Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Spencer, a prisoner at HMP Leicester, on 7 December 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Andrew Spencer died on 7 December 2019 of heart disease at HMP Leicester. He was 35 years old. I offer my condolences to Mr Spencer's family and friends.

Mr Spencer died within 12 hours of arriving at Leicester. He had severe alcohol withdrawal symptoms when he arrived. The pathologist who conducted the post-mortem examination noted that acute alcohol withdrawal may increase the risk of arrhythmia (abnormal heart rhythm), but he could not determine the precise trigger that caused Mr Spencer's death.

Despite Mr Spencer showing severe alcohol withdrawal symptoms and being very unwell when he arrived at Leicester, no one considered asking a doctor to assess him. Mr Spencer was subsequently prescribed medication for alcohol withdrawal but was not given his vitamin B medication because the prison had none in stock.

The clinical reviewer found that there was a lack of clinical monitoring of Mr Spencer's condition, given he was withdrawing from alcohol and extremely unwell. She found that this aspect of his care was not equivalent to that he could have expected to receive in the community.

As a new arrival, Mr Spencer should also have been checked hourly by prison staff. I am very concerned that an officer recorded in the observations log that he had carried out two afternoon checks when he had not done so, and that Mr Spencer was not checked at all between 7.40pm and 10.10pm, when he was found unresponsive.

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 **October 2020**

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Summary

Events

1. On 7 December 2019, Mr Andrew Spencer was remanded in custody charged with assault and sent to HMP Leicester. He was withdrawing from alcohol and had reportedly had seizures in both police and court custody.

2. Mr Spencer arrived at Leicester at 11.35am. At the reception health screening, a nurse noted that Mr Spencer took methadone (an opiate substitute) and had physical symptoms consistent with opiate and alcohol withdrawal. The nurse referred Mr Spencer to the Integrated Drug and Alcohol Treatment Services (IDTS).

3. A member of the IDTS team assessed Mr Spencer and found that he had mild opiate withdrawal and severe alcohol withdrawal. She could not complete a full assessment as Mr Spencer was so unwell: he was shaking, sweating and vomiting repeatedly.

4. At 12.13pm, staff took Mr Spencer to the Induction Unit and put him in a cell on his own.

5. At approximately 2.42pm, the on-call prescriber assessed Mr Spencer and prescribed chlordiazepoxide (for alcohol withdrawal), methadone and thiamine (vitamin B1). Later that afternoon, Mr Spencer was given chlordiazepoxide and methadone, but not thiamine as the prison had none in stock. He was still vomiting when he was taken to the medications hatch and appeared to be very unwell.

6. At 7.40pm, an officer carried out a roll check and noted that Mr Spencer was sleeping.

7. At 10.10pm, a nurse went to see Mr Spencer to administer some more medication. Mr Spencer appeared to be asleep. The nurse called to Mr Spencer from outside the cell but he did not respond, so the nurse asked officers to unlock the cell. When they went in, they realised that Mr Spencer had no pulse. Staff called a medical emergency code and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 10.20pm, but they were unable to resuscitate Mr Spencer and at 10.56pm, a doctor pronounced his death.

8. The post-mortem report concluded that Mr Spencer died from dilated cardiomyopathy (an enlarged heart). Cirrhosis of the liver was listed as a contributory factor. The pathologist noted that acute alcohol withdrawal may increase the risk of arrhythmia (abnormal heart rhythm) in people with an enlarged heart.

Findings

9. Mr Spencer showed severe alcohol withdrawal symptoms and was very unwell when he arrived at Leicester. However, no one considered asking a doctor to assess him. The fact that it was a weekend when there are no GPs on duty in the prison may have played a part in this.

10. Although staff later gave him medication for alcohol withdrawal, they did not give him thiamine (Vitamin B1) tablets because the prison had none in stock. Although injectable Vitamin B1 (Pabrinex) was available there was no one on duty over the weekend who was able to give an intramuscular injection. (People with high alcohol consumption can become vitamin B1 deficient, which can cause brain and nerve damage, heart problems and seizures.)

