

**Investigation into the circumstances surrounding the death
of a male prisoner at HMP Leeds in November 2005**

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

February 2006

This is the report of an investigation into the circumstances of the death of a male prisoner on 12 November 2005 at HMP Leeds. He died of apparent natural causes as a result of a heart attack. He was 45 years of age.

My colleagues and I would like to extend our sincere condolences to his family and friends for their loss.

One of my investigators conducted the investigation. A clinical reviewer carried out a clinical review on behalf of Leeds West Primary Care Trust.

I am grateful to the Governor of Leeds and his staff for their co-operation with my investigator. I am particularly indebted to the liaison officer who ensured that all necessary documentation was gathered and made available.

My report makes one recommendation and endorses the three recommendations made by the clinical reviewer.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

1. The prisoner died at the age 45 at HMP Leeds. He was serving five years imprisonment. This was not his first time in prison.
2. The prisoner complained of chest pains during the night of 11/12 November 2005. He was seen by a Healthcare Officer (HCO), who carried out extensive medical checks. All findings were within normal guidelines. The HCO then carried out an electrocardiograph (ECG), which read borderline/abnormal. He decided that this was due to possible myocardial ischaemia (the heart muscle being deprived of oxygen, causing it to be irritable and give off symptoms of pain).
3. Following these checks, the HCO decided that the prisoner was not in any cardiac distress and was breathing without any difficulty. The HCO told him to rest and, if he had any further pain throughout the night, to let the staff know and he would return to see him. He also said that he should see the wing nurse at treatment time in the morning, and that he would leave a handover note for the nurse so that she was aware of what had happened.
4. At 7:50am, the Catering Officers were unlocking the prisoners required to work in the kitchen. Once they had unlocked the prisoners who were needed, they waited at the end of the landing to escort them to the kitchen. At 7:58am, they were alerted by the prisoner's cellmate, calling for staff assistance. The officers approached the cell and an officer entered the cell to see the prisoner lying face down on the bed. His first thought was that he was dead, because he was very cold and blue. He called out to another officer who in turn called to other staff.
5. Medical assistance arrived almost immediately. The prisoner's death was officially confirmed at 8:40am by the paramedic.

Investigation Methodology

- 6.** All the initial indications were that this was a death from natural causes.
- 7.** My investigator was given access to all the prisoner's prison records, including his medical records, and was given copies of everything that was required.
- 8.** Notices to staff and prisoners were sent to the liaison officer appointed by Leeds, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.
- 9.** Having reviewed all the paperwork, my investigator did not feel it was necessary to conduct any formal interviews of his own. All the police interviews were made available to him.
- 10.** Leeds West Primary Care Trust (PCT) was invited to undertake a review of the clinical care the prisoner received while in custody.
- 11.** On 17 November, one of my family liaison officers's, wrote to the prisoner's nominated next of kin, to tell her of the investigation and to ask if she wanted to be involved or had any concerns that she wished to raise. In a telephone conversation, she expressed no concerns with the prisoner's treatment while in custody.

Background

The Prisoner

- 12.** The prisoner Lee was born in Sunderland on 3 May 1960, and lived in Newcastle upon Tyne. He was 45 years old when he died on 12 November 2005.
- 13.** He was sentenced to five years imprisonment on 24 April 2001. He had 13 previous convictions dating back to 1973. During his childhood, he lived in a succession of children's homes, assessment centres and approved schools. From the age of 14, he spent most of his life in custody, nearly always for burglary.
- 14.** In 1988, he suffered from a severe depressive illness, during which he attempted to harm himself. He was detained under the Mental Health Act and received extensive treatment.
- 15.** When he was released from custody in 1993, he worked as a temporary chef and obtained a City and Guilds Certificate in catering.

