Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Laventine, a prisoner at HMP Birmingham, on 21 June 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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 Lee Laventine died of multi-organ failure caused by a heart infection and liver disease on 21 June 2015, while a prisoner at HMP Birmingham. He was 46 years old. I offer my condolences to Mr Laventine's family and friends.

Mr Laventine had a long history of alcohol abuse and associated health problems, including advanced liver disease. The investigation found a need for better understanding of some aspects of the management of liver disease, but overall, Mr Laventine received a good standard of clinical care at Birmingham. I am satisfied that the care Mr Laventine received was at least equivalent to that he could have expected to receive in the community. However, I am concerned that, on occasions, when Mr Laventine went to hospital, prison managers authorised the use of restraints without a fully considered risk assessment or adequate review as his condition deteriorated.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. Mr Lee Laventine was remanded to HMP Birmingham in February 2014. In October, he was sentenced to two years in prison for theft and possession of an imitation firearm. Mr Laventine was released on licence on 17 February 2015, but was recalled to prison on 21 February after breaching his licence conditions.

2. Mr Laventine had alcoholic liver disease and suffered with oesophageal and gastric varices (enlarged veins in the oesophagus and stomach that bleed), and hepatic encephalopathy (confusion caused by a build-up of toxins in the blood stream due to liver failure).

3. On 1 April 2015, Mr Laventine was admitted to the prison's inpatient unit with dizziness, nausea, a rapid heartbeat and fever. A prison GP diagnosed a possible urinary tract infection and prescribed antibiotics, but did not investigate his symptoms further.

4. On 14 April, a nurse sent Mr Laventine to hospital as he had abdominal pain, tiredness and a rapid heartbeat. Doctors diagnosed a staphylococcal (bacterial) blood infection, endocarditis (a heart infection) and pneumonia. On 17 May, a scan of Mr Laventine's heart and lungs showed further damage. On 28 May, the hospital discharged him back to the prison's inpatient unit.

5. On 2 June, Mr Laventine was admitted to hospital again when he became confused and agitated, and his oxygen levels dropped. Doctors diagnosed septicaemia (blood poisoning) and prescribed strong antibiotics but Mr Laventine did not respond to treatment.

6. On 20 June, hospital doctors told Mr Laventine that further active treatment would not be possible. Doctors considered his life expectancy was just seven days and he was moved to a hospice, where he died on 21 June.

Findings

7. Although the clinical reviewer considered that there were indications, including in previous prescribing practice, that healthcare staff did not fully understand all the implication of the effects of liver disease, she considered that, overall, Mr Laventine received good clinical care at Birmingham. We are satisfied that the standard of care Mr Laventine received at Birmingham was at least equivalent to that he could have expected to receive in the community. However, we are concerned that, on occasions, when he went to hospital managers decided he should be restrained without a fully considered risk assessment that took into account how his health affected his risk at the time and without adequate review as his condition changed.

Recommendations

- The Head of Healthcare should ensure that all members of healthcare staff have training and a clear understanding of the effects and treatment of advanced liver disease.

- 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.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Laventine's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Laventine's clinical care at the prison. She interviewed a prison doctor by telephone.

11. We informed HM Coroner for Birmingham and Solihull of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Laventine's brother to explain the investigation. His brother did not have any specific matters he wanted the investigation to consider.

13. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

14. Mr Laventine's brother received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report.

Background Information

HMP Birmingham

15. HMP Birmingham is a local prison, principally serving the West Midlands courts, which holds up to 1,450 men. G4S Care and Justice Services manage the prison.

16. Birmingham and Solihull Mental Health Foundation Trust provide 24-hour health services at the prison. Birmingham Community Healthcare NHS Trust are subcontracted to provide primary care services

HM Inspectorate of Prisons

17. The most recent inspection of HMP Birmingham was in March 2014. Inspectors reported that health services were generally very good and valued by most prisoners. Patients with complex acute or chronic needs had access to a well-organised inpatient unit staffed by caring nurses and officers. The prison rarely cancelled external health appointments for security reasons.

Independent Monitoring Board

18. 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 published annual report, for the year to June 2013, the IMB noted that healthcare provision was available 24-hours a day. Doctors were on site every weekday and a locum service provided evening and weekend cover. Prisoners could usually see a GP within a week and almost immediately if urgent.

Previous deaths at Birmingham

19. Mr Laventine was the fourth prisoner to die from natural causes at Birmingham since January 2014. We have previously raised the issue of the need for a fully informed risk assessment to justify the use of restraints for seriously ill prisoners in hospital.

Key Events

20. On 6 February 2014, Mr Lee Laventine was remanded to HMP Birmingham. On 6 October, he was sentenced to two years in prison for theft and possession of an imitation firearm. He was released on licence on 17 February 2015, but he was recalled to prison and returned to Birmingham on 21 February, as he had breached his licence conditions.

21. Mr Laventine had been dependent on alcohol for over 20 years and had received treatment for alcoholic liver disease at hospital. He suffered from oesophageal and gastric varices and hepatic encephalopathy associated with his liver disease.

