Investigation into the death of a man in February 2010 at Leeds General Infirmary, while in the custody of HMP Leeds

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of the investigation into the circumstances surrounding the death of a man. The man died of bleeding on the brain at Leeds General Infirmary. He had been remanded into the custody of HMP Leeds two days earlier. I offer my sincere condolences to his family.

The investigation was carried out by one of my investigators. I am grateful to the Governor, his predecessor, and the staff at Leeds for co-operating with the investigation. I offer particular thanks to the establishment investigation liaison officer.

NHS Leeds commissioned a clinical reviewer to review the clinical care provided to the man at Leeds. I am grateful for his contribution.

The man's death was apparently the result of a head injury, which occurred sometime in the days leading to his death. The exact nature and cause of the injury has not been conclusively determined. The man had visible injuries on his face when he was arrested by the police. On his arrival in prison, he gave varying accounts of how he came by his injuries, sometimes saying that they were the result of his contact with the police and sometimes the result of a fight with acquaintances. His death has been the subject of a criminal investigation by South Yorkshire Police and an inquiry by the Independent Police Complaints Commission. My own investigation could not begin until the police had completed theirs, which inevitably led to a delay in publishing this report. I apologise for any additional distress caused as a result.

The man admitted to very heavy alcohol consumption and required medical treatment to prevent him suffering dangerous withdrawal symptoms. On his arrival at the prison, he was prescribed the appropriate medication and admitted as an inpatient to the healthcare unit. However, on the evidence available, it appears that the man showed no other signs of ill health. Indeed, just hours before he was found unconscious in his cell, he went to an educational class in the inpatients unit.

The clinical reviewer and I conclude that the care he received at the prison was generally of a good standard. I make two recommendations to the Head of Healthcare. I have found no evidence to suggest that staff missed any signs that the man was seriously unwell or any earlier opportunities to intervene.

I am very grateful to the man's family, who considered the report at the draft stage. Some changes have been made in the light of their comments. In addition, this report reflects the National Offender Management Service (NOMS) response to the recommendations made.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman **June 2011**

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SUMMARY

1. The man visited his sister on 2 February 2010. She saw injuries on his face and body but he would not tell her exactly how he had come by them. She was concerned about him and, knowing that he was wanted by the police, told them where they could find him. He was arrested later that day.

2. The arresting police officers thought that the man was very drunk and also noticed his injuries. They decided to take him straight to hospital for checks and treatment. Hospital staff examined him and found no evidence to suggest that his head injuries were serious. They thought he was well enough to be held in police custody. During the night, police custody staff checked him regularly and he was also assessed by a nurse. The man refused to tell hospital staff, the police or the nurse what or who had caused his injuries.

3. At his court appearance on 3 February, the man was remanded into the custody of HMP Leeds. On his arrival, staff in reception noticed his injuries. The man told one member of staff that they had been caused by the police during his arrest.

4. The man was assessed by a nurse and told her that he was dependent on alcohol. She referred him to the doctor for further examination. The doctor decided that the man needed to undergo an alcohol detoxification programme and should be admitted as an inpatient to the prison's healthcare centre. In interview, the doctor said that he had checked the man's injuries, particularly those on his head. He said that he found no evidence to suggest that they were serious or needed further treatment.

5. While an inpatient, the man gave varying accounts of how his injuries had been caused. He told some people that they had been inflicted by the police and others that they were the result of a fight with acquaintances. He did not appear to be very worried about the injuries and made no formal complaint against the police, or anyone else, while in prison.

6. On 4 February, his first full day at the prison, the man continued his alcohol detoxification programme and settled into the regime on the inpatients unit. During the afternoon, he went to a lesson in the healthcare centre. He participated well and seemed to have no problems.

7. Shortly after 4.00pm that afternoon, the man complained of feeling dizzy as he walked back to his cell with his tea. An officer helped him to his cell and asked a nurse on duty to check him. The nurse checked him and concluded that he was probably feeling dizzy because he was still withdrawing from alcohol. The officer left the man's cell door open so that staff could keep an eye on him more easily.

8. At about 4.40pm, the officer heard loud snoring sounds coming from the man's cell. He went to check and found him lying on the floor. When he could not wake him, he called for the nurse to come and help. She used her radio to alert staff to a medical emergency. The emergency response nurse and the prison doctor arrived soon after. They examined the man and concluded that he was seriously unwell. An ambulance was called and the paramedics took the man to hospital.

9. Hospital staff carried out tests which revealed that the man had bleeding on his brain and that surgery was not an option. His family were with him when he died.

10. I make two recommendations as a result of this investigation. However, I think that neither would have changed the final outcome for the man. Overall, the clinical reviewer and I find that the man received a good standard of clinical care at Leeds. I have found no evidence to suggest that staff missed signs that his was deteriorating.

THE INVESTIGATION PROCESS

11. My office was informed of the death of the man and the investigation was allocated to one of my investigators later that day. She visited HMP Leeds to open the investigation on 11 February. She was shown around the prison and spoke informally to members of staff.

