



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man while a prisoner
at HMP Leeds on 15 June 2014**

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 widespread cancer on 15 June 2014, while a prisoner at HMP Leeds. He was 46 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Leeds was undertaken. The prison cooperated fully with the investigation.

The man had been at Leeds since August 2013. When he arrived at the prison, a nurse noted he had a history of deep vein thrombosis (DVT) and suffered from depression. He had a history of drug misuse and began a methadone detoxification programme.

Healthcare staff reviewed the man frequently as part of his detoxification programme. In September 2013, he complained of a cough. From February 2014, he complained to nurses of pain below his ribs, especially when breathing. No one referred him to a GP specifically to review these complaints. He complained of coughing blood in April 2014. A nurse discussed this with a GP in early April 2014 and arranged an appointment. When he saw the GP, he did not refer to his chest problems and the GP did not take fully into account all his symptoms. The GP referred him to hospital where he was diagnosed with DVT. On 2 May, another GP was concerned about his health and sent him to hospital with suspected pneumonia. He remained in hospital and had a number of investigations for cancer. On 22 May, doctors diagnosed widespread incurable cancer and indicated that he had only a few weeks to live. He remained in hospital until his death.

The clinical reviewer found that healthcare staff at Leeds did not consider or investigate the full range of the man's symptoms, but looked at them in isolation. This led to a delay in referring him to hospital. He noted that, with his complex clinical history and presentation, this could also have happened in the community. While I am concerned that this led to a delay in his diagnosis, which prevented earlier treatment, I note the clinical reviewer's opinion that earlier diagnosis would have been highly unlikely to have changed the outcome for him. After his diagnosis, very little was done to pursue his application for compassionate release, although he had only a short time left to live. I am pleased to note that restraints were not used for the final weeks of his life, but I am concerned that, immediately before this, he was restrained for some days in hospital, against the advice of healthcare professionals.

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.

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SUMMARY

1. The man arrived at Leeds on 31 August 2013 and, shortly afterwards, received a six year sentence for theft. A nurse noted he had a history of deep vein thrombosis (DVT), a history of substance misuse and had suffered from depression. His medical records also show that he had a thyroid problem and was hepatitis C positive.
2. The man began a methadone detoxification programme and healthcare staff saw him frequently to monitor this. In September 2013, he complained of a cough to pharmacy staff. From February 2014, he complained to nurses of pain below his ribs, especially when breathing. In April 2014, he told a nurse he had been coughing blood. He had also complained of other symptoms, including leg pain, back pain and blackouts between October 2013 and April 2014, but the GP did not consider all of his symptoms. Each occasion a nurse or GP saw him, no one looked at his overall condition or considered whether there was any pattern or underlying cause to all his symptoms. In April, he was referred to hospital for leg pain and the hospital diagnosed DVT.
3. On 1 May, a prison GP examined the man and considered he might have pneumonia and sent him to hospital for tests. Although he was very ill, he appears to have been discharged in error a few hours later. He then went back to hospital and had a number of investigations for suspected cancer. On 22 May, doctors formally diagnosed widespread cancer and told him that he had just weeks to live. His family visited him frequently in hospital. His condition quickly deteriorated and he died at the hospital on 15 June. His family were with him at the time.
4. The clinical reviewer noted that the man's complex medical history and range of complaints, made diagnosis difficult. However, he was concerned that healthcare staff at the prison did not consider all of his symptoms and problems in the round. Had they done so, they might have referred him to hospital sooner. We are concerned that an application for compassionate release was not progressed quickly and that restraints were used on a very ill and dying man without proper justification. We make three recommendations.

