

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas George Jordan a prisoner at HMP Leeds on 6 August 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 Thomas George Jordan died of heart disease in hospital on 6 August 2015, while a prisoner at HMP Leeds. He was 80 years old. I offer my condolences to Mr Jordan's family and friends.

Mr Jordan was a frail, elderly man who had an extensive and complex medical history. Healthcare staff had care plans to manage his chronic conditions, saw him frequently and cared for him with compassion. Overall, I am satisfied that Mr Jordan received a generally satisfactory standard of care at the prison. However, the investigation found some weaknesses in medicines management and in continuity of care between the prison and community healthcare providers. I am also concerned that, when Mr Jordan's condition deteriorated, the prison did not inform his family, which meant they were unable to visit him before he died.

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

March 2016

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Summary

Events

1. On 25 April 2015, Mr Thomas George Jordan (known as George) was remanded to HMP Leeds. He was almost 80, suffered from ischaemic heart disease, an irregular heartbeat, renal failure, high blood pressure, chronic obstructive pulmonary disease and type 2 diabetes. He did not have any of his prescribed medication with him and this was re-prescribed on 28 April, when his community GP confirmed his medication. Mr Jordan was admitted to the prison's inpatient unit and healthcare staff began care plans to manage his conditions.
2. At an initial health screen, a nurse noted Mr Jordan had lesions on both legs but did not investigate further. On 18 May, a podiatrist diagnosed diabetic ulcers and referred him to a specialist clinic.
3. On 8 June, Mr Jordan was unwell and a nurse arranged for him to go to hospital. At hospital, doctors diagnosed kidney failure and toxicity from digoxin (a heart medication). Hospital doctors said Mr Jordan should no longer be prescribed digoxin but records show that healthcare staff continued to administer this between 13 and 26 June, after he arrived back at the prison.
4. On 6 August, Mr Jordan had chest pains and a fast and irregular heartbeat. At 2.15pm, he was taken to hospital by emergency ambulance. Prison staff did not inform his family that he had been admitted to hospital. Mr Jordan's condition continued to decline and he died in hospital that evening.

Findings

5. Healthcare staff at the prison created appropriate care plans to manage Mr Jordan's chronic conditions, reviewed him frequently and generally cared for him well. However, Mr Jordan returned from hospital twice without a discharge summary and staff did not chase this up to ensure appropriate continuity of care. Although there was a slight delay starting treatment for Mr Jordan's diabetic leg ulcers, his treatment and diabetic care was good. We are concerned that healthcare staff continued to administer digoxin for several days after hospital doctors had asked for it to be stopped, but this does not appear to have had any detrimental effect on Mr Jordan's overall health. When Mr Jordan's condition deteriorated, healthcare staff promptly assessed him and sent him to hospital but no one informed his family, which meant they were unable to visit him before he died.

Recommendations

- The Head of Healthcare should ensure there is an effective communications protocol between the prison and secondary care providers to ensure continuity of healthcare.

- The Head of Healthcare should ensure that all staff are aware of and adhere to the Nursing and Midwifery Council standards for the administering of medication.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. NHS England commissioned a clinical reviewer to review Mr Jordan's clinical care at the prison.
8. The investigator obtained copies of relevant extracts from Mr Jordan's prison and medical records. The investigator and the clinical reviewer interviewed two members of healthcare staff at Leeds on 21 September 2015.
9. We informed HM Coroner for West Yorkshire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Jordan's son, his next of kin, to explain the investigation. He asked whether Mr Jordan had appropriate continuity of care, and whether he was located appropriately for his ongoing healthcare needs. He was concerned that the prison had not informed him when his father was taken to hospital on 6 August.
11. Mr Jordan's son received a copy of the initial report. He identified one factual inaccuracy which has been amended.
12. The initial report was shared with the Prison Service. They identified no factual inaccuracies. The action plan has been added as an annex to this report.

Background Information

HMP Leeds

13. HMP Leeds is a local prison holding up to 1,120 men. Leeds Community Healthcare Trust runs primary healthcare 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 reported 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.

Independent Monitoring Board

15. 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 December 2014, the IMB noted that the Head of Healthcare and the Governor had agreed that inpatients in the prison healthcare centre would be assessed on admission and have documented treatment plans with the aim of providing a similar standard of care and patient involvement as in the community.

Previous deaths at HMP Leeds

16. Mr Jordan was the fifth prisoner to die of natural causes at Leeds since the beginning of 2014. We have previously recommended that the prison should inform the next of kin of seriously ill prisoners as soon as they are taken to hospital.

