

**Investigation into the circumstances surrounding
the death of a prisoner at HMP Leeds, in February 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

May 2009

This is the report of an investigation into the circumstances of the death from natural causes of a man on 9 February 2008 at St James' University Hospital, Leeds. The man, a prisoner at HMP Leeds, was 74 years old.

The man had lost touch with his family many years before his imprisonment. However, my colleagues and I would like to express our condolences to all those touched by his passing.

The investigation was led by my colleague. An independent review of the man's medical care in prison was commissioned from the Head of Strategic Development and Commissioning (Priority groups) at Leeds PCT, on 14 February 2008. A clinical reviewer was appointed to undertake the review and I received his report on 25 November. I am grateful for his assistance. I would also like to thank the management and staff at HMP Leeds for their co-operation during this investigation.

The man had been convicted in 2001 and sentenced to life imprisonment. Before he entered prison, his health had been seriously impaired by diabetes and related kidney failure. In custody, the man continued to receive regular National Health Service consultant supervision and review at hospitals in the West Yorkshire area, and was prescribed an extensive range of medications for his illnesses. His condition deteriorated rapidly on 4 February 2008 and he was admitted to St James' University Hospital. He died at the hospital five days later.

I conclude that the man received timely and appropriate medical care and support throughout his time in Leeds. His death could not have been prevented. However, I have made three recommendations. Two are about record keeping at Leeds. The other is directed nationally and concerns the recording of next of kin details.

The Prison Service responses to the recommendations I made in this report were received on 14 April for which I am grateful. Leeds NHS Primary Care Trust did not accept the first recommendation about the standard of clinical records at Leeds. I am pleased to see that HMP Leeds did accept the second recommendation about the recording of ACCT (Assessment, Care in Custody and Teamwork) documents. The third recommendation directed to the Prison Service was commented upon by HMP Leeds and a full response from the Prison Service is to follow at a later date.

I must apologise for the delay in issuing this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2009

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SUMMARY

The man was a prisoner at HMP Leeds, died on 9 February 2008 at St James' University Hospital, Leeds. He was 74 years old and had been suffering from diabetes and related ailments including renal failure. The man was serving a life sentence imposed in 2001 for manslaughter.

The man's health had been compromised by his diabetes and its complications before his imprisonment. His numerous healthcare needs and complex treatments were actively monitored by specialist clinics in the West Yorkshire area, an arrangement that continued after he was received into prison.

The man remained at Leeds except for a ten week period in 2002 when he was transferred to HMP Liverpool to undertake the first stage of his life sentence. During that period, the unsuitability of the transfer was brought to the notice of the Prison Service by a specialist doctor and the man returned to Leeds where he resumed his healthcare regime in the healthcare centre. The man remained there, making frequent visits to hospital clinics, until January 2006 when his health was considered to have stabilised sufficiently for him to be moved to a normal accommodation wing. However, his healthcare regime remained in place after this move. His condition deteriorated and in June 2007 he was re-admitted to the healthcare centre.

The night duty nurse on 3/4 February 2008 reported to day staff that the man was confused and unsteady. The prison's medical officer examined him and arranged a non-emergency admission to St James' University Hospital. A shortage of beds at the hospital delayed the man's admission for several hours.

During this time, nursing staff observed a further deterioration in the man's condition. After treatment with oxygen for low blood saturation levels, nursing staff again contacted the hospital and requested an emergency admission. The man arrived by emergency ambulance at hospital at 3.35pm and was later admitted to the ward. Soon after admission, ward staff asked the prison staff escorting the man for details of his next of kin. They were unable to give details immediately, but undertook to provide them the following day. The prison's family liaison officer found contact details for a sister living in Leeds and, on the evening of 5 February, told the man's brother-in-law that he was in hospital.

The man's condition deteriorated. On 8 February, hospital nursing staff warned prison staff that he was not responding to treatment and that if he suffered a respiratory or cardiac arrest he would not be resuscitated. The orderly officer at Leeds contacted the man's brother-in-law who said that his family did not wish to see him.

At 6.55am on 9 February, the man stopped breathing. The duty doctor confirmed that he had died at 7.00am. Hospital staff were unable to contact the man's family. Later in the morning, his brother-in-law was informed of his death and was able to provide contact information for another of the man's sisters and a brother living in the Irish Republic. Attempts were made to contact them but no responses were received.

A post mortem took place on 10 February which found that the man had died as a result of diabetic nephropathy, diabetes mellitus and hypertensive heart disease. An interim certificate of the fact of death and an order for his burial were later issued by the Coroner.

On 14 February, the prison's family liaison officer spoke to the man's brother-in-law who explained that he and his wife had had no contact with him for many years and felt they were unable to be involved. In a later telephone conversation on 18 February, the man's brother-in-law reiterated that his family were unable to be involved and advised that the prison should make the funeral arrangements. The man's funeral took place on 5 March and the prison met the cost.

The man's property was handed to his brother-in-law on 6 March. He expressed gratitude to staff for the care shown to the man. The family liaison officer offered further support to his wife (the man's sister) should she feel that it would help.