THE INVESTIGATION PROCESS

5. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
6. NHS England commissioned a clinical reviewer to assess the man's clinical care in prison.
7. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed three members of staff at Leeds on 4 August 2014. He later interviewed two further members of staff by telephone.
8. We informed HM Coroner for Leeds of the investigation, who provided the cause of death and a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. She did not have any specific issues for the investigation to consider.
10. The man's family received a copy of the draft report. They did not make any comments.
11. The draft report was issued for consultation with the Prison Service. They pointed out some factual inaccuracies. This report has been amended accordingly. The action plan has been added to the end of this report.
12. The investigation has assessed the main issues involved in the man's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

HMP LEEDS

13. 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

14. The most recent inspection of HMP Leeds was in January 2013. Inspectors found there was a comprehensive treatment programme for prisoners with substances use problems. Selected and trained officers on the recovery and post recovery wings provided prisoners with extra support.
15. 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 there were some delays with prisoners receiving medication. Long-term conditions were well managed and in-patient care was good. The report stated that mental health services were responsive and supportive. There were effective links with local Macmillan nurses and hospices. Staff training in end of life care had started.

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. It also noted that the hepatitis C screening and treatment offered was an example of best practice nationally. The IMB report noted that there were problems recruiting and retaining clinical staff.

Previous deaths at HMP Leeds

17. The man was the fifth prisoner to die from natural causes at HMP Leeds since June 2012. We have raised the issue of the need for fully considered security risk assessments for the use of restraints before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

18. On 31 August 2013, the man was remanded to Leeds and, on 3 September, he was sentenced to six years in prison for theft. A nurse carried out his initial reception health screening and noted that he had a history of drug use, deep vein thrombosis (DVT), was hepatitis C positive and depressed.
19. Later on 31 August, a prison GP saw the man and began a drug detoxification plan. He prescribed methadone (a heroin substitute), diazepam (for anxiety) and pregabalin (to control seizures). He also prescribed mirtazapine (an anti-depressant) and rivaroxaban (for deep vein thrombosis). Prison GPs reviewed his medication regularly.
20. Healthcare staff monitored the man frequently and noted he experienced a number of symptoms, including stomach cramps, which they considered were symptoms of drug withdrawal. On 4 September, a nurse examined him when he had fallen, after apparently passing out. She noted he was agitated and finding it difficult to cope with his withdrawal symptoms. She referred him to the integrated drug system (IDTS) team to review his detoxification regime.
21. On 17 September, a pharmacy technician saw the man and recorded that he had chest pain from coughing. She referred him to a nurse. A nurse saw him the next day, but the records do not show what action she took.
22. Between October 2013 and February 2014, healthcare and IDTS staff saw the man frequently in relation to his methadone detoxification programme. Throughout this period, he complained of sleeplessness, pain and discomfort in his arms and legs and passing out. Healthcare staff attributed these symptoms to withdrawal from drugs. GPs reviewed his medication regularly and prescribed him sleeping tablets.
23. On 20 February 2014, the man told a pharmacy technician that he had a pain on the left side of body, just below the ribs. He said that the pain was worse when he inhaled and exhaled. She referred him to a nurse. A nurse recorded that he had gone to his cell to see him but he was not there and, later that day, he had asked him to come to the wing treatment room. As he did not attend, the nurse noted that he assumed that his breathing complaint had improved.
24. On 3 March, a prison GP saw the man and discussed lowering the dose of his gabapentin, a painkiller medication. He said that he was experiencing pain in a number of parts of the body. She decided to maintain the current dose and re-prescribed sleeping tablets.
25. On 16 March, after a call from wing staff, a nurse went to see the man, who said he was unwell, in pain and unable to get out of bed. His clinical observations were normal and the nurse offered him paracetamol to relieve the pain. He refused the medication. The nurse noted that he was

aggressive and that he had asked him to calm down and to tell wing staff if he needed further support.

