Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Ledsome a prisoner at HMP Leyhill on 12 February 2019

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.

The Ombudsman's 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 Mark Ledsome died of pneumonia, chronic liver disease and an oesophageal varices bleed on 12 February 2019, while a prisoner at HMP Leyhill. He was 45 years old. I offer my condolences to Mr Ledsome's family and friends.

Mr Ledsome had long history of drug misuse in the community, including injecting drugs. In February 2018, he tested positive for hepatitis C while at HMP Guys Marsh. This was not recorded in the 'active problems' section of his medical records, as it should have been, and was not therefore picked up when Mr Ledsome transferred to HMP Leyhill on 8 August 2018. As a result, it went untreated.

I am also concerned that there is no evidence that healthcare staff at Guys Marsh told Mr Ledsome that he had hepatitis C or explained to him that this could be a life-threatening condition if left untreated.

It follows that I am not satisfied that the standard of care provided to Mr Ledsome was equivalent to that which he could have expected to receive in the community. He died as a result of complications associated with hepatitis C and I cannot say whether the outcome would have been different if he had been treated earlier.

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 2019**

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Summary

Events

1. On 19 December 2017, Mr Mark Ledsome was sentenced to three years and four months for conspiracy to supply class A drugs. He was sent to HMP Winchester.

2. When he arrived at Winchester, healthcare staff reviewed Mr Ledsome. He told a nurse that he had a long history of heroin and crack cocaine use, and was methadone dependant. He was offered screening for HIV and hepatitis B and C, which he declined.

3. In January 2018, Mr Ledsome was transferred to HMP Guys Marsh. Healthcare staff carried out a review and noted his history of substance misuse. He was offered screening for a number of conditions, which on that occasion he accepted. In February, the results of that screening showed Mr Ledsome had tested positive for hepatitis C. He was referred to hospital but did not attend the appointment. The reasons for his non-attendance were not recorded.

4. On 8 August 2018, Mr Ledsome was transferred to HMP Leyhill. As with the previous two reception health screens, he was offered screening because of his history of substance misuse, but he declined. The previous positive hepatitis C test was not picked up.

5. On 31 January 2019, healthcare staff saw Mr Ledsome after he reported feeling unwell, coughing up blood and passing blood from his rectum. He was sent to hospital by emergency ambulance.

6. Hospital staff diagnosed severe pneumonia and he was taken to the intensive care unit and put on a ventilator to help him breathe. He was subsequently diagnosed with influenza A. His condition continued to deteriorate.

7. On 7 February, Mr Ledsome had a substantial internal bleed. Hospital staff were unable to find the cause of the bleed. He had a blood transfusion, but his condition did not improve, and he died on 12 February.

8. The post-mortem report gave the cause of death as pneumonia, chronic liver disease and oesophageal varices bleeding. (Pneumonia and liver disease are recognised complication of untreated hepatitis C, and oesophageal varices are a complication of serious liver disease.)

Findings

9. The clinical reviewer is satisfied that healthcare staff at Leyhill responded appropriately when Mr Ledsome became unwell at the end of January 2019 and sent him promptly to hospital.

10. However, the clinical reviewer is not satisfied that, overall, Mr Ledsome received a standard of clinical care that was equivalent to that which he could have expected to receive in the community, particularly while at Guys Marsh.

11. Healthcare staff at Guys Marsh failed to record Mr Ledsome's positive hepatitis C blood test properly. As a result, healthcare staff at Leyhill were not aware of his condition.

12. There was no follow up when Mr Ledsome did not attend a hospital appointment following his positive hepatitis C test.

13. It is not clear from Mr Ledsome's medical records if he was informed of his positive hepatitis C result or the risks of leaving it untreated. It is, therefore, possible that he did not have the information he needed to make informed decisions about the importance of any follow up appointments.

14. We cannot say whether earlier treatment might have affected the outcome for Mr Ledsome.

Recommendations

- The commissioners at NHS England should ensure that:
    - healthcare staff at Guys Marsh correctly record medical diagnoses in prisoners' electronic medical records; and
    - any outstanding blood tests or referrals are made explicit when prisoners transfer between prisons.

