

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Conor Kavanagh, a prisoner at HMP Leicester on 6 March 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Conor Kavanagh died of a spontaneous bleed on the brain, while a prisoner at HMP Leicester, on 6 March 2015. He was 21 years old. I offer my condolences to Mr Kavanagh's family and friends.

I am satisfied that Mr Kavanagh received a good standard of clinical care and that staff at the prison could not have predicted or prevented his death. When he became unwell, the emergency response was appropriate. However, I am concerned that, despite being in a deep coma, the prison used handcuffs to restrain Mr Kavanagh when he was taken to hospital. It took more than an hour to inform Mr Kavanagh's family that he had been taken to hospital; in view of his critical condition, the prison should have informed them immediately.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2015

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Summary

Events

1. Mr Conor Kavanagh arrived at HMP Leicester on 25 February 2015. He did not disclose any serious medical conditions and the reception nurse had no concerns about his health. After seeing a doctor, who prescribed an antibiotic cream on 27 February, he had no other contact with healthcare staff.
2. At 8.45am on 5 March, during a gym session, Mr Kavanagh suddenly became unwell. He complained of a problem with his head, said he could not see and began to vomit. A physical education officer took Mr Kavanagh to the changing room and radioed for healthcare assistance at 8.50am. Two nurses arrived three minutes later.
3. The nurses initially found it difficult to assess Mr Kavanagh, as he was thrashing about. His condition deteriorated and two gym officers helped to move him to the gym classroom and put him in the recovery position on an exercise mat. Staff thought he might have taken drugs but Mr Kavanagh said he had not taken anything. After further assessments, at 9.22am, a prison manager requested an ambulance, which arrived at 9.32am. Paramedics noted Mr Kavanagh was now in a deep coma.
4. At 9.56am, the paramedics took Mr Kavanagh to hospital. Before they left the prison, the Head of Security decided that he should be restrained by two sets of handcuffs, one securing his wrists in front of him and the other attaching one wrist to an officer. Shortly after they arrived at the hospital, a doctor rang the prison to ask them to be removed, as it was evident that Mr Kavanagh was in a critical condition and would not survive. A prison manager agreed.
5. The prison did not inform Mr Kavanagh's mother of his admission to hospital until 11.20am. Mr Kavanagh was granted compassionate bail at 4.00pm. He died at 2.40pm on 6 March with his family at his bedside.

Findings

6. Prison and healthcare staff could not have predicted or prevented Mr Kavanagh's sudden death from a bleed on the brain. We agree with the clinical review that the level of clinical care Mr Kavanagh received was equivalent to that he might have expected to receive in the community.
7. We are concerned that, despite his very serious condition, and the fact that he was unconscious, the prison used double handcuffs to restrain Mr Kavanagh when taking him to hospital. Double handcuffs are usually used to escort high-risk prisoners in good health, yet Mr Kavanagh was assessed as a low risk of escape. Although quickly removed, this was at the request of the hospital; and their use in such circumstances was unjustified. We also consider that the prison should have informed Mr Kavanagh's mother, as soon as he was taken to hospital.

Recommendations

8. The Governor and Head of Healthcare 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.
9. The Governor should ensure that when a prisoner becomes seriously ill, staff notify their next of kin without undue delay.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Leicester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Kavanagh's prison and medical records.
12. Two investigators, interviewed three members of staff and one prisoner at Leicester on 20 April. The investigator also interviewed six members of staff by telephone, between 12 May and 1 July.
13. NHS England commissioned a clinical reviewer to review Mr Kavanagh's clinical care at the prison.
14. We informed HM Coroner for Leicester City and South District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report
15. One of the Ombudsman's family liaison officers contacted Mr Kavanagh's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His mother wanted to know the events leading up to Mr Kavanagh's death and details, including timings, of the emergency response.
16. Mr Kavanagh's mother received a copy of the draft report. She pointed out a factual inaccuracy relating to the spelling of Mr Kavanagh's name. This report has been amended accordingly. She made further comments that have not led to any factual changes within this report.
17. The draft report was shared with the Prison Service. There were no factual inaccuracies. The action plan has been added to the end of the report.