26. On 26 March, the man told a nurse that it was still painful when he breathed in and that it was painful when he touched his chest. She recorded that his observations were normal and advised him to rest and contact healthcare staff if his symptoms worsened. Later in the day, he said he was short of breath and had pain on the right side of his ribs and asked to see a nurse. A nurse examined him and noted that he did not appear to be short of breath. He repeated the advice the previous nurse had given him.
27. On 31 March, a nurse took a sputum sample from the man, but the sample was inadequate for testing. The next day, he told a pharmacy technician that he had been coughing up blood for the previous three days. A nurse examined him and recorded that his chest was clear and that there were no abnormal sounds. His blood pressure, pulse and temperature were all normal. She asked him to provide a further sputum sample. There is no record that he gave another sample.
28. On 4 April, the man told a nurse that he was continuing to cough up blood. She asked him to provide a sputum sample again and recorded that she would discuss this with a GP. On 9 April, a prison GP prescribed sleeping tablets. The records do not show whether he considered his reported chest pain, coughing blood or sputum sample. On 16 April, a nurse saw him in his cell. He complained of pains in his groin and back. She referred him to a GP. On 17 April, he told a nurse that he felt another nurse had not examined him properly. The next day, the nurse saw him again and noted that he had booked an appointment with the GP 'so that he can be examined and finally have a diagnosis from the doctor'.
29. On 22 April, a doctor examined the man and noted that he had a pain in the thigh and a further pain radiating from the top of his lower spine. He did not refer to his cough or chest pain. His mobility was very limited and he had needed two people to help him into the room. He booked appointments for further investigation at hospital later that day and the next day. At hospital, he had tests and scans to determine the cause of the pain. Hospital staff diagnosed DVT in his lower left leg and prescribed medication.
30. Nurses saw the man several more times over the next week as he continued to complain of back and chest pains as well as difficulty walking. On each occasion, no further action was taken. On 1 May, following concerns from wing staff, a nurse examined him and noted he was unwell. He had difficulty moving, was poor in colour and complained of back and chest pain, especially when he coughed. She took observations and noted that he had a fever. She measured his symptoms using NEWS (National early warning score for acute illness severity) and scored him high. A doctor examined him and referred him to hospital with suspected pneumonia. At around 11.00pm, two nurses saw him before he went to hospital. They noted that he was unable to mobilise and appeared weak and increased his NEWS score.

31. At 11.10pm on 1 May, the man went to hospital by ambulance. At around 3.00am the next morning, he was discharged back to the prison. A nurse saw him shortly after he arrived back and the escort officers told her that a member of staff at the hospital had told them he had a chest infection. She was concerned that he had no discharge letter identifying his diagnosis and had medication with another person's name on. He appeared very ill. He was unsteady on his feet and had to use crutches to walk. A nurse telephoned the hospital to raise her concerns about his discharge. A hospital nurse advised her to send him back to the hospital and he went back to the hospital at 4.30am. (The hospital incident is outside of the remit of the Ombudsman and is subject to a separate NHS investigation.)
32. The man remained very poorly and stayed in hospital. He had a number of investigations and including with the oncology department. Prison healthcare staff kept in contact with the hospital and on 19 May, a nurse telephoned the hospital for an update. Hospital staff told her that he was due to have a scan for suspected cancer and that he would probably need radiotherapy.
33. On 22 May, the hospital diagnosed the man with widespread metastatic adenocarcinoma, a cancer of the glands that spreads to other parts of the body. Hospital staff informed him of his condition and that he had just weeks to live. A hospital consultant wrote to a prison GP and said that due to his general deterioration and frailty, the cancer was incurable with a prognosis of around six weeks. He said that he was receiving palliative care and it was difficult to imagine how he would cope within the general prison population.
34. We are concerned about the length of time it took before the man's symptoms were fully investigated. He had complained of a cough (including coughing up blood) and chest pain to healthcare staff, a number of times for several months. He also increasingly complained of other symptoms, including leg pain, back pain and that he was passing out. Healthcare staff too often considered these symptoms in isolation or that they were as a result of his ongoing withdrawal from drugs. The prison GP said that it is often difficult to assess whether a prisoner is in genuine pain or whether it is drug seeking behaviour.
35. The man had a number of complex health problems and the clinical reviewer noted that he often brought up a range of different health issues other than those he had been referred for when he saw nurse and GPs. This made it more likely that symptoms and issues were missed. However, it is the responsibility of healthcare staff to check the reason for referral against a patient's medical records as well as the symptoms reported. Had this been done, the pattern of symptoms might have been identified, which could have led to earlier diagnosis and treatment. The National Institute for Health and Care Excellence (NICE) Guidance suggests that an urgent referral for a chest X-ray should be offered when a patient presents with haemoptysis (coughing up blood), or any of a number of unexplained or persistent (that is, lasting more than 3 weeks) symptoms or signs including cough and chest/shoulder pain.

