Investigation into the circumstances surrounding the death of a man at HMP Leeds in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

June 2011

This is the report of an investigation into the circumstances surrounding the death of a man in March 2010 whilst he was a prisoner at HMP Leeds. The man, who was 33 years old, died at Leeds as a result of a heart attack brought on by a sudden and severe asthma attack. His health when he was first recalled to prison just 17 days earlier was thought to be good although he was a smoker, with a history of asthma. The man was in transit from the London area to a prison in Scotland and was only due to stay at Leeds for a short time.

In the early morning of a day in March, the man rang his cell call bell to summon staff assistance because he was having difficulty breathing. An emergency ambulance was called but, whilst it was awaited, the man collapsed and cardio pulmonary resuscitation (CPR) was started. This continued when the paramedics arrived, but to no avail. One of the prison doctors made an assessment after 30 minutes that the man could not be revived and at 7.25am CPR ceased.

I would like to extend my personal condolences to the man's family and friends for their loss. I would also like to apologise for the delay in issuing this report and any additional distress this may have caused the man's family.

This investigation was carried out by one of my colleagues. A clinical review, for which I am most grateful, was undertaken by a clinical reviewer on behalf of Leeds Primary Care Trust. I would also like to thank the Governor of HMP Leeds at the time and his staff for their help and co-operation during this investigation.

I make no recommendations in addition to those made by the clinical reviewer in his review. I urge the Governor to consider the implications of the clinical reviewer's recommendations and to develop an action plan in conjunction with the Primary Care Trust.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2011**

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SUMMARY

The man was 33 years old when he was recalled to prison for breach of his licence conditions. He had been released by the Scottish Prison Service in 2008 and had gone to live in the Essex area. He failed to maintain contact, as instructed, with his offender manager and therefore his licence was revoked. He was arrested and taken to Basildon Police Station and, on 15 February 2010, was taken to HMP Belmarsh. On 23 February, he was escorted north to HMP Leicester, where he spent the night, and then on 24 February he arrived at HMP Leeds.

At both the police station and Leicester the man was given a salbutamol inhaler because he was asthmatic. A doctor at the police station noted that he had a slight wheeze in his chest, but he was not considered to have any other health problems. He was, however, a smoker. He underwent another reception healthscreen when he got to Leeds.

At 6.25am on a day in March, the man pressed his cell call bell asking for staff to go to his cell. An officer went to the cell on D4 landing and asked what the problem was. The man told her that he was having difficulty breathing and that his inhaler was not effective. She realised that the man was quite unwell and used her radio to call for medical assistance. Two nurses, who were already on D wing, went immediately to the man's cell. As they arrived, the night orderly officer arrived and they all went into the cell.

Two nurses assessed the man quickly and decided that he needed a nebuliser (which uses drugs that turn to a mist when administered through a mask with oxygen) to help him breathe. After approximately five minutes of this treatment it became obvious to the nurses that the man required hospital treatment and they therefore called for an emergency ambulance.

The man continued to deteriorate, so one of the nurses went to collect the emergency resuscitation equipment as a precaution. Whilst she was gone the man collapsed and stopped breathing. The remaining nurse started emergency cardio pulmonary resuscitation (CPR) and called for additional staff backup. The nurse who went to collect the emergency resuscitation equipment and two other nurses arrived at the cell at the same time.

Efforts to revive the man continued, including an automatic external defibrillation machine (AED), until the paramedics arrived. (An AED is a portable electronic device that diagnoses heart rhythms after cardiac arrest. It is attached to the patient and advises whether an electric shock should be given. In this man's case, no shock was delivered and the AED advised to continue with CPR.) The nursing team continued with CPR, trying to revive the man. They decided to move him to the ambulance and efforts to revive him continued until 7.20am when a prison doctor arrived at the ambulance (it had not left the prison). After assessing the man for any signs of life, the prison doctor declared at 7.25am that he had died.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of my investigators. He first visited Leeds on 12 March 2010 and was given access to the man's prison records. My investigator visited the healthcare unit and the unit where the man lived during his short time at the prison.

