Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lloyd Brown a prisoner at HMP Woodhill on 15 July 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 Lloyd Brown died in hospital on 15 July 2018 of a pulmonary embolism (blood clot in the lung) while he was a prisoner at HMP Woodhill. He was 54 years old. I offer my condolences to Mr Brown's family and friends.

Mr Brown was prescribed blood thinning medication after a stroke in 2012 but he often refused to take it, despite being made aware of the risks to his health.

When Mr Brown complained of chest pain on 8 July, the prison GP diagnosed a chest infection without assessing whether Mr Brown could have a pulmonary embolism. This aspect of his care was not equivalent to that which 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 staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **April 2019**

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Summary

Events

1. Mr Lloyd Brown was sent to prison in November 2008 for sexual offences. He spent time at several prisons before being moved to HMP Woodhill on 9 May 2018.

2. Mr Brown had a minor stroke in December 2012 and was prescribed medication to reduce the risk of blood clots. However, he often refused to take it, despite being made aware of the risks to his health. He also frequently refused food and drink. He was regularly monitored by staff during these periods.

3. On 4 June 2018, Mr Brown had his right leg amputated after being diagnosed with ischaemia (a restriction in blood supply to the tissues). He returned to Woodhill on 21 June.

4. On 8 July, Mr Brown complained of pain in his back and chest. A prison GP diagnosed a chest infection and prescribed antibiotics.

5. At 9.45am on 15 July, the prison chaplain alerted officers after he could not see Mr Brown in his cell. Officers attended and found Mr Brown collapsed on the floor. Healthcare staff performed cardiopulmonary resuscitation (CPR) and Mr Brown was taken to hospital by emergency ambulance. His condition continued to deteriorate and he died at 11.29am.

6. The post-mortem examination showed that Mr Brown died from a massive pulmonary thromboembolism (a blood clot that has formed somewhere in the body and then travelled to the lungs, blocking an artery), caused by recurrent deep vein thrombosis (when a blood clot forms in a vein, usually in the legs).

Findings

7. The clinical reviewer was satisfied that the care Mr Brown received up to 8 July was equivalent to that which he could have expected to receive in the community and that staff managed his periods of food and fluid refusal appropriately.

8. When Mr Brown complained of chest pain in July 2018, the prison GP did not consider the possibility of a pulmonary embolism and did not offer a blood test to check for signs of deep vein thrombosis and pulmonary embolism. The clinical reviewer considered that this aspect of his care was not equivalent to that which he could have expected to receive in the community.

Recommendation

- The Head of Healthcare should ensure that all clinical staff are aware of the risk factors for pulmonary embolism and complete a Wells score and, where appropriate, a D-dimer blood test on all patients with relevant symptoms.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison. He provided us with a clinical review report but we considered that it was incomplete and asked for further issues to be addressed. NHS England asked a GP to review Mr Brown's clinical care and write an addendum to the clinical review report. The investigation was suspended between 13 November 2018 and 18 March 2019 pending the final clinical review.

12. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Brown's next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

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 Woodhill

15. HMP Woodhill in Milton Keynes has a dual role as a local prison and a high security prison and can hold 727 men. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides physical and mental healthcare for prisoners.

HM Inspectorate of Prisons

16. The most recent inspection of Woodhill was in February 2018. Inspectors reported that health services had improved and partnership working between both providers and the prison was effective. Inspectors observed proficient interactions between staff and prisoners. There were some vacancies within the primary care and mental health teams, and recruitment was ongoing.

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 30 May 2018, the IMB reported that healthcare ran a full range of clinics to which access and waiting lists were the same or better than in the community. There was good access to wing based nurses who dealt successfully with minor issues. Nurses had access to the healthcare computer system on the wings.

Previous deaths at HMP Woodhill

18. Mr Brown was the 13th prisoner to die at Woodhill since July 2016. Seven of the previous deaths were from natural causes and five took their own lives. There have been three deaths since, one from natural causes, one awaiting classification and one prisoner took their own life. There were no similarities between Mr Brown's death and previous deaths at Woodhill.