11. The clinical reviewer was concerned about the lack of clinical monitoring of Mr Spencer after his arrival, given he was withdrawing from alcohol and very unwell. She found that this aspect of Mr Spencer's care was not equivalent to that he could have expected to receive in the community.

12. Leicester's policy is to observe all new arrivals hourly, in their first 24 hours. We are very concerned that two afternoon checks were not carried out on Mr Spencer, even though an officer recorded in the observations log that he had done the checks, and that Mr Spencer was not checked at all between 7.40pm and 10.10pm, when he was found unresponsive.

13. There was a lack of communication between prison and healthcare staff, and a lack of proper handover between day and night staff. We do not think that prison staff understood how ill Mr Spencer was.

Recommendations

- The Head of Healthcare and Turning Point Manager should review the access to thiamine and Pabrinex, particularly over the weekend.
- The Head of Healthcare and Turning Point Manager should ensure staff:
    - consider whether prisoners who are detoxing from alcohol and/or drugs should be seen by a doctor and record their consideration and the decision made; and
    - know how to call a doctor out of hours.
- The Head of Healthcare and Turning Point Manager should ensure that staff:
    - consider putting in place an observation and monitoring plan for all prisoners who are detoxing from drugs and/or alcohol and record their consideration and decision;
    - ensure the observation and monitoring plan sets out clearly who is responsible for carrying out any observations and when; and
    - ensure a full handover is given when there is a change of shift.

- The Governor should commission an investigation into the actions of an officer and his completion of the observations log on 7 December 2019, with a view to considering whether disciplinary action is appropriate.
- The Governor should ensure that staff on the Induction Unit carry out checks on all new prisoners at least hourly and complete the observation log accurately.
- The Governor and Head of Healthcare should ensure that:
    - information about prisoners detoxing from drugs and/or alcohol is shared between healthcare, Turning Point and discipline staff;
    - healthcare and Turning Point staff alert discipline staff to any concerns about a prisoner's welfare and highlight any signs to look out for that might indicate a deterioration in their condition; and
    - Induction Unit staff conduct appropriate handovers when shifts change and record relevant information in the observations log.
- The Governor and Head of Healthcare should share this report with an officer, a nurse, a healthcare assistant, pharmacy technician and an on-call prescriber and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

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

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

16. NHS England commissioned an independent clinical reviewer to review Mr Spencer's clinical care at the prison.

17. The investigator interviewed one member of healthcare staff, two members of Turning point staff and four members of custodial staff. The investigator and clinical reviewer jointly interviewed one member of healthcare staff and one member of Turning Point staff. Some of the interviews were completed in January 2020. Other interviews were planned for March but could not take place at Leicester because we were unable to visit prisons during the Covid-19 lockdown. These interviews took place by telephone in June. Unfortunately, there is no transcript or note of the interview with a pharmacy technician, as the quality of reception was too poor for the investigator to obtain a quality recording.

18. We informed HM Coroner for Leicester City and South Leicestershire district of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Spencer'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, but he asked for a copy of our report.

20. We shared aspects of this report with the prison, in line with our advance disclosure process.

21. Mr Spencer's next of kin received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leicester

23. HMP Leicester is a local prison that holds 350 men. The prison serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services at the prison. Turning Point provide substance misuse services.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Leicester in January 2018. Inspectors found significant improvement across many areas since their last inspection in 2015.

25. Inspectors reported that healthcare services had improved. Reception health screens were completed quickly, enabling swift transfer to the first night centre. Substance misuse services were excellent.

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. In its latest annual report, for the year ending 31 January 2019, the IMB reported that the transfer of services from Leicester Partnership NHS Trust to Nottinghamshire Healthcare NHS Foundation Trust went smoothly, and experienced staff were retained.