2. During this initial visit, my investigator met members of the Independent Monitoring Board (IMB), the prison chaplain and the Prison Officers Association (POA). He invited them to provide any information regarding the prison or the circumstances surrounding the man's death that they thought pertinent to my investigation. (Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.) My investigator also interviewed an inmate at Leeds who shared a cell with the man.

3. Leeds Primary Care Trust (PCT) was asked to undertake a clinical review of the care that the man received whilst he was in custody, particularly during his time at Leeds. They appointed a clincial reviewer to undertake the review on their behalf. The clinical reviewer was asked by the investigator to consider particularly whether the prison health authorities had acted promptly in identifying the man's condition and whether there had been any delay in his treatment.

4. One of my family liaison officers contacted the man's brother, as his next of kin, to explain the purpose of my investigation and invite him to ask any questions or raise any issues for consideration. The family raised no issues of concern at the outset of the investigation. The man's family received a copy of my draft report as part of the consultation period. No further comments were raised by his family in response to the findings of the investiagtion.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion of this investigation, a copy of my report will be sent to the Coroner.

HMP LEEDS

6. HMP Leeds was built in 1847. It accepts adult male prisoners from the courts in West Yorkshire. The prison has an operational capacity of 1,154 prisoners and always functions at or near full capacity. It was expanded from four to six wings in 1994. There are 680 cells with additional rooms and wards for 26 patients in the healthcare centre.

7. There are six units and the man was accommodated on D wing, which is the induction unit. It incorporates the First Night Centre and contains some Safer Custody cells and the Voluntary Drug Testing Unit (VTU), together with the CARATs (Counselling, Assessment, Referral, Advice, Throughcare for prisoners with drug or alcohol problems) and SDP (Short Duration Drug Programme).

Healthcare

8. There is 24 hour healthcare cover at Leeds. In daytime hours a doctor is in the prison, and there is nursing cover at all times. Nursing staff are based in the healthcare centre and conduct rounds on the wings.

Previous reports/recommendations

9. There have been 40 deaths at HMP Leeds, including that of this man, since I took over responsibility for investigating all deaths in prison custody in 2004. None of the earlier investigations have any similarities with the circumstances of this man's death.

HM Chief Inspector of Prisons' Reports

10. HMP Leeds was being inspected by HM Chief Inspector of Prisons in an unannounced inspection at the time of the man's death. The Inspectorate's previous report following their visit in December 2007 includes references to poor record-keeping in healthcare. The report also says:

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

This was again a feature of their 2010 inspection.

11. Both Inspectorate reports include a recommendation that, "Emergency cell call bells should be answered within five minutes and managers should check this regularly."

12. I am pleased to say in this report that the staff on duty on this occasion answered the man's cell call bell promptly and summoned help immediately

from nursing staff. Although the bell system does not include an electronic record, the man's cell mate confirmed that he did not wait long for a response.

13. At the prison's own debrief, it was noted that there was some confusion relating to the code blue radio call, but I am content that this did not impact on the man's care and that the prison are dealing with this issue internally. (Code Red and Code Blue are used to indicate a medical emergency. Code Blue is used where someone is not breathing or is having difficulty breathing. The use of such a code system informs healthcare staff which medical supplies and equipment may be needed and alerts any available healthcare staff to attend the incident to assist those already there.)

Independent Monitoring Board report

14. All prisons in England and Wales have an Independent Monitoring Board (IMB), responsible for monitoring life in the prison and ensuring proper standards of care and decency. The last report produced by the IMB for HMP Leeds is dated 2010 and does not contain any issues that need to be repeated here.

KEY EVENTS

15. When the man first arrived at Basildon Police Station on 12 February 2010, he was assessed by a doctor who prescribed a salbutamol inhaler because the man had a slight wheeze sound when he breathed out. He told the doctor that he had been asthmatic since he was a child.