I have made three recommendations. They relate to record keeping at Leeds and the recording of next of kin details. The latter is a matter on which I have made similar recommendations in the past. It is directed to the Prison Service nationally with a view to establishing a clear process for maintaining up to date information.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Leeds on 26 February 2008. He was given a full briefing about the circumstances surrounding the man's death by the appointed liaison governor. My investigator offered to meet representatives of the staff associations and members of the Independent Monitoring Board (IMB) but the offer was not taken up.
2. Invitations were extended to staff and prisoners, inviting anyone who might have information relating to the man to make themselves known to the investigator. No prisoners took up the invitation. The investigator met relevant prison staff, principally members of the healthcare department. There was no police involvement in the investigation of the man's death.
3. One of my own family liaison officers wrote to the man's sister in Leeds on 10 March to explain about the investigation and inviting her to make contact. My family liaison officer later received a letter that the man's brother had sent to HMP Leeds enquiring about his death, and she wrote to him on 25 November 2008. The man's brother had raised the following questions in the letter:
 - How did his brother meet his death?
 - Did a priest speak to him prior to his death?
 - Where were his personal effects?
 - Did he make any last requests regarding his family?

My family liaison officer wrote to the man's sister again on 26 November. To date, no further contact has been made by family members.

4. Leeds provided copies of the man's prison and medical records. The Head of Strategic Development and Commissioning (Priority groups) at Leeds PCT, was commissioned to provide a clinical review on 14 February. A clinical reviewer was appointed to undertake the review which was received on 25 November.

HMP LEEDS

5. HMP Leeds is a category B local prison built in 1847. It accepts all adult male prisoners from West Yorkshire. At the time of the man's death it had an operational capacity of 1,004.
6. Healthcare at Leeds is provided by the Leeds Primary Care Trust. The head of prison health is also responsible for Wetherby and Wealstun prisons. Daily medical services are provided by the clinical director, and by a permanent and a sessional general practitioner (GP). Out of hours medical cover is provided by a local GP service.
7. The in-patient department is a purpose built unit. It has seven single rooms and two double rooms, two safer custody suites (used for vulnerable patients) and one single room with anti-damage furnishings all with integral sanitation. There is also a purpose built Listeners suite occupied by two prisoners employed as in-patient unit cleaners. (Listeners are trained by Samaritans to provide confidential emotional support to fellow prisoners in distress.)
8. During the day, the in-patient department is staffed by a minimum of one registered mental health nurse and four prison officers. The latter may be officers not trained in medical matters, or healthcare officers (HCOs). One nurse and a prison officer provide healthcare cover at night.
9. There were four deaths in custody at Leeds between 1 February 2007 and 31 January 2008, of which two were apparently self inflicted and two were from natural causes. This is a significant reduction on the 11 deaths in the previous year of which four were from natural causes and the remainder apparently self-inflicted. The prison's Independent Monitoring Board (IMB) notes in its 2007/08 report that there is a sensitive procedure in place for contacting relatives of deceased prisoners and allowing them to visit the prison if they wish. A governor, family liaison officer and the chaplaincy team are involved. Counselling is offered to prisoners or staff members affected by a death.
10. HM Chief Inspector of Prisons, Dame Anne Owers, conducted an unannounced full inspection of Leeds in December 2007. She made no recommendations that impact on this investigation.

KEY EVENTS LEADING UP TO 9 FEBRUARY 2008

11. The man was remanded into custody at HMP Leeds on 14 October 2000, having been charged with murder. The prisoner escort record (PER) covering his time at court notes that, prior to appearing in court and following a visit from his solicitor, he was placed on a 15 minute watch. A Group 4 Court Services document completed by the solicitor at 9.20am records that the man asked to be viewed as vulnerable and to be segregated from the normal prison population when he was received in prison. No reason for the request was recorded. The PER records completed later in the day show that the man appeared to be in shock.
12. A West Yorkshire Police prisoner risk assessment dated 13 October 2000 went with the man to HMP Leeds. It contained a note indicating that the man suffered from diabetes, high blood pressure and poor eyesight. It was also believed by a mental welfare officer that he was in the “early stages of dementia and may exhibit strange or odd behaviour”. The clinical review indicates that, on his arrival at Leeds, the man was suffering from diabetes mellitus, hypertension (high blood pressure), glaucoma (raised eye pressure), diabetic retinopathy (impairment of vision due to long term diabetes), diabetic renal nephropathy (diabetes related kidney disease) and gout. The man’s medical records contain no reception health assessment or evaluation in regard to his health. He was located in the healthcare centre (HCC).
13. On 18 October, the man went to court and the relevant PER records that he was on an open F2052SH (a document used to monitor and care for prisoners at risk of self-harm or suicide, now superseded by the Assessment, Care in Custody and Teamwork (ACCT) process). Several further PERs between December 2000 and February 2004 refer to closed F2052SH documents. These documents were not available to my investigator and neither the safer custody unit at Leeds, nor the Litigation Manager, were able to trace any record of the opening, processing or archiving of the documents.
14. The man went to Newton Lodge Regional Secure Unit on 12 February 2001 for a mental health assessment. He returned to Leeds on 2 May following an appearance at Leeds Crown Court that resulted in his remand in custody. The Judge recommended that he be located in the prison healthcare centre.
15. The man was convicted of manslaughter on 3 September and sentence to life imprisonment the following day, with a minimum period to serve of six years. He was designated as a category B prisoner and, while remaining at Leeds to await transfer, was allocated to HMP Manchester to undertake the first stage of his life sentence.
16. Just over a week later, on 13 September, the man went to Clayton Hospital Specialist Eye Centre in Wakefield for Argon laser treatment on his right eye as a result of his diabetic retinopathy. Follow up arrangements were made for further laser treatment but no date was fixed.
17. On 1 October, a doctor from Bradford Hospitals Trust, wrote to Leeds to advise them that the man had been his patient until August 2000. He warned that the man’s kidneys could fail and that he would need regular dialysis. The doctor added that the

man had advanced renal failure and needed regular reviews of his blood pressure and blood tests. The prison asked the doctor to identify the man's requirements so that staff could set up an appropriate care package.

