned, she approached healthcare staff who were dispensing medications on the wing and asked them to assess him.

The nurses could not break off from dispensing, so asked a nursing colleague to assess the man. She went to see him. She questioned him, then returned to the healthcare centre to collect some equipment. While there, she read his medical file, then returned to assess him. She decided that he needed to see a doctor, but that his condition was not so serious as to need immediate treatment. He asked her if he was well enough to attend a scheduled videolink hearing with court that afternoon, and she said that in her opinion he was not. She reported back to the nurses who had asked her to see the man, and said that he ought to see a doctor. She also said that one of the nurses should see him.

After they had finished their dispensing duties, one of the nurses went to see the man. She did not carry out an examination but questioned him. She said that she would arrange for him to see a doctor that afternoon. She returned to the healthcare centre and asked the nursing co-ordinator to arrange for a doctor to see him.

At lunchtime, the cellmate collected lunch for himself and for the man and brought it back to their cell. Before they could eat the man was sick, and the cellmate noticed blood. He said he needed to go to the toilet, and as he did so he collapsed. His cellmate supported him and rang the cell call bell for assistance. There may have been a short delay in responding. When staff arrived medical assistance was immediately available and they attempted to resuscitate the man. Sadly, they were unable to do so.

The cause of death was given as 1a) massive gastrointestinal tract haemorrhage due to b) bleeding duodenal ulcer.

THE INVESTIGATION PROCESS

1. My investigator visited the prison and spoke to staff who came into contact with the man during his imprisonment. He interviewed eight members of staff and one prisoner. These interviews were tape-recorded and transcripts are annexed to this report. (Copies of the transcripts were sent to interviewees for them to sign and confirm their accuracy, and three signed transcripts were returned.) Notices were also posted to staff and prisoners about the investigation, inviting contributions of any relevant information. None was received. In addition, my investigator studied all relevant prison records relating to the man. These include his main prison record, medical records and statements made by staff. My investigator visited HMP Leeds and saw the wing where the man was held, including his cell.

2. The Primary Care Trust (PCT) identified a doctor to carry out a review of the man's clinical care. I am grateful to him for undertaking the review.

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

4. One of my Family Liaison Officers contacted the man's family to offer them the opportunity to raise any questions or concerns for the investigation to consider. They were also offered the opportunity to see my report at draft and/or final stages. The family had some concerns at the length of time it took for the doctor to arrive at his cell. They were also unhappy at the way the news had been broken to them by three members of staff, and the lack of information available. A copy of my report will be made available to the family.

5. My investigator discussed aspects of the man's treatment both with staff at HMP Leeds and the clinical reviewer. Additionally, the PCT carried out a Sudden Untoward Incident (SUI) investigation. My investigator discussed the man's care with the SUI investigator and had access to the report.

6. The police conducted an investigation into the man's death. My investigator spoke to the officer in charge of the case and visited the relevant police station. He had access to the police papers and their final report.

HMP LEEDS

7. HMP Leeds is a category B local prison, built in 1847. It accepts all adult male prisoners from West Yorkshire. The prison has 680 cells as well as rooms and wards for 55 in the healthcare centre. It was expanded from four to six wings in 1994, and had an operational capacity of 1,004 as of January 2008.

8. There are six units comprising:

- A Wing (housing normal location and vulnerable prisoners and incorporating the segregation unit)
- B and C Wings (both housing normal location prisoners, although at the time of writing B wing is closed for refurbishment)
- D Wing Induction Unit (incorporating the First Night Centre and Safer Custody cells and Voluntary Drug Testing Unit (VTU), CARATs (Counselling, Assessment, Referral, Advice, Throughcare)/RAPt (Rehabilitation of Addicted Prisoners Trust) group work);
- E and F Wings are VTUs, and are used as a follow-on from the VTU Induction Unit and include further RAPt and CARATs group work.

Healthcare

9. There is 24 hour healthcare cover in Leeds. In daytime hours a doctor is in the prison, and there is nursing cover at all times. Nursing staff are not based in the healthcare centre, but are allocated to wings. Although they do work on other wings on occasions when staffing levels require it, they are usually based on their own wings.

Previous reports/recommendations

10. There have been 32 deaths at HMP Leeds – including that of the man who is the subject of this report – since I took over responsibility for investigating all deaths in prison custody in 2004. These were a mixture of self-inflicted deaths and natural causes, but a feature of a number of these cases is a problem with healthcare note-taking and record-keeping. Additionally, there are references in my reports to the overall management of complex clinical cases, including the need for care plans.