HMP Leeds

- 16.** The main part of Leeds prison was built in 1847. It is one of the largest local prisons in the country. The prison comprises six wings and a healthcare centre. It takes all adult male prisoners remanded from the West Yorkshire area until trial, and convicted prisoners for short periods following sentence.
- 17.** HM Chief Inspector of Prisons (HMCIP) undertook an unannounced inspection of Leeds between 22 and 26 August 2005. The subsequent report commented that Leeds is a large overcrowded local prison. It is operating at 75 per cent above its certified normal accommodation, with a transient and usually short stay population.
- 18.** The Chief Inspector said her report showed how difficult it is to sustain progress in a crowded, inner-city local prison, where cultures are hard to change and which is operating under considerable daily pressure.

Events leading up to the death of the prisoner

- 19.** The prisoner was sentenced at Newcastle Crown Court on 23 April 2001 to a total of five years imprisonment, including a term for breach of licence conditions on a previous sentence.
- 20.** On 15 June 2001, he was transferred to HMP Frankland. On 18 February 2003, he completed the Sex Offender Treatment Programme to help address his offending behaviour. He remained at Frankland until 3 June 2004 when he was released on licence to a probation hostel (approved premises).
- 21.** On 27 October 2004, he failed to return to the approved premises and was returned to custody and his licence revoked. On 2 December 2004, he was transferred to HMP Leeds.
- 22.** On 12 December, he stated to staff that he was feeling quite down and he feared he might harm himself. He was placed on a self harm at risk form (F2052SH) with regular reviews being conducted and he was observed at least once an hour. He remained on this monitoring form until 4 January 2005.
- 23.** The prisoner was seen by the doctor on 3 October 2005 when he complained of a loss of weight and appetite. The doctor prescribed a three day course of Gaviscon Liquid, to be taken along with antacid tablets called Losec. Blood tests were also asked for at this time. However, on 10 October, he refused to give any blood to be tested.
- 24.** The prisoner had also been taking a drug called Ranitidine, but this was not prescribed by the doctor. Ranitidine is the same as Losec and was available from the wing nurse without a prescription or the doctor's approval.

Events of the early morning of 12 November

- 25.** At 12:30am, the prisoner and his cellmate were watching television. At 12:45am, he had a cigarette, said he was going to sleep and asked his cellmate to turn the television down a bit. At 1:00am, the cellmate turned off the television and went to bed himself. He said that he was next awakened by staff entering the cell to treat the prisoner for his chest pains.
- 26.** At approximately 3:30am, an officer went to attend to a cell bell activated in the prisoner's cell. He returned to the office and telephoned Healthcare Officer (HCO) and asked him to attend E wing cell E5.30, as a prisoner was complaining of chest pains. The officer also informed the Night Orderly Officer, who said that he would attend straightaway.
- 27.** There is a portable electrocardiograph (ECG) machine available. The HCO said in his police statement that "this machine is maintained and serviced

yearly”, and is checked weekly by Healthcare staff to ensure that it is operating correctly. The HCO is trained and has specialist expertise in the use of the ECG machine, and decided to take it along with him to the cell. As he entered E wing, he collected the resuscitation bag out of the wing treatment room. The HCO then left the treatment room and was joined by Senior Officer (SO), and two officers. They all made their way to the cell.

