

**Investigation into the circumstances surrounding the  
death of a man at HMP Leicester  
in May 2008**

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

**November 2009**

This is the report of an investigation into the circumstances of the death of a man in May 2008 at HMP Leicester. It was his first time in custody and he had been in Leicester for only 72 hours. He died from cardiac arrhythmia (a fatal irregular heartbeat) due to chronic biventricular heart disease. Alcohol withdrawal contributed to his death. He was 41 years old.

I would like to offer this public expression of sympathy and condolences to the man's family and friends for their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. His partner has raised a number of issues with one of my family liaison officers and I hope my investigation begins to offer answers. I regret the delay in the completion of this report.

The investigation was carried out by my colleague and her report has been written in conjunction with another colleague. A clinical review was conducted by a clinical reviewer on behalf of the local City Primary Care Trust, and I am very grateful for his contribution. I also thank the Governor and staff of HMP Leicester for their co-operation, in particular the establishment's liaison officer.

I believe that staff at Leicester managed the man's alcohol withdrawal effectively, and detoxification medication was prescribed appropriately. Although the clinical review has identified some issues of concern, it is now clear that he had chronic heart disease and was vulnerable to sudden illness. In this light, I believe that Leicester did all that they could given the information available at the time.

I endorse the recommendations of the clinical review and make two further recommendations in respect of suicide and self-harm management procedures and the coded emergency call system.

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.

**Stephen Shaw CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

The man was dependent on alcohol and had suffered from seizures when rapidly withdrawing from its use. He received a suspended sentence with a supervision order in January 2008 for driving whilst unfit. He appeared at court in May after breaching his supervision order. Due to his drunken state and abusive behaviour towards the Judge, he was charged with contempt of court. He was remanded into custody at HMP Leicester until the adjourned hearing on 12 May.

On arrival at Leicester, the man was interviewed by the doctor and nurse for his reception health screen. It showed he was a heavy drinker but there were no concerns about his physical health. He discussed previous alcohol withdrawal related fits, about which he was anxious, and previous medication. The doctor prescribed the prison's standard nine day detoxification programme of Chlordiazepoxide (Librium) to help reduce the likelihood of fits. Aside from his alcohol problem, the doctor had no undue concerns about him. He was transferred to the First Night Centre, where he remained during his short time in prison.

The man was seen over the weekend by a number of staff including nurses administering his medication and discipline staff on the wing. On 10 May, a nurse saw him for his substance misuse assessment. He agreed to go to the detoxification landing if and when a space became available. The nurse found his blood pressure to be very high, and that he had a whole body tremor and was sweating profusely. The symptoms were all consistent with his withdrawal state and she had no undue concerns about him.

In May, the man returned to court. His medication had to be delivered to him there due to an administrative error. He complained of feeling unwell in the dock. Upon his return to prison, he was described by escort staff as acting bizarrely and arguing with other prisoners. In reception, at around 2.00pm, he was placed in a holding cell alone. When the reception officer returned 20 minutes later, he had collapsed. The doctor and nurse on reception attended immediately. Initially, his pulse was rapid and he was pale and sweaty, but within a minute he regained consciousness and his pulse returned to normal. He told the prison doctor that he had felt light-headed and fallen to the floor. He said he had not had many fluids. The doctor tried to give him an extra dose of medication but he refused. The doctor concluded that the symptoms were consistent with his alcohol withdrawal, and that the man was a little dehydrated and anxious. He was felt to be well enough to go back to the wing at 3.00pm.

On the wing, the man became very agitated and started shouting and being aggressive to staff. His cellmate was moved and staff tried to calm the man down so they could go into his cell and talk to him. At about 4.30pm, in front of one of the officers, he tried to harm himself by cutting his wrist with a plastic knife. Emergency assistance was requested. Whilst waiting for the nurse to arrive, he smashed his television and tried to cut his wrist again. At this point staff had to enter his cell to prevent further injury. After lunging at one of the officers, the man was restrained and moved to the segregation unit. He calmed down and was examined by a nurse and the doctor who found superficial cuts to his wrists, nose and back, all consistent with the self-injury and use of restraint. Officers opened an ACCT (Assessment,

Care in Custody and Teamwork – a document used to support and monitor those deemed at risk of self harm or suicide). Due to his refusal of further detoxification medication and the episode of agitation and confusion, the doctor sent him to the Enhanced Care Facility (ECF – the healthcare unit) at around 5.15pm to remove him from the situation. His plan was to assess him, see how he responded and calm him down. The doctor considered that his behaviour appeared consistent with alcohol withdrawal.

The man's ACCT did not travel with him, so in the absence of guidance on the frequency of his observations the officer in the ECF decided to check him every ten minutes. The officer, who was on duty alone, had to call the doctor to clarify why the man had been brought to ECF and what he should be monitoring. He continued to be agitated, shouting and throwing things around in his cell. At 6.50pm, a senior officer tried to complete the ACCT action plan but got no response from him. At 7.00pm, the nurse came on duty and brought him his medication. She saw him sitting up and trying to talk, but she could not understand what he was saying. The officer on duty came to assist and shortly afterwards he collapsed on his cell floor. The officer immediately called for assistance to enter the cell and within minutes was at his side. Whilst emergency medical assistance was sought, the nurse commenced cardio-pulmonary resuscitation alone. She stopped when the doctor arrived. Despite her efforts, the man's life could not be saved and the doctor pronounced him dead at 7.18pm.