16. On 15 February, the man arrived at HMP Belmarsh and was seen by nursing staff there. He told them that he was generally fit and well, had asthma but did not need to be seen by the doctor.

17. The man reached Leeds on 24 February after spending the previous night in HMP Leicester. He had been seen by their healthcare staff and given another salbutamol inhaler. The man had a full assessment of his healthcare needs when he arrived at Leeds. His medical notes say that he was asthmatic, smoked about 20 cigarettes a day, was not registered with a doctor in the community and had no other health issues.

18. On 3 March, the man approached one of the induction wing nursing staff and asked her to help him obtain another ventolin inhaler (ventolin is a trade name for salbutamol). He told her that he had seen another nurse, whose name he did not know, earlier that day who had told him that he would get another inhaler. The nurse told the man that she would deal with the matter for him. She noted in his medical notes that:

> 'he appeared wheezy, but not unduly breathless. He is on salbutamol but inhaler has run out. Will discuss with pharmacy/doctor and ensure he gets inhaler tonight. Advised that if he becomes suddenly breathless to alert staff.'

The man was given his new inhaler that evening.

The day of the man's death

19. At approximately 6.25am on a day in March, shortly after coming into the prison, the man pressed his cell call bell. The night patrol officer was just completing her roll check count (a visual check and count of all prisoners) at this time. She went to the man's cell, which he shared with another inmate, and asked him what was wrong. He informed her that he was having difficulty breathing and that his ventolin inhaler was not working. The night patrol officer realised that he was poorly and contacted healthcare staff via the radio to ask them to come to D4 landing. The cell remained locked as the prison was in night patrol state and the night orderly officer must give permission for cells to be entered. Local security instructions dictate the procedures for opening cells at night or when fewer staff are on duty. This often means that the person in charge of the prison must be present when a cell is opened at these times.

20. Two nurses were in D wing treatment room when they heard a call on their radios to go to D4 landing. Both went immediately to the cell occupied by the

man and his cellmate. They decided that they would need to go into the cell to check on the man. The nurses were just in the process of asking for the person in charge during the night (Oscar 1) to come to the cell, when he arrived after being alerted by the initial radio message to the nursing staff. The man's cell was unlocked.

21. It was immediately evident to the staff that the man was having an asthma attack, so one of the nurses went to collect an emergency asthma kit. When he returned he gave the man an oxygen mask which is designed to allow the patient to breathe in special drugs which are turned into a fine mist (nebulised). The drugs are supposed to help open the airways of the lungs to help the patient breathe more easily. The man had difficulty keeping the mask on as he was agitated due to his distress at not being able to breathe.

22. The nursing staff measured the man's vital signs, including how well he was able to breathe (a peak flow reading). His pulse was very fast at 130 beats per minute, his blood pressure was slightly raised at 140/80, he was breathing at 28 breaths per minute (quite fast) and his peak flow reading was 200 litres per minute at best (it should normally be about 650 litres per minute).

23. The nurses used the nebuliser for seven minutes but it showed no sign of improving the man's breathing. They decided to call for an emergency ambulance. One of the nurses went to speak with the control room staff on the telephone to give them all the information that the ambulance control centre would need. When he returned, he thought that the man had deteriorated even further and so he asked his colleague to fetch the emergency resuscitation kit.

24. Whilst the nurse was collecting the emergency equipment, the man slumped to the floor and his colour changed to a dusky grey. At approximately 6.45am he stopped breathing. The remaining nurse immediately laid the man on the floor and placed a mask over his mouth. He asked one of the officers to make an emergency 'code blue' call to the control room. He started CPR and continued until the other nurse returned. At about the same time as she returned with the emergency equipment, two other nurses arrived. The man's cell mate was moved to another cell on D wing.

25. The nurses continued CPR and applied the automatic electronic defibrillator (AED) pads to the man's chest. The machine indicated that no shock should be given and instructed that CPR should continue. Staff continued CPR for a few more minutes, until the paramedics arrived at approximately 6.55am. After a handover of information, the paramedics took over CPR and decided to move the man to the ambulance in readiness for taking him to hospital. He was still showing no signs of life.

