

**Investigation into the circumstances surrounding the
death of a man in September 2008
at HMP Leeds**

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

February 2009

This is a report into the circumstances surrounding the death of a man at HMP Leeds in September 2008.

Shortly after lunch, the alarm was raised by his cellmate following the man collapsing in their shared cell. The officer who attended asked for healthcare assistance. Staff and paramedics attempted cardio pulmonary resuscitation, and he was taken to hospital. It was there that he was pronounced dead at 1.40pm. He had suffered a pulmonary embolism, or blood clot, in his heart. He was 48 years old. I offer my sincere sympathy and condolences to his family and friends for their loss.

On first reception into Leeds in 2006, the man had reported no medical concerns apart from stress caused by the charges he was facing. His stress levels quickly reduced once he was placed in a wing with other vulnerable prisoners. There is no further record of him ever complaining about any health concerns. His sudden collapse was a shock to all concerned.

The investigation was carried out on my behalf by my colleague. A clinical review of the man's healthcare at HMP Leeds was undertaken by a representative from the local Primary Care Trust. I am grateful for his comprehensive account. I would also like to thank the Governor of Leeds and his staff for their co-operation and assistance with this investigation. Particular thanks go to the Litigation Manager at HMP Leeds, for his help throughout the investigation process as Liaison Officer.

I am satisfied that staff did all they could to try to save the life of the man. However, I make four recommendations from this investigation and the associated clinical review.

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Prisons and Probation Ombudsman

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SUMMARY

The man had been remanded into custody at HMP Leeds on 29 April 2006 and, following conviction, was sentenced to 16 years and six months imprisonment. He had been in prison previously on a number of occasions.

On arriving at Leeds, the man was initially concerned about his safety which caused him some stress. However, this was reduced after he asked to be placed on Rule 45. (This is a rule whereby prisoners who feel vulnerable, either because of the nature of their offence or for other reasons, can be separated from the rest of the prison population.) He fitted into the regime on A Wing (the vulnerable prisoner unit) and followed the rules.

He did not report any further concerns about his physical health. He collapsed at approximately 12.27pm in his cell on 16 September 2008. The alarm was raised by his cellmate and the officer who responded called for healthcare assistance. Cardio pulmonary resuscitation (CPR) was carried out swiftly until the paramedics arrived and they continued trying to resuscitate the man. However, he was declared dead on his arrival at Leeds General Infirmary at 1.40pm.

THE INVESTIGATION PROCESS

1. The man died on 16 September 2008. The Ombudsman's terms of reference and notices of investigation were sent to the prison within three days of his death. The notices were displayed for prisoners and staff. No one came forward in response.
2. My investigator contacted the prison and asked for the man's prison records. The records from Leeds and previous prisons were examined, and my investigator drew up a list of people to interview. He attempted to contact the man's cellmate but, as he had been released, this proved unsuccessful.
3. A doctor was contracted by the local Primary Care Trust (PCT) to undertake a clinical review of the healthcare received by the man while in custody. The review is included as an annexe to this report.
4. My investigator travelled to Leeds for two days in early November 2008 to interview wing and healthcare staff.
5. Members of my staff offered to meet the man's family following his funeral but they chose not to do so and did not raise any issues that they wished my investigator to look into. A copy of this report will be sent to the man's family.

HMP LEEDS

8. HMP Leeds is a category B local prison dating from 1847 serving the courts in West Yorkshire. It accepts all adult male prisoners and had an operating capacity of 1,004 (at the time of the man's death) across six wings.
9. Leeds was last inspected by HM Chief Inspector of Prisons in December 2007. The inspection found that, although Leeds was not performing sufficiently well in any of the Chief Inspector's key areas, there had been progress in all aspects of the prison as managers sought to introduce improvements.
10. The Chief Inspector said A Wing contained vulnerable prisoners who had no restrictions on their regime. She said that, although the wing was shared between sex offenders and others (such as those in debt), most prisoners felt relatively safe on A Wing.
11. The healthcare centre currently provides beds for 15 patients. Although half the prisoners surveyed by HM Chief Inspector said that the healthcare services were either good or very good, her report made a number of recommendations. HM Chief Inspector of Prisons also commented that not all staff had had resuscitation training in the last 12 months, and recommended that this should be rectified.
12. Each prison has its own Independent Monitoring Board made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. Each Board produces an annual report for the Secretary of State. In their 2008 annual report on Leeds the IMB expressed its concern over the number of life-sentenced and IPP (indeterminate sentence for public protection) prisoners who found it difficult to take part in the courses and programmes necessary for consideration for release. The IMB also had concerns over the reception and visits areas, but praised the staff's efforts regarding diversity and safer custody.
13. Leeds suffered four deaths in custody in 2008, of which three were due to natural causes (including that of the man). There do not appear to be any significant similarities between them.