12. My investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to these notices.

13. The prison provided the investigator with relevant documentation covering the man's time in prison, including copies of his prison and medical records and staff incident statements written after his death.

14. South Yorkshire Police began investigating the circumstances of the man's death and so the Ombudsman's investigation was suspended until the criminal investigation ended. No one was charged in connection with the man's death. I am very grateful to South Yorkshire Police for sharing information with the investigator.

15. While in prison, the man told some people that his injuries had been caused by the police. As a result, the matter was referred to the Independent Police Complaints Commission (IPCC) who investigated the claims. They found no evidence that the man had been assaulted by the police either during his arrest or while in police custody or that he had received any further injuries while in their custody. I am very grateful to the IPCC for sharing the results of their investigation with my investigator.

16. The Ombudsman's investigation recommenced in August 2010. HM Coroner was contacted and informed of the nature and scope of the investigation and provided the investigator with a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist with his enquiries.

17. As my investigation was suspended for six months, much of the evidence considered came from the written information recorded by staff during the man's time at Leeds and information supplied by the police. In addition, my investigator carried out interviews with staff in November and December 2010. Another investigator interviewed one of the prison doctors on the investigator's behalf in late December. The Governor was given written feedback following the interviews.

18. NHS Leeds commissioned a clinical reviewer to undertake a review of the clinical care the man received while in prison. The clinical reviewer had access to relevant parts of the documentation provided by both the prison and the police and the transcripts of interviews carried out by the Ombudsman's investigators. The clinical review is attached as annex 1.

19. During the police investigation, another prisoner who had been living on the inpatients unit at the time of the man' death provided a statement. By the time the

Ombudsman's investigation began, he had been released from prison. The investigator wrote to his last known address asking if he would be prepared to contribute to the investigation. He did not reply.

20. One of my family liaison officers contacted the man's family to explain the purpose of my investigation and invite them to raise any questions or concerns to be considered. They asked why, when the man came to Leeds, he received treatment for his alcohol addiction but not for the physical injuries that were evident. I hope that my report provides them with more information about the events leading to his death.

HMP LEEDS

21. HMP Leeds is a category B local prison, holding just over 1,000 adult male prisoners from the West Yorkshire area. (Category B prisons hold those prisoners for whom the highest levels of security are not necessary but whose escape must be must be made very difficult.) It opened in 1847 and has undergone extensive expansion and refurbishment to improve the Victorian facilities.

22. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. For the past four published quarters, Leeds' performance has been judged "good" (with other possible assessments being exceptional, requiring development or serious concerns).

HM Chief Inspector of Prisons (HMCIP)

23. HMCIP last carried out an unannounced full follow-up inspection of Leeds in March 2010. The inspection report noted that the "close and effective" management of the prison had resulted in progress across all of the inspected areas. First night procedures were found to be good and staff-prisoner relationships had improved. Healthcare services had also improved.

24. The prison has a 20 bed inpatient unit, staffed by a mixture of prison officers and healthcare staff, who were found to work well as a team. The Inspectorate noted that inpatients had access to exercise and education.

Independent Monitoring Board (IMB)

25. Each prison in England and Wales is also monitored by an IMB, the members of which are volunteers from the local community. Board members have access to every part of the prison and each prisoner held there. The IMB must produce an annual report, with the latest available for Leeds covering 2010.

26. The Board highlighted the significant improvements made across the establishment. However they noted concern about overcrowding at the prison, writing that Leeds had been 100 percent full for most of the reporting year. The IMB recognised the impact this had on prisoners held there. The Board also highlighted that the inpatient facilities were "below standard", with cells in a dilapidated state. However, they reported that money has been set aside to refurbish about half of the cells in the near future.

Previous investigations

27. The Ombudsman began investigating all deaths in prison custody in 2004. Since then, 41 prisoners (including the man) have died at Leeds of a variety of causes. Three investigation reports issued in 2004 and 2005 recommended that improvements be made to the quality of record keeping in prisoners' medical records. A similar recommendation was made in a report of a death in 2007. Otherwise I find no other particular similarities between the circumstances of the man's death and those described in the Ombudsman's previous reports.

KEY EVENTS

28. The man was born and brought up in Leeds. As a young man, he worked as a roofer with two of his brothers. The man started drinking alcohol in his teens but drank more as he got older. His alcohol consumption played a large part in his life. The man began to use heroin and was addicted to it for a number of years. During this time he began to commit offences and had been in prison a number of times prior to February 2010.

29. In recent years, the man was unable to work because of his alcohol use. He had periods of homelessness but, before his death, had been living in a flat in Leeds with friends. Throughout his life, the man remained close to his twin sister, whom he saw regularly.