Background Information

HMP Leicester

18. HMP Leicester is a local prison that holds nearly 400 men. The prison primarily serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons (HMIP) last inspected Leicester in November 2013. Inspectors found that the prison was unacceptably overcrowded, though good staff-prisoner relationships offset some weaknesses in safety and credible work was underway to address areas where improvement was needed. One of these was healthcare – the previous service provided by SERCO had deteriorated badly at the end of their contract. Leicestershire Partnership Trust was beginning to address these failings but significant further improvement was needed. Nurses saw all new prisoners promptly for a comprehensive assessment and made appropriate referrals. Good community liaison ensured continuity of care. Inspectors noted that not all emergency equipment was stored together, which could delay emergency response, although all the equipment was checked daily and accessible. Too few officers had been trained in first aid.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2015, the IMB reported that permanent healthcare staff had replaced agency staff and there was a comprehensive programme of staff training and support. Care pathways and proper procedures for referral, triage and assessment were used. Reception staff were courteous and helpful and healthcare interviews were held in private.

Previous deaths at HMP Leicester

21. Mr Kavanagh was the second prisoner to die from natural causes since January 2013. There are no similarities with the other death.

Key Events

22. On 25 February 2015, Mr Conor Kavanagh was remanded to HMP Leicester, charged with attempted murder.
23. At a reception health screen, Mr Kavanagh told a nurse that two weeks earlier, he had burned his upper arm and body with boiling water. He mentioned he had missed hospital appointments for a head injury sustained in a car accident 'some time ago', as he had felt better. He gave no other details about the accident. The nurse noted that he felt well. She had no concerns about him as he had no symptoms of illness or pain. In line with routine practice, she requested his community medical records. She referred him to the prison GP to review the burns.
24. On 27 February, a doctor examined Mr Kavanagh and prescribed an antibiotic cream for his burns. Mr Kavanagh lived on the main residential wing at Leicester. He had no further contact with healthcare staff and did not report any health concerns.

Events of 5 March

25. At about 8.15am on 5 March, Mr Kavanagh left the wing to go to the gym. A Physical Education Officer collected the prisoners who were attending the gym that morning. As it was Mr Kavanagh's first time at the gym, he said he spoke to him about what he needed to take with him and what he could expect. The Physical Education Officer said Mr Kavanagh did not complain, or give any impression, of being unwell or in pain.
26. When they arrived at the gym a few minutes later, The Physical Education Officer showed Mr Kavanagh how to use some of the machines safely. He said Mr Kavanagh used the machines at a leisurely pace. He spent most of the time talking to his friend, another prisoner, and watching others in the gym.
27. The prisoner told the investigator that, after about 25 minutes, both he and Mr Kavanagh were sweaty and he offered to get Mr Kavanagh a glass of water from the water dispenser. When he came back, Mr Kavanagh was holding his head and said he felt bad. He then repeatedly complained about his head and shouted for help.
28. At about 8.45am, the Physical Education Officer said he heard moaning coming from the corridor between the weights room and the changing rooms. He found the prisoner with Mr Kavanagh, who had his hands on his head, groaning loudly. Mr Kavanagh asked the Physical Education Officer for help and said he could not see. The Physical Education Officer asked if he had been assaulted or had taken any drugs and he said he had not.
29. The Physical Education Officer said Mr Kavanagh's speech was slurred and he mumbled. He then suddenly vomited, uncontrollably. The Physical Education Officer guided him to the changing room toilet. He was unsteady on his feet and appeared not to be able to see as he was walking into walls and struggled to stand in front of the toilet.

