

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harry Wood a prisoner at HMP Leeds on 27 May 2018

A report by the Prisons and Probation Ombudsman

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 2018

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 I oversee can improve their work in the future.

Mr Harry Wood died on 27 May 2018 of acute cardiac failure, while a prisoner at HMP Leeds. Mr Wood was 60 years old. I offer my condolences to Mr Wood's family and friends.

Mr Wood received a good standard of clinical care while at Leeds, equivalent to that which he could have expected in the community. Healthcare responded appropriately to his changing care needs and his chronic conditions were managed well in accordance with clinical guidance.

However, I am concerned that, although Mr Wood's condition was deteriorating while he was being assessed by nursing staff on the day of his death, they did not use a simple scoring tool to help determine the level of clinical intervention needed. As a result, there was an unacceptable and avoidable delay of 45 minutes before an ambulance was called.

I am also concerned that a very frail elderly man was restrained for some of his hospital appointments, including while he was receiving treatment for a brain tumour. We have made recommendations to Leeds about the use of restraints during hospital visits on four previous occasions in the last three years. On each occasion, Leeds have accepted our recommendations and committed to act on them. Effective action must now be taken to implement our recommendation and we draw this unsatisfactory state of affairs to the attention of the Prison Group Director as well as the Governor.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	5
Findings.....	8

Summary

Events

1. Mr Harry Wood was charged with historic sex offences and remanded to HMP Leeds on 6 June 2017. He received a 36-year sentence on 17 May 2018.
2. Mr Wood had many chronic conditions. These were reviewed regularly by healthcare staff and he was prescribed appropriate medications. In December, Mr Wood was diagnosed with a brain tumour and underwent treatment in January 2018. A hospital doctor prescribed steroids, pain relief and anti-sickness medication.
3. Before he was diagnosed with a brain tumour, prison managers authorised the use of double cuffs and an escort chain for Mr Wood's escorts outside the prison. This was reduced to an escort chain once Mr Wood was in hospital and found to have a brain tumour. For two sessions of treatment, Mr Wood was restrained using an escort chain. For all other external escorts after this time, no restraints were applied.
4. Mr Wood was weak and he needed assistance from both a Zimmer frame and wheelchair to mobilise. On 27 May, an officer found him collapsed but conscious on the floor of his cell. He immediately called an emergency code over the radio and three nurses responded. The control room requested an ambulance but this was stood down when the nurses arrived at the cell.
5. Mr Wood was assisted back to bed and while he was having his basic observations taken, his condition started to deteriorate. The nurses asked a senior nurse to attend for her medical opinion on how best to treat Mr Wood.
6. The senior nurse attended and due to Mr Wood's condition requested an ambulance to take him to hospital. She noted that Mr Wood was in respiratory distress. The senior nurse said she responded within five minutes of nursing staff asking her to attend but the ambulance was not requested until nearly 45 minutes after it was originally stood down.
7. The ambulance arrived within five minutes and took Mr Wood to hospital. His condition deteriorated and he died that evening.

Findings

8. Mr Wood's chronic conditions were managed in line with NICE guidelines. His medications were appropriate and kept under review. Healthcare staff provided timely responsive care and ensured his care needs were met. Mr Wood received a good level of clinical care while at Leeds.
9. However, on the day of Mr Wood's death it is difficult to understand why it took 45 minutes for an ambulance to be requested after it was initially stood down. Considering Mr Wood's symptoms, it is unclear why the three nursing staff sought the opinion of a senior nurse. Although the delay is unlikely to have had an impact on the outcome for Mr Wood, in other circumstances it could be critical.

10. National Early Warning Score (NEWS) is a clinical assessment used to monitor unwell patients. It is a simple scoring system to determine the appropriate clinical response. Although the NEWS score was used during Mr Wood's many consultations with healthcare staff, the nursing staff who assessed Mr Wood on 27 May did not use the NEWS score when assessing his symptoms. Using the NEWS score would have assisted the nurses in assessing Mr Wood's condition and deciding the best clinical care. They could then have decided whether he required an ambulance without needing to seek advice from a senior colleague.
11. It is of particular concern that restraints were used on two occasions while Mr Wood was having treatment. We do not consider that restraints were necessary and proportionate to the risks he posed, over and above the control already available through the escorting officers.