30. On 2 February 2010, the man visited his twin sister at her house in Leeds. She saw that he had injuries on his face and became concerned about him. When interviewed by the police following her brother's death, she described the injuries as a "golf ball sized swelling" on his left eyebrow, with an "inch long" cut above it. She said his left cheek looked yellow and there was dried blood on his lips. The man told her that he had been stabbed near his left hip and showed her the wound. Although he did not tell his sister and niece (who was also at the house that morning) exactly what had happened, they understood that one of his flatmates had assaulted him. The man's sister was very worried about his physical condition and wanted him to get medical treatment. She knew that the police were looking for him because he had not kept to the conditions of his bail and had breached a court order. Thinking that he might receive medical attention while in police custody, she telephoned the local police station and told them where they could find him.

31. As a result, the police arrested the man at 8.50pm on 2 February. The arresting officers noticed that he had injuries and bruises on his face and down his sides and back. He was very drunk and had to be carried to the police van. The police officers decided that he should be taken straight to Leeds General Infirmary (LGI) for examination and treatment.

32. At the hospital the man was first examined by a nurse, who checked his pulse and blood pressure. The man was asked about his numerous injuries but would not tell the police or nursing staff who or what had caused them.

33. At 12.05am on Wednesday 3 February, a hospital doctor examined the man. The doctor provided a statement to the police in which she said that he would not reveal how he had received his injuries. She said that she repeatedly asked him if he had any other injuries, which he denied. The doctor assessed the man, finding his blood pressure and pulse rate to be normal. She gave him a Glasgow Coma Scale score of 14 out of 15. (The Glasgow Coma Scale is a medical assessment which determines the seriousness of brain injuries. It is based on three measures: whether the patient can move their limbs when directed, whether they are able to verbally respond to directions and whether they are able to open their eyes. A score of eight or less indicates a severe brain injury, nine to 12 indicates a moderate brain injury and 13 or above indicates a minor injury or no injury.) The

man was confused (but was also still drunk) and he could move his body and eyes when instructed to.

34. The doctor noted that the man had a bruise on the outer edge of his left eye socket. She concluded that he was very drunk and had some minor injuries, but that there was no evidence of significant trauma. She prescribed antibiotics to treat the healing stab wound near his hip. The doctor did not think the man needed to be admitted to hospital as an inpatient but asked the police officers to watch him carefully and bring him back to hospital if they had any concerns.

35. The man and the police left for the police station at 12.50am. He was examined by a nurse in the custody suite at 4.40am. The man refused to let the nurse examine him fully and so she recorded the visible injuries. He was still drunk and told the nurse to leave him alone. The man was monitored regularly during the night. Officers on duty in the custody suite told the detectives investigating the man's death that he appeared aware of his surroundings at all times and, by the early hours of the morning, was easier to wake when they checked him.

36. G4S (the private company responsible for escorting individuals to and from court in the Yorkshire area) collected the man from the police station at 11.15am on 3 February. The police officers had completed a Person Escort Record (PER). (The PER provides details of the risks the escorted person might pose, including whether they might try to harm themselves or someone else and whether they have any health or substance misuse problems. It also serves as a record of their time in the custody of the escort service.) The PER recorded that the man had been violent to police officers in the past, had a problem with alcohol, was prone to suffering fits while withdrawing from alcohol and had injuries to his face and stomach. It also noted that he had seen the nurse while in police custody but made no mention of his visit to hospital.

37. At 12.45pm, the man appeared at Leeds Magistrates' Court, charged with breaching an Anti-Social Behaviour Order (a court order to control an individual's anti-social behaviour) and failing to answer bail. He was remanded into custody until 17 February, arriving at HMP Leeds at 3.00pm.

38. A Senior Officer (SO) was on duty in reception at Leeds that afternoon. In his statement to the police, he said that he checked the man's personal information (such as his date of birth and next of kin) and made sure that he understood what had happened in court. The SO said that, as part of the process, he asks each prisoner if they have any pressing medical issues. He noticed that the man had a black and swollen left eye and looked "generally dishevelled" and so he asked about the facial injuries. The man was coherent and polite and told the SO that he had been in a fight. The SO did not ask any further questions about the injuries he saw.

39. Following the police investigation, the SO was also interviewed by the Ombudsman's investigator. He told the investigator that he had been working as a senior officer in reception for about five years. He gave further information about the man' facial injuries, explaining that, while his left eye appeared most bruised, he thought that there had also been some minor bruising around the

man’s right eye. He described the man as “laughing and joking” with reception staff. The SO told the investigator that the man had not said who had caused the injuries and made no mention of them being inflicted by the police.

40. The investigator asked the SO whether staff make any record of prisoners’ injuries in reception. He explained that, if the injuries are particularly concerning, staff might log these in the prisoner’s file but that there is no formal system. The SO that, if a prisoner claims they have been injured by the police, staff should complete a Security Information Report (SIR) which records information relating to prisoners’ safety or prison security. On this occasion the SO did not make any special note of the man’s injuries nor complete an SIR because the injuries did not appear serious and the man did not mention police involvement. He knew that the man would be assessed by the nurse in any case.