18. Prison records show that in October HMP Manchester refused the man's proposed transfer because of his age and medical condition, and he remained at Leeds.
19. A consultant forensic psychiatrist with Bradford Forensic Service, assessed the man on 31 October. He then wrote to the medical officer at Leeds, to advise that the man was not suffering from a treatable mental disorder and that he would be more appropriately allocated to HMP Wakefield, rather than HMP Liverpool or Manchester, so that his numerous and complex medical problems could be handled more effectively. The consultant forensic psychiatrist also wrote that, although he thought the man was not mentally ill, from time to time he would benefit from seeing psychiatrists at Wakefield who had dealt with him at Newton Lodge Regional Secure Unit. A note dated 15 November from the medical officer was sent to the Observation, Categorisation and Allocation (OCA) department at Leeds requesting that, in the light of the consultant forensic psychiatrist's letter, the man be transferred to Wakefield and that the Wakefield senior medical officer (SMO), was happy to accept him.
20. On 4 December a consultant in renal medicine at the General Infirmary at Leeds (known as the LGI), wrote to the medical officer following a consultation with the man on 27 November. He gave a synopsis of his renal and diabetic diagnoses, his medication and the prognosis for the future. The consultant in renal medicine instructed that the man's blood pressure be tightly monitored and, if it went over a specific level, to increase the medication.
21. The consultant in renal medicine wrote to the medical officer again on 28 December asking for clarification of the man's management status having realised that the doctor from Bradford Hospital Trust had been involved with his treatment and not wishing to duplicate or complicate matters. He also queried whether the man was likely to remain at Leeds. The medical officer replied on 7 January 2002 that he believed the man would remain at Leeds because of his short tariff. He considered that the most useful way forward would be to continue treatment at the appropriate clinics within the LGI. The consultant in renal medicine saw the man again on 22 January 2002 and followed this up with a letter detailing medication and treatment required, as well as review periods. The consultant in renal medicine also asked that he and the medical officer discuss the implications of the man requiring dialysis whilst serving his sentence.
22. The man transferred to the Lifer Unit at HMP Liverpool on 17 July and was moved into normal accommodation in F wing a few days later. A note on 8 August described him as having settled well despite his impaired sight. The reporting officer commended his "admirable independence".
23. On 4 September a diabetes and endocrinology consultant at the Diabetes Centre at Walton Hospital, Liverpool, examined the man. The following day, he wrote to Leeds expressing his view that it was inappropriate for the man to have been transferred to Liverpool. He pointed out that the man had severe complications and complex

medical needs and was under an active established regime at Leeds. The consultant further considered that the man should be transferred back to Leeds immediately before his medical conditions deteriorated further.

24. On the same day, a Senior Officer (SO) at HMP Liverpool wrote a lengthy note indicating that the consultant was so worried about the man's health that he was considering contacting the man's solicitor about the situation. The SO contacted the HCC at Leeds about the man's medical condition, and was told that he was fit for normal location despite the fact that prior to his transfer he had been located in the HCC. The SO expressed the view in his note that Leeds had "conned" Liverpool into accepting the man. It was the SO's intention to arrange a suitable transfer out of Liverpool, and he contacted the Liverpool Lifer Unit to obtain information regarding the man's health.
25. While at Liverpool, the man remained positive but expressed worries to medical staff about his declining health. He was mainly concerned about his diabetes, high blood pressure and failing eyesight. On 27 September, the Prison Service gave approval for the man to be moved back to Leeds, on a temporary basis, until a more permanent location could be found for him. The transfer took place on 3 October. Escorted by a discipline and a healthcare officer, the man was taken by taxi rather than in a cellular vehicle. When he arrived back at Leeds, the man was immediately re-admitted to the Acute Assessment Unit (AAU) in the HCC and quickly resumed his routine of frequent medical appointments at the hospitals supervising the management of his medical conditions. By 2004, it was clear that the man's renal disease had reached its final phase and would require renal replacement therapy at some point.
26. During 2004 and 2005, there were several instances of the man behaving inappropriately towards female staff. This led to referrals by healthcare staff for assessment of his mental state, but there is no record of the outcome. He was also subject to disciplinary action.
27. On 15 March 2005, the man had a fistula operation (repositioning of a vein in the arm nearer the skin surface to allow access to it) on his right arm in preparation for treatment by renal dialysis at a later date. He continued to be seen regularly in the joint Renal-Diabetes Clinic at Leeds Teaching Hospitals Trust (LTHT). Leeds HCC supported the treatments and ensured that the man's complex medication regime was adhered to.
28. The man made a last will and testament, signed and dated 8 October 2005, which was witnessed by a healthcare officer. He expressed the wish that all his possessions be given to his sister in Leeds. He also said that his body should be buried.
29. As he lived independently in the HCC, the man was discharged on 4 January 2006 to a normal cell location on F wing. A care plan was agreed which included daily blood sugar monitoring and weekly monitoring of his weight and blood pressure. The regular supervision of the man's case by LTHT consultants remained in place.