KEY FINDINGS

Between 29 April 2006 and 3 December 2007

14. The man arrived at HMP Leeds on 29 April 2006 on remand for serious offences. He underwent his first reception health screen when he revealed that he was not receiving any current medication, that his family had no history of any illnesses, and that he had no concerns about his physical health. He did not report any previous heart problems. He was five feet nine inches tall, weighing 12 stone with blood pressure of 116/76 and a pulse of 73 (both within normal range).
15. A cell sharing risk assessment (CSRA) was carried out the same day and he was judged to be high risk because he said he would attack his cellmate if he felt threatened. He applied under Rule 45 for Vulnerable Prisoner (VP) status on the same day due to the nature of his offence. The CSRA notes that his risk assessment could be lowered to medium once his application for VP status was approved. He was located in cell A4-28 on A Wing (the vulnerable prisoner unit).
16. The man initially suffered from stress due to the nature of the charges he was facing. He had been abused by other prisoners. However, following two appointments to discuss his stress with doctors in late 2006, there is no record of any further medical ailments.
17. In late 2006, he was sent to HMP Hull to await his trial in February 2007. He remained concerned about his safety and again asked to be placed on Rule 45. He was initially segregated on K Wing as he refused to leave his cell until he was placed on Rule 45.

Between 3 December 2007 and 16 September 2008

18. The man returned to Leeds on 3 December 2007 having refused to go to HMP Dovegate where there was no VP scheme. His application for VP status was approved and he returned to A Wing. Two officers were assigned as his personal officers. His behaviour was described as good and he kept his cell clean and tidy. He was polite and conversational with his personal officers, but did not come to them with any concerns or issues. One of his personal officers described him as wanting to better himself while in prison and being no trouble at all. She remarked that, while some prisoners could be quite demanding, he never complained or asked for things from the wing staff.
19. Officers said that the man mixed with the other prisoners well but kept himself to himself much of the time. He preferred to be busy and worked hard in the workshops, achieving a National Vocational Qualification (NVQ) in the sewing workshop in January 2008. He also built matchstick models for a charity to sell. This occupied much of his time and the Governor authorised the reimbursement of his costs as the models were for charity. He was also in the early stages of applying to be both a Listener and a Toe-to-Toe mentor. A Listener is a prisoner trained by the Samaritans to listen to other prisoners

who want to talk to someone. A Toe-to-Toe mentor assists other prisoners with literacy. Due to his consistent good behaviour, cleanliness and hard work his personal officers were in the process of recommending the man for 'enhanced status'. (Enhanced status is part of the prison's Incentives and Earned Privileges scheme and grants prisoners the right to wear their own clothes, and allows them an extra visit and extra time out of their cells.)

16 September

20. On 16 September 2008, the man collected his lunch as usual and took it back to his cell (A3-11) on the second landing. His cellmate later told staff that the man complained of feeling unwell after eating his lunch. He got down from his bunk and went into the toilet area where he vomited, and then collapsed. The cellmate pressed his emergency cell bell and an officer responded to the alarm at approximately 12.27pm. When he reached the cell he spoke to the cellmate through the door. The cellmate told the officer that the man had collapsed.
21. The officer first on scene immediately radioed Hotel 3 for medical assistance and then opened the cell door. (Hotel 3 is the radio call sign for a particular radio that one healthcare staff member will always be holding. This member of staff acts as first responder to any medical situation.) Once inside the cell the officer saw the man lying in the recessed toilet area. The cellmate had already placed him in the recovery position, and the officer could see that the man had vomited. The officer approached the man and realised he had difficulty breathing. He immediately radioed a code blue alarm. (A code blue alarm requests immediate healthcare assistance and indicates a medical emergency relating to breathing problems.) In his incident report, the officer said that other A Wing officers arrived at the cell within seconds.
22. A nurse held the Hotel 3 radio that day and was working on D Wing when the first request came through. She initially moved towards a telephone to call A Wing for further information. However, the code blue call came through almost immediately afterwards and so she headed straight for A Wing where she arrived within two minutes. Following her arrival, the first officer on scene left the cell to give his healthcare colleagues more room to work, and returned to his normal duties. The cellmate was removed from cell A3-11 and taken to cell A3-08.
23. The Hotel 3 nurse felt for the man's pulse which was faint, and then turned him onto his back. His face looked blue in colour so the nurse inserted an airway and asked a colleague to collect the oxygen cylinder. By the time the airway was inserted, a second nurse had arrived with the oxygen and they began cardio pulmonary resuscitation.
24. The Hotel 3 nurse told an officer that an ambulance would be needed and this request was made by the control room at 12.32pm. Soon afterwards, more nurses and the doctor arrived at the cell and assisted with the resuscitation attempt. An ambu-bag (a manual ventilation bag) was placed on the man and connected to the oxygen. A defibrillator was used but staff were not told to