Recommendations

- The Head of Healthcare should ensure that staff are aware of their responsibilities in a medical emergency and should not delay requesting an ambulance for patients who appear critically unwell.
- The Head of Healthcare at HMP Leeds should ensure that the NEWS tool is routinely used in clinical practice. This will ensure that there is a clear understanding of the patient's clinical state, risk of deterioration and prognosis, while also standardising the assessment of patients.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.
- The Prison Group Director for Yorkshire should assure himself that the Governor takes effective action to address the continuing inappropriate use of restraints for hospital escorts at HMP Leeds.

The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Wood's prison and medical records.
14. The investigator interviewed three members of healthcare staff at Leeds on 16 July 2018.
15. NHS England commissioned a clinical reviewer to review Mr Wood's clinical care at the prison. They conducted joint interviews.
16. We informed HM Coroner for County of West Yorkshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
17. The investigator wrote to Mr Wood's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked to receive a copy of the investigation report.
18. Mr Wood's wife received a copy of the initial report. She pointed out two factual inaccuracies. This report has been amended accordingly.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leeds

20. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Leeds was conducted in November 2017. Inspectors found leadership and oversight were well established with strong clinical governance in place demonstrating accountability for practice. Access to most clinics was reasonable and there were routine waits of about two weeks to see a GP. Medical leadership was clear and effective. The management of long-term conditions was impressive. Two experienced nurses provided effective assessment and oversight of patients with identified conditions. Complex care arrangements were good and there was effective liaison with community specialist services. Patients had good access to planned external hospital appointments. There were few cancellations, and any proposed modifications were clinically prioritised by a GP.

Independent Monitoring Board

22. 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 annual report for 2017, published in April 2018, the IMB reported the prisoners on the wings were generally satisfied with the delivery of healthcare, but frequently report difficulty in accessing the service in a timely manner and, as they had reported the previous year, the healthcare system regularly had missed appointments. They were concerned that far too frequently prison officers were not available to escort prisoners to their appointments in NHS hospitals. This threatened the on-going care of prisoners, caused difficulties at the hospitals, with a knock-on effect for the medical care in the prison, as routine problems could turn into emergencies requiring urgent action.

Previous deaths at HMP Leeds

23. Mr Wood's death was the fourth death from natural causes at Leeds since 2017. This is the fourth time we have made a recommendation about the inappropriate use of restraints since May 2015.

Key Events

24. Mr Harry Wood was remanded to HMP Leeds on 6 June 2017, charged with historic sex offences. He had chronic conditions, including ischaemic heart disease, arthritis, chronic obstructive pulmonary disease (COPD) and asthma, for which he took appropriate medications. About five years earlier, he had had his right lung removed due to cancer. During his reception screen with a nurse, he was noted to have been pale, underweight and breathless. His blood pressure was within the normal range.
25. Mr Wood saw healthcare staff regularly throughout 2017 for weight loss, dizziness and shortness of breath. Healthcare staff reviewed and examined Mr Wood according to his symptoms.
26. On 6 December, Mr Wood fell off the escort vehicle when he returned from court. He was unsteady on his feet, had numbness to his left hand and the left side of his face appeared weaker. Mr Wood was taken to hospital by ambulance as it was thought he was having a stroke.
27. The escort risk assessment showed that Mr Wood was considered a medium risk to the public and a low risk to staff, of escape and hostage taking. A prison manager authorised the use of double cuffs and an escort chain.
28. Mr Wood had investigative tests while in hospital to determine the cause of his symptoms. A magnetic resonance imaging scan (or MRI, a scan that uses magnetic fields and radio waves to produce detailed images of the inside of the body) showed that Mr Wood had a brain tumour. His restraints were removed for the purposes of the MRI scan and the escort chain was reapplied afterwards.
29. A hospital doctor prescribed steroids, pain relief and anti-sickness medication. Mr Wood returned to Leeds on 12 December and was placed on the healthcare wing.
30. In January 2018, Mr Wood had three sessions of gamma knife treatment. This is a specialised treatment used to treat tumours or malformations in the brain.
31. The escort risk assessments recorded that Mr Wood's considered risk had not changed. Because Mr Wood was weak and had limited mobility, a prison manager authorised the use of an escort chain. The escort chain was removed for an MRI scan and for one of the three gamma knife treatments.
32. Healthcare staff reviewed Mr Wood regularly for the on-going symptoms related to his brain tumour. Although he did not have a definitive prognosis, staff liaised with hospice staff for advice about symptom management and medications. Mr Wood was weak and used a Zimmer frame and wheelchair to mobilise. Healthcare staff helped him with his personal care needs.
33. Mr Wood was admitted to hospital on 12 February and 12 March. He was treated for a chest infection on both occasions and discharged back to Leeds. No restraints were applied for these or any subsequent escorts.
34. From 14 to 24 March, Mr Wood was transferred to a local hospice for symptom management.