36. The clinical reviewer considered that healthcare staff should have taken steps which might have identified the man's cancer earlier. However, he noted that, with his complicated medical history and presentation with a range of complaints, it is possible that the situation would have been the same in the community. He also noted that, while earlier detection of lung cancer might have led to a different course of pain control and care planning at an earlier stage, it is highly unlikely that it would have changed the outcome for him. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use prisoners' clinical records effectively to investigate and identify patterns of symptoms, and follow relevant national guidance in relation to referral and treatment.

The man's clinical care

37. The hospital was responsible for all of the man's clinical care after his diagnosis and this is outside the remit of this investigation.
38. On 23 May, a nurse from the prison visited the man at the hospital. She noted that he was very ill with practically no mobility. The next day, an escorting officer found he had a box of pregabalin tablets. He said that he had hidden the tablets with the intention of taking his own life after finding out that he had terminal cancer. The staff opened an ACCT document (ACCT is the Prison Service's suicide and self-harm prevention process) and escort officers monitored him closely. The prison closed the ACCT on 3 June when staff considered he was no longer at risk of suicide.
39. The man's health continued to deteriorate and he died at 4.45pm on 15 June. His family were with him at the time.
40. After a post-mortem examination, the Coroner gave the cause of death as carcinomatosis and adenocarcinoma of the lung.

The man's location

41. When the man first arrived at Leeds, he lived on D wing, a wing for prisoners undergoing detoxification from drugs and/or alcohol. In November 2013, he moved to a cell on a standard prison wing and remained there until he went to hospital in May 2014.
42. On 28 May, a nurse from the palliative care team of a hospice visited the man in hospital to assess his suitability for a hospice place. She informed prison health care that she believed that, given his poor health, a hospice would probably be the most appropriate location for him, but he had declined hospice care. The prison was also concerned about his risk of suicide at the time. They agreed that he should stay in hospital, with a review of his location later.

43. On 12 June, a nurse visited the man and discussed the benefits of hospice care with him. By now, his health had deteriorated significantly and he was in constant pain. He told her that he had discussed this with his family and he would now consider going to a hospice. Later that day, a nurse from a hospice assessed him, but considered that he was not frail to move. He remained at the hospital until he died, a few days later.
44. We are satisfied that the man's location was appropriate throughout his illness.

Restraints, security and escorts

45. When prisoners have to travel outside prison such as to a hospital, a risk assessment is conducted to determine the nature and level of any security arrangements including any restraints.
46. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity and maintain their dignity. The level of restraints used should be necessary in the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes account of factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner 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. It also deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.
47. On April 22, the man went to hospital and returned the same day. A risk assessment indicated that he was low risk to the public and of escape and was in a wheelchair. The document showed he should have two officer escorts and be restrained with an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The next day when he went to the same hospital for an afternoon appointment, the risk assessment again noted that he was low risk and in a wheelchair. This time, staff did not use restraints. The authorising manager noted that he 'has been out on a number of escorts – all successful'. Neither of these risk assessments contained satisfactory input from healthcare. There was only a tick to indicate no concerns.
48. At around 11.00pm on 1 May, two nurses assessed the man before he went to hospital. They noted in his medical record that he was unable to mobilise and appeared weak. This time a risk assessment indicated that he was medium risk to public, with a box ticked inaccurately, to indicate that he had not previously been out on a hospital escort. There was minimal healthcare input to the risk assessment and the medical section was signed by an

administrator, rather than a clinician. At 11.30pm, he went to hospital by ambulance. Records show that two officers escorted him using handcuffs.

