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 in February 2014 while in the custody of HMP Leeds.

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 investigation report into the death of a man, who died of multi-organ failure in February 2014, while a prisoner at HMP Leeds. He was 48 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at HMP Leeds was undertaken. The prison cooperated fully with the investigation. We suspended the investigation until we received the post-mortem report in October 2014. I am sorry that this led to a delay with issuing this report.

The man had been at HMP Leeds since receiving an eight year prison sentence in April 2010. He had a long history of drug and alcohol abuse and had hepatitis B and hepatitis C. Doctors started treatment for hepatitis C in July 2010, when a routine scan of his abdomen detected a cancerous tumour on his kidney. The kidney was later removed. Doctors also suspected he had cirrhosis of the liver, which they confirmed in February 2011. This led to additional health complications.

In October 2013, the man complained of a pain in his leg and an X-ray indicated that he had broken his femur. It is not clear when this injury happened. He had an operation to repair his femur but, after this, his general health declined. He later broke his femur again, after a fall, and developed sepsis. His compromised immune system and poor health resulted in multi-organ failure. He died in hospital in February 2014.

The clinical reviewer was satisfied that the multidisciplinary team at Leeds managed the man's complex needs, including long-term substance misuse and complications from liver disease, very effectively. It is disappointing that his cell was not adapted to meet his needs and that a physiotherapy assessment was delayed, but I agree with the clinical reviewer that, overall, he received an equivalent standard of care to that he could have expected to receive in the community.

I am concerned that the man was, at times, restrained in hospital without fully considered risk assessments and that family liaison arrangements were not as effective as they should have been.

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 **May 2015**

CONTENTS

SUMMARY

1. The man was sentenced to eight years in prison in April 2010, and sent to HMP Leeds. He had a long history of drug and alcohol abuse and was hepatitis B and C positive. In October 2010, doctors removed his left kidney after they discovered a tumour. In February 2011, doctors diagnosed cirrhosis of the liver, which led to further health complications, including ascites, a build up of fluid in the abdomen.

2. On 25 September 2012, a prison GP examined the man and took a blood sample that indicated anaemia and that his liver function had seriously deteriorated. Doctors admitted him to hospital for a blood transfusion and also diagnosed oesophageal varices (enlarged veins in the walls of the lower part of the esophagus that bleed) and pneumonia. The hospital discharged him on 10 October.

3. The man suffered from swollen legs, a symptom of cirrhosis, and other associated complications. He did not follow advice to keep his leg up to help reduce the pain and swelling. He became immobile and, on 12 October 2013, doctors admitted him to hospital and diagnosed cellulitis. The hospital discharged him on 15 October, but admitted him again the next day, after he developed signs of hepatic encephalopathy (a serious brain condition caused by liver disease).

4. The man complained of continued leg pain and an X-ray on 17 October found that he had fractured the neck of his femur (where the thigh bone joins the hip socket). It was not clear when or how this injury occurred. On 21 October, a surgeon mended the fracture. Afterwards, he fell three times, once in hospital and twice in prison.

5. On 5 January 2014, a nurse found the man collapsed in his cell and he was taken to hospital. Doctors found he had broken his femur again and removed a metal screw used in the original repair. He later developed sepsis (a whole-body inflammation caused by an infection). His condition deteriorated rapidly and he died in hospital of multi-organ failure in February.

6. The clinical reviewer was satisfied that the care the man received in prison was equivalent to that he could have expected to receive in the community. However, staff made no adaptations to his cell and took too long to arrange a physiotherapy assessment after he returned from hospital in November 2013. We are concerned that the prison restrained him in hospital without a properly considered risk assessment. There was an unacceptable delay in contacting his family when he was seriously ill and officers were not sensitive to him and his family in his final days. We make four recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed two members of staff at Leeds on 12 December 2014. She informed the prison of the preliminary findings of the investigation.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for the West Yorkshire Eastern District of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report. We suspended the investigation from 12 March until 27 October 2014, until we received the results of the post-mortem examination giving the cause of death. We regret the delay this has caused with issuing this report.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process. They asked us to consider the following issues:

    - The man's wife and daughter asked why there was a delay with prison staff informing them when he went into hospital in January 2014 and why staff originally went to the wrong address.
    - His daughter was concerned that escort officers at the hospital did not allow her any private time with her father or allow her to take some final photographs of them together.
    - His daughter wanted to know whether her father had been able to access appropriate healthcare in prison.

12. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

13. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

HMP LEEDS

14. HMP Leeds is a local prison holding up to 1212 men. Leeds Community Healthcare Trust provides primary healthcare services including an integrated drug treatment service for prisoners with substance misuse problems. Leeds and York Partnership Trust provides mental health in-reach services. The prison has an inpatient facility with 24 hour nursing care.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Leeds was in January 2013. Overall, inspectors found the range of health services was good. Prisoners were usually able to see a nurse every day on the wings and waiting times to see a GP were reasonable, but prisoners did not always receive medication on time. Healthcare staff managed long-term conditions well and inpatient care was good. Inspectors found that mental health services were responsive and supportive.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that all prisoners are treated fairly and decently. In its report for the year ending December 2013, the IMB commended a number of areas of good practice. It highlighted that the prison had won the national Patient Safety Awards, a positive reflection of the efforts made to reduce the number of deaths. The IMB report noted that there were problems recruiting and retaining clinical staff.

Previous deaths at Leeds

17. The man's death was the third death of natural causes at Leeds since January 2013. There have been three deaths from natural causes since. We have made previous recommendations about the use of restraints and escort risk assessments.

KEY EVENTS

18. On 21 April 2010, the man received an eight year prison sentence for robbery, possession of a firearm with intent and aggravated vehicle taking. He was sent to HMP Leeds.

19. A nurse carried out his reception health screen and noted that the man was positive for hepatitis B and C. He had used drugs since he was 15 and tested positive for benzodiazepine, cocaine, methadone and opiates. He smoked cigarettes and the nurse recorded his alcohol intake the week before his arrival in prison as 112 units. (National guidelines recommend a man should not drink more than 21 units per week.) He did not want any help to stop smoking.

20. In the community, the Leeds Addiction Unit had prescribed the man morphine and diazepam. A prison GP substituted methadone for morphine and referred him to the Drug Alcohol Recovery Service.

21. The man started treatment for hepatitis C on 15 July 2010. On 27 July, a scan carried out as part of hepatitis C monitoring, showed a lesion on his left kidney. Further investigations revealed a tumour and he had his kidney removed on 14 October.

22. On 9 February 2011, the man had an MRI scan, which confirmed he had cirrhosis of the liver (due to his drug and alcohol misuse) and portal hypertension (a complication of cirrhosis). He also had ascites (a build up of fluid in the abdomen). After this, healthcare staff monitored his liver function regularly.

23. There were no further significant entries about the man's physical health until 26 September 2012, when a prison GP examined him, after he had reported passing black stools. The GP noted that he was very pale, with ulcerated lips and said he had flu-like symptoms and had vomited. A blood test showed low haemoglobin and blood albumin (protein) levels, which indicated anaemia and a serious deterioration in his liver function. The doctor considered he had a high risk of hepatic encephalopathy as a result of his liver failure. (Hepatic encephalopathy is a result of toxic substances, which the liver normally removes. Symptoms include confusion and altered levels of consciousness.)

24. On 1 October, the GP consulted a hospital specialist and sent the man to the hospital for a blood transfusion. Doctors diagnosed oesophageal varices (enlarged veins in the walls of the lower part of the oesophagus that bleed) and pneumonia. After treatment, the hospital discharged him on 10 October.

25. On 14 January 2013, the man developed cellulitis (a bacterial skin infection of the deeper layers of skin) in his left knee. He went to hospital and received intravenous antibiotics.

26. The man continued to suffer with painful swollen legs, a symptom of liver cirrhosis and portal hypertension. He took a high dose of methadone and

tramadol for pain relief and the GP reviewed his medication a number of times. He told us that, because of the man's high opiate tolerance, he took the maximum safe level of pain relief, without increasing the risk of hepatic encephalopathy.

27. On 7 October, a nurse noted the man's left leg was swollen, red and hot to the touch. Nurses advised him to keep his leg raised to help reduce the pain and swelling. He did not follow this advice and, by 12 October, he was immobile with severe leg pain. The GP sent him to hospital, where doctors diagnosed cellulitis and gave him antibiotics. He returned to the prison on 15 October.

