Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leslie Twite a prisoner at HMP Doncaster on 23 May 2018

A report by the Prisons and Probation Ombudsman

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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*

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 Leslie Twite died at HMP Doncaster on 23 May 2018, due to infective endocarditis, an infection of the inner lining of the heart. Mr Twite was 63 years old. I offer my condolences to Mr Twite's family and friends.

Mr Twite had expressed suicidal thoughts in March 2018 and was being monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) when he died. We are satisfied, however, that he died of natural causes.

Infective endocarditis is a rare condition. The initial symptoms can be similar to the flu, and can often be non-specific, making the illness difficult to identify. There was no indication that Mr Twite was unwell in the weeks before he died, and when he became acutely ill on 21 May, healthcare staff at the prison responded appropriately and he was admitted to hospital promptly.

There were some failings in the management of his high blood pressure (hypertension), and Mr Twite was not seen at the prison's hypertension clinic as quickly as he should have been. However, there is no indication that this had an impact on Mr Twite's death.

I am concerned that the prison did not seek medical input before deciding to restrain Mr Twite in hospital and that he was restrained until 48 minutes before he stopped breathing.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **November 2018**

Contents

Summary

Events

1. Mr Leslie Twite was sentenced to seven years imprisonment on 8 September 2017, and was sent to HMP Leeds. He had a history of high blood pressure (hypertension), depression, and alcoholism. Mr Twite told staff that he had attempted suicide in June 2017 by taking an overdose of Ibuprofen and hypertension medication.

2. Mr Twite was at Leeds for just over three months. Twice during this time staff monitored him under Prison Service suicide and self-harm prevention procedures (known as ACCT) because he said he felt suicidal.

3. Mr Twite transferred to HMP Doncaster on 15 December 2017. There was a delay in managing his hypertension at Doncaster until 30 January 2018.

4. Between 7 February and 20 April, Mr Twite refused to take his hypertension medication. Healthcare staff assessed that he had the capacity to make this decision.

5. On 5 March, Mr Twite told a prison officer that he wanted to end his life, and staff began suicide and self-harm monitoring procedures (known as ACCT) which remained in place until his death on 23 May.

6. Between 15 and 19, and 28 and 29 April, Mr Twite refused food and fluids. This was managed under the ACCT process with the involvement of healthcare staff. He was assessed as having the capacity to make these decisions.

7. On 30 April, a prison GP diagnosed Mr Twite with a urinary tract infection (UTI) and prescribed antibiotics. Mr Twite was monitored by healthcare staff for 24 hours afterwards. On 14 May, he was seen by another GP for a review of his antidepressant medication and did not complain of any physical health problems or raise any other concerns during the appointment.

8. On the morning of 21 May, a prison officer asked a nurse to see Mr Twite because he thought he seemed unwell. Mr Twite was monitored by healthcare staff during the day and, when his condition deteriorated, he was taken to hospital by emergency ambulance at 7.00pm with suspected sepsis. He was not restrained. Hospital doctors diagnosed a suspected inflamed gallbladder and admitted him.

9. The following day an escort chain was applied in the afternoon when the bedwatch officers thought Mr Twite's condition was improving. They obtained permission to remove it at 1.25pm on 23 May when they thought Mr Twite's condition was deteriorating.

10. Mr Twite stopped breathing at 2.13pm and hospital staff started cardiopulmonary resuscitation (CPR). At 2.30pm, staff concluded that Mr Twite had died and stopped CPR.

11. The post-mortem investigation found that the cause of death was infective endocarditis, a bacterial infection of the lining of the heart.

Findings

12. Although Mr Twite was being managed under suicide and self-harm procedures at the time of his death, we are satisfied that his death was due to natural causes and not to an act of self-harm.

13. There were some initial shortcomings in the treatment Mr Twite received for his hypertension when he transferred to Doncaster on 15 December, and he was not referred to a GP for review as he should have been. However, the clinical reviewer was satisfied that from 30 January, the care Mr Twite received for his hypertension was of a very high standard and was in line with current NICE guidance.

14. Mr Twite had a history of non-compliance with his hypertension medication in the community, and he refused to take his medication for two and a half months at Doncaster. Staff managed his refusal within healthcare guidelines, monitored his blood pressure, explained the dangers to him and assessed that he had the capacity to refuse his medication.