## THE INVESTIGATION PROCESS

1. My investigator conducted a preliminary visit to HMP Leicester on 16 May 2008 and returned on a number of occasions to interview staff. During the course of her initial enquiries she was shown around the prison and visited the cell where the man had died. She reviewed all the relevant documentation and established a chronology of events.
2. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak with my investigator. No one came forward as a result. My investigator met representatives of the local branch of the Prison Officers' Association (POA) and members of the Independent Monitoring Board (IMB). They did not share any specific concerns.
3. The local Primary Care Trust commissioned an independent review of the man's medical care whilst he was in prison. The clinical reviewer carried out the clinical review. My investigator and the clinical reviewer visited Leicester on 18 June to interview staff jointly. My investigator conducted separate interviews with discipline staff and the man's cell mate. In addition, she spoke with his solicitor, his probation officer, and probation staff at court by telephone. All provided valuable background information.
4. 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, my report will be sent to the Coroner to assist in his enquiries into the man's death.
5. My investigator and one of my family liaison officers met the man's partner on 17 June 2008. The purpose of the meeting was to listen to her concerns about the circumstances surrounding his death. She also raised some issues on behalf of his parents. Her questions were:
  - About the medical treatment he received whilst he was in prison and whether the severity of his alcoholism was fully recognised?
  - Whether he was given sufficient medication to manage his detoxification and whether he was honest about his alcohol intake?
  - To discover whether the prison was made aware of his past history of fits on rapid withdrawal from alcohol.
  - Whether he should have been admitted to healthcare on his arrival at prison, and whether his doctor had been contacted about previous medical history?
  - What caused his distress just before he was removed to the segregation unit?
  - Whether he had demanded extra medication and whether he missed any medication (including when he was taken to court in May)?
  - About his black eyes. His parents were concerned about bruising on his body following his restraint and whether these injuries had caused or contributed to his death.

6. My investigator and the clinical reviewer explored these questions. In relation to the black eyes, the investigation has not been able to establish how they occurred and suggest that the inquest may be able to shed more light on this matter.
7. A copy of the draft report was sent to the Prison Service. The responses to the recommendations are repeated verbatim in the relevant section.
8. The man's partner was also sent a copy of the draft report. She expressed her disappointment that the severity of his alcohol dependency and withdrawal were not evident to the staff.

## **HMP LEICESTER**

9. HMP Leicester is a local category B prison in the East Midlands for adult males. It has a certified normal accommodation of 206 prisoners and operational capacity (total crowded capacity) of 392.
10. It is a small, old, inner-city prison. The main residential unit is a large, four-storey, early Victorian building. This is divided into a First Night Centre, segregation unit and behaviour improvement landing, a self-contained detoxification landing and vulnerable prisoner unit, and a landing holding prisoners on basic, standard and enhanced status (depending on behaviour).
11. Primary healthcare is commissioned by the local Primary Care Trust and provided by Serco Health. There is 24 hour cover with a daily GP and weekly visits from a psychiatrist, dentist, physiotherapist, psychologist and sexual health specialist.
12. The detoxification landing is supervised by a substance misuse nurse or other healthcare staff when the nurse is on leave. Prisoners go to the treatment room on the main wing to collect their medication and there is no nurse based permanently on the detoxification landing. The landing is managed by two members of discipline staff who are experienced in dealing with people withdrawing from substances. There are 32 beds in 16 double cells. Prisoners tend to stay there for about two weeks or as long as is necessary. The regime is more active than on normal location. About 25 per cent of prisoners involved in contact with the substance misuse nurse are detoxing from alcohol. Transfer to the detoxification landing can take a few days due to population pressures. Prisoners undergoing detoxification live in the First Night Centre and are monitored by healthcare and discipline staff until spaces become available.
13. Since my office took over responsibility for investigating all deaths in prisons in April 2004, there have been three deaths at Leicester due to natural causes prior to that of the man.

## KEY FINDINGS

### Events leading up to the man's death

14. The man arrived at Leicester at 2.20pm in May 2008 and was seen by officers in the prison's reception. The prisoner escort form (PER) that accompanied him from court showed that he had a medical condition related to alcohol issues and was an alcoholic. His next of kin was recorded as being his partner. At 4.06pm, the prison doctor and the reception nurse interviewed him as part of the First Reception Health Screen to assess his physical and mental health and formulate a plan of action for his care.
15. The reception nurse assessed the man as fit for normal location, work and any cell occupancy. He denied any suicidal thoughts and said he had not received medication for mental health problems or had any contact with psychiatric care in the community. He said he had been receiving prescribed medication, namely Citalopram (an anti-depressant), thiamine (vitamin B), Librium (a sedative and anti-convulsant medication) and Lansoprazole (used to prevent stomach acid). A confirmatory fax from his doctor a few days later showed that no medication had been prescribed since November 2007. No relevant family history was mentioned. The man said he was a smoker. His blood pressure and pulse were taken using an electronic sphygmomanometer (his pulse was not measured manually). His pulse was rapid though not irregular. In interview, the reception nurse said that he recognised the man was withdrawing from alcohol but he was coherent and did not appear to be intoxicated.
16. The prison doctor's assessment was that the man was a heavy drinker. He said his alcohol intake was 40 units a week or above (this is the maximum the computerised record system (EMIS) will record so it may have been higher). He smelt of alcohol. The man said that he had seen a doctor in the previous months but had no concerns about his physical health.
17. They explored the issue of the man's heavy drinking and the prison doctor prescribed a standard nine-day alcohol detoxification course of Chlordiazepoxide (also known as Librium), to help reduce the likelihood of alcohol withdrawal related fits and thiamine for two weeks. He received his first dose that afternoon. Had the prison doctor thought it necessary to vary the standard regime and increase the dose he could have done so at any time, but he told the investigation that the man was not unusual and nothing of concern was apparent at the time. He referred him to the detoxification nurse to be seen the following morning. The prison doctor remembered the man being well orientated but very anxious about his first time in prison and about the fits he had previously experienced when withdrawing rapidly from alcohol. The prison doctor reassured him that the drugs would help, and that the detoxification nurse would monitor him.
18. The man was moved to cell L1-21 in the First Night Centre (FNC) with a Polish prisoner. All prisoners go to the FNC on their first night, including those detoxifying, unless it is felt that they are too ill and are moved directly to

the detoxification unit or the Enhanced Care Facility (healthcare unit). It is unusual for prisoners to be moved to the detoxification unit at the weekend and the transfer process usually takes a few days. An FNC Officer carried out the man's first night centre interview on the wing. The Officer thought he appeared a bit drunk and smelt of alcohol. The man told him that he was in prison for contempt of court because he had 'mouthed off' at the Judge, and was returning to court on Monday when he expected to be released.