Key Events

17. On Saturday 25 April 2015, Mr Thomas George Jordan (known as George) was remanded to HMP Leeds. He was 79 and had an extensive medical history including ischaemic heart disease, atrial fibrillation (a fast and irregular heartbeat), kidney failure, high blood pressure, type 2 diabetes, and chronic obstructive pulmonary disease (COPD -the name for a collection of lung diseases including chronic bronchitis and emphysema).
18. At an initial health screen, Nurse A noted Mr Jordan's health conditions and that he had a small lesion on the top of his head and numerous lesions on both legs.
19. Dr A, a prison GP, reviewed Mr Jordan the same day and noted his medical conditions. The doctor noted that Mr Jordan looked well but had no medication with him. The doctor prescribed paracetamol as Mr Jordan complained of back pain. Healthcare staff asked his community GP for information about his recent and ongoing health and confirmation of any prescribed medications to ensure continuity of care. On Tuesday 28 April, Mr Jordan's community GP provided a list of his medication and a summary of his last three consultations. A prison GP prescribed his medication that day.
20. On 29 April, Mr Jordan was moved from the prison's induction wing to the healthcare inpatient unit, where he lived for the rest of his time at the prison. Healthcare staff began care plans to manage Mr Jordan's medical conditions and hygiene needs in the unit.
21. On 1 May, Nurse B noted Mr Jordan could not remember if he had eaten breakfast and started a food and fluid chart to monitor Mr Jordan's intake. Healthcare staff implemented a care plan to manage Mr Jordan's nutritional needs.
22. On 6 May, Nurse C examined Mr Jordan after prison officers were concerned about the lesion on the top of his head. The nurse applied a dressing and wound cream. That day, the nurse referred Mr Jordan to a podiatrist because the tops of his toes were showing slight pressure damage.
23. On 12 May, Nurse C on noted that healthcare staff should record Mr Jordan's weight weekly. At the time, his weight was 68kg. There is no record that his weight was recorded again.
24. On 13 May, a podiatrist saw Mr Jordan and diagnosed diabetic ulcers on his left foot and leg. Healthcare staff began a care plan to promote healing and prevent infection.
25. On 19 May, Dr B, a prison GP, saw Mr Jordan because he was refusing to eat. The doctor noted that healthcare staff should monitor Mr Jordan's food intake closely and prescribed nutritional supplement drinks twice a day.
26. On 3 June, Nurse D noted the diabetic ulcer on Mr Jordan's left foot had deteriorated. Dr C, a prison GP, considered it was infected and prescribed antibiotics. He referred Mr Jordan to the diabetes limb salvage clinic at St

James's Hospital, Leeds. The hospital arranged an appointment for 25 June and Mr Jordan attended the clinic regularly after this.

27. On 8 June, Nurse E examined Mr Jordan, who had vomited and looked pale and unwell. She noted that his blood pressure and temperature were low and considered he was dehydrated. The nurse arranged for Mr Jordan to be taken to Leeds General Infirmary.
28. Hospital doctors diagnosed Mr Jordan with kidney failure and digoxin toxicity. Hospital staff treated Mr Jordan with intravenous fluids to reduce the level of digoxin in his blood and stopped his digoxin. The hospital discharged Mr Jordan on 11 June and said that Mr Jordan's digoxin prescription should be discontinued. However, Mr Jordan's medical record shows he continued to receive digoxin between 13 and 26 June. It was not stopped until 27 June, when a new prescription chart was issued.
29. On 12 June, Mr Jordan complained of pain in the right side of his chest. Nurse B thought he might have fractured a rib and arranged for Mr Jordan to go to Leeds General Infirmary for further investigation. Mr Jordan returned to the prison the same day. The hospital did not provide a discharge summary to show what treatment he had received in hospital. There is no record that prison healthcare staff chased this up.
30. On 29 June, Mr Jordan complained of chest pains and was taken to Leeds General Infirmary. The hospital admitted him and discharged him the next day. Again, there was no discharge summary to show what the hospital had diagnosed or what treatment he had received. Healthcare staff at the prison did not chase this up.
31. Over the next five weeks, nurses saw Mr Jordan daily to treat his diabetic ulcers and administer his medication.
32. On 4 August, Mr Jordan said he was suffering from diarrhoea. Nurse F noted his blood pressure was a little low and his pulse was slightly fast. The nurse asked a GP to prescribe Imodium to treat the diarrhoea. The next day, the nurse checked Mr Jordan who said he still had diarrhoea. He had eaten little and she referred him to a GP.
33. At 9.25am on 6 August, Dr C examined Mr Jordan, noted his heart rate was fast and irregular, and prescribed a low dose of digoxin to regulate it. At 12.43pm, Mr Jordan told Nurse B that he had chest pain. The nurse noted his pulse was fast and irregular and his temperature was low. Dr C assessed Mr Jordan shortly afterwards. He gave him 300mg of aspirin to reduce the risk of blood clots and asked for an ambulance. At 1.25pm, paramedics arrived and carried out an electrocardiogram (ECG). At 2.15pm, the ambulance took Mr Jordan to Leeds General Infirmary.
34. After about four hours, Mr Jordan was moved to St James's Hospital in Leeds. Hospital staff told the prison officers escorting Mr Jordan that his blood pressure was very low. Mr Jordan's condition continued to decline and he died in hospital at 7.29pm that evening.

Contact with Mr Jordan's family

35. After Mr Jordan died, the prison appointed Officer A, as their family liaison officer. At 9.00pm on 6 August, The officer and the duty governor, went to see Mr Jordan's son and informed him of his father's death. They offered condolences and support. Officer A remained in contact with Mr Jordan's son until after his funeral, which was held on 24 August. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

36. After Mr Jordan's death, the duty governor debriefed the staff who were with Mr Jordan in hospital when he died. She offered her support and that of the staff care team.
37. The prison posted notices informing staff and prisoners of Mr Jordan's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Jordan's death.