28. The next day, 16 October, the GP noted that the man was dehydrated, felt hot to the touch and spoke in a whisper. He was concerned that the man might have hepatic encephalopathy and arranged for him to go to hospital again urgently.

29. Hospital doctors diagnosed the man with sepsis, a potentially life-threatening condition triggered by an infection, when the body's immune system over-reacts and can cause widespread inflammation, swelling and blood clotting. An X-ray of his leg on 17 October showed that he had fractured the neck of his femur (where the thigh bone joins the hip socket). It was not clear when this injury had happened. On 21 October, he had an operation to repair the fracture with a metal screw. There were no complications.

30. On 27 October, the hospital moved the man to the liver ward, to be treated for hepatic encephalopathy. On 7 November, a prison nurse spoke to the nurse in charge of his hospital care, who advised that a physiotherapist should review him after he got back to the prison, as he would have limited mobility due to the pin in his leg.

31. On 8 November, hospital staff found the man had fallen on the hospital bathroom floor. He remained on the liver ward until 12 November, when he returned to the prison with a walking frame to help him get about. He went to the prison's inpatient unit and staff gave him a wheelchair. His cell was a standard healthcare cell with no adaptations or handrails for prisoners with mobility difficulties.

32. The next day, the man fell in his cell and grazed his head. Healthcare staff encouraged him to move around his cell but noted that he was becoming reliant on the wheelchair. On 15 November, a nurse asked a physiotherapist to review him. She made a second request three days later, on 18 November.

33. A physiotherapist reviewed the man on 20 November. She noted that the walking frame the hospital had provided was broken and too small, which caused him to trip. She got him a new frame and observed that he was able to walk up and down the corridor using the frame unaided.

34. The man's leg remained very swollen and painful. On 3 December, a nurse noted his surgery wound had almost healed but remained red and warm to

the touch. A GP asked him to keep his leg elevated to improve blood flow, but he did not follow this advice.

35. On 11 December, the physiotherapist reviewed the man. She noted that he had forgotten everything she had taught him about how to get about safely with his walking frame. She advised him to use it at least six times a day. On 19 December, he fell in the disabled shower but did not appear to injure himself. He did not attend physiotherapy appointments on 20 and 23 December. The records do not show why. On 30 December, she saw him again and noted his mobility was worse than ever. To encourage him to use his walking frame, she asked staff to restrict his use of the wheelchair to meal times.

36. On the morning of Saturday 4 January 2014, the man complained to a nurse that staff had removed his wheelchair. She explained the benefits of using his walking frame and advised him to try to walk short distances, which would help reduce the swelling in his leg. She went to see him again later to take him his afternoon medication. He said he could not walk to the door to collect his medication through the hatch. He said that he had been unable to move all morning and it felt as if something had ripped in his leg. She booked a full assessment with a GP for Monday morning.

37. On Sunday 5 January, the nurse went to give the man his morning medication and found him lying motionless on the floor. An officer called a code blue at 8.56am (used to indicate an urgent medical emergency and to alert the control room to call an ambulance). Paramedics arrived at 9.06am and took him to hospital. Two officers escorted him, but did not use restraints. A prison manager instructed officers to apply an escort chain in hospital the next day. (An escort chain is a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer.)

38. Hospital staff told the prison that the man's condition was very serious. He had an internal bleed and needed a blood transfusion. They found that he had broken his left femur again and also treated him for liver failure.

39. On 21 January, after a manager made a further risk assessment, officers removed the restraints and did not use them again. The next day, the man had surgery on his hip. Afterwards, his condition deteriorated and he developed ascites, renal problems and respiratory problems.

40. On 17 February, a hospital nurse telephoned the prison and said that the man was very ill. He was receiving oxygen and showing signs of sepsis. The hospital asked for contact details for his wife as they considered they needed to inform his next of kin. That day, a prison manager telephoned the man's wife to tell her that he was unwell in hospital. The hospital called his daughter to inform her, and she visited her father that day. On 25 February, he moved to intensive care after showing signs of organ failure. The prison reduced the escort to one officer. He died shortly afterwards.

Liaison with the man's family

41. A prison manager acted as the prison's family liaison officer. On the morning of 26 February, he had gone to an address in Leeds, which the prison had recorded as his wife's address, and found that she no longer lived there. The telephone number he had used on 17 February to call her was now unobtainable. He obtained an address for the man's daughter from the escort officers at the hospital but, when he went there, it was the wrong address. He did not get her telephone number from the hospital.

