PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Leicester in March 2013

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of the investigation into the death of the man at HMP Leicester. He had a heart attack in his cell in March 2013. He was taken to hospital but could not be revived. He was 66 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A review of the clinical care which the man received in prison was undertaken by a clinical reviewer. The prison cooperated fully with the investigation.

The man entered prison in September 2011. He was already unwell, suffering from arterial disease and adult on-set diabetes which was poorly controlled. He was escorted to numerous outpatient appointments and spent two periods as an inpatient at the local hospital to treat the effects of his diabetes. He was under the care of the cardiology department when he suffered a sudden heart attack and died. The post-mortem examination found that his arteries were so blocked that he could have died at any time.

The clinical reviewer concludes that the resuscitation attempt by staff was appropriate and that the man received healthcare in prison equivalent to that offered in the community. I agree with his findings and do not make any recommendations.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2013**

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SUMMARY

1. The man was sentenced to prison in September 2011 and was taken to HMP Leicester. He had pre-existing health problems, including adult on-set diabetes and narrowed arteries, for which he had previously undergone surgery. His diabetes was poorly controlled and had already affected the circulation in his legs and feet.

2. He had regular outpatient appointments for his diabetes at the hospital across the road from the prison. The wounds on his feet were regularly dressed by the nurses. He was admitted to hospital for a month in the summer of 2012 when the condition of his feet deteriorated. When he was discharged he went to live in the prison's healthcare centre. A consultant subsequently reviewed him and decided that his feet were improving.

3. The man was admitted to hospital again for another month over Christmas and New Year. A diagnosis of heart failure meant that further surgery on his feet could not be considered at that time and he also suffered from anaemia. In February 2013 he saw a consultant vascular surgeon, who thought that his feet were improving again. He also saw a consultant cardiologist who prescribed medication for his heart problems. Further reviews were planned with the cardiology department.

4. In March 2013, staff discovered the man in his cell. He had suffered a heart attack. Staff moved him onto the bed and performed cardiopulmonary resuscitation. An ambulance was called and he was taken to hospital, but was pronounced dead a short while later.

5. A clinical reviewer completed a review of the man's clinical care. We agree with his finding that he received healthcare in prison equivalent to that offered in the community. We do not make any recommendations.

THE INVESTIGATION PROCESS

1. This office was notified of the man's death on 13 March 2013. Notices to staff and prisoners were displayed at HMP Leicester, encouraging anybody with information about his death to contact the investigator. Nobody came forward.

2. The investigator visited Leicester on 15 March. He collected copies of the man's clinical record and prison record and visited the unit and enhanced care facility where he had lived. He also interviewed a member of staff.

3. A clinical reviewer was appointed by the local PCT to review the man's clinical care.

4. On 12 April, the investigator interviewed two further members of staff.

5. The local Coroner has been sent a copy of this report.

The man's family

6. One of our family liaison officers wrote to the man's relatives but they did not contact her to communicate any concerns. They have not provided our family liaison officer with any comments on the draft report.

HMP LEICESTER

7. HMP Leicester is a small city centre prison which receives prisoners from the local courts.

Her Majesty's Inspectorate of Prisons (HMIP)

8. HMIP last inspected Leicester in October 2010. They had previously recommended that care for prisoners with life-long conditions should be developed. This recommendation had been achieved. The prison had implemented life-long conditions registers on SystmOne (the clinical electronic record system) and follow-up and occasional clinics for prisoners with diabetes, blood pressure problems, asthma and other conditions were held.

Independent Monitoring Board

9. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report, covering February 2011 to January 2012, the IMB wrote:

> 'The provision of healthcare from one supplier [rather than a number of providers as previously] has led to improved communications between services and lowered waiting times. This has been reflected in the reduction of applications to the Board concerning healthcare issues.
>
> 'The GP service has been provided by locums and this has led to a lack of consistency for prisoners.'