- The Head of Healthcare at Guys Marsh should ensure healthcare staff discuss blood test results with prisoners to enable them to make informed choices about their care
- The Head of Healthcare at Guys Marsh should ensure that healthcare staff encourage prisoners to attend hospital appointments. Where appointments are missed, healthcare staff should record the reason why and encourage prisoners to attend any rebooked appointments

The Investigation Process

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

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

17. NHS England commissioned a clinical reviewer to review Mr Ledsome's clinical care at the prison.

18. We informed HM Coroner for Avon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. We wrote to Mr Ledsome's next of kin 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.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Guys Marsh

17. HMP Guys Marsh is a category C training and resettlement prison in Dorset, holding up to 400 adult male prisoners, many of whom are serving longer-term sentences. Care UK Health and Rehabilitation Services Ltd provide physical and mental health care and EDP provide drug and alcohol services.

HM Inspectorate of Prisons

18. The most recent inspection of Guys Marsh was in December 2018/January 2019. Inspectors reported that there had been substantial improvements since their previous inspections in 2014 and 2016. Health services were very good overall. There was a wide range of primary care services, waiting times were acceptable and prisoners with long-term conditions were well cared for.

Independent Monitoring Board

19. 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 their latest annual report, for the year to November 2018, the IMB reported that a boost in staffing levels had improved morale and given impetus to urgently required improvements. They said that healthcare had shown sustained improvement since the appointment of Care UK.

HMP Leyhill

20. HMP Leyhill is an open prison in South Gloucestershire, holding up to 515 prisoners who require minimum security. Some are life sentence prisoners preparing for release.

21. Inspire Better Health, a partnership of eight health care providers led by Bristol Community Health, provides all health and substance misuse services. Primary care services are available on weekdays, at 8am to 4pm. A local NHS centre, Hanham Health, provides GP and out of hours services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Leyhill was in September 2016. Inspectors reported that Leyhill was, overall, a safe and decent establishment. In terms of the healthcare provision, the inspection found that a small team of experienced nurses ran effective clinics for most long-term conditions and GPs ran one for heart disease. Healthcare staff were easily identifiable and their interactions with prisoners were professional and compassionate. They were in date with all mandatory training and had good access to appraisals and clinical supervision.

Independent Monitoring Board

23. In their latest annual report, for the year to January 2018, the IMB reported that Leyhill was, overall, a safe and decent establishment. The Board considered that healthcare services provided were at least as good as those available in the outside community.

Previous deaths at HMP Leyhill

24. Mr Ledsome was the eighth prisoner to die from natural causes at Leyhill since February 2016. There was one other death at Leyhill which was not investigated. There are no similarities with those other deaths.

Key Events

25. On 19 December 2017, Mr Mark Ledsome was sentenced to three years and four months for conspiracy to supply class A drugs. He was sent to HMP Winchester.

HMP Winchester

26. Healthcare staff reviewed Mr Ledsome when he arrived at Winchester. They noted he was a smoker and offered him smoking cessation advice, which he declined. He told healthcare staff that he had a long history of heroin and crack cocaine use and was dependent on methadone (an opiate substitute). He was offered screening for HIV and hepatitis B and C – conditions which intravenous drug users are at risk of contracting – but he declined.

27. Following his review, a careplan was created to manage his addiction withdrawal. He was referred to the mental health in-reach team (MHIRT) and the integrated drug treatment service (IDTS) for support and to continue his drug withdrawal treatment. His prescription for a daily dose of 20 milligrams of methadone was reviewed and updated.

HMP Guys Marsh

28. On 2 January 2018, Mr Ledsome transferred to HMP Guys Marsh. A nurse carried out an initial healthscreen. He noted Mr Ledsome's previous drug use and drug treatment plan, which he reviewed and updated. Mr Ledsome was offered smoking cessation advice, but again refused. He was referred to MHIRT and IDTS for support.

29. During his healthscreen, it was noted that Mr Ledsome appeared underweight. He told the nurse that he had contracted Weill's disease in 2016 (a severe bacterial infection with flu-like symptoms) and that had caused his weight loss. The nurse referred him for blood tests, the results of which showed that Mr Ledsome had hepatitis C with an active infection (a virus that can cause serious and potentially life-threatening damage to the liver if left untreated).

30. On 9 March, a prison GP referred Mr Ledsome to the hepatology department at a hospital in Dorset, for a follow up blood test to confirm the diagnosis of hepatitis C. Mr Ledsome did not attend. The reasons for his non-attendance were not recorded. Because he did attend the appointment, the hepatology department discharged him from their care.

31. Mr Ledsome continued to be reviewed regularly by both MHIRT and IDTS staff and his care plans were updated regularly. He completed his methadone reduction programme.