15. Infective endocarditis is a rare condition. The initial symptoms are similar to the flu, and can often be non-specific, making the illness difficult to identify. Symptoms can develop rapidly over the course of a few days, or slowly over the course of weeks or possibly months. Mr Twite suffered from a urinary tract infection (UTI) at the end of April, which was properly treated by antibiotics and there is no indication there was any link between this and the infective endocarditis. There was no indication that Mr Twite was unwell before 21 May and we are satisfied that staff could not have anticipated that he would develop a life-threatening illness.

16. We are satisfied that when Mr Twite became ill on 21 May, he was treated and monitored appropriately by healthcare staff.

17. When Mr Twite was taken to hospital he was not restrained because he was considered to be too ill. We are concerned that the prison did not seek medical input to risk assessments after that and that an escort chain was applied the following day, and remained in place until very shortly before his death, because the bedwatch officers believed that his condition was improving.

Recommendations

- The Head of Healthcare should ensure that the first and second stage reception screenings are undertaken in line with NICE Guideline 57.
- The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated and treated in line with NICE guidelines.
- The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to hospital understand the legal position and that medical opinion about a prisoner's ability to escape must be

considered as part of the assessment process and reviewed as circumstances change.

The Investigation Process

18. The investigator issued notices to staff and prisoners at Doncaster informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

19. The investigator contacted the prison and obtained copies of relevant extracts from Mr Twite's prison and medical records.

20. The investigator interviewed eight members of staff and prisoners at Doncaster on 15 and 16 August 2018. She also interviewed five members of staff by phone on later dates.

21. NHS England commissioned a clinical reviewer to review Mr Twite's clinical care at the prison. She conducted joint interviews with the investigator at Doncaster on 15 and 16 August.

22. We informed HM Coroner for Doncaster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. The investigator wrote to Mr Twite's next of kin to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to the letter.

Background Information

HMP Doncaster

24. HMP Doncaster is a local prison, operated by Serco, which holds up to 1,145 remanded and sentenced men. Nottingham Healthcare NHS Foundation Trust provides physical and mental health services, and substance misuse services. HMP Doncaster directly employs qualified paramedics as part of their healthcare team, who respond to emergency calls within the prison.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Doncaster was in July 2017. Health services had improved considerably since the previous inspection in October 2015 and overall, were reasonably good. A wide range of primary care services was available and waiting lists were generally short, although too many patients failed to attend appointments. The management of prisoners with long-term conditions had improved, with several trained staff available to patients. The 24-hour in-house paramedic service was an example of good practice.

Independent Monitoring Board

26. 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. The IMB published its latest annual report for the year to July 2017.

27. The IMB noted that Doncaster held a high number of aging prisoners and expressed concerns that the healthcare team did not have any specialist older or palliative care available onsite. They noted that mental health care was only available in office hours and there was no on-call system, leaving prison staff and physical healthcare staff to do work that the mental health team should be doing.

Previous deaths at HMP Doncaster

28. Mr Twite was the tenth prisoner to die of natural causes at Doncaster in the previous three years. There were no similarities between the circumstances of Mr Twite's death and the previous deaths at the prison.

Key Events

29. On 8 September 2017, Mr Leslie Twite was sentenced to seven years imprisonment for sexual offences and was sent to HMP Leeds.

30. Mr Twite had a history of high blood pressure (hypertension), diagnosed in 2008. He been prescribed medication for his hypertension in the community but when he entered Leeds he told staff that he did not take the medication anymore. It is not clear whether this was because it had been discontinued by the GP or because he chose not to. He also had depression, for which he had previously been prescribed medication in the community, and was an alcoholic. Mr Twite told staff at Leeds that he had attempted suicide in June 2017 by taking an overdose of Ibuprofen and blood pressure medication.

31. While at Leeds, Mr Twite was twice monitored under ACCT procedures when he said that he felt suicidal. On both occasions, ACCT monitoring ended when Mr Twite said that he no longer had any thoughts of suicide. The last period of ACCT monitoring ended on 27 November 2017.

HMP Doncaster

32. On 15 December, Mr Twite moved to HMP Doncaster. A nurse carried out the medical reception screening. She identified Mr Twite's history of hypertension, and found his blood pressure reading was high, so she referred him to the hypertension clinic for further assessment. She wrongly recorded that Mr Twite had no history of self-harm or suicide but referred him to the mental health team for his depression. A nurse from the mental health team considered her referral a few days later and concluded that Mr Twite did not need any mental health support at that time.