30. Leeds referred the man to the Criminal Casework Team at the Immigration and Nationality Department (IND) (now the UK Border Agency) on 27 June to be considered for deportation at the end of his sentence. On 18 July, IND wrote to the man inviting him to put forward within ten days any grounds he might have for not being deported. No further information on this matter is available.
31. On 24 August, a doctor examined the man at the LGI Department of Renal Medicine, and reported to the medical officer at Leeds his diagnosis of approaching end stage renal failure, hypertension (high blood pressure) and hypercholesterolaemia (elevated blood cholesterol levels). He said that the man appeared well and his fistula was working and ready for use if and when needed.
32. A second doctor saw the man at the LGI on 12 September and wrote to the medical officer at Leeds confirming that he had type two diabetes mellitus, diabetic retinopathy, diabetic nephropathy, approaching end stage renal failure, hypertension and secondary hyperthyroidism (over active thyroid gland). He suggested a reduction of gliclazide to reduce the risk of significant hypoglycaemia (a diabetic reaction to the lack of sufficient glucose in the blood stream). A further review was scheduled at the clinic for six months time.
33. The man attended Clayton Hospital Specialist Eye Centre on 23 October. His ongoing diagnosis of diabetic retinopathy was reviewed and no new complaints were recorded. He was advised to continue with his current treatment and scheduled for a further review in six months time.
34. The Parole Board conducted a tariff expiry review on 18 December 2006. The Board concluded that the man should not be released or transferred to open conditions as no significant assessment and work on his offending behaviour had taken place because of the limitations placed upon him by his physical and mental health. They also expressed serious concerns about his mental health. A further formal review of his case was scheduled for January 2009.
35. Following an appointment at St James' Hospital on 5 February 2007, renal unit nursing staff contacted the HCC on 8 February and told them that the man's blood tests showed that he was anaemic. They prescribed appropriate medication (Aranesep 20mcgs) fortnightly. HCC staff briefed nursing staff on F wing and also explained the new medication procedure to the man. The Electronic Medical Information System (EMIS) record shows that the Aranesep was given again on 22 February.
36. The man returned to the LGI on 11 May for an appointment with a third doctor who reviewed his case. At the consultation, the man's blood tests revealed that his haemoglobin level was low, and he complained that he had not been given his Aranesep injections recently for his anaemia. LGI staff checked with Leeds who found that the medication had not been administered since 22 February. The oversight was attributed to confusion over when the drug should be administered. A further appointment was made for a month later. The EMIS record shows that the man received his next injection on 27 May and HCC staff continued to monitor him.

37. On 7 June, the man reported to a prison officer that he had taken an overdose of 24 50mg tramadol tablets and 12 paracetamol tablets during the previous night. The prison officer reported the matter to a prison nurse who recorded in the EMIS notes that the man said that he was feeling dizzy and had vomited at 8.00am. The prison nurse contacted the local poisons unit who told her that the first six hours after the overdose was the observation period and, because the overdose had been taken eight hours earlier, no further action was necessary. The prison nurse referred the man to the mental health nurse. She also recorded that all in-possession medication was removed from the man's cell. Later the same day, he was admitted to AAU for a period of observation.
38. An EMIS note indicates that an ACCT document was opened following the man's overdose, and a review was carried out prior to him leaving F wing for admission to the AAU ward. This ACCT document could not be found in the prison. The man said he felt much better since finding out that he was to return to the AAU, and that he was not at risk of further self-harm. The man's care plan remained relevant and was ongoing. His weekly reviews show that he was settled and living independently although, on occasions, he appeared weak.
39. The man attended an appointment at the renal clinic on 15 June. He was well and reported that he had been receiving his Aranesep injections regularly. No adjustments to his treatments were needed. He received a further appointment for 20 July which he attended and again there were no marked changes to his condition. He was given another appointment for 5 October. His clinical condition was monitored throughout by the HCC. On 18 August, owing to the closure of the ward for refurbishment, the man was moved to a single cell. He was recorded as being settled in the healthcare centre and remained independent and self-caring.
40. During October, the man attended appointments at eye and renal clinics. His treatment remained unchanged and he was given dates for follow up appointments between January and April 2008 at Clayton Specialist Eye Centre and St James' Hospital. A note on the man's EMIS record observes that his current care plan and diabetic regime continued. He also complained that his hearing and eyesight were deteriorating.
41. A series of blood tests were carried out on 24 December 2007 by St James' Hospital biochemistry department. The tests showed that the man's urea and creatinine levels were raised, an indication of end stage renal failure. The results were also sent to the Low Clearance Clinic in readiness for the man's 11 January appointment. The man was seen at the clinic by the third doctor who confirmed a few days later that the man had no new complaints. He was suffering from mild to moderate oedema (water retention in the tissues) in both legs and, if it persisted, his bumetanide should be increased to combat it. The third doctor had concerns about the fistula in the man's right arm and requested that it be examined with ultrasound equipment. His next review appointment was arranged for two months later on 14 March 2008.
42. On 23 January 2008, following a complaint by the man of pain in his left foot, a prison doctor diagnosed an abscess and cellulitis of the foot and lower leg. Flucloxacillin 250mg and penicillin 250mg (antibiotics) were prescribed to be taken

four times daily for seven days. He was monitored regularly and reviewed by the podiatrist (foot specialist). A nursing plan was completed, and by 30 January the infection appeared to be improving.