41. The SO explained that all arriving prisoners undergo a full body search (during the search the prisoner must, in stages, remove all items of clothing). He said that the purpose of the search is to make sure that prisoners do not bring prohibited items into the prison with them (such as mobile telephones, weapons or drugs). However, he explained that, if the searching officers notice the prisoner had “serious” injuries, they usually inform the senior officer.

42. Officer A and another officer conducted the full body search of the man while he was in reception. Officer A provided a statement to the police in which he said that he noticed the man had a black left eye. During the search, the officer also noticed that the man had a bruise to his left side but did not remember seeing any other injuries. The officer said that he did not ask the man how he had received his injuries as this is not part of the role of a searching officer. Neither officer raised any concerns about the man’s injuries with the SO.

43. The man was then taken to the first night centre on D wing. At 5.30pm, a member of healthcare carried out the First Reception Healthscreen with the man. (The purpose of the assessment is to identify any immediate mental or physical health problems requiring referral to the doctor or other specialist service.) She also provided a statement to the police. She noticed that the man had bloodshot eyes, was sweating and was very shaky. However, he was polite and coherent. She also saw that his left eye was swollen and bruised. The man said that he had received the injury about a week before, when he was assaulted. He did not say that he had been assaulted by the police.

44. The man told the healthcare worker that he was dependent on alcohol and that his last drink had been at 8.00pm the previous day. She recorded that he drank about 420 units of alcohol every week (the recommended weekly intake for men is currently no more than 21 units). No information about his drug use was recorded. The man said that he had received hospital treatment for his eye injury. She referred him to prison Doctor.

45. Prison doctor A examined the man at about 7.00pm. He also provided a statement to the police. The doctor explained that he knew the man already as he had been a patient at his community practice. The man told him that he drank about nine litres of cider every day and that he had “the shakes”. The doctor said

that he noticed purple, recent looking bruises around both of the man's eyes. The doctor said that he did not ask him any questions about the facial injuries but heard him tell staff outside the consulting room that they had been inflicted by the police. The doctor directed that the man be placed on a seven day alcohol detoxification programme and prescribed chlordiazepoxide (used to treat alcohol withdrawal) accordingly.

46. In December 2010, Dr A was interviewed as part of the Ombudsman's investigation. (The doctor did not have access to the man' medical record at the time of the interview.) He told the investigator that, during the examination, the man said he had moved areas and was "living a different lifestyle" to when he had been the doctor's patient. The doctor described him as "laughing and joking".

47. The doctor said that he asked the man about his health. The man replied that he had been drinking alcohol excessively and had been "assaulted by the police" while in custody. The doctor said that, as a result, he asked the man whether he had been knocked unconscious, whether he felt dizzy and other "typical head injury" questions. He recalled that the man had denied feeling dizzy or having any problems with his vision. The doctor told the investigator that he had decided that the man should be admitted to the inpatients unit because of his injuries. The information contained in the man's medical record suggests that he was actually admitted because of his alcohol withdrawal symptoms (which can, if not monitored, prove fatal). The doctor's entry in the medical record makes no mention of the man's injuries or of him having asked questions to assess the severity of them.

48. The doctor said that, having decided the man needed to undergo a chlordiazepoxide detoxification, he gave the man his first dose (30 milligrams) straightaway. He explained that nursing staff in the inpatients unit are responsible for administering doses over the coming hours and days, according to the detoxification plan. The chlordiazepoxide detoxification plan is set out in a document. The guidance on the form states that medical staff should "prescribe with caution if history of head injury in last 24 hours – omit if patient is drowsy and consider urgent emergency department assessment".

49. Dr A was asked about this guidance in interview. He explained that if the man had appeared drowsy during the examination, he would have asked that he be taken to hospital. The doctor said that he assessed the man against the Glasgow Coma Scale and identified no problems. On the basis of his examination, he was satisfied that it was appropriate to prescribe chlordiazepoxide. The doctor's entry in the medical record makes no mention of the Glasgow Coma Scale score, nor of any consideration of the guidance on the detoxification form.

50. The man was admitted to the inpatients unit at about 8.30pm. A second member of healthcare staff was working in the unit that evening. He provided a statement to the police in which he said that he met the man on his arrival at the unit. The man was sweating slightly and his hands were shaking, however he was alert and conscious, could walk unaided and held a "rational conversation" with the second member of the healthcare. The second member of healthcare staff had read the man's medical record and knew he had an injury over his left eye. He noticed his

left eyebrow area was swollen and his eye was bloodshot. There were two three centimetre cuts on his eyebrow, which appeared to have healed. The member of staff said that he saw no other facial injuries but he also asked the man if he had any other injuries. The man told him that he did not.

51. The second member of healthcare staff asked the man what had caused the injury. The man told him that he had been “brawling with the coppers” and had resisted arrest. The second member of healthcare said that the man seemed “blasé” during the conversation.