33. Mr Twite did not attend his second health screening on 18 December, the reason for this is not recorded. According to clinical guidelines he should have been referred to a GP because of his high blood pressure, but he was not.

34. On 9 January 2018, a nurse added Mr Twite to the prison's hypertension clinic waiting list and booked him an appointment at the clinic for the first available appointment on 30 January. In the meantime, nurses continued to monitor Mr Twite's blood pressure, which remained consistently high. On each occasion, the most senior nurse on duty was told and the reading was recorded in Mr Twite's medical records, but no further action was taken.

35. On 30 January, a nurse reviewed Mr Twite's hypertension in the clinic. She explained the dangers of leaving hypertension untreated to Mr Twite and gave him lifestyle and dietary advice. She prescribed him suitable medication, amlodipine and atorovastin.

36. Between 7 and 27 February, Mr Twite refused to take any medication. Almost every day, sometimes twice a day, healthcare staff rang the wing to ask prison staff to remind Mr Twite to come and get his medication but Mr Twite refused to attend.

37. On 27 February, a nurse reviewed Mr Twite at the hypertension clinic and they discussed his medication refusal. She recorded that Mr Twite appeared to have the mental capacity to refuse his medication. She referred Mr Twite to the mental health team and made an appointment with a GP to try and address his low mood, which she thought was his reason for not taking his medication.

38. On 2 March, the referral to the mental health team was rejected. Records indicate that a nurse reviewed Mr Twite's records and concluded that Mr Twite's concerns were related to his physical wellbeing, rather than any mental health problems.

39. On 5 March, Mr Twite told an officer that he felt suicidal and staff began ACCT procedures. He remained subject to ACCT monitoring until his death on 23 May.

40. On 9 March, a prison GP saw Mr Twite and assessed that he had the mental capacity to refuse medication. He and Mr Twite discussed prescribing antidepressants, but Mr Twite refused the offer.

41. On 16 March, the prison GP saw Mr Twite again to discuss his non-compliance with his hypertension medication. Mr Twite continued to refuse the medication and he recorded that Mr Twite had the mental capacity to refuse. Healthcare staff continued to monitor Mr Twite's blood pressure and encouraged him to take his medication, but Mr Twite continued to refuse.

42. On 12 April, a nurse reviewed Mr Twite's blood pressure, which remained high at 208/102mmHg (normal blood pressure is between 90/60mmHg and 120/80mmHg). Mr Twite told her that he would not take his blood pressure tablets as he did not want to live, however he said he would consider taking an antidepressant and she prescribed amitriptyline that day.

43. On 17 April, staff holding the ACCT case review recorded that Mr Twite had not been eating or drinking for 72 hours, and was not taking his medication. He said that family problems were causing him to feel low. The staff noted that they would refer Mr Twite to the healthcare department and start a food diary. After the meeting, a supervising officer called the healthcare department and discussed Mr Twite. Healthcare staff placed Mr Twite on the Multi-Professional Complex Care (MPCC) register for discussion.

44. Staff began a food refusal log that day and completed it until 22 April. Mr Twite started eating, drinking and taking his medication again on 20 April but was monitored for two more days by prison and healthcare staff.

45. On 26 April, Mr Twite was discussed at the healthcare MPCC meeting. As Mr Twite had started eating and taking his medication and no other issues were identified in the meeting, he was discharged from the MPCC caseload.

46. On 30 April, Mr Twite was diagnosed with a urinary tract infection. A prison GP prescribed antibiotics and Mr Twite was monitored by healthcare staff for 24 hours. He did not attend a follow up appointment on 3 May. The reasons for his non-attendance were not recorded.

47. On 14 May, a prison GP reviewed Mr Twite and prescribed him a different antidepressant (mirtazapine) to the one previously prescribed in April. Mr Twite

did not complain of any physical health problems or raise any other concerns during the appointment.

Events from 21 May 2018

48. At around 9.00am on 21 May, an officer asked an Advanced Nurse Practitioner to examine Mr Twite, because he thought he seemed unwell. She carried out a National Early Warning Score (NEWS) assessment of Mr Twite and noted that he scored two. (NEWS is a clinical assessment used to improve the detection of sepsis in adults. Six simple physical measurements are taken to form the basis of the score – respiration rate, oxygen saturation, systolic blood pressure, pulse rate, level of consciousness and temperature. A score of 0-4 is classed as low and indicates that further monitoring of the patient is required, at least every six hours.)