43. Two doctors reviewed the man on 1 February during the weekly in-patients ward round. He complained that his antibiotics did not agree with him. He said he felt nauseous, with occasional vomiting, which felt like indigestion and for which he had taken Milk of Magnesia. The second prison doctor thought that the complaint was possibly related to uraemia (accumulation of urea in the blood) and might be further raised by increased bumetanide. The first prison doctor therefore reduced the dosage of bumetanide and prescribed prochlorperazine, an anti emetic (anti sickness) medication.
44. On Sunday 3 February, the man remained in bed but allowed the second nurse to change the dressing on his foot and perform other nursing tasks. At interview with my investigator, the nurse said that the man appeared to be becoming more frail and a little confused. On the same day, the night duty nurse recorded in a weekly EMIS update that during the previous week the man had felt generally unwell and suffered intermittent nausea. She later noticed that he seemed confused when she went to administer his night time medication, and was not as alert as normal. He was also unsteady. The night duty nurse had concerns about his wellbeing and noted that she would raise them with the day staff when they arrived. She placed the man on the list to see the doctor as soon as possible.
45. On the morning of Monday 4 February, the second nurse came on duty at 7.30am and took the handover report from the night duty nurse. Part of that report was her concern about the man's general health. Soon after 7.30am, the prison doctor was in the in-patients ward and the night duty nurse's concerns were drawn to his attention. The man was seen by the prison doctor who noted that he had a temperature of 38 degrees, was confused, and was clearly unwell but the cause was not known. The prison doctor contacted St James' Hospital to request a non-emergency admission to which the hospital agreed. The hospital estimated that the man could be admitted within four hours and arranged for an ambulance to collect him.
46. Owing to a shortage of beds at the hospital, the man had not been admitted by midday. The second nurse telephoned the hospital to check when he was likely to be admitted and was told that, as the Accident and Emergency Department (A&E) was busy, it could be another one or two hours.
47. A third nurse then completed the lunchtime medication round and reported her concern that the man did not look well. She then went to his cell with the second nurse. They helped the man to sit up and gave him his medication and a drink. They recorded his physical observations. His blood pressure was normal and his heart rate was raised a little. His oxygen saturation level (commonly known as sats) was 64 per cent (90 per cent+ is the normal range.) The nurses then administered oxygen to the man from a cylinder via a face mask and continued to monitor him. The second nurse was worried that his sats could not be maintained at a normal level and his condition was deteriorating. She again contacted St James' Hospital and was told that the ambulance was on its way. She asked the hospital to upgrade

the man's case to an emergency admission which they did. She then informed the Security Department that the man was now an emergency hospital admission and that an ambulance would arrive to collect him. The second and third nurses and a healthcare officer prepared the man for his discharge to hospital. The prison doctor wrote a letter to accompany the man to the medical admissions department outlining his recent medical history and treatment. At 3.20pm, emergency ambulance service paramedics arrived at Leeds and took the man to hospital. The man's sats were 98 per cent at the time he left Leeds and his other observations were normal. However, the second nurse also observed that he was less responsive and quite confused.

48. The man was escorted by two prison officers. One of them was handcuffed to him and they took care to ensure that only the man's left wrist was used as he had the fistula in his right arm. The ambulance arrived at St James' Accident & Emergency at 3.35pm and, after assessment, the man was admitted at 7.10pm to a ward. At 9.00pm, hospital nursing staff asked the escort staff for details of the man's next of kin. The Senior Officer (SO), who was in charge of the bedwatch escort, requested the information from the prison control room. As the information had not been recorded on the man's computerised prison record, staff were unable to provide it but arranged for the information to be obtained the following day. The man underwent treatment on a dialysis machine and was taken off it an hour later at 10.30pm.
49. At 8.45am on 5 February, an officer recorded in the Bedwatch Occurrence Log that the man was not responding to other people. At 11.30am the same morning, he recorded that the doctor thought the man might have suffered a stroke and had arranged a computerised tomography (CT) scan which took place at 12.15pm. The man's responses remained poor.
50. Following the removal of the handcuffs for the CT scan, the escorting officer at that time, contacted Leeds at 2.00pm for permission to remove the handcuffs permanently. At 2.30pm, a Principal Officer (PO) paid a routine management visit to the man and noted in the log that he had developed blood poisoning due to kidney failure. He spoke to a Governor also requesting approval for the removal of the handcuffs and the provision of next of kin details. Later in the afternoon at 5.15pm, the man underwent a lumbar puncture (a procedure where spinal fluid is obtained for diagnostic purposes).
51. At 5.30pm, following a risk assessment by the prison, the Governor gave authority for the escorting officer to remove the man's handcuffs. She also told him that next of kin details could not be found and that police assistance had been sought.
52. The healthcare officer was also the man's personal officer and one of the prison's family liaison officers. The healthcare officer searched his cell in an attempt to find any contact details for his family. He found the details of one of the man's sisters who lived in Leeds, but he was unable to make contact with her as she was out of the country until 7 February. The man's nephew, his sister's son, was contacted during the evening of 5 February and told that his uncle was in hospital. He said that he would telephone the hospital for an update and contact his mother the following day. The healthcare officer telephoned the escorting officers at 9.30pm to inform them that the man's family was now aware of his situation.