HM Chief Inspector of Prisons' Reports

11. HMP Leeds was last inspected by HM Chief Inspector of Prisons in an unannounced inspection in December 2007. The Inspectorate's subsequent report includes references to poor record-keeping in healthcare. The report also says:

> "Cell call bells were tested daily. We saw some staff responding promptly to bells, but a number were left unanswered for more than 10 minutes. Prisoners said they sometimes waited 20 minutes or more, and we saw staff muting emergency bells in the wing office. There was no system for managers to check that arrangements worked effectively."

12. The Inspectorate report includes a recommendation that, “Emergency cell call bells should be answered within five minutes and managers should check this regularly.”

Independent Monitoring Board report

13. All prisons in England and Wales have an Independent Monitoring Board (IMB), responsible for monitoring life in the prison and ensuring proper standards of care and decency. The last report produced by the IMB for HMP Leeds covers the year up to 31 January 2008, and does not contain any issues that need to be repeated here.

KEY FINDINGS

14. The man was arrested in June 2007 on suspicion of selling class A drugs. He arrived in HMP Leeds, went through the induction process and was allocated to D wing.

15. As part of the induction process, the man was given a reception health screening. He had a history of asthma and used an inhaler. He was underweight. The only other medical history related to his drug use. When earlier released from HMP Leeds in January 2007 he had had a daily prescription of 70mls of methadone. He reported that since then he had been taking 80mls of methadone per day, along with heroin and cocaine. He was prescribed a progressively-decreasing amount of methadone to assist with his withdrawal from heroin, starting at 30mls per day. A referral was made to the prison doctor, and faxes were sent to his community drug worker and his doctor to obtain confirmation of his prescribed medication.

16. The daily dosage of 30mls of methadone was administered to the man that day, and the following two days (Thursday 7 June and Friday 8 June). However, when he went to collect his methadone at 10.00am on Saturday 9 June, nursing staff were concerned that he looked unwell. They withheld his methadone and referred him to the doctor.. He saw the doctor at 11.35am. The man complained of dizziness, stomach and back pain. The doctor noted that he was pale, sweating, and that his blood pressure was low. He assessed that he was suffering withdrawal, increased the daily dosage of methadone from 30mls to 50mls, and asked to see him again within the hour. He was given his methadone and kept under observation. He saw the doctor again at 12.30pm and reported that he felt much better. His blood pressure had risen, and the doctor asked to see him again after lunch. No care plan appears to have been put in place in light of the man's contacts with healthcare on the morning of 9 June. There are no entries on the medical record to suggest that a care plan should be formulated, and there is nothing to suggest that he was reassessed by a doctor after lunch.

17. The daily dosage of 50mls of methadone was given to the man on 10 and 11 June. His medical record contains a note on 11 June that a fax had been received from his Drug Intervention Programme worker on 7 June confirming his methadone dosage as 80mls per day. He was referred to the Prison Service's drug treatment service (Counselling, Assessment, Referral, Advice and Throughcare, known as CARATs) and the substance misuse clinic.

18. On the evening of Monday 11 June, the man complained that he felt dizzy. An officer saw him in his cell, and was aware that his blood pressure had been noted as low. The man said he was okay and that he had just stood up too quickly. The officer advised him to sit down, and to take his time when getting up. No further incidents came to the attention of staff that evening.

19. At approximately 8.00am the following morning, a first aid officer was checking on the man's cellmate, who was subject to self-harm monitoring, through the cell's observation panel. Whilst doing this she noticed that the man looked unwell. She asked him if he was okay, and he said that he was not. The officer is a trained first aider and had previously been employed as a paramedic. She went into

the cell and questioned him as to how he felt and what symptoms he was experiencing. He was extremely pale and said that he had noticed blood in his faeces. The first aid officer was concerned that this might indicate internal bleeding.

20. At this time two nurses were distributing medications on the fourth floor landing of D wing. The first aid officer approached the nurses, explained her concerns, and asked for a member of healthcare staff to assess the man. Distributing medications involves approximately 150 prisoners, and takes some hours to do. Being unable to break off from distribution duties at that point, one of the nurses contacted a colleague and asked her to go and assess the man. The second officer made a note in the wing observation book that staff should monitor him.

21. The assessing nurse went to the man's cell at approximately 8.30am, initially without having previous sight of his medical records. She questioned him about the symptoms he was experiencing and examined him. She noted that he reported suffering no nausea, vomiting or diarrhoea. He had not eaten much, but he told her that his appetite was always poor. She then went back to the office to collect some more equipment. Whilst there she looked at the man's medical records.