49. The nurse noted that Mr Twite had a possible chest infection and prescribed an antibiotic. She then asked her colleague, a Senior Paramedic, to check Mr Twite later that day. At around 11.30am, the Senior Paramedic examined Mr Twite and she noted that Mr Twite's NEWS had increased to four.

50. The Senior Paramedic told the investigator that at approximately 5.00pm, she was on her way to review Mr Twite in his cell, when an officer approached her and told her Mr Twite seemed very unwell. They both went to Mr Twite's cell and found him on his bed, sweating, clammy and pale. She and the officer took Mr Twite to healthcare using a wheelchair. Mr Twite was conscious and able to speak in full sentences.

51. The Senior Paramedic examined Mr Twite and noted his NEWS had increased to 10, with a low temperature, increased respirations, low blood pressure and low oxygen saturation levels. A NEWS of seven and above requires an emergency response. She started to treat Mr Twite, giving him oxygen therapy and intravenous fluids, and the officer called through to the control room for an ambulance.

52. The control room log shows that staff there called for an ambulance at 5.38pm, and the call was put through to the Senior Paramedic. She told the ambulance service that Mr Twite might have sepsis and required an emergency response.

53. At 5.50pm, the Senior Paramedic rechecked Mr Twite's vital signs and noted that his NEWS had reduced to two. However, due to the earlier high scores, she still felt that Mr Twite required hospitalisation.

54. At 6.05pm, the Senior Paramedic asked the control room to find out why the ambulance had not arrived. The service asked her how urgently Mr Twite required an ambulance and she told them within an hour of the original call. She stayed with Mr Twite while they waited for the ambulance to arrive.

55. The ambulance arrived at 6.33pm. The paramedics assessed Mr Twite and agreed that he should be taken to hospital. The ambulance left the prison with Mr Twite at 7.06pm. Before Mr Twite went to hospital, staff carried out a risk assessment and concluded that his physical condition meant he was not a risk of escape and so did not need to be restrained. When Mr Twite arrived at hospital his NEWS had increased to eight and he was admitted with a suspected inflamed

gallbladder. Two officers remained with Mr Twite at all times (known as a bedwatch).

56. On 22 May, two officers were carrying out bedwatch duties with Mr Twite. Officer A told the investigator that during the afternoon, Mr Twite got up to use the bathroom, unaided and with no difficulty. She and Officer B had not received any information from hospital staff to suggest that Mr Twite was seriously ill. Officer A reassessed Mr Twite's risk of escape, and concluded that given the improvement in his mobility, he should be restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) A Supervising Officer approved the decision. At 3.00pm, Mr Twite was restrained using an escort chain, attached to Officer B.

57. On the afternoon of 23 May, the two officers were with Mr Twite again. Officer A told the investigator that at around midday, Mr Twite was conscious and talkative and seemed well. Shortly after this, his colour began to change and his health deteriorated. Hospital staff began checking him more frequently. Officer A said that no one asked them to remove Mr Twite's escort chain but she could tell that Mr Twite's health was rapidly deteriorating. At 1.25pm, he asked the Supervising Officer for permission to remove the restraints and he agreed.

58. At 2.13pm, Mr Twite stopped breathing and hospital staff started cardiopulmonary resuscitation (CPR). At 2.30pm, staff concluded that Mr Twite had died and stopped CPR.

Contact with Mr Twite's family

59. Mr Twite's next of kin was his son. When Mr Twite was taken to hospital, the Head of Safer Custody acted as the Family Liaison Officer (FLO) and told Mr Twite's son that he was in hospital.

60. On 23 May, when Mr Twite died, both Mr Twite's son and niece were on their way to the hospital to visit him. The Head of Safer Custody decided it would be preferable to meet them at the hospital rather than pass on this upsetting news over the phone while they were travelling. She went to the hospital accompanied by an officer who was going to take over as FLO when they met the family. The officer and the Head of Safer Custody were waiting at the hospital when Mr Twite's family arrived and told them that that Mr Twite had died.

61. Mr Twite's brother was a prisoner at Doncaster, Mr Twite's son said he wanted to visit the prison to tell his uncle of Mr Twite's death. the Head of Safer Custody said the prison would tell Mr Twite's brother and a family visit would be arranged for the next day.