Cause of death

38. The coroner gave the cause of death as ischaemic heart disease, coronary artery atheroma (hardening of the arteries) and diabetes mellitus.

Findings

Clinical care

39. Mr Jordan was a frail, elderly man, who had an extensive and complex medical history. The clinical reviewer noted that, shortly after he arrived at Leeds, Mr Jordan was admitted to the prison's inpatient unit, which was appropriate. There were good care plans to manage Mr Jordan's chronic conditions and healthcare staff monitored and treated these regularly. Mr Jordan was often confused and had symptoms of dementia. His mental health was assessed appropriately and it is evident from the medical records that nurses treated him with care and compassion.
40. The clinical reviewer was satisfied that healthcare staff managed his diabetes in line with National Institute for Health and Care Excellence (NICE) guidance, although it was difficult to control because of his reduced appetite. While diabetic ulcers could potentially have been identified earlier, this was not detrimental to their management. The clinical reviewer noted that Mr Jordan received appropriate treatment, including referral to a specialist hospital clinic.
41. The clinical reviewer identified some areas for improved practice such as monitoring for pressure ulcers and monitoring nutrition. She has made recommendations about these issues in her review, which we do not repeat in this report but the Head of Healthcare will need to address.
42. When Mr Jordan's condition deteriorated, healthcare staff promptly assessed him, treated him in line with relevant NICE guidance, and sent him to hospital. We consider that his general care at the prison was of an appropriate standard but discuss continuity of care and medication management below.

Continuity of care

43. The clinical reviewer was concerned about effective continuity of care. She noted that Mr Jordan had an extensive and complex medical history. We are satisfied that when he arrived at Leeds, healthcare staff requested confirmation of his prescribed medication, and ongoing health concerns from his community GP. However, when Mr Jordan returned from hospital on 12 and 29 June there was no information about the treatment he received or any ongoing plan of care. There is no record that any member of healthcare staff followed this up.
44. Prison Service Order (PSO) 3050, Continuity of Healthcare, says that effective information sharing with other agencies (in particular the NHS) is key to enabling continuity of care. While it was the hospital's responsibility to provide discharge summaries, we consider that healthcare staff should have asked for information from the hospital when he arrived back from hospital without an outline of his treatment and care. To avoid this in future, we consider the prison needs an effective communications protocol with Leeds General Infirmary and other hospitals the prison has frequent contact with. We make the following recommendation:

The Head of Healthcare should ensure there is an effective communications protocol between the prison and secondary care providers to ensure continuity of healthcare.

Management of medication

45. On 8 June, hospital doctors diagnosed Mr Jordan with kidney failure and digoxin toxicity. The clinical reviewer confirmed that Mr Jordan's prescribed levels of digoxin, before going into hospital, were appropriate. She explained that when a patient suffers renal failure (and sickness and diarrhoea) they can become dehydrated and more digoxin is absorbed into the blood. This is a common problem with elderly patients. However, when Mr Jordan returned to the prison, he continued to receive digoxin for some days, after hospital doctors said it should not be re-prescribed. This decision was appropriately communicated to the prison in a discharge letter from the hospital.
46. The clinical reviewer said it was clear from reviewing Mr Jordan's prescription charts that healthcare staff had made a medication error. Although there is no evidence that this had a detrimental effect on Mr Jordan's overall health, this should not have happened. It is not clear whether this was an internal communication error, or a failure to act on the discharge information the hospital had provided.
47. The Nursing and Midwifery Council standards (effective from 31 March 2015) for administering medication state "that a registered nurse must make sure that the care or treatment they advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving". The clinical reviewer considered that that healthcare staff did not adhere to these standards when Mr Jordan continued to receive digoxin. We make the following recommendation:

The Head of Healthcare should ensure that nurses adhere to the Nursing and Midwifery Council standards for administering medication.

Liaison with Mr Jordan's family

48. Mr Jordan was in extremely poor health when he first arrived at Leeds in April 2015. On 8 June, hospital doctors admitted Mr Jordan to Leeds General Infirmary with a diagnosis of digoxin toxicity and kidney failure. He stayed in hospital until 11 June but no one informed Mr Jordan's family that he was in hospital.
49. At 2.15pm on 6 August, Mr Jordan was taken to hospital by emergency ambulance with chest pains and a fast and irregular heartbeat. Again, no one from the prison contacted his family to let them know he was in hospital. His son was not informed until after his death, later that evening.
50. Prison Rule 22(1) requires that when a prisoner is seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed." Prison Service Instruction (PSI) 64/2011, Safer Custody, says, "Where prisoners have a terminal illness or suffer an unpredicted and/or

rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner [and] engaging with their next of kin”.

51. We consider the prison should have informed Mr Jordan’s son of his admission to hospital on 8 June, and as soon as he was admitted on 6 August. Earlier contact would have given Mr Jordan’s family the opportunity to see him before he died. We have raised this issue with the prison before. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

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