26. The passage to the ambulance was difficult as the man's cell was on the fourth (top level) landing of D wing. The paramedics put the man into a transfer wheelchair and stopped on each landing to perform CPR. They continued their efforts in the ambulance. After some time, the prison doctor arrived at the ambulance (he had just come on duty at the prison). He asked

what had happened and was told that CPR had been continuing for approximately 30 minutes. The prison doctor examined the man for signs of life but concluded that he could not be revived and CPR was therefore stopped. The man was certified dead at 7.25am.

27. The post mortem report concluded that the man died as a result of a respiratory arrest (he stopped breathing because his heart stopped beating) as a result of a severe asthma attack. The clinical reviewer goes into some detail in his clinical review as to how this occurs, but it is sufficient for me to say that the man's heart was put under such severe pressure whilst trying to keep oxygen flowing through his body, that eventually it became exhausted and stopped. This was a direct consequence of his asthma and is, sadly, not an uncommon occurrence for people who suffer with the condition.

28. The prison initially had difficulty identifying the man's next of kin in order to notify them of his death. His girlfriend was listed as his next of kin, but her address was incorrect. The prison was able to trace the man's brother's address, and asked local police officers to break the news of his death because of information they had received from the local police.

29. The prison held debrief sessions for all the members of the team involved in the man's death, to ensure that they learned any lessons they could from the events of his death. All the staff completed incident forms which were made available to my investigator.

ISSUES

Whether the man's asthma was treated properly?

30. The man's final period in custody lasted just a few weeks and in that time he moved between three prisons and a police station. He was seen on a number of occasions by healthcare professionals including doctors and nurses. Although it was known that he had been asthmatic since childhood and used an inhaler, no staff thought that the man was acutely unwell at any time. However, unbeknownst to anyone, the man had in fact been given three inhalers over that three week period. This is an excessive use of inhaler and any doctor, who was aware of the facts, should be concerned.

31. That having been said, the man never complained to anyone, including his cell mate, that his asthma was causing him problems. The man's cell mate was asked in interview whether he thought his cell mate had been having breathing problems. He was clear that the man never displayed any signs of breathing difficulties.

32. The clinical reviewer in his review explains in great detail some of the mechanics of asthma and asthma attacks. He stresses the importance of proper and thorough management of the condition in a patient's day to day life. In this man's case, he was relatively unknown to prison health services at any of the prisons he visited during the short time of his licence recall. It went unnoticed that he had been given three inhalers in a short time. Peak flow recordings for the man were scant in the medical records, but then again, he had not shown any signs of having significant breathing difficulties up until the day of his death. Furthermore, the man had not said anything about having problems with his asthma.

33. Amongst the man's prison records, read after his death, was a psychological risk report completed by a forensic psychologist with the Scottish Prison Service. It was written in June 2006 and contains information about his overall risk of reoffending, together with some history regarding the man's original crimes. One theme that runs through much of the report is how the man was not someone who would normally be able or open to talking to anyone in authority if he was having a problem. This, it appears, stems back to him not wanting to appear stupid or less able intellectually. He would not ask questions if he did not understand something, and would not volunteer information about himself or his circumstances, preferring instead to say nothing. That report also says 'he admitted that he does not trust authority figures and will avoid discussing concerns with them.'

34. This distrust of authority may have been at the root of the man's reluctance to tell staff at Leeds that he was needing to use his inhaler more frequently than was advisable. Similarly, he may not have realised the significance of the increasing use he was making of his inhaler. The clinical reviewer says in the Summary section of his report:

> ‘I think that the overriding factor in this case is that [the man] did not fully realise how severe his asthma attack was becoming and so did not seek help until he was very seriously ill and close to collapse.’