30. At 8.50am, the Physical Education Officer radioed for healthcare assistance, stating a prisoner was being violently sick. Two nurses, who were in the treatments room on the main wing, responded immediately and arrived at the gym three minutes later. The nurse found Mr Kavanagh sitting on a chair in front of the toilet, sweating profusely and vomiting. She asked him if he had taken anything and he said no. The nurse said Mr Kavanagh kept slipping off the chair onto the floor, which initially prevented her taking a blood pressure reading or other physical observations.
31. A prison manager, also responded. The nurse told her that she thought Mr Kavanagh might need to go to hospital, but they needed to assess him first. Although he was vomiting, he was able to move about and talk at the time. The Custodial Manager left to arrange for a possible hospital escort. At 9.10am, the Physical Education Officer and another physical education officer moved Mr Kavanagh to a gym classroom and placed him in the recovery position on an exercise mat.
32. Mr Kavanagh continued to thrash about but the nurse managed to take his blood pressure, which was within normal limits. However, his pulse was low. He then appeared to fall asleep, his pupils were fixed and he did not respond verbally. The nurse and the Physical Education Officer thought that Mr Kavanagh might have taken 'mamba' a synthetic form of cannabis or new psychoactive substance (NPS), which can have severe adverse effects.
33. The Custodial Manager telephoned the nurse to check if Mr Kavanagh did need to go to hospital. The nurse said she had managed to get an accurate assessment of his basic observations (blood pressure and pulse) and he did need to go to hospital. The Custodial Manager contacted the control room, who requested an ambulance immediately, at 9.22am.
34. The Head of Security and Operations, authorised a risk assessment for Mr Kavanagh to go to hospital. The medical section of the risk assessment was a tick box 'yes' or 'no' format asking whether there were any objections to the use of restraints and whether the medical condition was likely to influence the escort. All the boxes were ticked 'no'. There was no comment from healthcare staff about Mr Kavanagh's condition. The risk assessment indicated that Mr Kavanagh was a medium risk to the public and a low risk of escape and hostage taking. The Head of Security and Operations authorised officers to use double handcuffs.
35. Just before the paramedics arrived, Mr Kavanagh hit his head on the wall while thrashing around. It did not cause an injury, but the nurse noticed his pupils were unequal.
36. The ambulance arrived at 9.32am. Paramedics assessed Mr Kavanagh and prepared to take him to hospital. They found his oxygen level was low and they used the Glasgow Coma Scale to assess his level of consciousness (on a scale of 3 to 15). Mr Kavanagh scored 3, the lowest score, which indicated he was in a deep coma. He was not moving, was unresponsive and did not react to painful stimuli. The ambulance report recorded that he was making rapid, noisy breaths and his pupils were not equal in size or reacting to light, suggesting a serious

injury to the brain. The report also noted that prison staff had insisted on using handcuffs and there had been a five-minute delay while they arranged escorts.

37. The Custodial Manager went into the ambulance and applied the handcuffs. The ambulance left the prison at 9.56am and arrived at hospital at 10.00am.
38. After assessing Mr Kavanagh, a hospital doctor telephoned the prison's duty manager at 10.08am. He explained Mr Kavanagh had had a 'devastating event in the brain', from which he would not recover and that he could die within a few hours. The doctor asked for the handcuffs to be removed and the manager agreed. Officers removed the restraints immediately.

Contact with the family.

39. At 11.25am, a prison chaplain went to see Mr Kavanagh's mother at her home and told her he was in a serious condition in hospital. Mr Kavanagh's mother and other family members went to the hospital. The prison's family liaison officer, met them at the hospital and gave ongoing support.
40. Mr Kavanagh's solicitor contacted the local court and applied for bail on compassionate grounds. It was granted at 4.00pm that afternoon. Sadly, he did not recover and died at 2.20pm on 6 March. His family were with him at the time.
41. In line with Prison Service guidance, the prison contributed to the costs of the funeral, which was held on 25 March.

Support for prisoners and staff

42. After Mr Kavanagh's death, prison managers debriefed the staff involved in the emergency response to give them the opportunity to discuss any issues arising. Managers and the staff care team offered support.
43. The prison posted notices informing other prisoners of Mr Kavanagh's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been adversely affected by Mr Kavanagh's death. A prison manager informed Mr Kavanagh's friend of his death and the prison's chaplaincy team gave him ongoing support.

Post-mortem report

44. The post-mortem report shows that Mr Kavanagh died from a spontaneous bleed on the brain. There were no signs of injury or trauma and no cause for the bleed was found.

Findings

Clinical care

45. Mr Kavanagh had been at Leicester for only one week before he became unwell in the gym. He appeared to be a relatively fit and healthy young man, and during his initial reception screen, did not report any significant current health problems. A nurse had no concerns and appropriately referred him to the prison GP for treatment of his burns. She requested Mr Kavanagh's community GP records, which would have had more information about his previous head injury and the outpatient appointment he had not attended, but the records were not received before he died. The clinical reviewer considered that, with Mr Kavanagh's presentation and lack of symptoms when he arrived, it was reasonable that healthcare staff did not immediately follow up Mr Kavanagh's report of an old head injury.
46. The clinical reviewer was satisfied that prison and healthcare staff could not have predicted or prevented Mr Kavanagh's fatal bleed on the brain and that the emergency response when he became unwell was appropriate in the circumstances. The nurse originally associated Mr Kavanagh's symptoms with those similar to having an adverse reaction to a new psychoactive substance (NPS). Not all NPS reactions require hospital admission and she wanted to get an accurate assessment of his condition before requesting an ambulance. The clinical reviewer said that this was an appropriate response to his symptoms at the time. By the time paramedics arrived, his symptoms had changed. The clinical reviewer concluded that the standard of clinical care Mr Kavanagh received at Leicester was equivalent to that he could have expected in the community.