Previous deaths at Leicester

10. In the last two years, we have investigated three other deaths at Leicester. All three were self-inflicted deaths. As a result of our investigation of the death of a man at Leicester in April 2011, we recommended that cardiopulmonary resuscitation be carried out outside the cell if necessary. This was because space in the man's cell was very limited. The prison rejected the recommendation. There was also very little space available in the man's cell because of fixed furniture and resuscitation had to be performed on his bed, which is not ideal.

KEY EVENTS

2011

11. On 2 September 2011, at Crown Court, the man received a 15 year prison sentence and was taken to HMP Leicester.

12. The man provided healthcare staff with a letter from his diabetes specialist in the community. He had suffered from type 2 diabetes since 1989 and had to inject insulin every day. He was overweight and particularly at risk of diabetic foot problems. He was at high risk of amputation of his lower right leg. He had high blood pressure, high levels of fat in the blood, loss of sensation and poor circulation in both feet, damage to the retinas of his eyes and foot ulcerations. He had previously undergone angioplasty on arteries in his legs in 2005 and 2009. (Angioplasty is an operation to widen narrowed or blocked arteries.)

13. Before he came to prison, the man's diabetes was not well-controlled. He required regular input from a dietician and a diabetes nurse specialist. Prison healthcare staff liaised with staff at the hospital to ensure that he attended fortnightly appointments at the diabetic foot clinic and regular appointments at the general diabetes clinic run by a doctor. They also completed a care plan for the ulcers on his feet and lower legs. He was supposed to move to HMP Rye Hill as a normal part of his sentence progression, but remained at Leicester because of his frequent visits to the hospital just across the road from the prison.

14. The man was initially admitted to the enhanced care facility, part of the prison's healthcare centre, but was discharged to a wing on 8 September. Nursing staff continued to treat his ulcers and change his dressings daily. He was allowed to keep his insulin in his cell. By October, he had been given a job as the stationery orderly, preparing the weekly prisoner letters. He shared a cell with another prisoner of a similar age who also suffered from diabetes.

15. In November, staff completed a Personal Emergency Evacuation Plan for the man because of his reduced mobility. The plan indicated that he should live on the ground floor, where he was already located.

16. In December, healthcare staff realised that the man was not taking the correct dose of insulin. His medication was therefore no longer given to him to keep in his cell and administered under supervision.

2012

17. When the man attended the diabetic foot clinic at hospital on 15 March 2012, it was noted that prison healthcare staff had failed to prescribe ciprofloxacin in addition to clindamycin (two different antibiotics) in accordance with a hospital letter sent after his last appointment on 16 February. Both were subsequently prescribed.

18. On 31 March, all of the vulnerable prisoners were relocated to a landing below ground level. Another prisoner had to collect the man's meals for him from this point onwards because the food servery was on the floor above.

19. After the man visited the multidisciplinary foot ulcer clinic at the hospital on 14 June, prison healthcare staff were advised to stop his antibiotics because his feet were improving and there was no sign of infection.

20. On 7 and 8 July, the man refused to have the dressings on his feet changed, saying that it was too painful for him to walk from his cell to the healthcare centre. Staff advised him that it was unsafe for them to change the dressings in his cell because the chance of infection was high.

21. The man was reviewed in the vascular surgery clinic at hospital on 9 July and a further urgent angioplasty was planned in the next few weeks.

22. On 11 July, the man saw one of the prison GPs, who prescribed co-codamol (a pain killer) and continued his prescription for amitriptyline (an antidepressant).

23. On 12 July, the man attended the multidisciplinary foot ulcer clinic at the hospital. He was being investigated by the vascular surgery team, who planned an angiogram (an examination of the coronary arteries) and then possibly another angioplasty. He was prescribed gabapentin (for pain relief) in addition to amitriptyline.

24. By 17 July, the necrosis (decay) on the man's toe had spread to his foot and staff agreed to change his dressings in his cell rather than having him walk to the healthcare centre. Staff contacted the hospital and brought forward his next appointment to 25 July, the earliest available, because they were concerned about the deterioration in his feet.