Key Events

19. On 5 November 2008, Mr Lloyd Brown was remanded in custody for sexual offences and sent to HMP Wormwood Scrubs. On 14 January 2011, he received an indeterminate sentence for public protection (IPP) with a minimum term of three years and six months.

20. Mr Brown was moved to HMP Isle of Wight on 14 July 2011. In December 2012, he had a minor stroke and prison GPs prescribed clopidogrel (to reduce the risk of heart disease, stroke and blood clots) and simvastin (to lower cholesterol). In May 2013, prison GPs noted that Mr Brown was refusing to take his prescribed medication and that he understood the associated risks to his health.

21. In August 2015, Mr Brown complained of right-sided numbness and a tremor in his right hand and a prison GP referred him to a neurologist. The GP discussed prescribing clopidogrel and simvastin again but Mr Brown refused to take them because he did not want chemicals in his body. Mr Brown also refused to take aspirin.

22. In March 2016, Mr Brown saw a neurologist at the hospital, Isle of Wight. The neurologist prescribed atenolol (used to treat high blood pressure) and encouraged Mr Brown to take clopidogrel and simvastin. Mr Brown refused to take his prescribed medication. He was moved to HMP Rye Hill in April 2016.

23. Mr Brown had periods of refusing to eat and drink which started in July 2016. Between 27 September and 25 November, Mr Brown refused to eat and drink and prison staff monitored him under suicide and self-harm procedures (known as Assessment, Care in Custody and Teamwork (ACCT)) and kept a food refusal log.

24. On 25 November, Mr Brown was admitted to the hospital. While in hospital, he complained of leg pain. Investigations showed no nerve damage or swelling in Mr Brown's legs. When Mr Brown returned to Rye Hill on 5 December, he said he was unable to walk and continued to complain of pain in his right leg. In October 2017, a prison GP examined Mr Brown and noted he could not find any clinical or physical reason why Mr Brown was unable to walk.

25. On 9 May 2018, Mr Brown was moved to HMP Woodhill. A prison GP completed Mr Brown's initial health screen and noted that he had a history of refusing his medication and was regularly managed under a food refusal log. Mr Brown used a wheelchair and said he was unable to walk independently. Mr Brown refused to discuss his healthcare and he made a referral to the prison's mental health team. On 10 May, a community psychiatric nurse saw Mr Brown in his cell. Mr Brown refused to speak to her. She made regular attempts to assess Mr Brown but he refused to see her.

26. On 11 May, a nurse saw Mr Brown in his cell. Mr Brown said he was refusing food because of pains in his legs. Mr Brown said the pain was caused by nerve damage and he did not want to see a GP.

27. At 4.20pm on 11 May, an officer began ACCT monitoring after Mr Brown said he would refuse to eat and drink until he was returned to HMP Rye Hill. A Custodial

Manager (CM) completed an immediate action plan and instructed staff to observe Mr Brown every hour. She contacted the prison's mental health team.

28. At 11am on 12 May, an officer from the safer custody team completed an ACCT assessment interview with Mr Brown and noted that prison staff had started a food refusal log. Mr Brown said he wanted to return to Rye Hill immediately and refused to engage in the assessment.

29. At 11.30am, a CM and the officer from the safer custody team held the first ACCT case review. Mr Brown refused to explain why he was refusing food. The CM assessed Mr Brown as a raised risk of suicide and self-harm (on a scale of low, raised and high) and decided to keep the ACCT open.

30. The CM also completed Mr Brown's caremap (designed to identify the main areas of concern and the actions required to reduce risk) and added three actions, for prison staff to investigate when Mr Brown could return to Rye Hill, for healthcare staff to monitor Mr Brown's food and drink intake and for healthcare staff to hold a meeting to discuss Mr Brown's complex care needs.

31. Healthcare staff saw Mr Brown daily and noted he continued to refuse food and drink. On 21 May, staff discussed his food and drink refusal at a multidisciplinary team meeting. A nurse noted that Mr Brown wanted to return to Rye Hill and had told prison staff he would continue to refuse food and drink until he was moved.