49. At around 3.00am the next morning, the man returned to the prison by taxi. He was very ill, unsteady on his feet and reliant on crutches to walk. The medical records show that his health had deteriorated since the initial escort the night before. At 4.30am, two officers took him back to hospital and again used handcuffs. Staff did not review the risk assessment. Shortly after the hospital admitted him, the officers replaced the handcuffs with an escort chain.
50. The man remained restrained by an escort chain. By 19 May, it was clear that his condition had worsened and doctors suspected he had cancer. On 22 and 23 May, prison healthcare staff visited him and contacted the duty governors each day to say that they did not believe restraints were necessary for someone because of his poor health and low risk. They recorded in the medical records that this was also the opinion of the escorting officers and hospital staff. On 27 May, the prison's Head of Security visited him. He completed a new risk assessment and agreed that restraints were no longer necessary. One officer stayed with him, as he was subject to ACCT monitoring at the time.
51. We are concerned that the original risk assessments did not have adequate input from healthcare staff, as the court judgement requires, and that the man continued to be restrained unnecessarily in hospital for some days, even after healthcare staff had advised against. The Head of Security told us that 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. 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.

Liaison with the man's family

52. Sometime around 19 May, once the seriousness of his condition became clear, the prison arranged for the man to telephone his brother, who was also a prisoner at Leeds. He told him that he had cancer. The prison's family liaison officer told us that he understood that his brother then informed the rest of the family. His sister telephoned the prison that day and spoke to a nurse, who explained how she could contact her brother at the hospital.
53. On 3 June, the prison brought the man's brother to visit him in hospital. He kept in contact with him by telephone and visited again on 13 June. On 4 June, his parents and sister visited him and continued to visit him during his stay in hospital.

54. On 13 June, the family liaison officer contacted the man's family to inform them of his worsening health. The next day, his parents and sister visited him and remained with him until he died.
55. The family liaison officer stayed in contact with the family after his death. The funeral was on 3 July and the prison contributed to the costs in line with national guidance.
56. We are satisfied that liaison with the family was appropriate. Records show they were well informed, both by the man himself and hospital and prison staff, about his condition. Appropriate arrangements were made to ensure his family, including his brother who was in prison, could visit him easily.

Compassionate release

57. Release on compassionate grounds is a means by which prisoners, who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. These include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).
58. On 23 May, a prison GP recorded that he had asked the acting duty governor on that day to begin an application for compassionate release. The duty governor told us he could not recall this request or any subsequent involvement with the application. The next day, the GP emailed the Governor with a medical report in which he stated that the man was unlikely to live more than a few weeks.
59. There is nothing further in the records until 10 June. That day the Head of Security emailed the deputy governor to begin process for the man's application for compassionate release. There is no record of any further action after this and the Public Protection Casework Section of NOMS told the investigator that they had never received an application for his compassionate release. He was very sick and, from 22 May, it was clear that he had only a matter of weeks to live. We consider that an application for compassionate release should have been submitted as soon as possible after this date. It is concerning that managers were unable to explain the reason for the lack of action in progressing the application after the prison GP's report of 24 May. We make the following recommendation:

The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds for terminally ill prisoners and that these are dealt with urgently.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff use prisoners' clinical records effectively to investigate and identify patterns of symptoms, and follow relevant national guidance in relation to referral and treatment.
2. The Director 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.
3. The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds for terminally ill prisoners and that these are dealt with urgently.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff use prisoners' clinical records effectively to investigate and identify patterns of symptoms, and follow relevant national guidance in relation to referral and treatment.	Accepted	<p>A new caseload management system is being developed to ensure that primary teams have overall responsibility for patients and the requirements of this recommendation are met.</p> <p>All NICE guidelines and required actions are being implemented through clinical governance systems.</p>	<p>Head of Healthcare</p> <p>31 March 2015</p>
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.	Accepted	<p>The prison has now introduced a new risk assessment procedure and form. This will help ensure that staff make appropriate decisions, taking into account the health of the prisoner and the actual risk posed at the time.</p> <p>The Head of Security will provide training to healthcare staff.</p>	<p>Head of Security</p> <p>31 January 2015</p>
3	The Governor should ensure that a nominated person is responsible for coordinating applications for early release on compassionate grounds for terminally ill prisoners and that these are dealt with urgently.	Accepted	<p>The Head of Safety is now the nominated person responsible for co-ordinating applications for early release on compassionate grounds for terminally ill prisoners and will ensure these are dealt with urgently. All senior management team members, including the Head of Healthcare, are aware of this.</p>	<p>Head of Safety</p> <p>Completed and ongoing</p>