52. The second member of healthcare staff showed the man to his cell and reminded him to drink plenty of water (which helps to combat the symptoms of alcohol withdrawal). He looked in on the man at 9.30pm and saw that he had gone to bed. He continued to monitor the man throughout the night. At 3.30am (on 4 February), he checked again and found him sitting in his chair watching television. The man said that he could not settle and they agreed that this was probably because he was withdrawing from alcohol. He gave him more hot water to enable him to make himself a hot drink, and told him he would be given another dose of chlordiazepoxide at 7.30am. On checking the man again at 6.15am, he found him asleep in his bed.

53. A prisoner was working as a cleaner on the healthcare wing in February 2010. He gave a statement to the police in which he explained that part of his responsibilities included giving clean clothes to inpatients each morning. He came to the man’s cell at about 9.00am on 4 February. The prisoner said that he noticed the man had a black and bruised eye and asked what had happened. The man told him he had “a rough and tumble with the police”. They did not discuss the injuries any further. As mentioned earlier, the prisoner has since been released from prison. The investigator wrote to him at his last known address asking him to participate in the Ombudsman’s investigation, but received no reply.

54. Shortly after 9.00am, the man and other inpatients were unlocked. The man approached a third healthcare officer (HCO) to ask where the showers were. The third HCO provided a statement to the police. He said that the man had “significant bruising” around his left eye. The man told the officer that he had been “roughed up” by the police before coming to prison and that his eye had been injured. He also showed the officer the healing stab wound, which he said was inflicted by a “drinking pal”. The officer described the man’s manner as “casual” and “blasé”.

55. Officer B was also working on the inpatients unit that morning. He noticed the man’ eye injury and struck up a conversation with him. In his police statement, the officer said that he asked the man directly how he had received the facial injury. The man replied “I took a good hiding in a flat in Beeston from some neighbours”. He then showed the officer the stab wound.

56. In December 2010, Officer B was interviewed by the Ombudsman’s investigator. He remembered that the man had approached him as he talked with a colleague. He said that “without any prompting”, the man began talking about his injuries, saying “I haven’t been beaten up by the police, I was beaten up at a flat by some

friends". Although a number of months had passed since the man's death, Officer B said that he could clearly remember the man saying that the injuries had not been inflicted by the police. The officer said that the injury around the man's left eye was most prominent but that he thought there might have been some bruising around his right eye too.

57. At about 1.45pm, the man attended a literacy and numeracy class on the healthcare wing. The teacher gave a statement to the police. She said that about nine prisoners attended the class, including the man. She noticed that his face was bruised and swollen, particularly around his eyes.

58. The teacher told the police that the man "took an active part" in the group discussions, engaging well with the other prisoners in the class. She described him as "alert, coherent and steady in his posture". He gave no indication that he was in any pain or struggling in any way. The lesson ended at about 3.30pm.

59. Officer B saw the man again at 4.10pm, as he walked down the unit landing towards his cell, carrying a plate of food. As the officer was showing him back to his cell, the man turned to him and said that he felt dizzy, perhaps because he had stood up too quickly. Officer B put the plate of food down on the floor and took the man by the shoulders, guiding him into his cell. The man became unsteady on his feet and so the officer supported him to the chair in his cell. Officer B thought the man might be experiencing the symptoms of alcohol detoxification. He told him not to move while he went and found a nurse to check him. The officer left the man's cell door open.

60. Nurse A, a mental health nurse, was responsible for delivering medication that afternoon. Officer B explained the situation to her and she went to see the man in his cell. The nurse was interviewed as part of the investigation and described her examination of the man, saying that she asked him if he had fallen over, which he denied. He also denied feeling dizzy or having a headache. He said that he had not been sick and that he was urinating as normal. The nurse said that she asked him to hold out both of his arms and when he did so she noticed that his hands were shaking slightly. The man asked when he would receive his next dose of chlordiazepoxide and the nurse said she would return shortly with the medication. She told him to drink plenty of water and he said he would try to eat some of his food.

61. As she was leaving his cell, Nurse A asked the man what had happened to his eye and he said the police had caused the injury. She said that he did not seem upset or angry about the injury. Her examination of the wounds and bruises suggested that they were healing well. In interview, she said that she had no reason to think he was particularly unwell. She described the man as fully coherent and able to converse normally with her.

62. Officer B returned to check the man at 4.25pm. He had left the cell door open so that staff could easily check the man or hear him if he shouted for help. The man was sitting on the edge of his bed and nodded when the officer asked if he was okay. In interview, Officer B said that he felt reassured that the man had recovered a little after his unsteadiness.

63. About 15 minutes later (4.40pm), Officer B heard loud snoring noises coming from the man' cell. Thinking the noise sounded unusual, the officer went to check him again and found him lying on the floor, with his head partially under the bed and his face obscured by the bed sheet. Officer B moved the sheet and tried to wake the man, who he thought was asleep. When he could not rouse him and the snoring continued he realised that the man was not well and shouted for Nurse A to help him.