HMP Leyhill

32. On 8 August, Mr Ledsome was transferred to HMP Leyhill. A nurse carried out his initial health screen. She noted his pre-existing medical conditions and reviewed his care plans. She also noted he had successfully completed methadone treatment in the previous month.

33. The nurse offered Mr Ledsome screening for a number of conditions, including hepatitis C, but he declined. There was no marker in his medical records to show to healthcare staff that Mr Ledsome had tested positive for hepatitis C while at Guys Marsh.

34. Mr Ledsome had little significant contact with healthcare staff until 30 January 2019. A nurse reviewed Mr Ledsome after he reported feeling unwell. He told the nurse that he had been coughing up blood for the previous two days and passing blood from his rectum for the past 24 hours. The nurse took his observations (measurements of temperature, respiratory rate, pulse, blood pressure and blood oxygen saturation, an indicator of a patient's state of health), which showed that he had an irregular heart rate.

35. The nurse sent Mr Ledsome to hospital by emergency ambulance for review. Hospital staff diagnosed severe pneumonia with a high risk of dying. They considered his chances of survival would be improved if he was placed into a medically induced coma (that is, kept sedated using anaesthetic).

36. Mr Ledsome was moved to the hospital's intensive care unit and was placed on a ventilator (which assists a patient to breathe). Hospital staff told healthcare staff at Leyhill that Mr Ledsome's condition was critical. They considered his chances of survival depended on how he reacted to treatment in the next 48 hours. Prison healthcare staff kept in contact with hospital staff daily and received updates on Mr Ledsome's condition.

37. On 4 February, hospital staff told healthcare staff at Leyhill that there had been no improvement in Mr Ledsome's condition. He remained critical. He continued to receive active treatment but his prognosis was poor.

38. Hospital staff told prison healthcare staff that Mr Ledsome had developed multiple organ failure and was receiving kidney dialysis. They also told healthcare staff he had been diagnosed with influenza A (a contagious viral infection that affects the respiratory system). Healthcare staff planned to review other prisoners at Leyhill who might have been at risk from the virus.

39. On 7 February, Mr Ledsome had a substantial internal bleed. Hospital staff were unable to find the cause of the bleed, and Mr Ledsome was given a blood transfusion.

40. On 11 February, Mr Ledsome had a cardiac arrest. Hospital staff considered that because he showed no signs of improvement it was appropriate to withdraw all life support. They agreed to keep him ventilated until his next of kin could be informed and was able to visit him in hospital.

41. At 10.23am, on 12 February, a nurse telephoned the hospital for an update on Mr Ledsome's condition. She was informed all treatment would be withdrawn. Hospital staff were waiting for Mr Ledsome's next of kin to arrive, but if Mr Ledsome's next of kin had not arrived by 11.30am, treatment would be withdrawn at that point and that Mr Ledsome was expected to die shortly afterwards.

42. At 11.30am, hospital staff withdrew all active treatment and Mr Ledsome died at 12.04pm.

Post-mortem report

43. The post-mortem gave the cause of death as pneumonia, with chronic liver disease and an oesophageal varices bleed. (Oesophageal varices are swollen veins which can develop in the gullet as a complication of liver disease and which can bleed, sometimes catastrophically.)

Contact with Mr Ledsome's Family

44. On 31 January 2019, the Head of Residence contacted Mr Ledsome's next of kin, his partner, to inform her of Mr Ledsome's admission to hospital and the seriousness of his condition.

45. The same day, the prison appointed a Supervising Officer (SO) to act as family liaison officer (FLO). On the 2nd February the FLO attempted to contact Mr Ledsome's Partner, but without success. She eventually contacted her on 3 February.

46. Mr Ledsome's partner told the FLO that she lived in a hostel and could not afford the train fare to visit him in hospital. The FLO advised her to contact her probation key worker to see if they could assist with the cost of her travel. Despite SO Tyson contacting the key worker on her behalf, Mr Ledsome's partner was unable to get help with the costs of her travel. The FLO remained in contact with her, keeping her updated on Mr Ledsome's condition.

47. A CM also contacted Mr Ledsome's brother to inform him of Mr Ledsome's condition. He told the CM that he had had no contact with Mr Ledsome due to his offending behaviour, but he would tell the rest of his family to give them the opportunity to visit him if they wished to do so.

