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 August 2014 at 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 a heart attack in August 2014 at HMP Leeds. He was 77 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.

The man was remanded to HMP Leeds on 19 May 2014. He had a number of pre-existing medical conditions for which he took prescribed medication. He was distressed at being sent to prison and collapsed shortly after he arrived. A prison GP admitted him to the prison's healthcare inpatient unit. At first, he refused food, drink and all medication. Healthcare staff persuaded him to begin eating and drinking again, but he continued to refuse to take his medication. He signed an order stating he did not wish to be resuscitated in the event of a cardiac or respiratory arrest. Doctors were satisfied that he had full mental capacity. He remained an inpatient in the healthcare unit and nurses regularly monitored him. His health did not appear to deteriorate.

In August, a nurse found the man unresponsive in his cell. A GP attended and could find no signs of life. In line with his wishes, staff did not attempt to resuscitate him. A prison GP confirmed that he had died.

The investigation found that there were good care plans to manage the man's health conditions. Although unsuccessful, healthcare staff made repeated efforts to persuade him to take his medication. The clinical reviewer considered that the failure to take his medication did not contribute to his death. I am satisfied that he received a good standard of care at Leeds.

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 **March 2015**
Prisons and Probation Ombudsman

CONTENTS

SUMMARY

1. On 19 May 2014, the man was remanded to HMP Leeds. He was elderly and had poor mobility. He had a number of existing health conditions for which he was prescribed medication, including aspirin for heart disease.

2. When he got to the prison, the man collapsed in a distressed state. He told nurses that he wanted to die. Prison staff began to monitor him as at risk of suicide and a GP admitted him to prison healthcare inpatient unit. He remained in the unit until he died.

3. The man initially refused all food, drink and medication. Nurses explained the risks and encouraged him to eat and drink. After three days, he began to drink fluids. However, he continued to refuse food. A GP referred him to a psychiatrist to assess his mental capacity and nurses successfully persuaded him to start eating again a few days later. The psychiatrist assessed that he was of sound mind.

4. The man signed an order stating that in an emergency he did not want to be resuscitated. He continued to refuse all medication and reiterated that he wanted to die. Nurses continued to monitor him daily and he did not appear to have any symptoms that suggested his health had deteriorated.

5. One morning in August, a nurse found the man unresponsive in his cell, with no signs of life. A GP attended and, at 8.48pm, confirmed that he had died. A post-mortem showed that he had suffered a heart attack. The clinical reviewer considered that his death was unrelated to his decision not to take his medication.

6. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Leeds was equivalent to that he could have expected to receive in the community. Healthcare staff at the prison frequently monitored his health and offered appropriate treatment for his conditions. Mental health staff also reviewed his mental health regularly. We make no 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 him. No one responded.

8. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

9. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He and the clinical reviewer interviewed one member of staff at Leeds on 22 September 2014. He interviewed a further member of staff by telephone on 10 December 2014.

10. We informed HM Coroner for Leeds of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report**.**

11. One of the Ombudsman's family liaison officers contacted the man's granddaughter, his nominated next of kin, to explain the investigation. She did not have any specific issues for the investigation to consider and wanted to acknowledge the excellent support she had received from the prison's family liaison officer.

12. The man's granddaughter received a copy of the draft report. She did not make any comments.

13. The draft report was issued for consultation with the prison service. There were no factual accuracies

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 there were some delays with prisoners receiving medication. Long-term conditions were well managed and inpatient 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. The IMB report noted that there were problems recruiting and retaining clinical staff.

Previous deaths at HMP Leeds

17. The man was the seventh prisoner to die from natural causes at HMP Leeds since December 2012. There were no similarities with the circumstances of his death.

KEY EVENTS

18. The man was remanded to HMP Leeds on 19 May 2014, charged with historic sexual offences. He was very distressed and shortly after arriving at the prison, while waiting for a health assessment, he collapsed in a holding cell in the reception area. Two nurses examined him. One nurse recorded his basic medical observations were stable. However, she was unable to complete a full initial health assessment as he was too distressed and appeared to be in shock. He said that he wanted to die. The nurses took him in a wheelchair to see a prison doctor.

19. A doctor assessed the man and recorded that his blood pressure, oxygen saturation and heart rate were normal. The doctor admitted him to the prison's healthcare inpatient unit for further observations and staff began Prison Service suicide and self-harm prevention procedures as he had said he wanted to die. (Staff ended the suicide monitoring procedures on 21 July, when they considered he was no longer at risk of suicide.)