35. However, the clinical reviewer also notes that the man had used two full inhalers in the previous 20 days when he asked a nurse for another inhaler on 3 March. The clinical reviewer calculates that the man had been taking ten doses per day for the previous 20 days, a level he describes as excessive. The nurse realised that the man was slightly breathless and gave appropriate advice. The clinical reviewer considers that she could have gone further by asking him how often he was using his inhaler. He says in his review ‘This would have given some idea as to whether it was being excessively used suggesting relatively poor asthma control’. He adds ‘...[the man] was certainly using his salbutamol inhaler excessively and so his asthma must have been out of control. His asthma attack had already started.’

36. The clinical reviewer continues:

> ‘It is difficult to determine how bad [the man’s] asthma was on the evening of 3 March. It is very likely that it continued to gradually deteriorate over the next 36 hours as it had been doing over the previous few days. In my opinion it is certain that interventions could have been undertaken then that would have improved his asthma control and led to a different outcome.’

He does acknowledge though that ‘With hindsight it is now easier to make this judgement.’

37. Three separate groups of medical professionals (at Basildon Police Station, HMP Leicester and HMP Leeds) prescribed and issued inhalers to the man in the relatively short period between 12 February and 3 March. He had been at Leeds for one week when he asked for a new inhaler on 3 March. The clinical reviewer understands that the asthma team at Leeds tries to issue an appointment within three weeks of a prisoner’s arrival there.

38. The clinical reviewer observes that when the man was given another inhaler on 3 March it would have taken a close inspection of the paper medical records to ascertain that this was the third such request in a limited period. For the clinical reviewer, the key is that the man did not appear to be unwell or perceive himself to be sufficiently unwell to ask for help from any member of staff until the early morning of the day of his death.

39. I am well aware of the major practical difficulties faced by staff at very large local prisons, such as Leeds, where prisoners arrive and depart in high numbers, sometimes after extremely brief stays. I do not censure the nurse but note that in his commentary the clinical reviewer writes that she did not ask the man on 3 March how often he had been taking his salbutamol inhaler. Such a question could have enabled her to establish whether he was using the inhaler excessively. If relatively poor asthma control had been established, ‘an immediate assessment of the peak flow rate and other

examinations could have been pursued to determine the severity of his asthma at that time'.

40. I do not report on many asthma related deaths in prison and I fully endorse the three recommendations made by the clinical reviewer.

Where asthma treatments are recorded in prison medical notes, the frequency of use of inhalers such as salbutamol should be recorded as well.

Excessive use of inhalers should be ascertained at reception or when replacements are being sought, but especially in individuals with symptoms. Excess use should trigger an immediate assessment of asthma control.

All prisoners who are asthmatic should be issued with simple written instructions regarding the use of inhalers and especially the signs to watch out for in acute illness.

Responding to the cell bell

41. In view of the Chief Inspector of Prison's comment in her reports of 2008 and 2010 regarding the length of time before staff responded to cell call bells, I thought it prudent to investigate if there was evidence on this occasion of any delay in the staff response to the man's call for help. Although there is no electronic recording system in place at Leeds for cell call bells to be logged for D wing, the man's cell mate was asked to estimate how long the man waited for a member of staff to respond when he pressed the cell call bell. The man's cell mate could not be certain, but he was of the view that the man did not wait long for an officer to arrive.

42. The officer recalled in interview that she had started her early morning roll check at about 5.45am, beginning at the man's cell. She noticed that the man was awake and sitting at the back of his cell, but he did not speak to her at that time. Shortly after she finished her roll check and recorded the roll in the appropriate log book, the man pressed his cell bell. She went immediately upstairs to D4 landing and spoke with the man. She then called, on her radio, for nursing staff to attend D4 landing. She could tell by looking over the railings of the landing that two nurses were on their way soon after she requested assistance.

43. My judgement is that on this occasion there was no delay in the man being attended to once he pressed his cell bell for help. It appears that once the nurses arrived, they went promptly into the cell. After they had assessed the man and tried one form of treatment, they called for an emergency ambulance. There was no undue delay in the ambulance's arrival either.