22. The assessing nurse returned to the man's cell and on examination found that his blood pressure was low and his blood sugar level was considerably higher than normal. However, she noted that he had just eaten an orange, and wanted to ensure that sugar from the orange on his fingers was not affecting the reading. She washed his hands thoroughly and retested him, and the new reading was much lower. The man told the assessing nurse that he had recently blacked out on two separate occasions, one on the previous day and the other during the night. These are not noted on his medical records, and staff may not have been aware that this had happened.

23. As he was due to attend a videolink with court that afternoon, the man asked if he was well enough to do so. The assessing nurse told him that in her opinion he was not. He protested and said that he felt well enough and did not want to have to cancel. The assessing nurse told him that she could not stop him attending, but her opinion was that he was not well enough to attend.

24. The man said that he thought that his symptoms were due to the effects of withdrawing from drugs. The assessing nurse did not think this to be the case. She told my investigator that, had a doctor been on duty, she would have asked them to come and see him at that point. The duty doctor was not expected to be in the prison for another hour, however, and in the assessing nurse's opinion the man was not so ill as to require immediate treatment. She therefore went to report her conclusions to the two nurses dispensing medication. She said that the man ought to see a doctor, and she asked one of the dispensing nurses to go and see him. She did not at that time arrange for a doctor to see him. The assessing nurse then returned to her normal duties.

25. The dispensing nurse went to see the man in his cell at 10.00am. She did not examine him. He told her that he felt a little better, although he was still pale and lethargic. She told him that she would arrange for him to see the doctor that

afternoon. She returned to the healthcare centre. Nursing staff do not arrange for doctors to see prisoners themselves, so the dispensing nurse asked the nursing co-ordinator to make arrangements for a doctor to see him.

26. During the late morning, the man's cellmate was moved to another cell. Another prisoner moved in. The new cellmate had known him outside prison and noticed that he did not look well. He was lying on his bed, and the new cellmate told him to stay there while he tidied the cell.

27. Lunch was served on D wing, and by midday prisoners were all back in their cells. The man had not felt well enough to collect his meal, so his cellmate had collected a packed lunch for him with his own meal and brought them both back to the cell. When they were locked in the man asked his cellmate to pass him the bin, and when he did so he was sick into it. His cellmate noticed that there was blood in the vomit. He asked the man if he was alright, and he said he needed to use the toilet. He climbed off his bed but needed his cellmate's support to get to the toilet. As he lowered his clothing, he soiled himself.

28. By this point his cellmate was concerned about the man's wellbeing and rang the cell call bell. According to the cellmate's statement, after approximately five minutes a prison officer came to the observation panel and asked if the man had soiled himself. The cellmate confirmed that he had, but that he thought that he needed medical attention. The officer, who my investigator has not been able to identify, closed the observation panel and went away. The cellmate assumed he had gone to get some help. However, after a few more minutes no one else had come to the cell and the man had begun to shake as if having a fit. The cellmate was supporting him and rubbing his back. Becoming more concerned, he pressed the cell call bell again.

29. An officer was on duty on D wing at that time, carrying out the lunchtime roll call. He told my investigator that at 11.50am he looked through the cell observation panel and noted that the man was sitting on his bed. He continued with the roll call. At 12.02pm, the man and his cellmate's cell emergency light was activated. The wing officer responded to the call. In interview, the wing officer said that he did not respond to more than one call. He did not notice any other member of staff responding to any previous call from that cell. Cell call bell records are not kept so my investigator was unable to clarify exactly what happened.

30. The wing officer opened the observation panel and the cellmate told him that the man had soiled himself and collapsed on the toilet. The wing officer could only see the man's feet protruding from behind the modesty panel, and he asked the cellmate if he was conscious. The cellmate told him that he was not. The wing officer then called to the senior officer (SO), who was standing only a short distance away, and told him what was happening. The SO called for a first aid officer and put out an emergency Blue Call across the radio. (A Blue Call is code for an incident where a prisoner has stopped breathing.)

31. The first aid officer responded to the SO's call and entered the cell along with a colleague. They found the man on the toilet, slumped over and apparently unconscious. First aid officers usually carry Rescucaids on their belts. (Rescucaids

are plastic face shields with small tubes to be used for assisted breathing, sometimes referred to as mouth-to-mouth resuscitation.) On this occasion, however, the first aid officer was not wearing her belt, so she told her colleague to obtain one from the nearby wing office.

