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 July 2014, while in the custody of 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 man, who died of a brain aneurysm in July while a prisoner at HMP Leeds. He was 49 years old. I offer my condolences to those who knew him.

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

The man had been a prisoner at Leeds since 20 November 2009. He had frequent contact with healthcare staff about mental health and substance misuse problems, arthritis, migraine and recurrent abdominal pain. However, there were periods when he did not always engage or attend for physical health reviews. In March 2013, staff found that he had raised blood pressure. Initially, he would not discuss this, but at the end of May a doctor prescribed medication for anxiety related hypertension and his blood pressure reduced. He continued to see healthcare staff sporadically, but did not always attend follow up appointments. In March 2014, against medical advice, he decided to stop taking the medication. On 25 July, he collapsed in his cell. He was taken to hospital and found to have a massive bleed on his brain, caused by an aneurysm. He later died.

The man's death was sudden and unexpected and the clinical reviewer noted that people with undiagnosed aneurysms do not generally show symptoms. I am satisfied that he received a good standard of care at Leeds, at least equivalent to that he could have expected to receive in the community.

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
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. In November 2009, the man was remanded to HMP Leeds and later sentenced to an indeterminate prison sentence for public protection, with a minimum period to serve of four and a half years before he could be considered for release.

2. The man had a history of substance abuse and saw healthcare staff frequently for a range of issues including mental health problems, spondylosis (a form of arthritis), migraine and recurrent abdominal pains. He had a diagnosis of personality disorder but sometimes refused to engage with healthcare staff. He believed he had Asperger syndrome and was frustrated that healthcare staff did not agree.

3. In March 2013, a blood pressure reading showed the man had borderline high blood pressure. He initially declined further appointments to investigate this but eventually, at the end of May, and after further tests, a doctor diagnosed anxiety related hypertension (high blood pressure). The doctor prescribed propranolol to reduce his anxiety. He took the propranolol as prescribed, and the treatment appeared to be successful as later checks showed that his blood pressure had gone down.

4. In March 2014, the man decided to stop taking his medication, against medical advice, and signed a disclaimer about this. He would not engage with healthcare staff further until June 2014. In July 2014, 11 days before he died, a health support worker recorded that his blood pressure was now low. A nurse from the team specialising in long term conditions reviewed the result and agreed that it should be checked again, but did not consider it was sufficiently worrying to need an urgent follow up.

5. On 25 July, the man stumbled in his cell and banged his head. A nurse assessed him and found him fully conscious. His clinical observations, including his blood pressure, were all within the normal range. While the nurse was with him, he suddenly collapsed and became unresponsive. The nurse called an emergency code and the prison's control room called an ambulance immediately. Other nurses came and helped with emergency treatment. Paramedics arrived quickly and took him to hospital. A scan showed he had had a massive bleed in his brain from which he could not recover. The hospital removed life support and he died.

6. We agree with the clinical reviewer that the man's care in prison was good and that his sudden death was not foreseeable.

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 her. Two prisoners responded.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed two members of staff and another investigator interviewed two prisoners in September. She informed the Governor of the initial findings of the investigation.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. We informed HM Coroner for West Yorkshire of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

11. The man had not given the prison any next of kin details. After his death no family members were traced.

12. The prison considered our draft report and did not raise any inaccuracies.

HMP LEEDS

13. HMP Leeds is a local prison holding up to 1,212 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. 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.

Independent Monitoring Board

15. 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

16. There have been six deaths from natural causes at Leeds in the past two years. There were no significant similarities with the circumstances of the man's death.

KEY EVENTS

17. The man was remanded to HMP Leeds on 20 November 2009, and on 11 November 2010 received an indeterminate sentence for public protection with a minimum period to serve of four and a half years before he could be considered for release. Healthcare staff saw him frequently for a range of problems from mental health issues to abdominal pain. Sometimes he refused to attend appointments, despite encouragement.

18. The man had been diagnosed with a personality disorder but believed that he had Asperger syndrome. He was frustrated about his diagnosis and periodically refused to engage with healthcare staff.

19. On 11 March 2013, the man saw a prison GP about problems passing urine and the GP asked for blood tests. A healthcare assistant took a blood sample and his blood pressure. She noted his blood pressure was raised and informed the doctor.

20. A prison GP asked the man to start a hypertension (high blood pressure) assessment programme in line with guidance produced by the British Hypertension society and NICE in 2011 for people with suspected high blood pressure. The healthcare assistant assessed the man again on 13 and 15 March. The results indicated that he was on the borderline of a diagnosis of high blood pressure. He did not want to have this investigated further.

21. On 2 May 2013, a substance misuse nurse recorded that the man's blood pressure was 145/100. (An ideal reading is 120/80. A consistent reading of 140/90 or over is considered high.) She asked the primary care team to do a follow up check. The next day, the healthcare assistant took his blood pressure which was 130/100. She referred him for an appointment with a GP, but he did not attend the appointment on 8 May or a rearranged appointment the next day.

22. The man undertook a benzodiazepine detoxification programme in May 2013. A nurse tried to discuss his blood pressure with him, but he would not engage. This coincided with an assessment by the Autism Society which concluded that he did not have Asperger syndrome. He was upset about this and did not want to speak to healthcare staff.

23. On 30 May, the man told a nurse that he was unwell. The nurse noted that his eyes were bloodshot and he had chest pains. She took his blood pressure and the reading was 219/111. She made an emergency appointment for him to see the GP later that morning but he refused to attend. A nurse took his blood pressure again the next day when it was 180/140. She made another appointment for him to see a GP the next day.