19. A healthcare nurse saw the man early on the morning to give him his medication. In interview, she commented that he looked very tired and he had agreed and said he had not had much sleep. She asked how he felt withdrawing from alcohol, and he said he did not feel too bad. She reminded him to return for his lunchtime and teatime medication.
20. The man had an appointment at 10.00am with a substance misuse nurse for an assessment for his alcoholism and withdrawal. He agreed to go to the detoxification landing (B2) when a space became available and the nurse put his name down on the FNC noticeboard. The substance misuse nurse explained in interview that the man would not have been moved on a Saturday but kept on the FNC where he would be monitored by the nurses handing out medication and the discipline staff. Discipline staff were aware that he was withdrawing from alcohol and, if they had concerns, they could contact healthcare staff or a doctor if she was not on duty. Prison officers are responsible for allocation to the detoxification wing once spaces become available and there is often a delay of several days. The substance misuse nurse can indicate if there are priority cases.
21. The substance misuse nurse recalled that the man was very pleasant and co-operative. She noted that he felt anxious most of the time, had a constant and severe headache, complained of shivering and said that he felt very low. He told her he had no concerns about his physical health and no history of physical problems. He had experienced multiple episodes of alcohol withdrawal seizures since July 2007 and had been in hospital once for observation and assessment. This had happened when he abruptly stopped drinking. The substance misuse nurse measured his pulse and blood pressure. His pulse was very rapid but she could not recall any irregularity (for which she said she would have called the doctor) and his blood pressure very high. He had not had any sleep the night before and she felt this would have disturbed him. He was restless, had a whole body tremor and was sweating profusely. However, she told the investigation that nothing she saw raised concerns about him, apart from the history of fits, which they discussed. She assessed that he had been prescribed appropriate medication to manage the withdrawal and prevent fits. The substance misuse nurse said that he really wanted to address his alcohol issues.
22. At lunchtime, the man collected his medication from the healthcare nurse and told her he was feeling a bit better. At teatime he collected his medication but said nothing. In interview, the healthcare nurse did not recall him looking unwell that day. The man had an interview with the chaplain who noted that

this was his first time in prison, that he was detoxing, and that healthcare staff were aware of this.

23. On Sunday 11 May, a second healthcare nurse was on duty giving medication on the FNC wing and signed the man's medications sheet three times. In interview, she did not specifically remember him but said that if he were unwell she would have gone to his cell. As she had not done so, she assumed he was well. During association on the wing, the man told the First Night Officer he was a company director. This surprised the Officer. The man was a bit shaky but the Officer was not concerned about him. In interview, another officer also recalled the conversation and answering his cell bell when the man asked to go to chapel that day. She saw him going to get his medication on one occasion. He was sweaty and clammy, but when she asked him if he was okay he said that he was fine, just detoxing. Nothing of concern stood out for her.
24. In interview the man's cellmate said that he had been sweating and trembling over the weekend and was cold. They had been unable to communicate a great deal because the cellmate's English was very limited. He said the man did not like the window open, watched the television a lot, and liked the light on in his cell all the time. The man had left the cell for meals and exercise.
25. The man was due to attend court in the morning. Before going to court, the cellmate said that the man had told him he would never come back to prison and was trembling. At 7.35am, an officer was assisting on reception and unlocked the man's cell so that he could attend court. He was sweating profusely, unsteady on his legs and seemed agitated. When the reception officer asked if he was okay, he said that he was detoxing but was otherwise alright. At 7.55am, a prison officer and the reception officer searched him before discharging him to court. At this point, he seemed to be more stable on his legs and was sweating less.
26. The reception nurse saw the man at around 8.00am in a cell with other prisoners. He assessed him as fit for court and gave him his medication. At 8.25am the Orderly Officer formally discharged him to Leicester Crown Court. In interview, he said there were no obvious concerns at this time. The man's PER noted that he had drug/alcohol issues and was an alcoholic. He arrived at court at 9.00am.
27. At 9.50am, an officer spoke to the reception nurse from court about the man's medication. The reception nurse confirmed that he would receive them on his return to prison. At 11.20am, he received a further call from court staff to say that the man was concerned that, if he did not receive his lunchtime medication, he would have a seizure. After discussing the matter with the doctor, the reception nurse confirmed he would bring them to court himself around 12.00pm. At 12.35pm, he arrived at court and gave the man his medication. In interview, he said that the man appeared quite normal. The reception nurse said that it was an omission that the man had not been given his medication to take to court. Normally, it is given in a separate envelope that goes to court with prisoners on the bus. At 12.57pm, the man again

appeared in court and was remanded into custody and returned to Leicester at 2.00pm.

28. A prison officer was working in reception and recalled in interview that the court escort had remarked on the man's bizarre behaviour in court that day. There was no record of this on the PER. The escort asked the prison officer to keep an eye on him. The prison officer said the man came off the bus shaking and sweating quite a lot, so he asked him if he was alright. The man said that the other prisoners were 'animals'. He then tried to push the prison officer, so he told him to slow down, asked him if he wanted to talk and asked if he was alright, to which he replied 'no comment'. The prison officer tried to ask him what happened and wondered whether the other prisoners might have been tormenting him on the bus by shouting, but the man would not talk to him. He decided to place him in a holding cell on his own. The reception nurse remembered seeing the man mumbling and talking to himself. The prison doctor also saw him standing in reception.
29. At 2.20pm, the prison officer searched the other three prisoners as they returned from court, and then went to see the man to do the same. At about 2.30pm, he opened the cell door to find him lying face down on the floor with his head on his arm, breathing very heavily. He asked him if he was alright but got no response. The prison officer called for medical assistance and radioed for Hotel 4 (the emergency response nurse) to come to reception (although there is no control room record of this). The reception nurse who was on reception attended to check the man's breathing and pulse which were present, and then called the prison doctor as she could get no response from him. The prison doctor assessed him and found his pulse to be very rapid although he detected no arrhythmia (irregular heartbeat) and he was pale and sweaty. The man opened his eyes within a minute, but was a little confused. The prison doctor encouraged him to lie on the floor but within a couple of minutes the man was able to sit up. Although shaky, his confusion cleared and he was able to talk.
30. The man said that he had not felt very well in court. He had felt hot, shivery and sweaty and had had to sit down in the dock. He had felt he was going to pass out but had not done so. The man added that he had not had much fluid to drink. He told the prison doctor that he had felt his vision blur and been light headed, and had fallen to the floor of the holding cell on his return to the prison. The prison doctor saw no signs of injury. In interview, the prison doctor mentioned that when a patient is shaking or moving a lot, it is difficult to get an accurate reading from the electric blood pressure and pulse monitor. Initially, the man's pulse was fast and his blood pressure high, but the prison doctor did not know how much of this was to do with the shakiness picked up by the machine so he continued to check it. Within 15 to 20 minutes, the man's pulse had returned to normal and he appeared more relaxed.
31. The prison doctor confirmed in interview that there was no indication that the man had been fitting when he collapsed and there was no indication of paroxysmal tachyarrhythmia (an irregularly fast heartbeat that comes and goes). He was offered a further dose of chlordiazepoxide, but he refused

saying he did not want to be 'doped up'. The doctor concluded that his symptoms were consistent with alcohol withdrawal, and that he was a little dehydrated and anxious. He was on his third day of detoxification, which I understand is a particularly difficult day in terms of withdrawal. The prison doctor encouraged the man to drink plenty of water and, having made a reasonable recovery, judged him fit to return to the wing. The man was cooperative and chatty. He was escorted back to the main block at around 3.00pm and appeared settled.