25. The man was then admitted to hospital from 19 July until 24 August. His toe was amputated and he developed a urinary tract infection and diarrhoea. Towards the end of his stay, the other toes on his left foot were amputated. He returned to the prison with two discharge letters and a care plan for his wounds.

26. When the man returned to Leicester, he moved to a cell in the prison's enhanced care facility. Although he was now living upstairs, the building has a lift. The equalities manager oversaw reasonable adjustments to his living environment to take account of his disability. His mobility was now reduced so he either used a wheelchair or walked with a stick.

27. At the end of August, the man complained that his pain relief was ineffective during the night. The doctor saw him and amended his prescription.

28. In September, the man started his job as stationery orderly again. He also saw a physiotherapist who encouraged him to exercise to reduce the pain in his feet. His prescription for nightly pain relief was switched to tramadol. In

October, he was given a new mattress and saw a physiotherapist again, who advised him to keep practising walking with a stick.

29. On 22 October, a consultant vascular surgeon reviewed the man at his hospital clinic and thought that his foot wounds were doing well. He considered that they would slowly heal and he did not plan to see him again.

30. A physiotherapist reviewed the man again in November. He was able to walk a short distance during the session but would not normally attempt this day to day. The physiotherapist noted that his wheelchair was unsafe. It was removed and he was not immediately provided with a replacement. He began to walk to appointments and his mobility improved. Another wheelchair was provided but was not reserved for his sole use.

31. On 14 November, the man was prescribed flucloxacillin (an antibiotic) when he visited the diabetic foot clinic.

32. On 8 December, a GP reviewed the man and diagnosed a wound infection on his feet. He was taken to the hospital for treatment and returned later that day. His antibiotics were increased. On 10 December, a GP diagnosed anaemia (a lack of iron in the blood) and ordered blood tests. The next day the physiotherapist reviewed him.

33. The man was admitted to hospital on 13 December and underwent a blood transfusion for his anaemia. He had to have an angiogram before further surgery on his infected toes and feet could be considered. He was too short of breath to have the angiogram and therefore surgery was postponed. He was given medication to improve his shortness of breath and eventually had the angiogram on 31 December. This showed cardiac problems which needed to be resolved before he could have any further surgery or amputation. He remained under the care of the cardiology department for outpatient appointments and it was decided that the ulcers on his feet would be treated with antibiotics and dressings.

2013

34. The man returned to the prison on 9 January 2013. The hospital doctor had prescribed ciprofloxacin and doxycycline (an antibiotic). His wound was still infected, and he was prescribed co-codamol for the pain.

35. The man saw the physiotherapist again on 22 January. He was prescribed flucloxacillin after he visited the diabetic foot clinic at the hospital on 7 February. He attended the diabetes clinic on 11 February. The registrar thought that he ‘remained well’.

36. On 12 February, the man went to see a consultant, who examined his feet and thought they were the best he had ever seen them and that they would probably heal in due course. He was also issued with a pair of soft boots. The physiotherapist reviewed him again on 19 February. He was pleased with his progress and thought that he did not need any further reviews.

37. The man saw a consultant cardiologist at the heart failure clinic at a different hospital in Leicester on 27 February. The cardiologist prescribed medication for heart failure. He was due to see a heart failure specialist nurse four weeks later and the cardiologist again four months later.

38. The man moved into cell 2 on the enhanced care facility on 5 March.

March 2013

39. On the day of the incident, healthcare staff changed the man's feet dressings at about 2.30pm and he went back to his cell at about 3.50pm. An officer locked him in and saw him sit down in his chair before he locked the door. A healthcare assistant checked him again at about 4.30pm when he seemed well.

40. The man had asked to see a doctor earlier that day to discuss his antibiotic prescription. A locum GP came on duty at 4.50pm and after seeing his first patient, he went to see him. At 5.10pm, the healthcare assistant, doctor and officer went into his cell and discovered him sitting in his chair with his back to the door. At first it looked like he was watching television, but he was unresponsive and they realised that he was not breathing.