53. The man's condition deteriorated and he remained unresponsive. At 7.00am on 8 February, he was taken to the intensive care unit (ICU), and at 9.15am nursing staff warned the escorting staff that the man could go into respiratory arrest. The officer relayed the information to the prison control room. Staff told him that the Orderly Officer had contacted the man's brother in law, his sister's husband, who felt that his family was unable to help. He did however provide information that there were other family members living in the Irish Republic.
54. Hospital staff told the second nurse that, because the man was no longer responding to treatment, he would not be resuscitated should he go into respiratory or cardiac arrest. The man was moved back to a ward from ICU at 11.00am. Nursing staff briefed the oncoming escorting staff about the serious nature of the man's condition and the likely outcome. At 7.55pm, the liaison governor gave the man's sister's telephone number to one of the escort staff.
55. The man stopped breathing at 6.55am on 9 February, shortly after the on-coming escort staff, changed shift. A doctor confirmed that the man had died at 7.00am and provided a Notice of Death. Escort staff were told by hospital nursing staff at 7.30am that they had been unable to contact the man's next of kin.

After the man's death

56. Immediately after the man's death, the Leeds death in custody contingency plan was activated. The process was modified because the man's death was the result of a long term serious illness, was not unexpected, and happened in an outside hospital.
57. Later that morning, the man's brother-in-law was informed of his death and was able to provide contact information for another of the man's sisters and a brother living in Ireland. Although attempts were made to contact them, no responses were received.
58. A post mortem took place on 10 February at Pinderfields Hospital, Wakefield. This found that the man had died as a result of diabetic nephropathy, diabetes mellitus and hypertensive heart disease. An interim certificate of the fact of death was issued by the Coroner to that effect.
59. On 14 February, a family liaison officer at Leeds, spoke to the man's brother-in-law. He explained that he and his wife had had no contact with her brother for almost 40 years. They felt unable to be involved and did not want his property. However, in a later telephone conversation on 18 February, the man's brother-in-law agreed to accept the property. On behalf of Leeds prison, the healthcare officer offered help with the funeral expenses. The man's brother-in-law reiterated that the family had no wish to be involved and advised the healthcare officer to make the funeral arrangements.
60. On 20 February 2008, seven days after the man's death, the Coroner opened an inquest and made an order under the Coroners' Rules 1984 authorising burial only. The man's funeral took place on 5 March at New Wortley cemetery. HMP Leeds sent a floral tribute. No family members were present.

61. In line with the wishes expressed in the man's will, the healthcare officer handed his property to his brother-in-law at a meeting on 6 March. His brother-in-law expressed gratitude to Leeds staff for the care shown to the man. The family asked Leeds to donate his clothing to charity and his radio to the prison chaplaincy. The healthcare officer offered further support to the man's sister but no further contact was made by the man's sister or other members of the family.

62. One of my family liaison officers made several unsuccessful attempts to contact the man's sister in Leeds by telephone and letter. On 5 May 2008, his brother in Ireland requested information about his brother's death such as the whereabouts of his personal effects, whether a priest spoke to him prior to his death, and if he made any last requests regarding his family. My investigator became aware of the letter in November 2008, but enquiries have been unable to establish whether the prison responded to the letter. My family liaison officer made unsuccessful attempts to contact the man's brother using the telephone and postal contact details in his letter. She wrote explaining how my investigation would develop, and asking him to contact her if he wanted to receive a copy of the draft report. She also wrote again to the man's sister in Leeds. To date no responses have been received.

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical care

63. On reception into Leeds on 14 October 2000, the man's health was seriously affected by diabetes. Its complications affected his sight and he suffered from kidney disease. He was also believed by a mental welfare officer to be in the early stages of dementia.
64. The clinical review was based on the man's prison medical record. It included an assessment of the care provided for the man throughout his sentence, focussing on that provided by staff at Leeds after his reception there until his death on 9 February 2008. The clinical reviewer concludes that:

"The man had a complex medical history and was at high risk of a number of life threatening complications (including infections). During his stay at HMP Leeds his illnesses were managed well by Prison Healthcare. Detailed clinical notes and nursing care plans were kept throughout his stay at HMP Leeds.

"The man was under appropriate NHS Consultant care and review for his complications related to Diabetes.

"It is not possible from the notes to say what caused his final illness however he was promptly reviewed and admitted to hospital where his condition deteriorated and did not respond to treatment for an underlying infection."