22. At a reception health screen on 21 February, Mr Laventine said that despite his liver disease he continued to drink alcohol. He took a variety of medication including furosemide and spironolactone (for liver disease), lactulose (for hepatic encephalopathy – a brain disorder resulting from liver disease) and thiamine and vitamin B (for alcoholism). A prison GP reviewed and re-prescribed his medication.

23. On 24 March, a prison GP spoke to Mr Laventine about his continued alcohol misuse, when he smelled of alcohol. Mr Laventine admitted to making and drinking alcoholic 'hooch' in his cell.

24. On 1 April, a nurse examined Mr Laventine, after he had a nosebleed and complained of dizziness, nausea and a headache. She noted that he was jaundiced, had a rapid heartbeat and a fever. She admitted Mr Laventine to the prison's inpatient unit. A prison GP reviewed him and diagnosed a possible urinary tract infection. He prescribed antibiotics and considered the jaundice was related to Mr Laventine's liver disease. He did not investigate Mr Laventine's symptoms further.

25. A prison GP prescribed a further dose of antibiotics on 7 April. Mr Laventine's condition improved and he returned to a standard wing on 9 April. A nurse reviewed him the following morning and noted no concerns.

26. On 14 April, a nurse examined Mr Laventine after he complained of abdominal pain, tiredness and being cold. He had a rapid heartbeat of 125 beats a minute and she sent him to hospital. Two prison officers escorted Mr Laventine and used handcuffs to restrain him.

27. Mr Laventine was admitted to hospital and doctors diagnosed a staphylococcal (bacterial) blood infection and endocarditis (inflammation of the tissue surrounding the heart). Doctors prescribed strong antibiotics. On 26 April, a scan of his heart showed aortic stenosis (narrowing of the left ventricle of his heart).

28. Between 27 April and 1 May, Mr Laventine was admitted to the hospital's intensive care unit with pneumonia. He spent another period in intensive care between 3 and 11 May. He stayed in hospital for a month and a further scan revealed damage to his lungs and mitral valve (in his heart). A physiotherapy assessment on 28 May showed he was able to walk to the toilet unaided and he no longer required regular oxygen. The hospital discharged him that day.

29. Mr Laventine was admitted to the prison's inpatient unit when he returned to Birmingham. Hospital doctors had prescribed prednisolone (a steroid medication for his chest) and made an outpatient cardiology referral to discuss his scan results.

30. On 29 May, a prison GP noted Mr Laventine appeared generally well but had swollen legs and abdomen due to liver disease. On 2 June, Mr Laventine became confused and agitated. His oxygen levels had dropped to 85% and the GP sent him to hospital. Two prison officers escorted him using single handcuffs.

31. Mr Laventine was admitted to hospital again and doctors diagnosed septicaemia. A consultant said he would need a four-week course of strong antibiotics with possible surgery to repair the damage to his heart. Doctors expected Mr Laventine to be in hospital for about six weeks. On 12 June, during a visit to the hospital, a prison nurse noted that Mr Laventine had been aggressive towards hospital staff, which was due to encephalopathy.

32. On 17 June, hospital doctors told Mr Laventine that he would remain on strong antibiotics for another four to six weeks. A hospital multidisciplinary team decided that heart surgery was not in Mr Laventine's best interests.

33. The hospital consultant in charge of Mr Laventine's care spoke to him and his family on 20 June. Mr Laventine had not responded to treatment and his kidneys were failing. The hospital consultant said that due to the poor state of his liver and heart, further active treatment was not possible. Mr Laventine's life expectancy was now about seven days. Mr Laventine and his family agreed that he should be moved to a hospice. Mr Laventine said he did not want to be resuscitated if his heart or breathing stopped. He had remained restrained throughout his stay in hospital but, that day, officers removed the restraints. He was taken to a hospice for end of life care. Mr Laventine died at the hospice on the evening of 21 June.

Contact with Mr Laventine's family

34. When Mr Laventine went to hospital on 14 April, the prison's Healthcare Manager contacted his brother to let him know. The prison arranged for visits. When the hospital re-admitted Mr Laventine on 2 June, she again notified his brother. She kept in contact during both hospital admissions.

35. On 20 June, the Head of Safer Custody and a nurse met Mr Laventine's family and discussed his condition and the move to the hospice.

36. After Mr Laventine died, the Head of Safer Custody went to the hospice to see his family and offer condolences and support. The Healthcare Manager acted as the family liaison officer because she had had ongoing contact with Mr Laventine's family. She telephoned Mr Laventine's brother the next morning to discuss her role and offer further support.

37. Mr Laventine’s funeral was on 17 July. The prison paid costs in line with national policy.

Support for prisoners and staff

38. After Mr Laventine’s death, the Head of Safer Custody debriefed the escort officer at the hospice, and offered her support and that of the staff care team.

39. The prison posted notices informing staff and prisoners of Mr Laventine’s death, offering support. Staff reviewed all prisoners assesses as at risk of suicide and self-harm, in case they had been adversely affected by Mr Laventine’s death.

Post-mortem report

40. A post-mortem examination found that Mr Laventine died of multi-organ failure caused by infective endocarditis (infection in the heart) and alcoholic liver disease.