shock him as his heart was asystole, meaning that it did not have a shockable rhythm. (A defibrillator is a machine that provides an electric shock to the heart to try to get it started again. A defibrillator would not be used when the heart does not have sufficient rhythm as it would not have any effect.)

25. The ambulance arrived at the prison at approximately 12.40pm, and was directed through to A Wing. It arrived at A Wing at 12.41pm, and the paramedics arrived at the cell within ten minutes of the ambulance being called. The paramedics took over CPR and inserted an endotracheal tube into the man's throat to try to ensure that air reached his lungs. During the resuscitation attempt the man breathed on his own for short periods of time. However the electrocardiogram reading was asystole throughout.
26. The governing Governor was informed of events at 12.55pm and arrived at the man's cell at 1.08pm. At 1.18pm, the paramedics took the man to the ambulance in a wheelchair. The ambulance left HMP Leeds at 1.27pm with two officers accompanying him to the hospital. They arrived at Leeds General Infirmary at 1.30pm but, following further attempts at resuscitation, he was declared dead by the supervising doctor at 1.40pm.
27. While the man was taken to hospital, the duty governor undertook a hot debrief at 1.30pm. It was attended by all the members of staff who were involved in the situation, including healthcare staff. The debrief was felt to be useful by those who attended as it allowed staff to express their emotions and recount what they had undertaken. The IMB, chaplaincy and Care Team were able to offer support. Following the man's death the Governor released a notice to inform staff and prisoners.
28. A senior officer (SO) was appointed Family Liaison Officer (FLO) at 2.00pm following the news of the man's death. The SO's first task was to establish contact with his family to inform them of his passing. The SO initially looked on the computer system and in the man's core record for the information. Her searches revealed that there were three family members recorded – his 16 year old son, his sister and a woman who worked for the charity that the man supported. There was no address given for his son or sister. The SO contacted the appropriate Social Services Department who were able to provide an address for his son's mother. The prison was aware that his son was only 16 years old and, as he was a minor, the SO needed to find out if an adult would be present when he was told of his father's death. The Social Services Department confirmed that his mother was with him at home, as they had just spoken to her. The SO, the duty Governor, and a member of the chaplaincy team drove to the family's address and broke the news of the man's death to them at 5.20pm.
29. The family were understandably shocked by the news, but did not wish any further involvement and requested the prison organise the funeral and inform them of the date. His property was returned to his family.

30. The friend of the man who worked for the charity was made aware of his death but the prison was unable to contact the man's sister as neither telephone number was in use.

After 16 September

31. The SO rang the mother of the man's son on 22 September to inform the family that the cause of death was a pulmonary embolism. She asked if the man could be laid to rest at a named cemetery in their local area. Following the family's choice of cremation and the issuing of an interim death certificate from the Coroner, the SO organised the funeral for 8 October and the prison offered to pay the expenses. Prisoners on A Wing bought a wreath, and the SO and two members of staff from the workshops attended. The family were offered a visit to the prison but they declined the offer.

ISSUES

The man's clinical care while in prison

32. The man only had brief contact with the medical staff while at Leeds. Upon his arrival his blood pressure was recorded as 116/76 which the clinical reviewer describes as a reading which would have given no cause for concern. After the initial appointments with the healthcare team regarding his stress-related symptoms, he did not see a doctor from late 2006 until he collapsed.
33. The clinical reviewer notes that the man only apparent risk factor in terms of the development of coronary problems was his smoking. In his clinical review the doctor recommends:
- “The Head of Healthcare should consider that those prisoners identified at high risk of cardiovascular disease are managed in line with agreed national standards of care.**
- “The Head of Healthcare should consider that all smokers are offered appropriate smoking cessation services which are at least equivalent to those offered in the community. And that these are re-offered at least annually even if initially declined.”**
34. The clinical reviewer concludes his account of the man's clinical care at Leeds by writing:
- “... I find that the clinical care of [the man] during his time in prison was to an acceptable standard and equivalent to the care that could have taken place in a community setting.”