32. Wing records show the man's cell bell being rung twice after he returned from court at 3.04pm and 3.22pm. His cell mate said that the man was furious, shouting and aggressive. He shouted at wing officers about his right to be respected. A wing officer responded to the cell bell calls two or three times. He found the man to be agitated, sweating profusely and quite incoherent at times. The wing officer tried to talk to him to calm him down, but he remained agitated saying, 'You've broken me, I need to be released now, I want to go home.' The wing officer explained why this was not possible.
33. At about 3.30pm, the man covered his observation panel with newspaper and the whole of the inside of the doorframe with toothpaste, so that officers could not see inside. The wing officer and another officer had to enter the cell again to explain that the observation panel should be clear. They saw some wet t-shirts hanging from the man's bed and, as the floor was very wet, they assumed that he had tried to wash them. They also asked him to stop pressing the bell for non-emergency reasons and warned that if it happened again he would be placed on disciplinary report. He did not appear to be listening, was incoherent and argumentative. He kept saying the same things about wanting to be released. He was sweating profusely. Both officers were aware that he was detoxing, but they did not know from which substance. Once the officers left, the man started kicking and banging the cell door.
34. A wing cleaner informed staff that the man had obscured his panel again, so another officer went to see him. He tried to reassure him but, in interview, recalled him as being incoherent and unable to listen to or understand what he was saying.
35. Two officers went to carry out the cellmate's induction to the FNC at around 4.00pm. They saw the man sweating and shaking, but thought this was nothing out of the ordinary because they knew he was detoxing. In interview, the first officer did say he had never seen someone sweat so much, and thought it was the worst detoxification symptoms he had ever seen. As he tried to close the cell door, the man tried to stop him, saying that he wanted to get out. The first officer refused and made a note in the wing records that he was being abusive towards staff and had been warned about his language and manner. During his induction interview, the cellmate asked to move cells.
36. Throughout the interview, the man was banging his door and shouting at staff. However, the second officer told the investigation that he was co-operative, albeit agitated, as staff moved his cellmate from the cell. Afterwards, he

continued punching and kicking the cell door and was shaking and sweating. The first officer recalled him walking around his cell trying to clean the sides.

37. At 4.15pm, the man was still punching and kicking his door. Ten minutes later, the reception officer arrived on duty and the first officer went to see if he could calm him down. The man asked him to open the door and let him out, But the first officer refused unless he could calm down. At 4.30pm, the first officer saw the man take a plastic knife from the top of his locker and cut the inside of his right wrist, shouting that he had to open the door now. The first officer immediately shouted for assistance and three officers and a Governor attended. They did not go into the cell as the man was extremely aggressive, kicking his cell door and shouting demands at the staff. At 4.33pm, the control room log shows a call for emergency medical assistance (Hotel 4) to attend the FNC. The second officer told the man that healthcare staff were on their way and that he should calm down. At first, the man ignored him but then seemed to calm down a bit. The second officer asked him to wrap a sheet around his wrist and to sit down.
38. The man then started banging and shouting again and being more aggressive. He threw his television against the rear wall and it smashed on the floor. The Governor went to find the nurse at 4.35pm. The man again tried to cut his wrist. At this point, officers decided to go into his cell to prevent any further injuries. He lunged at the second officer and tried to grab or strike his head, and he was restrained using control and restraint procedures. The second officer held his right arm and pushed him with his palm to the back of the cell. During the struggle, the man and one of the officers fell to the ground because the floor was slippery, and the man cut himself on his back on bits of broken glass from the smashed television. The first officer took control of his left arm and the reception officer controlled his head. Both the first and second officers struggled to get a good grip to apply a wrist lock, due to the amount of sweat and the blood, but they managed to get his arms behind his back.
39. The man continued to be aggressive, and struggled as the manual holds were so slippery. The reception officer decided to apply ratchet cuffs (hinged handcuffs used as part of the control and restraint procedures) and the second wing officer secured them behind his back. At 4.37pm, the control room logged another emergency call for medical assistance. The healthcare nurse arrived at the FNC and saw the man being restrained so she waited outside the cell door and was present throughout. She recalled him saying, 'This is wrong, I shouldn't be here in prison.'
40. The Orderly Officer asked officers to move the man to the segregation unit a few minutes later at 4.40pm. The reception officer faced the man and talked to him throughout the procedure to try to calm him down. He explained he was being moved to the segregation unit for his own safety, but he did not cooperate.
41. The reception officer tried to hold the man's head down as he was spitting at him. On the way, the man stumbled twice and was helped back to his feet.

The reception officer explained that, if he did not spit or head butt, he could walk upright and the man agreed. The Governor accompanied them to the segregation unit.