32. On 22 May, a prison GP saw Mr Brown in his cell. He was satisfied that Mr Brown had the mental capacity to decide to refuse food and drink and understood the risks to his health if he continued to do so. Mr Brown said he would consider drinking bottled water but would not be pressurised into doing so.

33. On 23 May, the prison GP admitted Mr Brown to the prison's clinical assessment unit for continuous monitoring. A nurse created a food and fluid refusal care plan to monitor his nutritional needs.

34. On 24 May, a CM held an ACCT case review with a nurse and an officer. The CM told Mr Brown that he would return to Rye Hill when a suitable cell became available. Mr Brown agreed to have nutritional drinks. The CM decided to keep the ACCT open to monitor Mr Brown's food and drink intake.

35. On 26 May, a prison GP saw Mr Brown and noted that he was complaining of pain his right leg which was caused by sciatica (pain from the sciatic nerve which runs from the hips to the feet). He noted that Mr Brown said his calf was tender but refused to be examined. Mr Brown refused to have any blood tests. He prescribed Mr Brown amitriptyline (antidepressant used to treat nerve pain).

36. Healthcare staff saw Mr Brown daily in accordance with his care plan. On 31 May, a nurse noted that Mr Brown had refused his nutritional drink. Mr Brown's cell was dirty and he had urinated on the floor. The nurse made a referral to a prison GP. The same day, a prison GP saw Mr Brown in his cell. Mr Brown refused an examination and he noted he looked weak and frail. He arranged for an emergency ambulance to take Mr Brown to the hospital. Two prison officers accompanied Mr Brown and did not use restraints.

37. Hospital doctors noted that Mr Brown's right foot was cold to touch and he refused further examination or treatment. Hospital doctors completed a mental capacity assessment which showed Mr Brown had the mental capacity to understand the implications of refusing treatment. A hospital consultant explained to Mr Brown he was at risk of having his right leg amputated if he continued to refuse treatment.

38. On 1 June, hospital doctors decided that, following a deterioration in his condition, Mr Brown no longer had the mental capacity to refuse treatment. Investigations showed that Mr Brown had ischaemia (a restriction in blood supply to tissues) and moved him to the intensive care unit. Mr Brown was treated with intravenous fluids and antibiotics.

39. On 2 June, a hospital consultant contacted the healthcare unit at Woodhill and explained that Mr Brown would need to have his right leg amputated. She said an independent mental capacity advocate would act on Mr Brown's behalf because he did not have the mental capacity to agree to surgery.

40. On 4 June, Mr Brown was moved to the hospital. Prison managers contacted Mr Brown's friend, his nominated next of kin, to inform her but she did not respond. Surgeons amputated Mr Brown's right leg above the knee. On 12 June, the results of a mental capacity assessment showed that Mr Brown continued to lack the mental capacity to make decisions about his healthcare. Hospital doctors inserted a feeding tube.

41. On 21 June, Mr Brown was returned to Woodhill. A nurse saw Mr Brown and noted he refused to be examined. The nurse created a complex needs care plan. A prison GP prescribed Mr Brown morphine sulphate (for strong pain) and dihydrocodeine (for moderate pain and swelling). Mr Brown agreed to have nutritional drinks and eat fruit but continued to refuse his meals. Healthcare staff continued to monitor Mr Brown in accordance with his care plans.

42. On 8 July, Mr Brown complained of pain in his back and the left side of his chest. The prison GP diagnosed a chest infection and prescribed antibiotics.

Events of 15 July 2018

43. At 7.45am on 15 July, a nurse saw Mr Brown sitting in his wheelchair. At 9am, an officer checked Mr Brown in accordance with his ACCT plan. Mr Brown was sitting in his wheelchair and did not express any concerns.

44. At approximately 9.45am, the prison chaplain was unable to see Mr Brown in his cell. The chaplain called for assistance and two officers immediately attended. They entered Mr Brown's cell and found him collapsed on the floor. One officer radioed a medical emergency code blue (which indicates a prisoner has breathing difficulties or is unconscious). The control room immediately called an ambulance.