27. The Board found that members of the healthcare team formed a cohesive and well organised group and were fully integrated into essential prison meetings and reviews. They liaised effectively with the Integrated Drug and Alcohol Treatment Services (IDTS) and Safer Custody. The Board noted that the IDTS provider, Turning Point, was held in very high regard. Turning Point practitioners had taken over the administration of twice daily IDTS medications.

Previous deaths at HMP Leicester

28. Mr Spencer was the fifth prisoner to die at HMP Leicester since December 2017. Of the previous deaths, three were self-inflicted and one was drug-related. There are no similarities between our findings in Mr Spencer's case and our findings in our investigations into the previous deaths at Leicester.

Key Events

29. On 7 December 2019, Mr Andrew Spencer was remanded in custody charged with assault and sent to HMP Leicester. While in police and court custody, Mr Spencer had been under constant watch because he had reportedly had seizures due to alcohol withdrawal.

30. Mr Spencer arrived at Leicester at 11.35am. A nurse carried out Mr Spencer's reception health screen. Mr Spencer said he typically consumed 20 cans of 9% lager a day and had last had a drink the night before. He was also on methadone (an opiate substitute). The nurse noted, 'Withdrawing from alcohol and opiates. Patient presenting as shaking and did express that he does experience alcohol withdrawal seizures. Referred to IDTS [Integrated Drug and Alcohol Treatment Services]'.

31. The nurse took clinical observations which showed that Mr Spencer's pulse was on the higher side of average and his blood pressure was high. These readings were in keeping with Mr Spencer suffering from physical withdrawal symptoms.

32. Mr Spencer had brought vitamin B tablets and used inhaler cartridges into the prison (he said he had COPD – chronic obstructive pulmonary disease). The nurse told the investigator that Mr Spencer had his medication in a plastic bag and it looked very dirty, so he took it from him and disposed of it in the prison pharmacy. Mr Spencer said that he had depression but had not been taking his medication. The nurse made a GP referral so they could prescribe Mr Spencer's medication. When interviewed, he said that GPs dealt with these requests remotely and he was not sure when it would have been actioned.

33. The nurse referred Mr Spencer to Turning Point (IDTS). He gave a Turning Point healthcare assistant, paperwork informing her that Mr Spencer had had diazepam in police custody and had had an unobserved seizure.

34. The healthcare assistant was unable to complete all of Mr Spencer's substance misuse assessment because he was so unwell; he was sweating, shaking and vomiting repeatedly. She completed the COWS (Clinical Opiate Withdrawal Scale) and an alcohol audit (SADQ – Severity of Alcohol Dependence Questionnaire). Mr Spencer's COWS score was 12 (mild opiate withdrawal) and his SADQ score was 36 (severe alcohol withdrawal).

35. The healthcare assistant told a pharmacy technician about Mr Spencer's condition, and he asked the Turning Point on-call prescriber to attend.

36. A reception officer asked the healthcare assistant to return Mr Spencer to the holding cell in reception. She told the investigator that she told the reception officer that Mr Spencer was really unwell, and staff needed to keep an eye on him. He vomited bile in the holding cell.

37. CCTV footage shows that Mr Spencer was taken to the Induction Unit at 12.13pm (Leicester does not have a detox unit). He was put in a cell with a hatch (so nurses can give medication) on his own, on a bottom bunk (to reduce chances of injury should he have a seizure and fall out of bed).

38. New prisoners at Leicester should be checked hourly during their first 24 hours on the induction wing. At 12.27pm, CCTV shows that an officer looked into Mr Spencer's cell and completed the log to say he was sleeping. A female officer also looked into Mr Spencer's cell one minute later. Someone (probably a nurse) also looked into Mr Spencer's cell at 1.05pm.