64. Nurse A joined the officer in the man's cell. She saw that the man was lying on his back, with his arms straight by his sides. His lower arms and hands appeared to be contracting rhythmically and so she thought he might be having a seizure, perhaps due to alcohol withdrawal.

65. Officer B looked around the man's cell and saw a cluster of blood spots on the floor, near to the chair where the man had originally been sitting. Nurse A also saw the blood and so they agreed to move the man from under the bed so they could examine him properly. The nurse noticed that one of the healing cuts above the man's left eyebrow was now bleeding.

66. A third member of the HCO joined the two members of staff in the cell and helped to place the man in the recovery position (this is the safest position to place someone in when they are unconscious). The man was beginning to snore less but the staff were still not able to wake him. Nurse A used her radio to alert other staff to the emergency and Nurse B, the on duty emergency response nurse, arrived quickly after (there are no specific timings detailing when staff arrived at the man' cell).

67. Nurse B told the investigating police that she went to the man's cell as soon as she heard the radio message. When she arrived she saw his bruised and swollen left eye. She saw that his hands and face had turned slightly blue and realised that he was seriously unwell. Nurse B asked Nurse A to get the oxygen cylinder and mask and placed the mask on the man. The man's teeth were tightly clenched and so she could not check that his airway was clear. His arms and legs were twitching. The nurse took blood pressure and pulse readings and tested his pupils to see if they reacted to light. She described the reaction as "sluggish". She used the Glasgow Coma Scale and scored him five out of 15 (suggesting a serious brain injury).

68. The other staff present explained that the man was dependent on alcohol and so she thought he might have had an alcohol induced fit. She rubbed his sternum (the bone at the front of the chest) with her knuckles and saw his arms and legs tense (this is a simple check which can indicate whether the patient is unconscious). At this point, she concluded that he had some kind of problem with his brain.

69. Dr B, one of the prison doctors, received a telephone call asking him to go to the inpatients unit. When he arrived at the man's cell, he undertook his own checks and scored him four out of 15 on the Glasgow Coma Scale, indicating that he was "profoundly unconscious". He had raised blood pressure and there were signs

that he had had a seizure. Dr B instructed the third HCO to call for an emergency ambulance. (In interview, Nurse A said that either she or Nurse B had already requested one. The control room log records that the call was made at 4.59pm.) While waiting for the paramedics to arrive, the doctor wrote a letter to accompany the man to hospital outlining his findings.

70. Principal Officer (PO) A was on duty that day and arrived at the man's cell. He instructed Officer C and Officer D to prepare to accompany the man to hospital (also referred to as bedwatch).

71. The paramedics arrived at the cell at 5.15pm and took over the man's care. He was placed on a spinal board and transferred to the ambulance, where the paramedics continued to work on him. The PO agreed that the man should not be restrained by handcuffs while he remained very unwell. (When a prisoner leaves the prison for any reason, a risk assessment must be undertaken which helps to decide whether the prisoner should be restrained in any way whilst out of the prison.) The ambulance left the prison at 5.35pm and arrived at LGI's accident and emergency department ten minutes later.

72. Officer E arrived at the hospital at about 7.10pm to carry out bedwatch duties. In his statement to the police, Officer E said that Officer D told him that the man's injuries had been inflicted by the police before he arrived in prison. When the man's sister asked Officer E about her brother's injuries, he repeated what he had been told by Officer D.

73. Hospital staff carried out a computerised tomography (CT) scan (a special type of x-ray) of the man' brain. The scan showed that the man had blood on his brain (known as a haemorrhage). He was admitted to the Neuro Intensive Care unit. Staff there concluded that he had an inoperable and unsurvivable brain injury.

74. The man's condition deteriorated. At 9.20am, a doctor pronounced that he had died.

Contact with the man' family

75. At 5.30pm on 4 February, on the instruction of the then prison governor, a governor contacted the man's nominated next of kin, his sister. In his statement to the police, the governor explained that he spoke to the man's sister on the telephone and told her that the man had been taken to hospital and was very unwell. When the conversation ended, the governor asked one of the prison's trained family liaison officers, to go to LGI and meet the man's family.

76. The prison liaison officer remained at the hospital with the man's family until the early hours of the morning on 5 February. He returned at 8.15am and stayed with them until the man died. In line with Prison Service Order 2710, Follow up to deaths in custody, the prison offered financial assistance with the cost of the funeral. Three members of staff went to the man's funeral.

Support for staff and prisoners

77. Once the man had been taken to hospital, the duty governor asked the staff involved to make written accounts of what had happened. Staff involved said that they had been offered support. However, one officer said that he would have liked senior managers to have recognised the work the staff did and provide more reassurance.

78. Prisoners were informed of the man's death by way of a notice from the governor. Officer B said that prisoners on the inpatients unit were told by staff and offered support as necessary.