35. On 6 May, a nurse noted that Mr Wood's feet were swollen and she advised him to lie in bed and elevate them with a pillow as much as possible.
36. On 17 May, Mr Wood was sentenced to 36 years imprisonment. He was said to have been upset at the length of his sentence.
37. On 22 May, a prison GP prescribed a diuretic to treat Mr Wood's fluid retention in his feet and ankles.
38. Mr Wood's appetite and condition had improved over the previous week. On 25 May, it was noted in his medical record that he had showered independently and was in good spirits. His mobility had improved with the use of his Zimmer frame.
39. On 27 May, an officer was on the wing when he heard banging. He said he did not know where it was coming from so started to walk down the wing. He said he then heard shouts for help coming from Mr Wood's cell. The officer looked in the cell and saw Mr Wood on the floor. He immediately called a code blue emergency over the radio, at 6.39am. (A code blue emergency signifies a medical emergency relating to breathing difficulties, a fit, or collapse.)
40. Three nurses responded straight away. When they entered the cell, Mr Wood said he had fallen out of bed. They assisted him back into bed and the nursing staff asked for the ambulance to be stood down at 6.44am.
41. Mr Wood had a superficial cut to his left arm. A nurse started to take Mr Wood's basic observations such as blood pressure and oxygen saturations. During the examination, Mr Wood said he had a headache and increasing weakness to his left side. A nurse questioned whether he was having a stroke. Mr Wood's blood pressure was slightly raised and his pulse high. He became increasingly short of breath and was put on a nebuliser. His oxygen saturations were low at 85% while he was on oxygen. A nurse asked a Sister to review Mr Wood and for her opinion as to whether he should go to hospital.
42. The Sister assessed Mr Wood. She said he was in bed and had a tremor, but was alert and conscious. His blood pressure and pulse were still raised. The Sister noted that he was pale and in respiratory distress. She asked the control room to request an ambulance and this was done immediately, at 7.27am.
43. The ambulance arrived at 7.33am and Mr Wood was taken to hospital at 8.20am. No restraints were applied. His condition deteriorated and he was pronounced dead by a hospital doctor at 8.30pm that evening.

Contact with Mr Wood's wife

44. A prison officer, was appointed as the prison's family liaison officer (FLO) after Mr Wood was diagnosed with a brain tumour. She kept Mr Wood's wife up to date on his condition and when he was admitted to hospital. Mrs Wood was able to visit her husband and, on 15 March, prison managers authorised unrestricted visits to Mr Wood on the wing.
45. The FLO provided on-going support to Mrs Wood. She explained the FLO role and the next steps after Mr Wood's death, such as the coronial process and assistance with funeral arrangements.

46. On 27 May, at 10.10am, the FLO tried to contact Mrs Wood via telephone to inform her that Mr Wood was seriously unwell in hospital. She was unable to make contact, so she visited her home and delivered the message in person. She went to the hospital with Mrs Wood at 1.00pm.
47. The FLO continued to provide support to Mrs Wood after Mr Wood died. In line with national guidance, the prison made a financial contribution to the funeral, which was held on 22 June.

Support for prisoners and staff

48. After Mr Wood's death, a prison manager debriefed the staff on the bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Wood'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 Wood's death.

Post-mortem report

50. The post-mortem report shows that Mr Wood died from acute cardiac failure, caused by ischaemic heart disease and coronary artery atherosclerosis (blocked arteries). The report states that there was sufficiently severe coronary artery atherosclerosis to impair sufficient blood flow to the heart muscle and cause sudden death.

Findings

Clinical care

51. Mr Wood had many chronic conditions, for which healthcare staff appropriately reviewed and treated him. His medications were appropriate and were kept under review. In December 2017, Mr Wood was diagnosed with a brain tumour. He received a round of treatment but was given no definitive prognosis. Shortly before he died, Mr Wood appeared to be getting stronger and was finding it easier to mobilise and meet his personal care needs.
52. The clinical reviewer was satisfied that Mr Wood's ischaemic heart disease was managed according to NICE guidelines on cardiovascular disease. Healthcare staff provided responsive care and his specialist needs were met. Care plans were relevant and up to date. Mr Wood received a good standard of care, equivalent to that he could have expected in the community.