20. On 20 May, a nurse examined the man and completed his initial health screen. She noted he had a number of pre-existing conditions including, heart disease and a urostomy (an artificial opening for the urinary system). The nurse recorded that he had been prescribed a number of medications to treat his various conditions, including aspirin for heart disease. However, he refused all food, drink and medication. He repeated to the nurse that he wanted to die. She booked an appointment for him to see the GP that afternoon. A doctor assessed him and, after a urine test, diagnosed him with a urinary infection. He prescribed an antibiotic, which the man refused to take.

21. Nurses created care plans to manage the man's mental and physical health conditions. They saw him daily and supported him in line with the care plans. They tried to persuade him to eat, drink fluids and take his medication. They took basic medical observations daily and monitored him using the National Early Warning Score (NEWS) tool, which helps detect deterioration in health. His score remained consistently low, indicating there was no serious deterioration. Mental health staff reviewed him regularly and a named nurse was responsible for his day-to-day care.

22. On 22 May, the man began drinking fluids again, but continued to refuse all medication. He later signed a disclaimer that he understood the consequences of his refusal. On 23 May, a prison GP explained to him the harmful effects of refusing medication and the life-threatening effect of his food refusal. He said that he planned to refuse all care, as he wanted to die. The doctor recorded that he was uncertain whether the man was able to weigh up fully the consequences of not eating. He arranged for him to see a psychiatrist to assess his mental capacity. Nurses continued to encourage him to eat and on 26 May, he began eating again. Staff monitored his food and liquid intake for a further six weeks. He continued to refuse his medication.

23. On 3 June, a psychiatrist assessed the man and found no evidence of any thought disorder. Although he was depressed, he was of sound mind. The next day, a doctor saw him and recorded that he had the mental capacity to decide to refuse medication. He said he did not want to be resuscitated in the event of cardiac or respiratory failure and signed an order to this effect. The doctor explained the consequences of this to him and was satisfied that he fully understood.

24. In July, a doctor and the man's named nurse discussed the possibility of him moving to the main prison. His health was stable and he had not complained of any symptoms of heart disease. However, the doctor decided not to discharge him because of his poor mobility and possible vulnerability.

25. Records show that, throughout July and the first two weeks of August, nurses saw the man every day. They noted he continued to refuse medication but appeared stable.

26. One morning in August, a nurse went to the man's cell to wake him. He did not respond when she called him and she asked an officer to open the cell. Two nurses went in and found him unresponsive. He had no pulse and no other signs of life. In line with his wishes, the nurses did not attempt to resuscitate him. A doctor attended and noted that the man was cool and his pupils were fixed and dilated. At 8.48am, the doctor confirmed that he had died.

27. Later that day, a prison family liaison officer visited the man's granddaughter, his nominated next of kin, to inform her of his death and offer support. On 21 August, she visited the prison and spoke to the staff who had been involved in his care. In line with national guidance, the prison offered a contribution to the cost of the funeral, which took place on 1 September.

28. The Governor issued notices informing staff and prisoners of the man's death and offering support. Prisoners considered at risk of suicide and self-harm were checked in case they had been adversely affected by his death. A senior manager debriefed staff involved in his care and offered them support.

Post-mortem

29. A post-mortem showed that the man died from haemopericardium (blood in the sac around the heart), ruptured acute myocardial infarction (a heart attack resulting in tearing of parts of the heart) and coronary artery atheroma (fatty deposits in the arteries).

ISSUES

Clinical care

30. When the man arrived at HMP Leeds, he initially refused all fluids, food and medication. He was distressed at being in prison and told staff that he wanted to die. Healthcare staff regularly spoke to him to explain the consequences of his refusal and to try to persuade him to change his mind. A GP referred him to see a psychiatrist, to assess his mental capacity to refuse food. Before the assessment, he began drinking and eating again. The psychiatrist was satisfied that he was of sound mind. The clinical reviewer said that the lack of liquid and food for a short time did not have an adverse effect on his physical health.

31. The man said he did not want to be resuscitated if he had a cardiac or respiratory arrest. Again, the GP satisfied himself that he had full mental capacity to make this decision. He continued to refuse all medication during his time at the prison. When staff found him unresponsive, they were aware that he had signed an order indicating he did want to be resuscitated and complied with his wishes. A doctor arrived very quickly and confirmed that he had died.

32. The clinical reviewer said that had the man taken his aspirin medication, this would only have had a small effect in reducing his risk of having a heart attack and his decision to refuse medication was unrelated to his death.

33. The clinical reviewer concluded that the man's clinical care in prison was equivalent to that which he could have expected to receive in the community. There was structured monitoring of his health, and he was appropriately referred to the mental health team who regularly assessed him. The reviewer considered that the dedicated nursing care that he received from his named nurse was commendable and followed best practice. He made no recommendations.

34. We agree with the clinical reviewer's assessment of the standard of the man's care in prison and are satisfied that he received appropriate support.