24. A GP saw the man on 31 May and recorded that his blood pressure was 170/112. He diagnosed hypertension linked to anxiety and prescribed 80mg per day of propranolol (a beta blocker used to reduce anxiety).

25. The man did not attend a follow up appointment a GP had arranged for 5 June. The GP asked nurses to monitor his blood pressure and let him know if it went over 160/90. Monitoring showed his blood pressure reduced.

26. The man started refusing to engage with healthcare staff again about a number of physical health matters and did not attend GP reviews and appointments with the substance misuse service. He stayed in contact with the mental health team. On 11 March 2014, against medical advice, he asked to stop taking propranolol and signed a disclaimer to say that he understood the risks.

27. On 9 April, the man told a nurse that he had stomach pain. She took his blood pressure, which was 170/100. A nurse made an appointment for him to see the Citywide Team (nurses who specialise in long term conditions) on 15 April. He did not attend.

28. On 15 July, a healthcare assistant took the man's blood pressure as part of a quality control exercise for prisoners with long term conditions. The reading was 85/60, which was low. (Readings below 90/60 are regarded as low.) A nurse from the Citywide Team agreed it should be checked again. As the reading was not significantly low, he did not regard this as urgent.

29. Sometime after 2.00pm on 25 July, a prisoner went to the man's cell to give him some cigarette papers. His cell had not been unlocked and he slid the papers under the door. He came over to collect them and as he did, stumbled and banged his head against the door. The prisoner shouted to a wing cleaner, who alerted an officer.

30. Two officers went to the man's cell and found him sitting on the floor, holding his head in both hands. He said he needed a nurse as something was wrong. He had a pain in his neck and felt dizzy. An officer went to the wing office to ring for a nurse, but saw a nurse on the way. They went back to the cell, where he was still sitting on the floor.

31. The man told the nurse what had happened and said that he had not lost consciousness. The nurse tested him on the Glasgow Coma Scale and his score was 15/15, the highest achievable score. This meant that he had good verbal, eye and motor responses. The nurse could not see any sign of a head injury and asked the officer to turn the light on.

32. When the officer turned the light on, the man complained that it hurt his eyes so he switched it off again. The nurse measured his blood pressure, pulse, oxygen saturations, respiration and temperature. All were in the normal range. The officer then left the cell. The nurse decided to phone a doctor, but the man did not want him to leave him as he was worried that something might happen. The nurse tried to reassure him, but he began to shake, went stiff and slumped to the left hand side.

33. The nurse and officer put the man in the recovery position and the nurse radioed an emergency code blue. The control called an ambulance immediately, at 2.44pm. At approximately 2.49pm, another nurse arrived and helped the first nurse maintain the man's airway. Another nurse arrived shortly after, followed by another nurse with the emergency bag.

34. A nurse inserted an airway into the man's mouth. The nurses monitored his clinical observations. The nurse took a blood glucose reading and another nurse counted his respirations. The nurses placed a mask to administer oxygen therapy over his nose and mouth but he vomited shortly afterwards. They removed the mask and airway and he was able to breathe. Paramedics then arrived, at 2.52pm, and took over the treatment. He began to show signs of improved consciousness and at 3.22pm the paramedics took him to hospital. He was not restrained.

35. At hospital the man had a CT scan which showed that he had a massive bleed on his brain which doctors could not treat. He was taken to the Intensive Care Unit on life support for tests of his brain stem function. The hospital removed life support and he died.

36. The man had not nominated any next of kin and the prison was unaware of anyone else to contact when he was admitted to hospital. Despite investigations after his death, the police and the Coroner were unable to find any living relatives or anyone else that should be informed of his death. The prison arranged and paid for his funeral.

37. A manager debriefed the staff involved in the emergency response and offered them the support of the prison's care team. Staff were asked to offer support to prisoners affected. A prisoner told us that he had good support from staff and a Listener (a prisoner trained by the Samaritans to support others).

38. The post-mortem report concluded that the man died from a ruptured anterior communicating cerebral artery aneurysm with underlying hypertension.

ISSUES

Clinical Care

39. The clinical reviewer considered that the man received good clinical care at Leeds. He had a number of physical and mental health problems resulting from many years of substance abuse. He had extensive contact with healthcare staff but, despite encouragement, did not engage with them consistently, particularly for physical health matters. During his time at the prison, he had 346 recorded contacts with healthcare staff and there were 49 appointments when he did not attend.

40. The man's lack of cooperation with blood pressure monitoring and treatment, prevented healthcare staff from forming a full understanding of what was causing his high blood pressure. The clinical reviewer considered that it was a reasonable assumption that anxiety was a contributing factor and this was supported by the fact that his blood pressure returned to normal limits after being prescribed propranolol. When his blood pressure was found to be low on 15 July, the clinical reviewer was satisfied that this did not indicate any immediate cause for concern.

41. The emergency response when the man collapsed on 25 July was appropriate. Healthcare staff responded to the emergency quickly and control room staff called an ambulance as soon as a code blue was broadcast. Paramedics arrived quickly.

42. The clinical reviewer noted that there was nothing in the man's records that would have indicated that he was suffering from an aneurysm. Diagnosis of the condition would have been very difficult as people with undiagnosed aneurysms do not generally show symptoms. The clinical reviewer was satisfied that healthcare staff adequately managed the risks associated with his long term conditions and he received a level of service, likely to be higher than he would have received in the community. He commended the mental health team for their approach in dealing with his psychological wellbeing.