42. When he arrived at the segregation unit the man was placed in cell S1-09. He appeared a little less aggressive but looked disorientated and was unsteady on his feet. He was described as rambling bizarrely but he understood instructions from officers. The Orderly Officer attempted to calm him down with some success allowing the second wing officer to remove the handcuffs as he sat on the bed. The officers then left the cell leaving 3 segregation unit Officers to search him. The Governor and the healthcare nurse waited outside the cell. The man continued making threats to staff and the officers described him as somewhat delusional, making random comments about being a commander in the army. He was given clean prison clothes and a cup of water. He washed his face and used the toilet.
43. The healthcare nurse then examined him. She observed superficial cuts to his right wrist, nose and lower back, and marks on both wrists from the handcuffs. She assessed him but he would not let her clean his wounds. He became very agitated and kept saying that everything that was happening was wrong and that he should not be in prison. The prison doctor arrived shortly afterwards and talked to him to persuade him to take his medication. In interview, the prison doctor said that the man was surrounded by about six people in his small cell and was becoming quite agitated and aggressive. The prison doctor asked some of the people to leave the cell and he calmed the man down. After initially agreeing to a blood sugar test requested by him, the man refused when the nurse got the needle out. The prison doctor spent some time trying to persuade him to take his medicine, but again he refused.
44. At 4.45pm, the prison doctor signed the medical officer report on form F213SH and said the man was hallucinating, anxious, shaky, and made poor responses to simple requests. At 4.50pm, the wing officer opened an ACCT (suicide and self-harm monitoring document). He made a record of the cuts to the man's wrist and his intention to harm himself. He observed that he was incoherent and agitated. The wing officer then took the ACCT to the centre office to be progressed by the senior officer, in line with the prison's protocol.
45. A Senior Officer (SO) was collating the prison roll at the time and carrying out other duties, so did not deal with the ACCT to confirm the levels of the man's observations until 6.45pm. In the meantime, the prison doctor concluded that, due to his refusal of detoxification drugs and the episode of agitation and confusion, it was best to send him to the healthcare unit. His plan at this stage, which he discussed with the Governor, was to assess the man, see how he responded, and try to calm him down and settled. The doctor judged that his behaviour was consistent with alcohol withdrawal.

#### **Events surrounding the man's death**

46. The man was escorted to the healthcare unit by three officers at around 5.15pm. He was compliant but a bit unsteady on his feet and no restraints

were used. One of the officers noticed that he was showing signs of detoxification, seeming confused and incoherent. They handed over to the Healthcare Officer (HCO) who was on duty on the healthcare unit, informing him that an ACCT had been opened but was being processed at the centre. (the HCO is a member of discipline staff who works on the healthcare unit but is not medically trained.) The officers asked the HCO to keep an eye on the man as he had been quite volatile and had tried to self-harm. It is unclear whether anything specific about alcohol detoxification was mentioned. The second healthcare nurse was also on duty at the time, but shortly after the man arrived she had to go the wings to carry out treatments. Although the HCO did not know the recommended levels of ACCT observations, he made a judgement to check him about every ten minutes.

47. Two officers returned to the man's cell at about 5.40pm to return his glasses. They saw the HCO talking to him through the hatch asking him to stop banging his door. In interview, one of the two officers said that the man was acting most bizarrely, telling him to watch out because something was coming at him. He was still sweating quite a lot and breathing heavily, but less aggressive. They stood at the hatch having a conversation about calming down and suggested that he lie down on the bed.
48. The HCO was on duty alone from about 6.00pm until 7.00pm. As he was unclear about the level of monitoring, he called the doctor for clarification at about 6.30pm. Although in interview the prison doctor could not remember the exact details, he recalled asking how the man was. The doctor asked the HCO to observe him, keep him calm and encourage him to take his medication. The prison doctor was aware that the second healthcare nurse would not be administering medication in the healthcare unit until around 7.00pm. The HCO said the doctor had told him the man was there for observation but the doctor was still looking into the details. The prison doctor had told him about the alcohol withdrawal and that the man had collapsed earlier in reception. Therefore, if he were to stop breathing, collapse or start to fit, then the HCO should go into the cell to intervene. The man continued being very noisy, throwing things in his cell. When the HCO asked him if he was okay, he did not answer. He was pacing up and down and throwing his chair around. The HCO heard him muttering incoherently and not making any sense.
49. Between 6.30 and 6.44pm, the SO finished supervising the evening meal and returned to the centre office where he found the man's ACCT. He decided that observations should be four an hour with conversations recorded in the morning, afternoon and evening. The man should be given access to the Samaritans telephone and access to a Listener (a prisoner trained by the Samaritans). The SO then went to the healthcare unit at 6.50pm to discuss the ACCT with him, but he appeared asleep on his bed facing the wall. The SO called to him but got no response, although he was moving. He thought that he might be ignoring him and the SO said he would return in ten minutes to complete the ACCT.

50. The second healthcare nurse finished her treatments at 6.50pm. The HCO called her to ask who was going to give the man his medication and she said she was on her way up as she was allocated to in-patients between 7.00 and 9.00pm. She arrived at 6.55pm, prepared the medication and paperwork and went straight to the cell. In interview, the second healthcare nurse remembered hearing him shouting and banging his cell door. The SO handed over the ACCT paperwork to the HCO at about 7.00pm and he recorded his first observation which was that the man was still noisy at 7.05pm and had refused his medication.
51. The second healthcare nurse had reached the man's cell at about 7.05pm and called to him that she had brought his medication. He was trying to talk but she could not hear what he was trying to say. He was sitting on the floor, with his knees held to his chest and his arms leaning on his knees. She called the HCO for assistance and he recalled that, by the time he arrived, he was standing up. He asked him to take his medication but got no response. The man just stared back at them.
52. At about 7.10pm, the man collapsed to the floor on his left hand side, with his right arm across his left arm and his legs bent. His head banged the cell door as he fell so that he was blocking the doorway. The HCO immediately ran to the nearby office to telephone for assistance to enter his cell. (Due to the earlier volatile behaviour, he judged that entry was unsafe without another officer being present.)
53. An officer was on duty in the Storm Unit downstairs and answered the call for assistance from the HCO. The officers found it was difficult to open the door because the man's body was in the way. They moved him further into the cell, turned him over onto his back, and the second healthcare nurse checked for signs of life but found none. He was cyanosed (blue in colour) whereas he had been pink before he collapsed. She started cardio pulmonary resuscitation (CPR) on her own without assistance from the officers, and continued for around five minutes.
54. During this time, the HCO made a radio call for a medical emergency and to summon the Duty Governor, 'Oscar 1' (The code for the Orderly Officer) and a doctor to healthcare. A Code Blue (an emergency call to signify that an incident requiring resuscitation equipment has occurred) was not specified.
55. The control room log shows a call at 7.17pm for Hotel 3 and Hotel 4 (healthcare responders) to go to healthcare immediately. The log shows Oscar 1 being called at 7.19pm. The doctor was in reception and came straightaway. He only had to travel up two flights of stairs and through two double doors, so he arrived within minutes. The prison doctor did not instruct the second healthcare nurse to stop CPR, but in interview she said that she stopped to let him attend to the man. The prison doctor said that when he went into the cell, the second healthcare nurse and the HCO came out and CPR was not in progress. The second healthcare nurse went to collect oxygen, but on her return the doctor pronounced the man dead. The time was 7.18pm.