45. At approximately 9.50am, a prison GP and a nurse arrived and started cardiopulmonary resuscitation (CPR). At 9.58am, the paramedics arrived and took over Mr Brown's care. At 10.56am, Mr Brown was taken from Woodhill to the hospital. Two officers accompanied Mr Brown and did not use restraints. His condition continued to deteriorate and he died at 11.29am.

Contact with Mr Brown's family

46. Two officers acted as the prison's family liaison officers. At 3pm on 15 July, the prison's family liaison officers visited Mr Brown's friend, his nominated next of kin, and informed her of Mr Brown's death. They offered condolences and support. Mr Brown's friend said she had not been in contact with Mr Brown for approximately eight years and asked the prison to arrange his funeral.

47. One of the prison's family liaison officer telephoned Mr Brown's friend on a regular basis but she did not return his calls. Woodhill arranged and paid for Mr Brown's funeral in line with national instructions.

Support for prisoners and staff

48. After Mr Brown's death, a prison manager debriefed the staff involved in the emergency response 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 Brown'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 Brown's death.

Post-mortem report

50. A post-mortem examination found that Mr Brown died of a massive pulmonary thromboembolism (a blood clot that has formed somewhere in the body and then travelled to the lungs, blocking an artery), caused by recurrent deep vein thrombosis (when a blood clot forms in a vein, usually in the legs).

Findings

Clinical care

51. Mr Brown had a history of stroke but persistently refused to take blood thinning medication. The second clinical reviewer was satisfied that prison GPs informed Mr Brown of the associated risks to his health and assessed Mr Brown's mental capacity to refuse his prescribed medication. The second clinical reviewer commented that, after Mr Brown had his lower leg amputated, hospital doctors did not advise prison GPs to prescribe anti-coagulant medication.

52. The second clinical reviewer commented that there was no evidence that Mr Brown had a blood clotting disorder and no ongoing medical conditions that would predispose him to thrombosis. She said that Mr Brown complained of various forms of leg pain, none of which indicated a deep vein thrombosis. When Mr Brown complained of a tender calf in May 2018, he refused an examination from a prison GP. The second clinical reviewer noted that prison GPs were therefore unable to assess Mr Brown's risk of developing a deep vein thrombosis or a pulmonary embolism.

53. The second clinical reviewer considered that these aspects of Mr Brown's clinical care were equivalent to that which he could have expected to receive in the community.

54. When Mr Brown complained of chest pain on 8 July, a prison GP treated him for a chest infection and did not consider the possibility of a pulmonary embolism. The second clinical reviewer noted that the prison GP did not use the Wells score (an assessment tool to predict a patient's risk of developing a deep vein thrombosis). The clinical reviewer commented that Mr Brown was a moderate risk of having a pulmonary embolism and should have been offered a D-dimer test (a blood test to help diagnose deep vein thrombosis and pulmonary embolism). We make the following recommendation:

    The Head of Healthcare should ensure that all clinical staff are aware of the risk factors for pulmonary embolism and complete a Wells score and, where appropriate, a D-dimer blood test on all patients with relevant symptoms.

Management of Mr Brown's food refusal

55. Mr Brown frequently refused food and drink in prison. PSI 64/2011 Chapter 10 – *Management of prisoners who refuse food and/or fluids and medical treatment* says that food and fluid refusal is not considered in law to be a form of self-harm, but that an ACCT may provide a useful way of recording the care offered and facilitate information sharing. PSI 11/2012 *Incident Reporting* says after 72hrs food refusal is reportable to the National Operations Unit (NOU).

56. Guidance from the Department of Health says it is critical a thorough assessment of a person's mental capacity and nutritional status is undertaken immediately and there should be regular reassessments of the person's physical and mental state.

57. The second clinical reviewer commented that repeated and prolonged episodes of food refusal were likely to have led to dehydration and predisposed Mr Brown to thrombosis because of dehydration and electrolyte imbalance in his metabolism. However, she concluded that it was impossible to determine which incident of food refusal caused a blood clot.

58. We are satisfied that on each occasion Mr Brown refused to eat and drink, prison and healthcare staff managed his food refusal appropriately.

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