32. As the colleague left the cell, a third officer entered and with the first aid officer lifted the man onto the floor. The first aid officer started administering cardio-pulmonary resuscitation (CPR) by performing chest compressions while the third officer supported his head. The first aid officer told my investigator that in her opinion the man was already dead at this point, but that she nevertheless went ahead with attempts to revive him.

33. Within a minute of the Blue Call going out, another nurse reached the man's cell and took the third officer's place. The nurse said in interview that in her professional opinion the man was already dead at this point. His eyes were open and dilated, his mouth was open, there was no pulse, and he was not breathing. Nevertheless, she commenced assisted breathing while the first aid officer continued to perform chest compressions.

34. The assessing nurse arrived and the nurse who answered the blue call asked the first aid officer to stop CPR to allow the assessing nurse to take over. However, having started, the first aid officer wanted to carry on, so she continued to perform CPR. The nurse who answered the blue call and the first aid officer continued for 12 cycles (each comprising 30 compressions and two assisted breaths) before the assessing nurse eventually took the first aid officer's place. Other healthcare staff were also present, handling equipment. One of the dispensing nurses called the duty doctor and asked him to attend.

35. Both nurses continued to attempt to resuscitate the man until the duty doctor arrived at approximately 12.12pm. The duty doctor assessed the situation, and advised the nurses that attempts at resuscitation should not continue. He pronounced the man dead at 12:16pm.

36. The cell was sealed and staff attended a hot debrief. (Hot debriefs are held as soon as possible on the same day after a death in custody. They ensure that staff involved have an opportunity to discuss any issues arising.) The Care Team attended and staff were offered support if they felt they would benefit from it.

37. It is usual practice for the prisoner's family to be informed of a death in person. However, the man's father was due to visit his son that afternoon, and the Governor wanted to ensure that he was aware of what had happened before he arrived at the prison. The Governor therefore telephoned the man's family and informed them of his death. This was subsequently followed up with a visit from three members of staff.

Cause of death

38. The cause of death was given as 1a) massive gastrointestinal tract haemorrhage due to b) bleeding duodenal ulcer.

The PCT investigation

39. The Primary Care Trust (PCT) conducted a Serious Untoward Incident investigation into the man's death. The investigation found that:

- systems for following up and monitoring patients need to be improved
- acute clinical assessment of patients needs to be systematic
- clinical assessment of drug withdrawal needs to be systematic
- induction onto methadone needs to be based on systematic clinical assessment
- systems for recording and monitoring vital signs should be improved
- clinical facilities need to be improved
- prescription processes need to be reviewed to minimise the need for temporary prescribing
- the doctors' rota should be reviewed
- reception should be reviewed to ensure all prisoners are assessed on the first night
- links with CARATs services should be improved
- communication between discipline and medical staff should be improved
- training is required for clinical staff on the significance of blood pressure and pulse reading as an indicator of clinical condition in drug-users.

The Police investigation

40. The Police conducted an investigation into the man's death. My investigator was in frequent contact with the police throughout their investigation and, on its conclusion, visited the officer in charge. He was given access to police files and to their report.

41. As part of their investigation, the police sought expert medical opinion from a consultant physician at a London hospital. The consultant physician concluded that, even in the environment of a fully equipped Accident and Emergency Department, it is unlikely that the man's death would have been prevented. He also offered the opinion that there was no evidence that any staff involved acted negligently. The observations and descriptions recorded in the medical notes did not indicate an immediate crisis. The consultant physician does say that, in light of the nurse's assessment of the man, he should have had regular monitoring of his blood pressure and pulse, should have been in a medical environment with the option to administer intravenous fluids and CPR facilities, and should have been referred to a medical practitioner urgently. However, the haemorrhage he seems to have suffered would have made it likely that, even under those circumstances, his death would not have been preventable.

42. The consultant physician says in his report that prison staff took the proper course of action. The nursing assessment was appropriate and comprehensive. The likely haemorrhage was sudden. There was no evidence that medical staff were negligent. Even in the best case scenario, diagnostic treatment stemming from the first aid officer's observations would not have been sufficiently advanced at the time the man died to have prevented his haemorrhage.

ISSUES

43. There are some issues that should be addressed arising from the man's clinical care. The clinical reviewer says that the man would have been likely to have experienced severe withdrawal symptoms if dropping from his reported drug usage outside prison to a prescription of only 30mls of methadone per day. It is a standard approach in HMP Leeds to use a safe dose of methadone to aid withdrawal until a prisoner's true dose can be confirmed. However, a fax confirming his methadone dosage was received in the prison from his community drug worker on 7 June, but was not noted in the prison's computerised medical records until 11 June. Furthermore, his medication was not reviewed in light of this. If a care plan had been formulated, this might have been picked up more promptly. Had his withdrawal symptoms been better managed, it is possible that the symptoms of his bleeding ulcer might have been addressed differently.