- 28.** On arrival at the cell door, the SO looked through the cell observation flap to ensure that it was safe to enter the cell. Before they entered, The SO informed the prison control room that they were unlocking the door. (The control room is an area within the prison where staff maintains running records of all movements, and it is the central point for all communication.)
- 29.** The HCO and the SO entered the cell; the other officers waited outside in case they were needed. Once inside the cell, they noticed that the prisoner’s cellmate was still asleep on the top bunk bed and that the prisoner was sitting on his bed holding his left arm across his chest.
- 30.** The HCO started talking to the prisoner, asking him what the problem was and where he was feeling pain. He replied that he had pains across his chest and they had been there since early evening. The prisoner was asked if he was taking any medication for heart problems. He replied that he was not. He told the HCO that he had seen the doctor who had given him Gaviscon. He did not say how long ago he saw him, but he did say that the doctor wanted him to have some blood tests.
- 31.** The HCO noticed that he had a good colour to his skin and did not appear to be in any respiratory distress. He was not showing any signs of cardiac distress or discomfort. The HCO then checked the prisoner’s blood pressure and pulse, finding that both were within normal limits with no cause for concern. All the way through these checks, the prisoner was told what was happening to help keep him calm.
- 32.** The HCO then decided to check him using the ECG machine. The readings from the test confirmed that there were apparently no problems. The HCO checked the printout of his heartbeat, the rhythm and the beats of the heart, and he told the police that all were satisfactory. All other readings from the machine were within normal tolerances.
- 33.** The HCO then read the screen on the ECG machine. This read borderline/abnormal. The HCO decided that this reading was due to a possible myocardial ischaemia (meaning the heart muscle is deprived of oxygen causing it to be irritable and give symptoms of pain). The HCO checked his pulse again. It was still fine, his skin colour was good and he was not panting or having any difficulty breathing. The HCO decided that he appeared to show no early signs of severe cardiac problems.
- 34.** The prisoner was asked if there was any history of heart problems within his family. He indicated that there might have been, but he did not go into detail. The HCO carried on with his observation while talking to him. He asked if he

was at all anxious, perhaps because of an outstanding court case or because something else was worrying him, as this could cause a tightening of the chest.

35. The prisoner stated that the pains had now eased off and he was feeling much better and a lot more comfortable. It was therefore decided that no further treatment was required at this time. However, the HCO did say to him that if he felt any more pain at all he was to notify the staff straightaway and he would come back to see him. If he felt alright, he should see the wing nurse at treatment time in the morning. The account given by the HCO is confirmed in the statements of the officers present at the time.
36. The staff then left the cell, which was re-locked, and they returned to their other duties. The HCO returned to the E wing treatment room to record the treatment he had given him on a continuation sheet. He pinned the reading from the ECG machine to the sheet and left both for the nurse in the morning.
37. One of the officer stated in his police statement that, "at approximately 5:00am, he returned to the prisoner's cell and looked through the observation flap, to ensure he was alright. He appeared to be asleep lying on his right side."

Events at the morning unlock of 12 November.

38. The morning roll check, which is completed by the staff coming on duty for the day shift, was carried out at 7:30am. The purpose of the roll check is to establish that the correct number of people are in each cell. No reports were made of anything untoward in cell E5.30.
39. At approximately 7:50am, the catering officers were unlocking prisoners required to work in the prison kitchen. They usually unlock between 20 and 25 prisoners, unlocking each door, saying good morning to the occupant and then moving on to the next cell. Once the doors were unlocked, the prisoners required for work would begin - within two or three minutes - to make their way towards the end of the landing to have their names checked on the roll board before moving on to the kitchen.
40. On the morning of 12 November, the catering officers were waiting at the end of the landing when they heard shouting coming from a prisoner further down the landing. He was shouting for help from prison staff. The prisoner who was shouting was the cellmate of the deceased.
41. The catering officers made their way down towards the cell, where they entered the cell. They looked at the prisoner who was lying face down on the bed, and one said "I think he is dead, he was very cold." One of the officers then left the cell and shouted to other staff to get medical help. He then turned his attention to the cellmate, who appeared to be in shock. The catering officer returned to the cell to collect a jumper, but was handed a blanket instead which was placed around him.