44. The ambulance crew arrived at the man's cell believing that they were responding to an asthma attack. Once inside the cell, they discovered that the man was in respiratory arrest and they did not have their own equipment

to hand. However, they managed, albeit with some difficulty, to use the prison's emergency equipment and continued CPR whilst they moved the man down to the ambulance. They continued resuscitation attempts for some time after they arrived at the ambulance, until the prison doctor arrived. After examining the man, the prison doctor was of the view that he could not be revived and therefore he suggested that resuscitation attempts should cease.

45. I conclude that neither delay nor lack of equipment played any part in the man's death. The clinical reviewer makes two observations to support this. He says:

> 'I do not think that there was any compromise to the outcome of the resuscitation by either the Blue emergency call not being put out properly by the control room or the fact that the ambulance crew did not take their full resuscitation equipment to the prison cell'.

He adds:

> 'The extra resuscitation equipment that the ambulance crew would have provided would have been intravenous drugs and such things as endotracheal tubes [a flexible plastic tube that is put into the mouth and then down into the airway]. These were used by the paramedics within eight to ten minutes of their initial observations and I do not believe that slightly earlier use would have led to a different outcome in the resuscitation.'

46. I accept the clinical reviewer's conclusion that the man's death was neither predictable nor preventable. Had the man alerted staff at any time to the increased use he was making of his inhaler, then perhaps medical staff at Leeds might have conducted some further assessment of his condition. However, I note that the concluding paragraph of the clinical review expresses the opinion, in relation to the acute severe asthma attack that the man suffered on the morning of his death, that, 'it is entirely possible that even if such a collapse had taken place in hospital or on the way to hospital in an ambulance then the outcome would have been the same.'

CONCLUSION

47. The man was arrested and sent back to prison for breach of his licence conditions. After initial reception at Belmarsh, he was on his way back to a Scottish prison when he arrived at Leeds on 24 February 2010. To all intents and purposes he appeared healthy and well, although he was known to be asthmatic. The authorities at Leeds were not aware (although there was supportive evidence) that the man had been given two inhalers for his asthma in a very short timescale.

48. On 3 March, when he was last seen by a member of the healthcare team at Leeds, in response to his request for a third inhaler, the nurse recognised that he was wheezy and she gave some advice. Unfortunately, her enquiries did not establish that the man had been over-using his inhalers and therefore that he was probably already beginning a severe asthma attack.

49. The man appears to have been someone who did not readily seek assistance and he may have been mistrustful of authority. In any event, he failed to alert staff to the continued deterioration of his breathing until 6.35 am on the morning of his death. I am satisfied that nursing staff arrived promptly at his cell and after initial assessment and some treatment for his breathing difficulties, they summoned an ambulance.

50. Before the ambulance arrived, the man collapsed and stopped breathing. Despite the efforts by the nursing staff and paramedics, he could not be revived and his death was pronounced at 7.25 am.

RECOMMENDATIONS

For the Healthcare Manager in conjunction with the Primary Care Trust

1. **Where asthma treatments are recorded in prison medical notes, the frequency of use of inhalers such as salbutamol should be recorded as well.**

   Service response: Recommendation accepted. All patients with a long term condition such as asthma will have the condition coded into the patient's medical records on reception as part of the reception screening process and a full assessment made of the patient's needs including frequency of use via the city wide team.

2. **Excessive use of inhalers should be ascertained at reception or when replacements are being sought, but especially in individuals with symptoms. Excess use should trigger an immediate assessment of asthma control.**

   Service response: Recommendation accepted. All patients with long term condition including asthma, will at reception, be referred to the prison's healthcare Long Term Conditions team using the referral function on SystmOne, who will make a full assessment of patient needs including confirmation of care from previous GP/prisons.

3. **All prisoners who are asthmatic should be issued with simple written instructions regarding the use of inhalers and especially the signs to watch out for in acute illness.**

   Service response: Recommendation partially accepted. Not all patients are literate and may not understand written instructions. However, patient information will be developed regarding use of inhalers that patients can understand including signs and symptoms to look out for acute illness.