65. During his time at Leeds, the man's treatment was managed by the specialist doctors who had overseen him prior to his imprisonment. Alterations made to the man's medical regime by hospital doctors were addressed promptly by Leeds and anomalies resolved. Attempts were also made to normalise the social aspects of his life in prison. The man was treated with compassion and understanding, and I judge that the care given to him was appropriate for his conditions and was of a good standard.
66. The clinical reviewer judges that detailed clinical notes and nursing care plans were kept throughout the man's time at Leeds. I am bound to say that the medical notes to which my investigator had access were incomplete. In particular, there is an absence of detail available regarding mental health issues and assessment outcomes. These matters were relevant from the very beginning of the man's time in prison custody.

I recommend the PCT should review the standard of clinical records, particularly those relating to long term prisoners, ensuring completeness and that records are logical, legible and easy to follow.

Family issues

67. No concerns were raised by the man's family directly with either my family liaison officer or investigator. However, in a letter to HMP Leeds dated 5 May 2008, the

man's brother raised several questions:

- How did his brother meet his death?
- Did a priest speak to him prior to his death?
- The whereabouts of his personal effects?
- Did he make any last requests regarding his family?

68. I hope that this report details the events and circumstances that led up to the man's death. So far as I am aware, he did not speak to a priest during his time at the hospital, nor did a priest visit him. Indeed, the man did not respond at all to those around him. The man's personal effects were dealt with in accordance with a will he made in October 2005. He made no other requests beyond that.

Allocation to HMP Liverpool

69. Following reception at Leeds and sentencing in September 2001, the man was allocated to HMP Manchester to undertake the first stage of his life sentence. Manchester refused to accept him and he was subsequently allocated to HMP Liverpool.

70. The consultant forensic psychiatrist, a consultant forensic psychiatrist, assessed the man on 31 October. He then wrote to the medical officer at Leeds, arguing that because of the man's complex medical and mental problems, which were well known to doctors locally, he should be allocated to HMP Wakefield. The medical officer sent a note to the Observation, Categorisation and Allocation Department asking that the man be transferred to Wakefield, where the senior medical officer was happy to accept him.

71. On 4 December 2001, the consultant in renal medicine wrote to the medical officer giving a synopsis of the man's diagnoses and medication. He also identified the expected progression of his condition and specified the monitoring required. The consultant in renal medicine wrote again on 28 December asking whether the man was likely to remain at Leeds. The medical officer replied on 7 January 2002 that he believed the man would remain at Leeds, and agreed that the way forward was for him to be treated at the local hospitals.

72. On 17 July 2002, the man transferred to HMP Liverpool. The diabetes and endocrinology consultant at the Walton Hospital, saw him on 4 September. Following that consultation, the consultant wrote a strongly worded letter to Leeds expressing his view that it was totally inappropriate for the man to have been transferred to Liverpool. His opinion was that he should be transferred back to Leeds immediately to resume his care regime before his medical condition deteriorated. Following the consultant's recommendation, the man returned to HMP Leeds on 3 October. Back at Leeds, he was re-admitted to the HCC and resumed his frequent medical appointments at local hospitals.

73. The man did not suffer unduly because of the transfer to Liverpool, although he did express concerns to the medical staff there about his deteriorating health. However, it was perverse that within a few months he should have been sent to a prison well away from his established medical support, against the background of his long term

medical history, underpinned by the opinion of the doctors actively managing his case in Leeds that he should to remain in the area. No comprehensive supporting documentation is available to explain the decision to transfer the man to Liverpool. The available notes from Liverpool indicate that the level of the man's condition and the care required was not well understood by staff there before his reception.

74. It is very regrettable that an elderly man with serious medical and mental health problems was transferred away from his established care, without a similar regime being prepared to receive him in advance of that transfer. I am conscious that a great deal of time has elapsed since this happened, and therefore make no formal recommendation. However, the governor and PCT might wish to review the protocol on transfers to other prisons to ensure that due weight is given to professional medical and mental health opinion.

Self harm/suicide documents

75. The man's Prison Escort Record (PER) shows that on 14 October 2000, following a visit to him at court, his solicitor completed a Group 4 Court Services document requesting that the man be segregated from the normal prison population. He was located in the prison healthcare centre on arrival.
76. On 18 October, the man's PER records that he was subject to an open F2052SH. A PER dated 5 September 2001 notes that the F2052SH document was now closed. Several subsequent PERs refer to closed F2052SH documents.
77. On 7 June 2007, while living on F wing, the man reported that during the night he had taken an overdose of drugs held in possession. A reference in the EMIS record indicates that an ACCT document was opened and he was admitted to the healthcare centre.
78. No record of the F2052SH or the later ACCT document, other than references noted in the PER or on EMIS, are evident in the man's prison record. Enquiries of the safer custody unit at Leeds made by my investigator and the Leeds Litigation Manager have established that no self-harm documents referring to the man were recorded as being opened or subsequently archived after the documents were closed.
79. The existence or otherwise of F2052SH or ACCT documents relating to the man has, in this instance, no bearing on his later death from natural causes. Evidence of these documents exists, but they are neither registered nor available. This points to a shortcoming at Leeds in the recording and archiving of these documents in this particular case. Although once again a significant amount of time has elapsed, the loss of such documents could have potentially serious consequences so I feel bound to make a formal recommendation.

