

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dieter Thorp a prisoner at HMP Leeds on 26 February 2017

**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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Dieter Thorp died on 26 February 2017 of complications related to cancer of the lungs and brain in Leeds General Infirmary. He was 48 years old. I offer my condolences to Mr Thorp's friends.

The investigation found that, before Mr Thorp went to hospital in February, the care he received at Leeds was good. However, the standard of care he received after being returned to the prison with a terminal diagnosis was not equivalent to that he could have expected to receive in the community. In particular, the care plan put into place when Mr Thorp returned from hospital was inadequate and he did not receive medication he had been prescribed.

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

September 2017

Contents

Summary 1

The Investigation Process 2

Background Information 3

Key Events 4

Findings 6

Summary

Events

1. On 7 December 2016, Mr Dieter Thorp was remanded into custody at HMP Leeds for breaching a sexual offences order. On 5 January 2017, he was sentenced to nine months in prison.
2. Mr Thorp had a history of short custodial sentences and this was his fifth time in HMP Leeds in the last three years. He suffered from asthma, which was treated with inhalers. He had no other history of illness either in the community or in prison.
3. On 15 February, staff noted that Mr Thorp was acting out of character and requested a nurse to see him. After an examination, a prison GP sent him to hospital as an emergency referral. The GP was concerned that he may be suffering from a brain problem, or may have had a stroke.
4. After a CT scan and biopsy, hospital doctors told Mr Thorp he had terminal lung cancer, which had spread to his brain and liver. Mr Thorp remained in hospital until 24 February, when he was discharged back to prison with medication to reduce the swelling of his brain. Mr Thorp did not receive this medication.
5. On 26 February, a healthcare assistant found Mr Thorp slumped in his cell, and he was sent to hospital as an emergency. He died later that day in Leeds General Infirmary.

Findings

6. Staff acted quickly when Mr Thorp began to act out of character, and referred him for further examination. When the hospital discharged him back to Leeds on 24 February, a prison GP did not review Mr Thorp, and the observations made did not comply with the care plan started when he returned to prison.
7. There was confusion between the nurse who took Mr Thorp's medication when he came back to prison and the pharmacy unit. As a result, Mr Thorp did not receive dexamethasone to reduce brain swelling that hospital doctors had prescribed.

Recommendations

- The Head of Healthcare should ensure that prisoners returning from hospital are thoroughly assessed and appropriate healthcare plans put in place, including for taking and recording observations.
- The Head of Healthcare should ensure that there are no delays in prescribing and delivering medication.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Leeds on 27 March 2017 and obtained copies of relevant extracts from Mr Thorp's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Thorp's clinical care at the prison. The investigator and clinical reviewer interviewed three members of nursing staff at HMP Leeds on 3 April 2017.
11. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Thorp's solicitor as his nominated next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.
13. Both the prison family liaison officer and the police have made exhaustive enquiries to identify Mr Thorp's immediate family. To date, no family has been identified.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Leeds

15. HMP Leeds is a local prison holding up to 1,219 men. Care UK runs primary healthcare services. The prison has an inpatient facility with 24-hour nursing care.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Leeds was in December 2015. Inspectors reported that, overall, the prison had not kept up the improvements they had observed in January 2013, but they were confident that good leadership and a positive staff culture would lead to improvements. Inspectors considered that the healthcare services had declined, but outcomes for prisoners remained reasonable. They found that the management of long-term conditions was impressive, prisoners had good access to hospital appointments and liaison with specialist services was effective. The healthcare team had developed palliative care pathways, and used them well.

Independent Monitoring Board

17. 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 2015, the IMB was concerned about major changes to staffing levels and the management structures, but noted that staff continued to treat prisoners with care and respect. Overall the IMB considered that healthcare provision had improved over the previous 12 months, although the IMB was concerned about the potential impact of a change of healthcare provider to Care UK in April 2016.

Previous deaths at HMP Leeds

18. Mr Thorp was seventh person to die of natural causes at Leeds since January 2015. There were no similarities with previous deaths. There have been two subsequent natural cause deaths.