The attempted resuscitation of the man

36. The first officer on scene responded to a cell bell at approximately 12.27pm when he spoke to the cellmate. Once told about the man's condition the officer called for healthcare assistance. The initial request did not indicate an emergency which explains why the Hotel 3 nurse was originally going to telephone A Wing for more information. It was only after the officer went into the cell and saw the severity of the man's condition that a code blue call was made. However, the difference between the two calls was a matter of seconds and, prior to the officer seeing the man, he had insufficient knowledge of the situation to immediately alert staff to an emergency.
37. The arrival of the wing staff was very prompt and the Hotel 3 nurse arrived from D Wing within two minutes. Once at the cell, CPR was carried out promptly and appropriately. The response time of the paramedics was also impressive and they continued the CPR for 20 minutes before the decision was made to take the man to hospital.
38. The clinical reviewer says that:

“... the procedures for dealing with a medical emergency on A Wing appear to have been followed correctly and there was an adequate response in terms of appropriate numbers of the trained personnel arriving in a timely fashion to try and resuscitate [the man]. The manner of resuscitation using chest compressions and providing artificial respiration together with continuous oxygen appears appropriate and of a sufficiently high standard. The use of equipment in terms of a cardiac monitor and defibrillator was also a sign of good clinical practice in a setting such as a prison. This sort of equipment is not always readily available in community settings.”

39. The clinical reviewer does raise some concerns over the quality of the record keeping which have resulted in a recommendation to the Head of Healthcare:

The Head of Healthcare should remind staff involved in serious medical incidents such as resuscitations of the importance of making same day entries in the medical records.

40. However, the clinical reviewer also writes:

“...the care provided at the time of his collapse was in my opinion to a relatively high standard and was at least equivalent if not better than that which could have been expected in the community. I have no cause for concern that anything could have been done differently at the time of his collapse or that there were significant delays during resuscitation which led to any worsening of the eventual outcome.”

41. I endorse these views.

Liaison with the man’s family

42. The Family Liaison Officer had some difficulty in contacting the family due to the incomplete details provided by the man. The prison was unable to contact his sister but tried each of the numbers provided by him. Prison staff informed his friend from the charity that he supported.

43. Contacting the man’s son required the SO to ask the Social Services Department for the address of his mother. It was also necessary to ensure that she would be present as his son was a minor. Prison staff spent quite a long time establishing these details, so his son and his mother were only informed of his death at 5.20pm on 16 September. However, given the difficulties involved and the need to ensure that his mother was present at the time of the meeting, I think that staff acted appropriately and as quickly as they could. Having complete next of kin details would have helped prison staff contact the man’s family quicker or, in the case of his sister, at all. I therefore recommend:

The Governor should remind staff of the need to collect next-of-kin details continuously throughout the sentence of a prisoner.

44. The family wanted no further involvement and wished the prison to organise the funeral. I understand that the SO organised the funeral at a location that the family chose, and the prison offered to meet the expenses. I recognise the efforts of the Family Liaison Officer in undertaking this task. The prison also returned the man's remaining money and valuables to the family, and are currently organising the return of his remaining property. This seems entirely in line with the prison's responsibilities.

Support for staff and prisoners

45. The Governor released a notice to inform staff and prisoners of the death of the man and alerted the IMB, Care Team and chaplaincy. All members of staff involved in the resuscitation attempt to whom my investigator spoke were complimentary about the support offered by the prison, and said there was considerable support available if needed.

RECOMMENDATIONS

I make four recommendations:

1. The Governor should remind staff of the need to collect next-of-kin details continuously throughout the sentence of a prisoner.

The Prison Service accepted this recommendation and said:

“HMP Leeds now has forms on the PIDs (Prisoner Info Desks) so that prisoners can submit any changes as and when they occur. Additionally Personal Officers will collect this information as part of their work (under the new personal officer scheme which is being implemented) and remind prisoners of the need to keep them informed if there are any changes.”

2. The Head of Healthcare should consider that those prisoners identified at high risk of cardiovascular disease are managed in line with agreed national standards of care.

The Prison Service accepted this recommendation and said:

“This will be taken forward as an element of the chronic disease management plan.”

3. The Head of Healthcare should consider that all smokers are offered appropriate smoking cessation services which are at least equivalent to those offered in the community. And that these are re-offered at least annually even if initially declined.

The Prison Service accepted this recommendation and said:

“A joint initiative with Public Health Services will be undertaken.”

4. The Head of Healthcare should remind staff involved in serious medical incidents such as resuscitations of the importance of making same day entries in the medical records.

The Prison Service accepted this recommendation and said:

“Staff reminded though staff meetings. Annual medical records audit implemented. Regular peer reviews of medical records to aid learning.”