Emergency response

53. When Mr Wood was found collapsed in his cell on 27 May, a prison officer appropriately called an emergency 'code blue'. An officer in the control room called an ambulance immediately and nursing staff responded quickly. Within five minutes of the code blue being called, nursing staff had arrived at Mr Wood's cell and conducted an initial assessment. They decided an ambulance was not required and they asked the control room to stand the ambulance down.
54. The nurses helped Mr Wood back to his bed and did further clinical assessments. While Mr Wood was being assessed, his condition started to deteriorate to the extent that a nurse questioned whether he was having a stroke. Instead of re-requesting the ambulance, the three nurses in attendance decided to ask a Sister for her opinion. Although the Sister says she went to Mr Wood's cell within 5 minutes and requested an ambulance immediately, the ambulance was not re-requested until 7.27am. This was about 45 minutes after it had been stood down.
55. Given one of the nurses thought Mr Wood might be having a stroke, and his clinical observations were not good, it is difficult to understand why nursing staff required the opinion of the Sister. The delay of 45 minutes is unacceptable and, although it is unlikely to have impacted the outcome for Mr Wood, in other circumstances such a delay could be critical. We make the following recommendation:

The Head of Healthcare should ensure that staff are aware of their responsibilities in a medical emergency and should not delay requesting an ambulance for patients who appear critically unwell.

National Early Warning Score

56. National Early Warning Score (NEWS) is a clinical assessment used to monitor unwell patients. It is a key element of patient safety and of improving patient outcomes. It is based on a simple scoring system in which a score is allocated to the patient's vital signs (respiration rate, oxygen saturations, blood pressure,

pulse rate, level of consciousness or confusion and temperature) to determine the degree of illness and the extent of any deterioration.

57. There is evidence in Mr Wood's medical record that healthcare staff used the NEWS system during clinical observations with Mr Wood. It is concerning therefore that when nursing staff responded to Mr Wood on 27 May, they did not use NEWS when assessing him, which would have provided a better assessment of the extent of his deterioration. Instead, nursing staff asked for the advice of a senior nurse. Although Mr Wood did eventually go to hospital, the NEWS score would have helped nursing staff to decide whether Mr Wood needed to be taken to hospital without needing to delay any action by seeking a further opinion from a senior nurse. We repeat the clinical reviewer's recommendation:

The Head of Healthcare at HMP Leeds should ensure that the NEWS tool is routinely used in clinical practice. This will ensure that there is a clear understanding of the patient's clinical state, risk of deterioration and prognosis, while also standardising the assessment of patients.

Restraints

58. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
59. A High Court judgement in 2007 highlighted a number of factors that prisons should consider when deciding upon the use of restraints. These included addressing the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit, and those risks posed by the same prisoner when suffering from a serious medical condition.
60. When Mr Wood went to hospital in December with a suspected stroke, two members of staff escorted him using double cuffs. (This means a prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.) An escort chain was also used. (This is a long chain with a handcuff at each end, one of which is attached to a prison officer). A full risk assessment indicated that Mr Wood presented a medium risk to the public and low risk to staff and of escape. For Mr Wood's hospital appointments in January for gamma knife treatment and an MRI scan, the escort chain was removed for the scan, but only for one of the treatments.
61. "Double cuffing" is usually required for moving category A or category B prisoners in good health. Although we recognise that Mr Wood was a remand prisoner at the time of his appointments, we question whether the use of restraints was, in fact, proportionate to the actual risk which Mr Wood posed given his age, frailty, limited mobility and very poor health. It is also difficult to understand why the escort chain was removed for two initial procedures, but not the subsequent two. We, therefore, question whether all staff were aware of their

responsibilities to consider the balance between security and humanity when completing risk assessments.

62. It is the Governor's responsibility to ensure that the risk assessment process is managed properly, and all prison managers need to show a clear justification for any use of restraints in carrying out the risk assessment. We are troubled that this is the fourth time in three years that we have expressed concern about the inappropriate use of restraints on prisoners at Leeds. Given the prison's failure to introduce effective measures to address our concerns, we make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that risk assessments show clear justification for the use of restraints.

The Prison Group Director for Yorkshire should assure himself that the Governor takes effective action to address the inappropriate use of restraints for hospital escorts at HMP Leeds.

63. We are satisfied that Mr Wood's condition was appropriately considered in the risk assessment for subsequent hospital escorts and that no restraints were applied.

**Prisons &
Probation**

Ombudsman
Independent Investigations