48. On 7 February, Mr Ledsome's daughter telephoned the prison and spoke with a Custodial Manager (CM) who had been appointed as deputy FLO. Mr Ledsome's daughter asked to be kept informed of any changes to his condition by telephone. The same day Mr Ledsome's partner was scheduled to visit him but didn't attend.

49. At 8.30am on 12 February, a CM tried to telephone Mr Ledsome's partner to inform her that hospital staff had noted a deterioration in his condition and that they planned to withdraw all treatment at 11.30am. However, despite numerous attempts, there was no answer.

50. The Head of Residence eventually contacted Mr Ledsome's partner at 10.51am and told her that Mr Ledsome was not expected to survive once that treatment had been withdrawn. Mr Ledsome's partner told him that she was on her way. The Head of Residence also telephoned Mr Ledsome's daughter to inform her of her father's condition.

51. The Head of Residence remained in telephone contact with Mr Ledsome's partner to establish when she would arrive at the hospital. However, Mr Ledsome died before she arrived.

52. As arranged, the Head of Residence telephoned Mr Ledsome's daughter to inform her of her father's death.

53. After Mr Ledsome's death, the FLO, the Head of Residence and a Reverend from the prison chaplaincy remained in regular contact with his family to offer them support.

54. Mr Ledsome's funeral was held on 13 March and was conducted by a member of the chaplaincy team at Leyhill. Representatives of the prison attended the funeral. In line with national guidance, the prison offered a financial contribution to his funeral.

Support for prisoners and staff

55. After Mr Ledsome's death, a prison manager debriefed the staff who were with him at the hospital when he died, giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

56. The prison posted notices informing other prisoners of Mr Ledsome'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 Ledsome's death.

Findings

Clinical care

57. The clinical reviewer noted that when Mr Ledsome arrived into prison, he had a long history of intravenous substance misuse, including crack cocaine and heroin. He was appropriately prescribed methadone and successfully completed substance misuse treatment in July 2018.

58. The results of a blood test at Guys Marsh in February 2018, showed that Mr Ledsome was hepatitis C positive with an active infection (which can result in liver failure over time if left untreated). This was not recorded in the 'active problems' section of Mr Ledsome's electronic medical records, as it should have been.

59. Mr Ledsome was referred to hospital specialists in April 2018, but he did not attend the appointment. There is no record of why the appointment was missed or whether Mr Ledsome knew about it, and no evidence that healthcare staff followed up the missed appointment with Mr Ledsome.

60. There is also no evidence in Mr Ledsome's medical records to show that that he was told he had hepatitis C. We are concerned that, unless Mr Ledsome knew this and knew about the potential implications of leaving hepatitis C untreated, he would not have been in a position to make an informed decision about whether or not he wanted to attend hospital appointments.

61. Because healthcare staff at Guys Marsh had not recorded Mr Ledsome's positive hepatitis C blood test properly in his electronic medical record, healthcare staff at Leyhill were not aware of his condition when he transferred there in August 2018 and did not take any follow up action.

62. The clinical reviewer is satisfied that healthcare staff at Leyhill responded appropriately when Mr Ledsome became acutely unwell in January 2019, and that they sent him to hospital promptly by emergency ambulance.

63. He subsequently died of pneumonia and chronic liver disease (both of which can be complications of untreated a hepatitis C infection). It is, therefore, possible that his hepatitis C contributed to his death. We cannot say whether earlier treatment for this condition might have affected the outcome.

64. The clinical reviewer concluded that the clinical care Mr Ledsome received, particularly while at Guys Marsh, was not equivalent to that he could have expected to receive in the community. We make the following recommendations:

    The Head of Healthcare at HMP Guys Marsh should ensure healthcare staff discuss blood test results with prisoners, to enable them to make informed choices about their care.

    The Head of Healthcare at Guys Marsh should ensure healthcare staff encourage prisoners to attend hospital appointments. Where appointments are missed, healthcare staff should record the reason why and encourage prisoners to attend any rebooked appointments.

- **The commissioners at NHS England should ensure that:**
    - **healthcare staff at Guys Marsh correctly record medical diagnoses in prisoners' electronic medical records; and**
    - **any outstanding blood tests or referrals are made explicit when prisoners transfer between prisons.**

Restraints, security and escorts

65. When prisoners must 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 must 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 considering factors such as the prisoner's health and mobility.

66. Mr Ledsome was not restrained during his final admission to hospital on 30 January 2019.We are satisfied that this was appropriate.

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