39. The officer completed the observations log stating that at 1.30pm, Mr Spencer was sleeping. CCTV shows that this check was not carried out. At 1.52pm, the officer collected Mr Spencer from his cell and took him to the office for five minutes before Mr Spencer returned to his cell himself. The officer said that Mr Spencer was a little unsteady on his feet and told the officer that he was detoxing and just wanted to go to sleep.

40. At 1.59pm, Mr Spencer left his cell and went off the wing with a member of staff (probably a nurse). The officer completed the observations log to say that at 2.20pm, Mr Spencer was sleeping. He was not in his cell at that time. Mr Spencer did not return to his cell until 2.34pm. At 2.35pm, the officer went to Mr Spencer's cell and went into it.

41. At 2.42pm, an on-call prescriber for Turning Point and a pharmacy technician, saw Mr Spencer in his cell. Mr Spencer said he had taken his methadone the day before. Mr Spencer said he had had two seizures in police custody and had been given two 5mg diazepam tablets. He said he had also had a seizure in the court cell. He said he had last had an alcoholic drink before his arrest.

42. The on-call prescriber recorded Mr Spencer's pulse rate as above 98 (higher side of average), that he was sweating, restless and agitated, had signs of tremor, had been vomiting, reported joint pain and pins and needles in his leg. He noted that Mr Spencer's COWS score was 12, and his Clinical Institute Withdrawal Assessment (CIWA) was 16 (severe alcohol withdrawal).

43. He recorded that his plan was to continue to give Mr Spencer 80ml methadone daily. He prescribed chlordiazepoxide (for alcohol withdrawal) and noted that Mr Spencer should be monitored for five days.

44. He also prescribed thiamine (Vitamin B1). He recorded that he did not prescribe Pabrinex (Vitamin B1 injection) as it was the weekend (Saturday) and he would not be able to get it until the Monday. (People who consume high amounts of alcohol can become deficient in Vitamin B1 which can cause serious problems including brain and nerve damage and heart problems). Thiamine can be given in tablet form or, when a higher dose is needed, as an intramuscular injection (Pabrinex) to prevent seizures.

45. At 3.29pm and 4.37pm, an officer checked Mr Spencer and recorded in the observations log that Mr Spencer was sleeping.

46. A nurse told the investigator that at around 4.00pm, he went to the Induction Unit and added to Mr Spencer's Cell Sharing Risk Assessment (CSRA) that he was withdrawing from opiates and alcohol and needed a lower bunk. He said he told an officer that he was adding this to the CSRA and that Mr Spencer needed monitoring. He said he also added Mr Spencer to the handover sheet, which listed prisoners that healthcare staff needed to be aware of.

47. At 4.37pm, a healthcare assistant took Mr Spencer to the medication hatch. She told the investigator that Mr Spencer was still sweating and shaking, and he vomited on the way and when he arrived at the hatch. A pharmacy technician gave Mr Spencer chlordiazepoxide (for alcohol withdrawal) and 80mls of methadone. Thiamine was not in stock. The healthcare assistant returned Mr Spencer to his cell at 4.46pm.

48. At 5.30pm, an officer checked Mr Spencer and recorded in the observations log that Mr Spencer was eating. (The officer had also briefly looked through the flap at 5.17pm as had another officer at 5.12pm).

49. At 6.22pm and 7.03pm, an officer checked on Mr Spencer and recorded in the log that he was asleep on both occasions.

50. The last check was conducted by an officer at 7.40pm when he carried out a roll check (a physical count of the number of prisoners locked up). According to the officer, Mr Spencer's television was on, but he appeared to be asleep.

51. At approximately 8.15pm, a nurse started his shift and received a handover from a nurse. He told the investigator he could not recall being told any specific details about Mr Spencer.

52. At 10.10pm, a nurse went to Mr Spencer's cell to administer medication and take observations. The nurse opened the observation hatch and switched on the night light.