41. The duty governor was in an office on the enhanced care facility with a nurse at the time when they heard shouts for assistance and went immediately to the cell. The doctor thought that the man had had a heart attack and asked for an emergency ambulance to be called. The nurse telephoned the control room and instructed them to call an emergency ambulance. Meanwhile, another nurse went to collect the emergency response bags and defibrillator from the treatment room on the ground floor, two floors down.

42. Because the man was a heavy man, staff found it difficult to move him. They managed to move him to the bed, and the doctor and healthcare assistant began cardiopulmonary resuscitation (CPR). There were two beds in the cell which were fixed to the floor, and also a heavy cabinet which meant that there was no space for staff to lie him safely on the floor and still have room to attempt resuscitation. With the doctor's agreement, staff decided to perform chest compressions while he lay on the bed.

43. The duty governor radioed a 'code blue' emergency to the control room. (This communicates that the patient is not breathing.) She asked for the radio network to be switched to 'talk through' to allow her to communicate with a Senior Officer (SO), the orderly officer. She did not immediately make this call because she (as duty governor) and healthcare staff were on the scene straight away and an ambulance had been called. She asked the SO to put staff at the gate to escort the paramedics who were on their way. She also radioed another SO to prepare the escort risk assessment.

44. Both nurses arrived at the cell within a couple of minutes with emergency response bags, oxygen and a defibrillator. Two other nurses joined the

resuscitation effort. The officer took over chest compressions from the healthcare assistant while the nurses gave the man oxygen. The defibrillator detected a heart rhythm and advised a shock, which the doctor administered. Staff continued to perform CPR. A first response paramedic arrived at 5.15pm, joined the resuscitation effort and delivered a second shock when the defibrillator instructed. Two other paramedics arrived in an ambulance at 5.19pm. At this point the prison staff withdrew and the three paramedics continued the resuscitation attempt.

45. At 5.55pm, the man was taken by ambulance to the hospital across the road from the prison, arriving at 5.56pm. He was accompanied by two officers and was not restrained. He was taken to the accident and emergency department but was pronounced dead at 6.07pm.

46. The duty governor chaired a 'hot debrief' meeting for staff as soon as the man was taken to hospital for staff to identify any immediate lessons from the emergency and check on each other's welfare.

47. At 8.20pm, the deputy governor, the chaplain and the family liaison officer visited the man's partner, his named next of kin.

48. The funeral was held on 5 April. The prison contributed towards the cost of the service.

49. The post-mortem examination found that the man's death was caused by ischaemic heart disease resulting from severe coronary atheroma (an accumulation of debris in the arteries). The degree of atheroma of all three major coronary arteries severely restricted the blood supply to the heart, producing a risk of sudden death at any time.

ISSUES

Clinical care

50. A clinical reviewer reviewed the man's clinical care. He comments:

> 'The man had medical problems which required a special degree of medical care, and these were carried out adequately and appropriately within the prison environment. He complied with his treatment and was not a difficult patient to manage in the Enhanced Healthcare Facility.
>
> 'His medical condition was a risk for coronary artery disease and he was at risk of sudden death from heart disease. The mode of dying was consistent with this, and this was also borne out by the post mortem findings.
>
> 'The response to his being found in a state of collapse was appropriate, and the equipment used in attempted resuscitation was in date, suitable and had been regularly checked and these checks are documented.
>
> 'In my opinion, the standard of healthcare provided in this case was of a standard which would be expected, and was equivalent to, that available in the community.'

51. Staff attempted to resuscitate the man on his bed. The preferred option is to perform cardiopulmonary resuscitation on a firm surface. However, it was a struggle to move him even the short distance from his chair to the bed because of his size. There was no room to place him on the floor of the cell because of fixed furniture. We recommended in a previous investigation at Leicester that prisoners should be moved to the landing if there was insufficient space in the cell for a resuscitation effort. However, we think staff acted sensibly on this occasion in not attempting to move him any further and it is likely that the prison bed provided an adequate firm surface. We agree with the clinical reviewer that the resuscitation attempt was appropriate.

52. We agree with the clinical reviewer that the healthcare the man received in prison was equivalent to that offered in the community. We do not make any recommendations.