56. The first healthcare nurse (Hotel 4) also heard the call for emergency assistance as she was finishing her treatments and returning to the ECF. She did not hear a Code Blue so did not collect the defibrillator kept in the main wing treatment room or an emergency bag. As she got to the cell the doctor was already there and her involvement ended. One prison record records an ambulance being called at 7.29pm, but the control room log show paramedics were in the prison and sent over to the healthcare unit at 7.30pm.
57. Staff were offered support by the prison's care and welfare team. The prison chaplain was called at 7.25pm to inform her of the man's death. She arrived at 7.40pm and spoke to the staff involved and to the police to arrange to inform his next of kin. The chaplain left with the police at 10.40pm to inform his partner of his death. They arrived at her home 11.25pm and told her that he had died earlier that night. They remained with her to offer their support and encouraged her to call a relative to be with her. The prison's designated family liaison officer contacted the man's partner the following day. It was agreed that she would contact his parents. The prison's family liaison officer arranged for the family to view his body at Leicester Royal Infirmary, and to visit the prison after the funeral when the chaplain conducted a short service in the cell.
58. The post mortem results show that the man died of natural causes. The cause of death was cardiac arrhythmia due to chronic biventricular heart disease (he had a chronically damaged heart) and that alcohol withdrawal contributed to his death.

## **ISSUES**

### **Clinical Issues and Recommendations**

59. The clinical reviewer has concluded that it would have been difficult to detect the damage to the man's heart while he was alive and is not critical of the prison's medical staff for failing to do so. He was a heavy drinker and had a history of fits on rapid detoxification from alcohol. This was identified at his screening interview when he was immediately prescribed appropriate medication to reduce the risk of fits. (It should be noted that the risk of fitting would not have been completely removed.)

#### ***The post mortem report***

60. The post mortem examination of the man's heart showed it to be markedly enlarged with myocardial fibrosis and fatty infiltration of the right side which, especially in an enlarged heart, can cause a cardiac arrhythmia. The changes of the heart were of such severity that they could have caused a fatal arrhythmia at any time. Alcohol withdrawal can trigger cardiac arrhythmia especially in a chronically damaged heart.

61. All the man's external injuries were consistent with self-infliction by plastic cutlery. The bruising to his arms, legs and back were consistent with restraining attempts whilst he was in an agitated state. The pathologist concluded that none of these injuries caused or contributed to his death. He also had cirrhosis of the liver, possibly another sign of chronic alcohol abuse.

#### ***EMIS system***

62. The clinical review has found that the clinical software system only records a maximum coded entry for alcohol usage of 40 units per week. Given that the greater the level of alcohol consumed, the higher the risk of adverse events during detoxification, it would be appropriate if higher levels of drinking could be entered accurately. The clinical reviewer recommends that the Prison Service consider updating the software to record higher maximum coded entries for alcohol usage. This is something I feel warrants further exploration.

#### ***Whether the man's alcohol withdrawal was managed effectively***

63. HMP Leicester follows a substance misuse protocol specifically designed for the management of alcohol misusers. The substance misuse nurse described the regime for alcohol withdrawal as a nine day Chlordiazepoxide detoxification, with slowly reducing levels of medication followed by 14 days of thiamine. Doses can be increased if the symptoms are severe. The man was immediately given medication and was seen by the detoxification nurse within 24 hours. Although he did not go directly to the detoxification unit, he was monitored by the nurses administering his medication and by the discipline staff. If necessary, in an emergency he could have been referred to healthcare or the doctor in an emergency.

64. The substance misuse nurse said that if she had particular concerns about a prisoner she could recommend them as priority, but only if the case was severe would they be moved to the detoxification wing on a Saturday. I assume that the substance misuse nurse thought this was unnecessary. She had no concerns about him other than his fits, which they discussed. In interview, she said that he was prescribed appropriate medication which should have helped prevent fits. The substance misuse nurse felt that his agitation and possible confusion might have been identified earlier if he had been on the detoxification landing, but she was not sure whether it would have made any difference to his management.
65. The prison doctor reiterated that, in a severe case of withdrawal, prisoners could be admitted as a priority to the detoxification unit or to the healthcare unit. The man's symptoms were not severe in his view, and he seemed to be like other prisoners with an alcohol problem. The prison doctor was well aware of the man's history of fitting on rapid alcohol withdrawal and said this was a known complication of the process. He expected that the Librium would reduce the chance of fits. In his experience, it was very rare for prisoners detoxing from alcohol to fit and he could only remember one case when the prisoner was admitted to hospital. The prison doctor had assessed that the man was not sufficiently unwell to require admission to healthcare until he saw him later in the segregation unit. Until then, he had appeared to be a normal heavy alcohol user who was having a bad withdrawal.
66. The doctor said that with hindsight it was clear that unfortunately there was some underlying problem that no one had previously been aware of. It became apparent very suddenly and he had not thought there was anything out of the ordinary for someone who drunk heavily. The prison doctor concluded that there was nothing to indicate that the man had suffered a fit in reception on his return from court, or when he collapsed before his death. He detected no arrhythmia on any of the occasions he assessed him that day. Both after his collapse in reception and in the segregation unit, the doctor assessed his symptoms as consistent with alcohol withdrawal.
67. The prison doctor said he was aware that the man would not receive his next medication until 7.00pm when he went to the healthcare unit. Although he had repeatedly refused his medication, the prison doctor was surprised that he had collapsed and had not expected him to deteriorate so quickly. He said that days three to five of an alcohol detoxification programme are "always a little more dangerous". In prison he saw a number of people who become confused and aggressive, but they usually settled well with extra fluids, more care and increased medication. The man had no past history of other serious conditions which would increase this risk. The HCO checked him every ten minutes and, although he was noisy and throwing things around, the doctor had no cause for concern which required him to examine the man further.
68. The prison doctor said that the healthcare team now paid more attention to alcoholics after the man's death, but he did not think that the treatment had altered significantly and the only alternative was admission to hospital. The

prison doctor confirmed that the man presented in much the same way as other drinkers detoxifying from alcohol, and that there was nothing to suggest that he was at any greater risk than others in his situation. On the basis of what I have learned in my investigation and the opinion of the clinical reviewer, I am satisfied that prison and medical staff managed his detoxification and symptoms effectively, promptly and appropriately.