I recommend that the Governor reviews the current ACCT arrangements to ensure that all instances of the use of ACCT documents are recorded and, when the documents are closed, they are properly archived.

Hospital admission

80. Overnight on 3/4 February 2008 in Leeds HCC, the man's health gave cause for concern. He was seen by the prison doctor at around 7.30am who arranged for a non-emergency admission to St James' Hospital. An ambulance was arranged to collect him and the hospital estimated that he could be admitted within four hours. At midday, the man had yet to be admitted to hospital and nursing staff were told that the delay could be another one or two hours. The man's condition deteriorated further and, when they were unable to halt his decline, nursing staff upgraded the hospital admission to emergency status. An emergency ambulance collected the man from HMP Leeds at 3.20pm and arrived at St James' Hospital at 3.35pm. He was assessed and admitted to a ward at 7.10pm.
81. The man's condition and its likely progression was well known to medical staff at Leeds. The deterioration that led to him being admitted to hospital on 4 February was rapid. Medical staff reacted promptly to the circumstances as they unfolded, recognising as they did the need for an emergency admission to hospital. The original delay in the man's admission to hospital was outside the control of prison staff.

The use of restraints

82. The rapid deterioration in the man's health precluded any consideration of release on compassionate grounds or on temporary licence. He was therefore escorted to hospital by two prison officers, one of whom was handcuffed to him as instructed in the prison escort risk assessment. Proper care was taken to ensure that the escorting officers used the man's left wrist for the handcuff as his right arm had a fistula in place.
83. At 2.30pm on 5 February, in light of the man's physical condition, escorting staff and a visiting senior supervising officer separately requested a review of the level of restraint needed. Management staff at Leeds properly re-assessed the man's risk and at 5.30pm authorised the permanent removal of the handcuffs. From that point until his death four days later, the man was under escort but not subject to mechanical restraints. I am pleased to observe that escort staff reacted sympathetically to the man's condition and took steps to remove the restraints at an early stage.

Information about the man's next of kin

84. The man had little contact with his family. On reception into prison he did not name next of kin, nor suggest anyone else to be notified in an emergency. The name and address of his sister was discovered by searching his cell. However, he had made a will witnessed by his personal officer which had also given her name and address.
85. In emergency situations it would minimise delay and relieve the pressure on prison staff if prisoners' next of kin details were kept up to date. I have commented on this and made recommendations to this effect in several previous investigation reports. Although the man had initially declined to give contact details when he was received into prison, there is no evidence that it was reviewed in the intervening years. There

appears to be no standard guidance on this matter and I direct the following recommendation to the Prison Service.

The Prison Service should provide guidance to prisons on adopting a formal process to ensure that the accuracy of next of kin details, particularly those of elderly long term prisoners, is maintained throughout a prisoner's sentence. It is suggested that an annual check of the information held by the prison is carried out as part of the sentence planning process.

Funeral arrangements

86. Following the man's death, family members felt unable to be involved and advised Leeds to make the funeral arrangements. The Leeds Coroner authorised his burial and the man's funeral took place at New Wortley cemetery. HMP Leeds arranged a dignified and timely funeral and met the costs. The prison also provided a floral tribute at the graveside.

Conclusion

87. The man entered prison with serious and debilitating medical conditions which worsened over the years and eventually led to his death. It is evident that he received a good standard of care and treatment to manage his health needs. Notably, he was able to benefit from continuous treatment by specialists who had been responsible for his care in the community. I conclude that his death could not have been prevented. However, I make three recommendations regarding ancillary prison procedures.

RECOMMENDATIONS

1. I recommend the PCT should review the standard of clinical records, particularly those relating to long term prisoners, ensuring completeness and that records are logical, legible and easy to follow.

Leeds NHS Primary Care Trust did not accept this recommendation.

The PCT responded that “The Clinical Reviewer stated that the clinical records were kept appropriately throughout the man’s stay in Leeds. His case was indeed complex and the notes amounted to two very large bundles. The clinical reviewer believed that the notes were well kept and as a consequence the PCT feel unable to accept this recommendation.”

During his initial visit, my investigator was given copies of the man’s medical record upon which this report was substantially based. It is now evident from the PCT response that the record was incomplete as my investigator did not have access to the bundles of documents to which they refer. The absence of documents was mentioned in paragraph 69 of my report and gave rise to the recommendation. The PCT appointed clinical reviewer therefore had access to a more comprehensive record than was available to my investigator.

2. I recommend that the Governor reviews the current ACCT arrangements to ensure that all instances of the use of ACCT documents are recorded and, when they are closed, they are properly archived.

HMP Leeds have accepted this recommendation and comment that “Since April 2008 HMP Leeds have had a full time admin officer who has devised and operates robust systems for the management of ACCT documents.”

3. The Prison Service should provide guidance to prisons on adopting a formal process to ensure that the accuracy of next of kin details, particularly those of elderly prisoners, is maintained throughout a prisoner’s sentence. It is suggested that an annual check of the information held by the prison is carried out as part of the sentence planning process.

The Prison Service did not formally responded to this recommendation but have indicated that a full response will follow.

HMP Leeds commented that “[the man] had had no relationship with his family for a number of years. If prisoners do not want their next of kin details recorded then establishments have little choice but to accept this.”