53. Mr Spencer was lying on the bottom bunk on his right side. He appeared to be asleep and did not respond when the nurse called to him. The nurse went to the officers' staff room and asked them to unlock Mr Spencer's cell, so he could administer medication. A Custodial Manager (CM) opened Mr Spencer's cell after knocking on the door, calling his name and getting no response. Four officers also attended.

54. The nurse shouted Mr Spencer's name and shook his shoulder vigorously but got no response. Mr Spencer's mouth was blue, and he had no pulse. There were no obvious injuries. The nurse asked for a code blue to be called which the CM called over his radio at 10.12pm. Staff in the control room called an ambulance at 10.13pm.

55. The nurse asked the officers to start cardiopulmonary resuscitation (CPR) while he went to get the emergency equipment. Two officers administered CPR. An officer went to the gate to assist when the ambulance arrived, and an officer maintained the ACCT checks on other prisoners on the wing. An officer was sprayed with a yellow liquid from Mr Spencer's mouth and after this, officers stopped mouth to mouth but continued with chest compressions.

56. The nurse returned and inserted a guedel airway and 15 litres of oxygen. He connected the defibrillator which did not advise a shock. The nurse measured Mr Spencer's glucose levels which were low.

57. The ambulance arrived at Leicester at 10.20pm but because of the layout of the prison the paramedics had to go to the wing on foot, arriving there at approximately 10.23pm. The nurse was about to administer glucagon when the

paramedics arrived**.** He advised them of Mr Spencer's current IDTS plan and his seizure risk.

58. Officers and paramedics moved Mr Spencer out of the cell to make treatment easier, and paramedics administered intravenous medication including glucagon. The officers continued with chest compressions and an officer delivered air as instructed by the paramedics. Mr Spencer's hands were noted to be blue. His blood glucose levels rose but he did not regain consciousness. A doctor who arrived with another crew of paramedics pronounced Mr Spencer's death at 10.56pm.

Contact with Mr Spencer's family

59. On 7 December, the prison appointed the family liaison officer (FLO). The police were at the prison and one of the police officers knew both Mr Spencer and his father. He offered to break the news to Mr Spencer's next of kin himself and the prison agreed to this. The FLO contacted Mr Spencer herself, by telephone on 9 December to offer advice and support.

60. Mr Spencer's funeral was on 3 January 2020. The Governor attended. In line with national policy, the prison paid for the funeral costs.

Support for prisoners and staff

61. After Mr Spencer's death, a prison manager and the CM debriefed staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Spencer's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm, and all other prisoners on the induction wing, in case they had been adversely affected by Mr Spencer's death.

Post-mortem report

63. The post-mortem examination found that Mr Spencer had cirrhosis of the liver (scarring of the liver caused by long-term liver damage). The pathologist noted, however, that the circumstances of Mr Spencer's death suggested a rapid death rather than a period of deterioration as would often be expected with end-stage liver disease. He found that Mr Spencer's heart was markedly enlarged and dilated (dilated cardiomyopathy - where the heart's ability to pump blood is decreased because the heart's main pumping chamber is enlarged and weakened), which is commonly associated with longstanding excess alcohol consumption.

64. The pathologist noted that patients with dilated cardiomyopathy are at risk of sudden death due to arrhythmia (abnormal heart rhythm) at any time. He also said that while the chance of a fatal arrhythmia may be increased by factors such as stress or acute alcohol withdrawal, the precise trigger could not be determined at post-mortem.

65. Toxicology tests showed that Mr Spencer had a potentially toxic level of methadone in his system but, as Mr Spencer would have developed significant

tolerance to methadone, the pathologist considered it unlikely that this had caused his death. Medications to treat alcohol withdrawal were detected but these were not present at levels likely to have caused significant cardiorespiratory depression. Evidence of previous cannabis use, cocaine and opiates were detected but traces of these substances would not be expected to cause sudden death.

66. The post-mortem report concluded that Mr Spencer died from dilated cardiomyopathy with cirrhosis of the liver as a contributory factor.