44. The clinical reviewer identifies that there were a number of systems failures. A number of actions undertaken by healthcare staff were not recorded in the man's medical record, and this affected the flow of information between different members of staff. Care plans were not formulated, and he was not reviewed by a doctor on the afternoon of 9 June despite this being requested. The clinical reviewer comments that, while it cannot be gauged with any certainty, it is possible that immediate action taken on the morning of 12 June might have prevented the final outcome. However, he says that the response to the man's collapse at lunchtime on 12 June was prompt and appropriate.

45. The clinical reviewer recommends that systems and processes in healthcare relating to care plan development, clinical review and handover between teams require urgent redesign. I agree. The man was identified as a drug user on reception into prison and was rightly identified as having specific healthcare needs. However, the fact that he was a drug user seems to have meant that any healthcare issues were at least initially attributed to his withdrawing from drugs. This may have masked his underlying condition. Both the PCT investigation and the clinical review point to the need for training in relation to substance misuse. Furthermore, there was not a smooth flow of information between staff, and I draw the Head of Healthcare's attention to the recommendations in the PCT's investigation and the clinical review:

Recommendation: the Head of Healthcare should consider systems to ensure continuity of care.

Recommendation: the Head of Healthcare should ensure that where necessary care plans are put in place.

Recommendation: the Head of Healthcare should remind staff of the importance of proper record-keeping.

46. When uniformed staff attended the cell at lunchtime on 12 June 2007, a Resuscaid had to be collected from the wing office for use in attempts to resuscitate the man. In this instance, it is unlikely that it made any material difference to what happened. However, in another scenario, it might do. I do not make a formal

recommendation, but I ask the Governor to consider whether all staff who come into contact with prisoners and who have received CPR training should carry Resuscaids as standard.

47. The man's cellmate reported a delay in staff answering the cell call bell. The most recent report of HM Chief Inspector of Prisons also makes reference to delays in answering cell call bells. When my investigator asked, there were no records available of cell bell activation and answering times. He was also unable to identify an officer who answered the cell bell before the wing officer. I am not therefore able to confirm the cellmate's account, although I have no reason to disbelieve him. Nevertheless, I bring his comments to the Governor's attention and suggest that he reminds staff of the potential emergency nature of every cell bell activation.

48. The most sensitive way to inform a family of a death in custody is in person. However, in this case, the man was due a visit from his family on the afternoon that he died. In these circumstances, I think it was right that the Governor made contact with the man father by telephone so he was aware of what had happened before making his way to the prison. I note, though, that the man's family were less than happy with how the subsequent visit from prison staff went. They felt that three members of staff was too many, and that there was too little factual information available at that time.

CONCLUSION

49. The man was a young man with a history of drug use. When received into Leeds his drug use was identified, and he had continual contact with healthcare to aid his withdrawal. This is as it should be, and the regular contact with healthcare was well maintained. However, having been identified as a drug user, there seems to have been at least an initial assumption that any physical problems were a symptom of withdrawal.

50. There were failings in communication between staff. On 9 June, the man was referred to a doctor, and a request for a further consultation was overlooked. Records were not properly updated, including a delay in noting information from his community drug worker. When he was identified as possibly needing medical care on the morning of 12 June, there was a long chain of communication between medical staff being informed and the man being seen by a doctor. Sadly, the process was overtaken by events and before a doctor saw him he had died. The clinical reviewer says that it is impossible to know whether there might have been a different outcome had immediate action been taken that morning. I note the opinion of the consultant in the report given to the Police that the severity of the haemorrhage suffered by the man meant that, even had he been in a medical environment at the time, it is unlikely that his death would have been prevented.

RECOMMENDATIONS

The Head of Healthcare should consider systems to ensure continuity of care.

The Prison Service have accepted this recommendation. There are plans to develop a system of handover when shifts change, to be in place by October 2009.

The Head of Healthcare should ensure that where necessary care plans are put in place.

The Prison Service have accepted this recommendation. They comment that better identification through EWS (Early Warning System) will ensure that patients can be transferred to the observation ward for monitoring and ongoing management through a care plan.

The Head of Healthcare should remind staff of the importance of proper record-keeping.

The Prison Service have also accepted this recommendation. They comment that all healthcare staff have undertaken health record training. The prison is implementing a system for peer review of quality of clinical records