Restraints

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
48. The risk assessment, authorised by the Head of Security and Operations did not include any detail about the seriousness of Mr Kavanagh's condition and focused on his alleged offence. The Head of Security and Operations said that he saw Mr Kavanagh before he signed off the risk assessment and, although he was obviously unwell, he was conscious at the time. The nurses told him they did not know what was wrong with Mr Kavanagh, but that his symptoms suggested a possible adverse reaction to a new psychoactive substance. Mr Kavanagh was

assessed as a medium risk to the public and a low risk of escape or hostage taking.

49. The ambulance patient report says that prison staff insisted on using handcuffs, but The Custodial Manager said the paramedics had no objections to them applying them. However, it was the prison's responsibility to apply the appropriate test and, when the handcuffs were applied, Mr Kavanagh was in a deep coma. Ambulance staff also noted that the security arrangements caused a five-minute delay in taking him to the hospital. It is not possible to know if the delay affected the outcome for Mr Kavanagh, however a five-minute delay in other circumstances could be critical.
50. Double cuffing is usually required for moving high-risk prisoners in good health. Although Mr Kavanagh might have been conscious when the Head of Security and Operations saw him, it was evident that this was not the case when the handcuffs were applied. It is difficult to see how handcuffing a deeply unconscious man, particularly one assessed to be at low risk of escape, would be justified. The clinical reviewer noted that it was clear from the records, that the physical signs observed by the nurses and paramedics could not have been faked; he was not lightly unconscious and could not wake up at any time. Public protection is fundamental, but the risk assessment used was based almost entirely on his alleged offence, with little consideration of how his condition impacted on this risk, as the 2007 High Court judgement requires. We make the following recommendation:

The Governor and Head of Healthcare 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.

Informing Mr Kavanagh's family

51. Prison Rule 22 says that when "a prisoner dies, becomes seriously ill or, sustains any severe injury or is removed to hospital on account of a mental disorder, 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."
52. Mr Kavanagh arrived at hospital at about 10.00am. At 10.08am, a hospital doctor said that Mr Kavanagh was likely to die in the next few hours. The manager said that before informing Mr Kavanagh's mother, he asked the family liaison officer and chaplain to go to the hospital to get as much information as they could. This resulted in an hour's delay in informing Mr Kavanagh's family. The information given by the hospital doctor highlighted the urgency of the situation and the need to contact Mr Kavanagh's mother immediately. In such circumstances, prisons should not delay informing families and there is no need to visit in person, otherwise this risks families missing the opportunity to see a loved one before they die. We make the following recommendation:

The Governor should ensure that families are notified immediately when a prisoner becomes seriously ill.

Action plan

No	Recommendation	Accepted / Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare 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.	Accepted	<p>Additional lines will be added to the local escort risk assessment document to ensure that there is consideration given to the prisoner's health and the security risk the prisoner poses at the times. The lines to be added will ask: 'does the physical or mental condition of the prisoner reduce the risk identified in this assessment sufficiently for restraints not to be used?'</p> <p>The local risk assessment document at HMP Leicester will take into account the requirements contained in the standard risk assessment form within the National Security Framework</p> <p>Guidance and on the job training will be delivered to all staff in September undertaking risk assessments to ensure that this is delivered effectively</p>	<p>Governor Head of Healthcare</p> <p>Target date for completion: 01/09/15</p> <p>30/09/15</p>	
2	The Governor should ensure that when a prisoner becomes seriously ill, staff notify their next of kin without undue delay.	Accepted	<p>A notice to staff will be issued in September to remind them that when a prisoner becomes seriously ill, they must notify their next of kin without undue delay.</p> <p>Contingency Plans that involve serious injury or illness will be reviewed in September 2015 and have updated lines added to the document reinforce this point.</p>	<p>Governor</p> <p>Target date for completion: 01/09/15</p> <p>30/09/15</p>	

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