69. There is a delay of several days in the transfer of prisoners detoxifying from substances to the detoxification landing due to a lack of space. Two officers confirmed the referral process described by the substance misuse nurse. Prisoners who need to go to the unit have 'detox' written by their name on a board in the FNC office. As space becomes available they are moved up, but moves do not typically happen on a weekend. Although I am satisfied that in this case the man's alcohol withdrawal was dealt with appropriately, it would be preferable to move prisoners more quickly so they can benefit from the dedicated substance misuse nurse. The clinical reviewer concludes that alcohol detoxification is much more dangerous than opiate detoxification (as is benzodiazepine withdrawal) and that priority should be given to those withdrawing from alcohol. I concur with the clinical reviewer and endorse the recommendation.

**Offender Health should consider whether priority (for allocation to the detoxification landing) should be given to prisoners who are withdrawing from alcohol and benzodiazepines, particularly when the opiate maintenance service is introduced in the prison.**

***Staffing on the healthcare unit (the Enhanced Care Facility)***

70. My investigator found that there was only one member of staff on duty in the ECF between 5.00 and 7.00pm on the evening of the man's death. The HCO was on his own from 6.00 until 7.00pm with seven patients. It does not appear that officers gave a handover to a member of medical staff about the man's medical condition, since none was on duty. The healthcare nurse said that a nurse is normally present all day on the unit and she was unsure why no one was present that day. The clinical reviewer is concerned that the healthcare unit was only staffed by a single discipline officer, even though he was experienced in working in healthcare. Although I am satisfied that the man was observed regularly and appropriately, I endorse the following clinical review recommendation:

**The Governor and Head of Healthcare should review the staffing levels that it provides in the healthcare unit**

***Handover of the man's care from segregation to ECF staff***

71. My investigator found that the handover from segregation staff to the HCO was also ineffective. It is unclear from the evidence exactly what information was passed on from the doctor, and the HCO had to call the doctor to check what he should be observing and monitoring. Since the ACCT document had been delayed, the HCO could not glean any information from here. He

decided to err on the side of caution and check the man every ten minutes. I endorse the clinical reviewer's recommendation that:

**When prisoners are transferred to the healthcare unit it should be a priority to develop a care plan for them.**

### ***Emergency medical response***

72. The clinical reviewer comments that, when the second healthcare nurse observed the man through the cell hatch before his collapse, he was pink in colour. When staff gained access some minutes after he collapsed, he was already significantly cyanosed (blue). The clinical reviewer therefore concludes that staff recollections about the time taken to gain access to the man may have been inaccurate.
73. Although it is impossible to be certain of the timings of events (the inaccurate control room log did not assist), my investigator found on the balance of evidence that the time between the man collapsing and the doctor pronouncing death was between eight and ten minutes. Local policy stipulates that in the interests of prison security more than one officer is required to safely gain access to a cell. The HCO therefore had to wait for another officer to accompany him. In light of the man's earlier volatile behaviour I think this was a sound judgement, and I do not criticise the HCO for not gaining access to the cell alone. It took less than a minute for the Officer to run upstairs. Decisions such as these are obviously dependent on the facts of each case, but I am satisfied that staff reached the man as quickly as they could.
74. The clinical reviewer concludes that CPR was ineffective, most likely because of the delay in its commencement, since no clearly irreversible event (such as a massive pulmonary embolism) was found at the post mortem. He concludes that, had staff reached the man more quickly and started CPR earlier, there is a 'theoretical' possibility that he might have been found to have a reversible cardiac arrhythmia that could have been treated by defibrillation. However, the critical word here is theoretical. Based on the post mortem findings, the man's heart either suddenly began to beat irregularly and ineffectively (arrhythmia), or alternatively it simply stopped beating altogether (asystole) at the moment of his collapse. CPR can preserve blood flow artificially until a diagnosis of the type of arrhythmia can be made. If the type is ventricular fibrillation, it can be reversible by means of defibrillation. If CPR had started more quickly, and a defibrillator or ECG been available, we might know whether his arrhythmia was reversible and whether he could have been saved. All that can be said with certainty is that, by the time he was reached, he was in asystole and beyond help. This may have been the case from the moment of his collapse.
75. The healthcare nurse confirmed that she did not bring a defibrillator to the healthcare unit when she responded to the emergency call because she did not hear a Code Blue being called. She said a defibrillator is not kept on the

healthcare unit but in the treatment room on the main wing. The clinical reviewer makes the following recommendation which I endorse:

**The Governor and Head of Healthcare should review the number and site of defibrillators in the prison.**

76. Self-evidently, any delay in bringing potentially life saving equipment is to be regretted. Had the Code Blue been called, the healthcare nurse might have been alerted to bring a defibrillator with her from another part of the prison.

**I recommend that the Governor reminds all staff of the importance of using the medical emergency call codes to signify to staff the type of incident and equipment required.**

77. The second healthcare nurse carried out CPR on her own, without the assistance of those officers who were present. In interview, the HCO said that he did not offer to help because he and the other officer were merely keeping an eye on the man at the time. Although trained in CPR, he did not get involved because the nurse was present and doing everything. The other officer said that the nurse did not ask for any assistance and started CPR automatically. She was not going very long before the doctor arrived. He too was also first aid trained but said he did not see any purpose in getting in the way and let her continue.

78. The second healthcare nurse carried out chest compressions at the necessary ratio. In interview, she confirmed she felt satisfied that CPR was effective and that she was getting chest movements with the ventilation. She confirmed the two officers were in the cell with her but she did not ask them to help her and they did not offer. The clinical reviewer concludes that CPR is much more effective if carried out by two trained people than by one individual. He feels that the officers should have offered to help and, if they did not, the second healthcare nurse should have asked for help. The clinical reviewer recommends that:

**The CPR training of both healthcare and discipline staff should be reviewed to ensure that staff are aware that CPR is more effective if it is carried out by two members of trained staff.**

79. The prison doctor did not instruct the second healthcare nurse to stop CPR. She said she stopped when she saw him arrive at the cell door and let him attend to the man. In contrast, the prison doctor said that when he went into the cell the second healthcare nurse and the officer were coming out and CPR was not in progress. It is therefore unclear from the evidence whether CPR stopped before the doctor arrived in the cell, or at the same time. In any event, it should have been the doctor's decision to call an end to the resuscitation. The clinical reviewer says he would have expected the nurse to continue until the doctor had an opportunity to assess the situation and they could come to a joint decision about the appropriateness of continuing.