Key Events

19. On 7 December 2016, Mr Dieter Thorp was remanded in to custody and sent to HMP Leeds for breaching a sexual offences order. On 5 January 2017, Mr Thorp was sentenced to 9 months in prison.
20. At an initial health screen on 7 December, a nurse noted that Mr Thorp did not have any significant health problems and requested his community health records. He had a history of asthma for which he was prescribed an inhaler. Mr Thorp had a routine asthma review on 24 January 2017.
21. On 20 January 2017, a nurse saw Mr Thorp who complained of feeling dizzy. The nurse did several tests including taking his temperature, pulse, breathing rate, oxygen levels and blood pressure. All were within the normal range.
22. On 15 February, a prison officer decided that Mr Thorp was not fit for work because he appeared disorientated and arranged for him to see a nurse. A nurse saw Mr Thorp and noted that he appeared vacant, had delayed reactions when communicating and was unsteady on his feet. The nurse noted that Mr Thorp was not displaying symptoms of a stroke, such as facial droop or limb weakness. She arranged an urgent GP appointment for the next day.
23. At 9.30am on 16 February, a nurse assessed Mr Thorp and noted he was unable to remember his name or date of birth. Mr Thorp also refused to give a urine sample and was agitated and appeared suspicious of simple requests. At 11.30am, a prison GP examined Mr Thorp and arranged a full set of blood tests. The GP also noted that Mr Thorp was increasingly vacant, was unsteady, demonstrated intermittent confusion and could not understand and follow simple commands. The GP arranged for an emergency ambulance to take Mr Thorp to Leeds General Infirmary. The ambulance left the prison at 12.40pm. Two prison officers escorted Mr Thorp using an escort chain in the ambulance and single cuffs at hospital, which were removed during treatment.
24. In hospital Mr Thorp had a CT scan of his head. The same day he had emergency surgery to ease pressure on his brain, and a biopsy.
25. On 23 February, hospital doctors diagnosed lung cancer which had spread to Mr Thorp's brain and liver. Mr Thorp was informed that his condition was terminal and that he needed more tests to assess the best treatment. The hospital prescribed dexamethasone to reduce swelling in the brain, dihydrocodeine and paracetamol for pain relief, and lansoprazole to reduce acid reflux in the stomach.
26. On his return to prison on 24 February, a nurse assessed Mr Thorp and made a care plan, noting that Mr Thorp should be observed at least twice a day. There was no mention in the plan about how to manage Mr Thorp's extensive medical needs or his day to day tasks.
27. Officers handed the medication prescribed and provided by the hospital to a nurse, who sent it to the pharmacy unit so it could be booked in. Due to an oversight, the dexamethasone (a steroid to reduce swelling in the brain) did not reach the health care wing. As a result, Mr Thorp did not receive any of this medication prior to his death.

28. During overnight observations on 26 February, a nurse saw Mr Thorp who was sitting on his bed clutching his head. The nurse gave Mr Thorp dihydrocodeine and paracetamol for pain relief. She noted that Mr Thorp had not received his dexamethasone.
29. Later that morning, a healthcare assistant carried out a routine observation where he took Mr Thorp's temperature which was low (35.9 degrees), oxygen levels which were normal (100%), pulse which was low (59 beats per minute) and blood pressure which was high (154/102 – 120/80 is considered within normal range). The healthcare assistant recorded that he was drowsy.
30. At 11.45am, an officer alerted the healthcare assistant that Mr Thorp was slumped across his bed. Mr Thorp was incontinent of urine and appeared confused and uncooperative. The healthcare assistant made Mr Thorp comfortable and he requested that prison nurses attended immediately as he noted that Mr Thorp had limited movement in his right arm and leg.
31. Two nurses attended within a few minutes and one of them radioed an emergency code blue (which indicates a prisoner is unresponsive or having difficulty breathing). The control room immediately called an emergency ambulance. The healthcare assistant and a nurse moved Mr Thorp on to his bed and gave him 15 litres of oxygen. Mr Thorp's blood pressure was recorded as very high (219/92), and he was unresponsive.
32. At 12.08pm, the paramedics arrived and took control of Mr Thorp's care. At 12.14pm the ambulance left the prison. Two prison officers went with Mr Thorp in the ambulance and did not use restraints. Mr Thorp's condition continued to deteriorate and he died at 3.40pm.

Contact with Mr Thorp's family

33. On 16 February, the prison appointed a supervising officer as the family liaison officer (FLO). Mr Thorp had named his solicitor as his nominated next of kin and did not have contact with his family. The FLO made extensive enquiries to identify a family member without success.
34. Mr Thorp's funeral took place on 24 April. The prison arranged and paid for the funeral in line with national policy.

Support for prisoners and staff

35. The prison posted notices informing other prisoners of Mr Thorp's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Thorp's death. Staff in the health care unit held an immediate debrief.

Cause of death

36. The coroner concluded that the cause of death was intracranial herniation (pressure in the brain). Mr Thorp also suffered from lung cancer which had spread to his brain.

Findings

Clinical care

37. Before Mr Thorp went to hospital in February, the care he received was good. He was reviewed for asthma in line with national guidance, and was assessed quickly when he showed signs of confusion. However, the clinical reviewer considered that the standard of care Mr Thorp received after coming back to prison on 24 February, was not equivalent to that he could have expected in the community. We agree with this assessment.
38. On 23 February Mr Thorp was diagnosed with lung cancer which had spread to his brain and liver. On his discharge from hospital back to HMP Leeds on 24 February, Mr Thorp's clinical assessment and care plan was not of the standard expected. Mr Thorp had complex care needs and these were not recognised or highlighted in his care plan. Mr Thorp was not seen by a prison GP when he returned from hospital. This impacted on the continuity of care provided to Mr Thorp.
39. Mr Thorp's poor care plan and the lack of clinical observations, as well as the fact he did not receive prescribed medication are a matter of concern. We make the following recommendation:

The Head of Healthcare should ensure that prisoners returning from hospital are thoroughly assessed and appropriate healthcare plans put in place, including for taking and recording observations.

40. Communication between the nurse who took Mr Thorp's medication when he came back to prison and the pharmacy unit was poor. Mr Thorp did not receive the medication (dexamethasone) he had been prescribed by hospital doctors for two days, which was to reduce the swelling on his brain. This could have had serious consequences but the clinical review was not able to offer a definitive view in this case.

The Head of Healthcare should ensure that there are no delays in prescribing and delivering medication.

**Prisons &
Probation**

Ombudsman
Independent Investigations