62. On 24 May, in the morning, the FLO and the Head of Safer Custody told Mr Twite's brother that Mr Twite had died, and that his nephew and wife would visit him later that day. At 11.30am, the family visit took place. The FLO also visited Mr Twite's brother on the wing on several occasions after this to check on his welfare and to keep him updated on whether he would be allowed to attend Mr Twite's funeral. He was not allowed to attend for security reasons, but on the

day of Mr Twite's funeral he was visited by the prison Chaplain and his welfare was monitored by prison staff.

63. The FLO kept in contact with Mr Twite's son while the funeral was arranged, and she arranged the return of Mr Twite's possessions.

64. The FLO and the new Head of Safer Custody attended Mr Twite's funeral on 6 July. The prison contributed towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

65. After Mr Twite's death, the Head of Safer Custody debriefed the staff on bedwatch duty to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

66. The prison posted notices informing other prisoners of Mr Twite'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 Twite's death.

Post-mortem report

67. A pathologist concluded that Mr Twite died from infective endocarditis, a bacterial infection of the lining of the heart. There was nothing in the post-mortem report to suggest that Mr Twite's pre-existing health conditions had caused the endocarditis or made it more serious.

Findings

Clinical care

68. The clinical reviewer concluded that the care Mr Twite received at Doncaster was equivalent to that which he would have received in the community.

69. There was no indication that Mr Twite was seriously unwell in the days or weeks before he was taken to hospital on 21 May. There is no indication in the post-mortem or clinical review that the infective endocarditis could have been prevented. It is a rare illness and can develop suddenly, and the evidence suggests that this was the case with Mr Twite.

70. When prison staff first noticed Mr Twite was unwell on 21 May, they told healthcare staff promptly. Healthcare staff assessed Mr Twite using the NEWS tool, and a plan was put in place for monitoring his condition. There was good communication between healthcare staff that ensured continuity of care. When Mr Twite's NEWS increased to 10, he was transferred to the healthcare wing and an emergency ambulance was called. We are satisfied that this response was appropriate.

Management of high blood pressure (hypertension)

71. Mr Twite had a history of hypertension and was prescribed medication in the community (which he did not always take as prescribed). The clinical reviewer found that there was a delay in discussing treatment for his hypertension with Mr Twite following his transfer to Doncaster because he was not referred to a GP as he should have been.

72. The clinical reviewer also considered that healthcare staff should have expedited Mr Twite's appointment at the hypertension clinic when his blood pressure readings were consistently high in January 2018. However, she concluded that, once Mr Twite was reviewed at the hypertension clinic on 30 January, the care received was of a very high standard and was in line with NICE guidance.

73. We make the following recommendations;

    The Head of Healthcare should ensure that the first and second stage reception screenings are undertaken in line with NICE guideline 57.

    The Head of Healthcare should ensure that high blood pressure is promptly and appropriately investigated and treated in line with NICE guidelines.

74. Mr Twite refused to take any medication from 7 February to 20 April. We agree with the clinical reviewer that Mr Twite's medication refusal was managed appropriately by the prison. Healthcare staff regularly monitored his blood pressure, discussed the risks of not taking his medication with Mr Twite and assessed that he had the capacity to refuse. He was also referred to the mental health team and had an appointment with a GP to try and address his low mood, which was thought to be his reason for not taking his medication.

Risk of suicide and self-harm

75. When Mr Twite said he felt suicidal, staff appropriately started suicide and self-harm monitoring procedures (known as ACCT) and involved healthcare staff when Mr Twite refused medication and food. We are satisfied that Mr Twite received appropriate support.

76. We are also satisfied that Mr Twite's death was due to natural causes, not self-harm.

Restraints, security and escorts

77. When prisoners have to travel outside of 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. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and reviewed as circumstances change.

78. Mr Twite was not restrained when he was taken to the hospital on 21 May by emergency ambulance. He was escorted and monitored by two officers. We are satisfied that this was appropriate.

79. However, decisions about restraints after that were taken solely on the basis of views of the bedwatch officers, and were not informed by clinical advice about the extent to which Mr Twite's health might affect the risk he posed. As a result, Mr Twite was restrained the day before he died and the restraints were only removed 48 minutes before he stopped breathing.

80. We consider that the prison should have discussed Mr Twite's condition with hospital staff in order to inform their decisions about Mr Twite's risk and the need for restraints. We make the following recommendation:

    The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to hospital understand the legal position, and that medical opinion about a prisoner's ability to escape must be considered as part of the assessment process and reviewed as circumstances change.

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