Findings

Clinical care

41. Mr Laventine had advanced liver disease before he arrived at Birmingham. Healthcare staff assessed him appropriately and admitted him to the prison's inpatient healthcare unit. The clinical reviewer considered that doctors and nurses at the prison gave him generally appropriate clinical care and referred him to hospital when necessary.

42. Mr Laventine had a 20-year history of alcohol abuse. The clinical reviewer commented that had Mr Laventine remained in the community, he would almost certainly have continued to drink alcohol and it was likely that he would have died sooner than he did. Overall, she considered that the care Mr Laventine received in prison was at least equivalent to that he could have expected to receive in the community and some aspects were better.

43. However, the clinical reviewer considered that healthcare staff did not appear to have a complete understanding of some of the wider effects of Mr Laventine's advanced liver disease. She noted that some entries in his records in 2014, suggested a lack of awareness that some of his behaviour was likely to have been caused by encephalopathy. This was partly due to poor communication from the hospitals responsible for his care at the time. She also noted some minor episodes of prescribing of sedatives and analgesia, during his earlier period at Birmingham, which were not appropriate for someone with liver disease. In April 2015, she was concerned that a doctor prescribed antibiotics for an unconfirmed urinary tract infection, without further investigating whether, in view of his liver condition, this could have been due to a more serious infection.

44. We are satisfied that, overall, Mr Laventine received good care at Birmingham and that staff were kind and caring. There was nothing staff at Birmingham could have done to prevent his death. However, the clinical reviewer has identified some areas for improved practice, which would be of benefit in view of the number of prisoners with alcohol problems and associated liver disease. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff are trained in and have a clear understanding of the effects and treatment of advanced liver disease.

Restraints, security and escorts

45. 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 judgment 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.

46. When Mr Laventine went to hospital on 14 April, a prison manager assessed him as a normal risk to the public and of escape, and a low risk of hostage taking. There was no healthcare input into the assessment as the court judgment requires. The manager decided officers should restrain Mr Laventine with handcuffs on the way to hospital and use an escort chain when he was admitted to a ward. (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.) A prison manager reviewed the use of restraints on 20 April, but did not change the level of restraint. There is no evidence of any healthcare assessment as part of this review.

47. While Mr Laventine was in intensive care from 27 April, officers continued to use an escort chain. On 29 April, the Head of Safer Custody reviewed the use of restraints and decided that officers should remove the escort chain during the night as Mr Laventine was using a machine to help him breathe at night. Officers were instructed to reapply the chain every morning. While the decision to remove the chain at night showed that she took some account of his condition, there is no record of a healthcare assessment to support the decision to use the escort chain during the day.

48. On 30 April, escort records show that a prison manager discussed Mr Laventine's condition with a hospital consultant. The manager decided that as Mr Laventine had "become more unwell" restraints should be removed. The next day, when Mr Laventine moved back to a standard hospital ward, the manager decided that officers should use the escort chain again. Restraints were not used when Mr Laventine was admitted to the intensive care unit again on 3 May.

49. When Mr Laventine was re-admitted to hospital on 2 June, he was confused, had low oxygen levels, and his legs and abdomen were swollen. A prison manager (it is not clear who) assessed him as low risk, but decided that officers should use handcuffs for the journey and an escort chain in hospital. The healthcare assessment indicated there were no medical objections to the use of restraints and that his medical condition did not restrict his ability to escape by ticking boxes on the form, but gave no further information. We consider an appropriate healthcare assessment should include more information about the prisoner's condition.

50. Escort records show that the prison's Healthcare Manager authorised officers to remove restraints at 5.40pm on 2 June "due to Mr Laventine's health". The records are incomplete after this date, but it is clear that restraints were reapplied, as at 3.15pm on 10 June an officer removed the escort chain when Mr Laventine had a seizure. Officers reapplied them when he recovered from the seizure.

51. On 12 June, a prison nurse visited Mr Laventine and recommended that due to an aggressive outburst caused by his encephalopathy, he should remain restrained for the safety of other patients and staff. The use of restraints had not prevented Mr Laventine's aggression, which was related to his condition, and we do not consider that this was sufficient in itself, to justify their use. Nor would this have prevented future outbursts. Officers continued to restrain Mr Laventine until 20 June, when he moved to a hospice, the day before he died. There was no

healthcare input into the decision to restrain Mr Laventine between 12 and 20 June, as Mr Laventine's condition declined.

52. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We do not consider that the risk assessments fully took into account Mr Laventine's condition, or that the prison reviewed the decision to use restraints promptly when circumstances changed, as the 2007 High Court judgment requires. When Mr Laventine was moved to the intensive care unit on 27 April, the prison should have immediately reassessed the need for restraints, particularly as he was already regarded as a low risk of escape.

53. Mr Laventine was seriously ill and had limited mobility due to his swollen legs and abdomen. Throughout his time in hospital, there was limited healthcare input into how Mr Laventine's condition affected his level of risk. We have previously identified with Birmingham the need for the use of restraints for seriously ill prisoners to be based on fully considered risk assessments. We make the following recommendation:

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.

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