## ***Electrocardiogram***

80. The prison doctor agreed in interview with the clinical reviewer that it might be worth considering a routine baseline ECG for seriously heavy drinkers entering the prison. If resources were available this could be possible within the first day or two of admission. When an enlarged heart or irregular heartbeat was found, he might be more inclined to admit them to hospital for detoxification. However, as noted earlier the clinical reviewer does not criticise staff for not detecting the damage to the man's heart whilst he was alive, although he says an ECG might increase the chances of detecting people with such health issues. The clinical reviewer makes the following recommendation that I endorse:

**Offender Health should consider whether a baseline ECG might be appropriate for any group of prisoners when they are admitted to prison.**

## **Other Issues**

### ***The man's ACCT***

81. Prison Service Order 2700 sets out Prison Service policies for suicide prevention and self-harm management. Annex 8G establishes the ACCT procedures staff should follow. Paragraph 2 states that ACCT plans must always move with the prisoner, whether a daily movement, an internal transfer, or a move to another prison. Leicester's 'Caring for the suicidal and those at risk of self-injury policy' reiterates this. However, when the man left the segregation unit, his ACCT did not travel with him to the ECF and staff there did not know what levels of observations to use or any other details. The man was moved from the wing to the segregation unit and then to the healthcare unit within a short space of time, so this may have caused confusion. However, due to the delay in the SO dealing with the document, from about 5.20 to 7.00pm no written observations were made. In the absence of guidance, the HCO used his common sense and decided to observe the man once every ten minutes, although nothing was recorded.

82. In interview, the SO confirmed that the ACCT usually travels with the prisoner, but in this case it had been left in the office. He also confirmed that the level of observations is the decision of the officer deciding on the action plan. Without speaking to the man he made the decision for four hourly observations based on his judgement about his detoxification state and the risk of self-harm. Asked by my investigator how in the absence of the ACCT staff are meant to know how many observations to do, he said that "the honest answer was that they do not". He would have hoped that an officer observing a prisoner would assume every 15 minutes as a default position in the absence of guidance from the SO. The Governor confirmed that the SO would have had to finish his duties before completing the action plan. In the meantime, she felt that staff in the ECF would have maintained some level of observation whilst waiting for the document, but she accepted that this might not have been documented. Although I am satisfied that the man was observed regularly and that this issue had no bearing on his death, it is very

important for the ACCT to travel with the prisoner so that staff are aware of the seriousness or otherwise of the self-harm risk and of appropriate action to take.

**I recommend that the Governor reminds all staff of the importance and relevance of the ACCT moving with the prisoner, in accordance with PSO 2700 and Leicester's own local policy.**

## **CONCLUSION**

83. The man spent 72 hours in custody following a routine court appearance during which his drunken behaviour led him to being remanded. Once at HMP Leicester, he was given medication to help with his alcohol withdrawal. Although obviously detoxing over the weekend, his behaviour did not give cause for concern. However, after returning to court on Monday 12 May 2008, he collapsed in reception. After he came round, he was returned to normal location where he began to behave violently. He was eventually placed in the healthcare unit for observation. Given his chronic heart disease, he was vulnerable to sudden illness and I believe that Leicester did all that they could given the information available at the time.

## RECOMMENDATIONS

### Clinical Recommendations

1. Offender Health should consider whether priority (for allocation to the detoxification landing) should be given to prisoners who are withdrawing from alcohol and benzodiazepines, particularly when the opiate maintenance service is introduced in the prison.

The recommendation was accepted. All prisoners withdrawing from opiates, alcohol, benzodiazepines and stimulants must be located onto the stabilisation unit directly from reception on the first night in prison. This is a key deliverable for all Integrated Drug Treatment Systems (IDTS) local prisons.

2. The Governor and Head of Healthcare should review the staffing levels that it provides in the healthcare unit.

The recommendation was accepted. A full review of healthcare staffing took place prior to the introduction of IDTS in June 2009.

3. When prisoners are transferred to the healthcare unit it should be a priority to develop a care plan for them.

The recommendation was accepted. A care plan for all prisoners admitted to the healthcare unit will be in place within 24 hours of their admission as a patient.

4. The Governor and Head of Healthcare should review the number and site of defibrillators in the prison.

The recommendation was accepted. An additional defibrillator has been ordered, the East Midland Ambulance Service has been asked to review all of out emergency equipment.

5. I recommend that the Governor reminds all staff of the importance of using the medical emergency call codes to signify to staff the type of incident and equipment required.

The recommendation has been accepted. A staff information notice regarding the use of medical emergency codes has been re-issued. A regional review carried out by the Regional Healthcare Lead to standardise the emergency medical codes throughout the East Midlands establishments is currently underway.

6. The CPR training of both healthcare and discipline staff should be reviewed to ensure that staff are aware that CPR is more effective if it is carried out by two members of trained staff.

The recommendation was accepted. All SERCO healthcare staff have been trained in Immediate Life Support, additional Laerdal masks have been

purchased and will be located so that they are readily available in all prisoner areas. Prison staff trained in CPR will attend briefing sessions facilitated by SERCO's Immediate Life Support trainer; this will include CPR handover techniques and the use of the Laerdal mask.

7. Offender Health should consider whether a baseline ECG might be appropriate for any group of prisoners when they are admitted to prison.

The recommendation was partially accepted. An initial assessment of the healthcare needs of all prisoners in reception to identify existing health problems and plan any subsequent care. If immediate health needs are detected the prisoner is referred to appropriate care. PSO 3050

#### **Other Recommendation**

8. I recommend that the Governor reminds all staff of the importance and relevance of the ACCT moving with the prisoner, in accordance with PSO 2700 and Leicester's own local policy.

The recommendation was accepted. The management of the ACCT documents within the establishment has been reviewed; guidance issued to staff regarding the handover of ACCT documents, the management checking process has also been strengthened to support this.