Post mortem report

79. A mortem examination was carried out at the request of HM Coroner. The cause of death was found to be a head injury, which had caused a bleed on the man's brain. The examiner was unable to definitively conclude whether the injury was the result of a fall or an assault. He was also unable to determine the exact time the man received the head injury, although he suggested it had most probably occurred within two days prior to his death. He concluded that the degree of "blunt force impact" to the head that caused the bleed "may not have been necessarily excessive".

ISSUES

The cause of the man’s facial injuries

80. When the man arrived at Leeds on 3 February, staff in reception saw that he had several facial injuries. In fact, his sister had been concerned about his physical condition when she saw him on 2 February. The police who arrested him later that day were also concerned and took him to hospital.

81. While in prison, the man gave different accounts of how he was injured. He told Dr A, the second member of the healthcare, and the third member of staff and Nurse A and a prisoner in the inpatients unit that the injuries had been caused by the police. Staff interviewed by the police and as part of this investigation said that the man seemed unconcerned and “blasé” when he said this. He suggested to some that he had been resisting arrest when the injuries occurred. Certainly, the man made no formal complaint against the police while in police custody or once he had arrived at the prison. The matter was referred to the IPCC, who carried out an independent investigation. They found no evidence to suggest that the injuries had been inflicted whilst the man was in police custody or through any contact with police staff.

82. The man told the SO, the first member of healthcare staff and Officer B that the injuries had been inflicted during a fight either with drinking associates or his flatmates prior to his arrest. As a result, South Yorkshire Police carried out an investigation but, ultimately, did not charge anyone in connection with the man’s death.

83. As outlined earlier, the post mortem report by the examiner concluded that the man’s death was caused by a head injury which led to bleeding on his brain. However, whether the injury was the result of an assault or a fall could not be established. Nor could the exact timing of the injury, although he suggested that it had probably occurred within two days prior to his death.

84. This investigation has found no evidence to suggest that the man suffered an assault while in the prison’s custody. There is no direct evidence to indicate that he accidentally banged his head either, certainly he did not mention having done so to staff. I appreciate that it must be very distressing and frustrating for the man’s family to be no closer to understanding how he came by the injuries that, ultimately, led to his death.

How staff assessed the man’s physical condition

85. Shortly after the police arrested the man, they took him to hospital so that his visible injuries could be checked. He was examined by a doctor who, having carried out assessments, decided that the man was well enough to be detained by the police and did not need hospitalisation. The man was very drunk when he was arrested and it took some time for the effects of the alcohol to wear off. The police custody records indicate that, at times, he was difficult to look after and, when a nurse tried to check him in the police cells, he refused. However, other than the effects of alcohol consumption and the onset of alcohol withdrawal, the

police and escort company recorded no specific concerns about his physical health.

86. Reception staff on duty when he arrived at Leeds saw that the man had some physical injuries. They also knew that he misused alcohol. Although the staff did not make any written record of the injuries, the man was photographed as part of the normal reception process. The photograph clearly shows his facial injuries. Those reception staff interviewed by the police and the Ombudsman's investigator described the man as coherent, steady on his feet and relatively light hearted.

87. The man was initially taken to the first night centre and at 5.30pm, was assessed by the first member of healthcare staff. It is not clear whether any records relating to his hospital treatment accompanied him to the prison. However, during her assessment, she identified that the man had alcohol misuse problems and physical injuries and that he needed to be examined by the doctor on duty. The clinical reviewer notes that the first member of healthcare staff apparently did not ask about, and certainly did not record any information about the man's use of drugs. Questions about substance use are part of the standard First Reception Healthscreen and should be asked of all new prisoners. However, in this case I am satisfied that the failure to record full details of the man's substance misuse history played no part in his death. On that basis I make no formal recommendation, but the Head of Healthcare may wish to assure herself that comprehensive reception screening is taking place.

88. Dr A examined the man later that evening. He made a note of the examination in the man's medical record. His written entry suggests that he largely focused on the man's use of alcohol and how to manage his alcohol withdrawal. The doctor placed the man on a chlordiazepoxide detoxification programme as a result. In interview, the doctor was asked about prescribing chlordiazepoxide to patients with head injuries. The doctor explained he would not have prescribed the drug if the man had seemed drowsy or if he had any concerns about his head injuries. This approach is in line with the guidance contained on the alcohol detoxification form. The doctor decided that the man should be admitted to healthcare as an inpatient.

89. The clinical care offered to the man at Leeds was reviewed by the clinical reviewer. He noted that the Dr A did not prescribe vitamin B or thiamine following his assessment. (Chronic alcohol misuse can cause deficiencies in vitamin B and so both vitamin B and thiamine should be prescribed to those on alcohol withdrawal programmes.)

The Head of Healthcare should remind clinicians placing prisoners on alcohol detoxification programmes to prescribe vitamin B and thiamine.