42. The catering officer took the other prisoners away to the kitchen. At 8:09am, an officer, that is an E wing member of staff, arrived at the cell. He told the cellmate to go down to the office where he could be comforted and reassured by other staff. The duty Governor was asked to contact E wing.
43. At 8:10am, a Principal Officer, who was the orderly officer and in charge of the running of the prison, arrived at the cell and took control. At 8:15am, the control room made a 999 call for the paramedics to attend the prison. The healthcare staff arrived at 8:16am. They checked the prisoner for signs of life, realised that they could not assist and left the cell at 8:22am, when it was locked awaiting the arrival of the paramedics.
44. The paramedics arrived at 8:40am. The cell was unlocked for them and a paramedic confirmed the prisoner's death. They left the cell at 8:45am and it was again locked waiting for the police to arrive.
45. At 9:11am, a Police Sergeant and a Police Constable, arrived and entered the cell, leaving at 9:14am. At 11:11am, a Detective Inspector, and a Detective Sergeant, Detective Constable and the Scenes of Crimes Officer (SOCO) arrived at the cell, entering at 11:15am. The SOCO took photographs of the cell and the police searched it, removing the prisoner's medication and his clothes.
46. The Coroner's officer, arrived at the cell at 12:20pm leaving at 12:21pm. The SOCO eventually left the cell at 12:35pm.
47. At 1:25pm, the undertakers arrived at the cell to remove the prisoner's body from the prison. They departed at 1:30pm.
48. In his police statement, one of the catering officer explained that he felt quite traumatised by the discovery of the prisoner. He did not remember leaving the cell and it all seemed to be a blur. He was consoled by another member of staff and then taken by two nurses to the medical room. Following this, he was supported along with all other staff involved by the Staff Care and Welfare team. This support has been on-going.

Breaking the news to the prisoner's family

49. Following his death, his nominated next of kin, was informed of his death by Police Constable at just after 11.00am. A Governor and a Sister from the prison visited her at home between 12:35 and 1:10pm to offer their condolences and to ensure that she had any contact details that she might require. The Sister returned at the request of the family at 2:30pm the same day, giving the family the coroner's details at this time.

Support for the prisoner's cellmate

50. The prisoner's cellmate was offered support by staff. He is himself a member of the Listeners team at Leeds. (Listeners are prisoners selected and trained by the Samaritans to offer confidential support to fellow prisoners on a 24

hour basis.) He was also offered support by the chaplaincy and his cell was left unlocked for the rest of the day. He was then placed in a cell with another prisoner whom he knew, before asking for a single cell.

51. The cellmate was also offered some time off from his work in the prison workshop, but he declined. He was offered further support from the prison chaplaincy which was also declined. However, he talked to wing staff on a regular basis to help him through this very difficult period.
52. A letter was received by my investigator from the cellmate in which he states he “felt he was offered all the support possible by the staff on E wing and the chaplaincy of the prison.” he “would like to express his thanks to the staff who ... deserve praise for the professional way in which they conducted themselves throughout this difficult time.”

Clinical Review

53. The clinical reviewer states that the response to the prisoner’s medical problem on the night of 11/12 November was timely and appropriate.
54. Because of the arrangements within the prison, a call from E wing would not have been made to Healthcare over the radio but by telephone. Consequently, the nurse in charge may not have been aware the call had been received.
55. The response by the HCO was timely. However, both the clinical notes and the witness statement indicated that an inadequate clinical history was taken and recorded. The cardiac nature of the pain was not elicited or recognised.

Findings and Conclusions

56. The electrocardiograph machine should be checked once a week. However, it had not been checked since 24 October. The checks due on 31 October and 6 November had not been completed prior to the prisoner’s death. When the machine was checked following his death it was found to be working and fully operational. The next two checks were completed according to schedule on 13 and 20 November.
57. The clinical reviewer states that the initial response to his clinical problem was timely and appropriate. However, the clinical history was not properly taken or recorded. Likewise, an ECG was undertaken but not interpreted correctly. Action required on the basis of the clinical history was not taken. The nurse in charge appears not to have been informed of the care given to him during the night.
58. The clinical reviewer says, “It is not possible to say that a different outcome would have resulted, but evidence has shown hospital based interventions for acute coronary syndrome reduces mortality.”

Recommendations

The Governor should review procedures to ensure that checks of all life saving equipment are carried out in a timely manner.

I further endorse the recommendations of the clinical reviewer.

- Clinical policies relating to out of hours clinical incidents are reviewed to ensure roles and responsibilities are clear and that communication is appropriate.
- The prison reviews the training of Health Care Officers to ensure their clinical skills remain current and that the limits of these are clearly defined.
- Healthcare undertakes a critical review of this incident to ensure that the lessons arising are learnt and acted on.