42. When he got back to the prison that day, the prison manager found that the man's wife had called with a new number and asked that someone should contact her. He rang and arranged to collect her from her home in Manchester and take her to the hospital. They arrived at the hospital at 2.12pm, just after the man had died.

43. The prison manager and the deputy governor visited the man's wife in Manchester the next day to offer condolences and support. The funeral was on 21 March 2014. The prison contributed towards the costs, in line with national policy.

Support for staff and prisoners

44. A Governor's notice informed staff and prisoners of the man's death. A senior manager debriefed the escort staff and offered them the support of the prison's care team. Staff offered prisoners on his wing appropriate support and access to Listeners (prisoners trained by the Samaritans to provide emotional support to other prisoners). Staff checked prisoners considered at risk of suicide or self-harm, in case the news of his death had adversely affected them.

Post-mortem

45. A post-mortem examination found that the man died from multi-organ failure as a result of sepsis.

ISSUES

Clinical care

46. The man had a long history of drug and alcohol abuse and healthcare staff referred and treated him appropriately for both problems in prison. His chronic liver disease was a result of his lifestyle. He had multiple and severe health problems related to chronic liver disease. The clinical reviewer found that healthcare staff also managed and treated these appropriately. The clinical reviewer considered that healthcare staff at the prison reviewed his leg pain as necessary and referred him to hospital for investigation when required.

47. In October 2013, hospital staff found that the man had a fractured femur. After surgery, he fell three times: once in hospital and twice in prison. When he went back to hospital on 5 January 2014, after collapsing in his cell, doctors found another fracture in his left hip. It is not possible to know whether any of the falls caused this fracture. The pathologist who conducted the post-mortem examination considered that his liver disease, along with the sepsis and cellulitis he had experienced in October 2013, meant there was a high risk that the bone would become infected and the initial repair to the femur would fail.

48. The clinical reviewer noted that the multidisciplinary team at Leeds managed the man's very complex presentation of long-term substance misuse and his many complications of liver disease very effectively. We agree with the clinical reviewer that he received a standard of care in prison equivalent to that he could have expected to receive in the community.

Cell adaptations and Physiotherapy

49. When the man went back to the prison on 12 November, after surgery to repair his femur, he had a standard healthcare cell. His mobility was very poor, but there is no evidence that anyone had assessed the cell to check whether adaptations, such as grab rails next to the toilet were needed. (The investigator noted that there were such grab rails in the cell next door.) He fell over in his cell the next day.

50. A physiotherapist did not assess the man until 20 November, eight days after he returned from hospital. The physiotherapist found that the walking frame he had been given in hospital was inadequate and defective. We consider that the prison should have made arrangements in advance for an early physiotherapy assessment, which the hospital had advised. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with limited mobility, discharged from hospital to the healthcare centre, have their accommodation assessed and adapted as necessary and have prompt physiotherapy assessments when required.

Use of restraints

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that prison staff need to make a distinction between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and the risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that managers taking decisions must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

52. The man was assessed as a low risk of escape, but a medium risk to the public, when officers escorted him to hospital on 5 January 2014. The healthcare section of the risk assessment noted his history of kidney cancer and hip replacement and made no objection to restraints. It did not comment on whether his condition affected his risk of escape as the 2007 High Court judgement requires. He was not initially restrained, but a prison manager instructed the escort staff to apply an escort chain once he was on a ward. Escort staff did not do this immediately as he had surgery. At 5.45pm on 6 January, another prison manager instructed escorting officers to apply an escort chain until a manager could review the risk assessment.

53. A prison manager did not review the risk assessment until 12 January, six days later. She now considered the man low risk in all areas. A member of healthcare staff noted no objection to restraints, but also noted his poor mobility and that he used a wheelchair and a walking frame to mobilise. Again, there was no healthcare input about whether his condition affected his risk of escape. She decided that officers should still restrain him by an escort chain. No one reviewed the risk assessment again until ten days later, on 22 January, when a prison manager considered that he was low risk in all areas and decided that officers should remove the restraints.

54. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which staff should fully consider and balance against the security risks. The man was not mobile and was very ill. It is difficult to understand why he was restrained at all in hospital, why it took so long to review the initial and subsequent risk assessments and why, when a prison manager considered he was low risk in all areas, that she concluded an escort chain was necessary. The need to justify the use of restraints for infirm prisoners in hospital is a matter we have raised with the prison before. Although the prison has accepted previous recommendations about this matter, it does not appear that it has put them into practice. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time, and are kept under review.

Liaison with the man's family

55. Prison Rule 22(1) requires that when a prisoner is seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, Prison Service Instruction (PSI) 64/2011 Safer Custody requires prisons to have procedures to engage with the next of kin when prisoners have a terminal illness of suffer an unpredicted and/or rapid deterioration in their physical health.

56. When the man went to hospital on 5 January 2014, hospital staff told the prison that his condition was very serious and he needed a blood transfusion. His condition continued to deteriorate in hospital, but the prison did not contact his wife until 17 February, after the hospital had asked for contact details. We consider that the prison should have informed his wife as soon as he was admitted. Earlier contact would have allowed his family the opportunity to spend valuable time with him before he died. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.

57. Records show that the man's daughter first visited him at the hospital on 17 February, and then on 20 and 22 February. She said that officers did not allow her any private time with her father in hospital. She was upset that officers would not allow her to use her phone to take a photograph of her and her father together.

58. The man was critically ill and not mobile; he was considered a low risk by this time and not restrained. We consider that officers should have moved away from the bedside to allow his daughter some private time with him. Prisoners are not usually allowed access to cameras or mobile phones but in these circumstances, we consider the officers should have acted more compassionately and allowed her the opportunity to take a final photograph with her father. At the very least, they should have sought advice from a senior manager at the prison.

59. Had the prison appointed someone to liaise with his family at an earlier stage, as PSI 64/2011 requires, and as we recommend above, that person could have resolved this matter. It is important that officers supervising critically ill prisoners in hospital understand the supportive as well as the security aspect of their role. We make the following recommendation:

The Governor should ensure that officers accompanying prisoners to hospital understand the supportive as well as the security aspects of their role and, where possible, allow family members appropriate private time with prisoners who are critically ill.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with limited mobility, discharged from hospital to the healthcare centre, have their accommodation assessed and adapted as necessary and have prompt physiotherapy assessments when required.

2. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time, and are kept under review.

3. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.

4. The Governor should ensure that officers accompanying prisoners to hospital understand the supportive as well as the security aspects of their role and, where possible, allow family members appropriate private time with prisoners who are critically ill.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that prisoners with limited mobility, discharged from hospital to the healthcare centre, have their accommodation assessed and adapted as necessary and have prompt physiotherapy assessments when required.	Accepted	Leeds Community Health now has two physiotherapists working in HMP Leeds who can responsively see patients requiring immediate physiotherapy assessments. Wider discussions are taking place with Leeds City Council to explore the development of adult social care needs and plans are in place to train nurses to assess for various aids and order them from the equipment store as required.	Completed Leeds Community Health Head of Healthcare July 2015
2	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time, and are kept under review.	Accepted	The prison has now introduced a new risk assessment form and procedures to help ensure staff take appropriate decisions about the use of restraints for prisoners in hospital. The Head of Security has provided training to healthcare staff on the completion of risk assessments.	Completed The Governor Head of Security
3	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.	Accepted	The Head of Corporate Services is the lead for Family Liaison Officers. At the point critically ill prisoners are identified and information is shared by healthcare staff, consideration to appointing a Family Liaison Officer (FLO) will be given by the	31 March 2015 The Governor, Head of Safety, Head of Corporate Services and Leeds Community Health

			Head of Healthcare, the Head of Safety and the prisoner himself and if it is deemed appropriate they will support the family and keep them informed. The Head of Safety is now the dedicated person responsible for coordinating applications for early release on compassionate grounds for terminally ill prisoners.	
4	The Governor should ensure that officers accompanying prisoners to hospital understand the supportive as well as the security aspects of their role and, where possible, allow family members appropriate private time with prisoners who are critically ill.	Accepted	The Governor authorising the Risk Assessment will assess the necessity to have escorting staff accompanying any prisoner who is critically ill and will approve any visiting arrangements to appropriately maintain security and protect the public whilst being decent and sensitive to the situation. Family members will be allowed appropriate private time with prisoners who are critically ill if the risk assessment allows, a FLO will also be appointed for dedicated communication with the family.	Completed The Governor