90. Dr A's entry in the medical record makes no mention of the man's injuries, his hospital treatment, the extent to which the doctor explored the nature and extent of the injuries, or of any care plan to treat or monitor them.

91. In interview with the Ombudsman's investigator, Dr A said that he had used the Glasgow Coma Scale to assess the severity of the injuries. The result of this test

is not recorded in the medical record. It is clearly important that any doctor assessing a prisoner carries out a full examination which identifies any immediate physical or mental health needs. While Dr A says that his examination of the man achieved this, I am concerned by his apparent failure to make comprehensive notes in the medical record. The entry provides no specific instructions for healthcare staff to monitor the man.

The Head of Healthcare should remind all healthcare staff (including clinicians) of the importance of making comprehensive entries, including the details of any care management plan, in the medical record following contact with a prisoner.

92. During their investigation, South Yorkshire Police took statements from all staff who had contact with the man while he was at Leeds. They provided copies of the statements to the Ombudsman's investigator. In addition, the Ombudsman's investigator undertook interviews with some members of staff. It is clear from the evidence gathered in both investigations that no staff had any concerns about the man until he complained of feeling unwell late in the afternoon on 4 February. In fact, the man held coherent conversations with a variety of staff and went to a lesson earlier that afternoon, when he participated well. I am satisfied that there were no obvious signs that the man' health was deteriorating or that there were any missed opportunities for medical treatment to be offered.

Staff response on the afternoon of 4 February

93. The man complained of feeling dizzy and appeared unsteady on his feet at about 4.10pm on 4 February. Officer B helped him to his cell and asked Nurse A to examine him. The nurse did so straightaway and was satisfied that the man was not seriously ill. The man, who was still able to talk articulately, said that he needed his dose of chlordiazepoxide. The nurse said that the man did not complain of any pain or appear unduly anxious.

94. Officer B decided that the man's cell door should be left wide open so that staff could see and hear the man if he needed any help. I consider this to have been a thoughtful and appropriate decision.

95. About 20 minutes after Nurse A left the cell, Officer B heard a strange snoring sound coming from the man's cell. On checking, he found the man lying on the cell floor, partly under the bed. When he could not wake him, the officer called for help from the nurse. The two staff quickly realised that the man was not at all well. The nurse used her radio to ask for emergency assistance from other healthcare staff. Shortly after Nurse B and Dr B arrived and carried out checks. Both used the Glasgow Coma Scale and realised that the man had a serious brain injury. An ambulance was requested about 20 minutes after the man was found collapsed, however, throughout that time he was under the care and supervision of several medical professionals. The clinical reviewer praises the emergency response in his clinical review and I agree.

96. One officer told the investigator that he would have liked more reassurance and recognition from managers. I am sure that this is something the Governor will want to give thought to.

CONCLUSION

97. The man, a serious alcohol misuser, was arrested by the police on 2 February. At the time of his arrest, the police noticed he had injuries on his face and was very drunk. As a result, they took him to hospital. Hospital staff checked him and decided he was fit to be held in police custody. He appeared in court the following day and was remanded to Leeds.

98. On his arrival at the prison on 3 February, the man was examined by a doctor who placed him on an alcohol detoxification programme and admitted him to the inpatients unit. Although the man showed some signs of alcohol withdrawal, staff thought that, otherwise, he seemed well. They said that he talked easily with them and engaged in jokes and light hearted conversations. On 4 February, having recently returned from a lesson in the healthcare department, he complained of feeling dizzy. He was assessed and no major concerns were raised. However, at about 4.35pm, staff found him collapsed and unconscious in his cell. Tests indicated that he was seriously unwell and an ambulance was called. The man died in hospital on 5 February as a result of bleeding on the brain.

99. While in prison, the man gave varying accounts of his injuries. He said to some that they had been inflicted by the police and to others that they had been the result of a fight with friends. As a result, his death has been the subject of an investigation by South Yorkshire Police, an independent investigation by the IPCC and my own investigation into his time at HMP Leeds. None has been able to determine the cause of the head injuries that lead to his death.

100. I make two recommendations as a result of this investigation. The first relates to prescribing supplements to prisoners undergoing an alcohol withdrawal. The second concerns recording information in the medical records. The clinical reviewer concludes that, generally, the care the man received was of a good standard. Both he and I find no evidence that staff missed earlier opportunities to offer clinical treatment that might have saved the man.

RECOMMENDATIONS

1. The Head of Healthcare should remind clinicians placing prisoners on alcohol detoxification programmes to prescribe vitamin B and thiamine.

This recommendation has been partially accepted by NOMS. They note that thiamine is prescribed as standard to patients undergoing alcohol detoxification, but vitamin B is not. They agree to review the substance misuse policy to include the appropriate prescribing of vitamin B.

2. The Head of Healthcare should remind all healthcare staff (including clinicians) of the importance of making comprehensive entries, including the details of any care management plan, in the medical record following contact with a prisoner.

NOMS accepted this recommendation.