Findings

67. The post-mortem report concluded that Mr Spencer died from natural causes, as a result of an enlarged heart (dilated cardiomyopathy). The pathologist noted that patients with this type of heart condition were at risk of sudden arrhythmia (abnormal heart rhythm) at any time, and that factors such as stress or acute alcohol withdrawal could trigger a fatal arrhythmia, though it was not possible to determine the precise trigger at post-mortem.

68. The clinical reviewer was satisfied that Mr Spencer did not display any symptoms of heart problems when he arrived at HMP Leicester. He presented with symptoms of alcohol withdrawal, for which he was given medication. While acute alcohol withdrawal could trigger a fatal arrhythmia in someone with dilated cardiomyopathy, we cannot say whether alcohol withdrawal was a factor in Mr Spencer's death.

Clinical care

Medication

69. The clinical reviewer found that staff at Leicester prescribed appropriate medication (chlordiazepoxide) for Mr Spencer's alcohol withdrawal. However, they did not give him thiamine (vitamin B1). Thiamine can be given in tablet form or, when a higher dose is needed, as an intramuscular injection (Pabrinex). Mr Spencer arrived at Leicester with some thiamine tablets but a nurse told the investigator that the tablets looked dirty, and he took them to the pharmacy to be disposed of in line with the prison's pharmacy protocol.

70. The "Alcohol Use Disorder Prescribing Policy for Turning Point Community Drug and Alcohol Services" dated January 2018, recommends the use of the "Pabrinex Prescribing Scoring System for Vitamin Needs During Alcohol Detoxification" or the WEKP tool as a guide to assess whether oral thiamine or intramuscular thiamine should be given. (The WEKP tool is a 10-question assessment.)

71. The on-call prescriber did not use an assessment tool to establish Mr Spencer's need for thiamine. He based his decision on the level of Mr Spencer's alcohol use. He prescribed thiamine tablets as he understood that the intramuscular injection (Pabrinex) was not available over the weekend.

72. The pharmacy technician told the investigator that Pabrinex was not held in stock and had to be ordered for each person and that this would have been done on the following Monday. The clinical reviewer has since established with the Turning Point Manager that this is not correct: the medication was available but needed to be given by a Substance Misuse Nurse as it is an intramuscular injection and no SMS nurse was on duty over that weekend.

73. At 16.42, the pharmacy technician gave Mr Spencer chlordiazepoxide and methadone, but he did not give him the prescribed thiamine. He told the clinical reviewer it was out of stock and would have had to have been ordered on the Monday. He said he made a note of this in the 'day book' – a book staff used to pass important messages to one another between shifts.

74. We make the following recommendation:

The Head of Healthcare and Turning Point Manager should review the access to thiamine and Pabrinex, particularly over the weekend.

Lack of assessment by a GP

75. Mr Spencer was not seen by a doctor during his time at Leicester, despite withdrawing from alcohol and appearing to be very unwell.

76. A nurse made a routine referral for Mr Spencer to see a GP, but this was in relation to prescribing him his medication rather than his alcohol withdrawal symptoms. The nurse said that these types of request were dealt with remotely and he was not sure when it would have been actioned. Given how unwell Mr Spencer was, we think the nurse should have considered if he needed to be seen by a doctor, even though there were no doctors in the prison over the weekend.

77. A healthcare assistant told the investigator that she thought Mr Spencer would have benefitted from seeing a doctor, and that she wished she had pushed for it. However, she was unsure of the process as no doctors were on duty over the weekend. However, she said that Mr Spencer had appeared to be a bit better when she saw him later on that afternoon. We make the following recommendation:

The Head of Healthcare and Turning Point Manager should ensure staff:

- **consider whether prisoners who are detoxing from alcohol and/or drugs should be seen by a doctor and record their consideration and the decision made; and**
- **know how to call a doctor out of hours.**

Lack of clinical monitoring

78. All new arrivals at Leicester should be observed hourly. The hourly observations are carried out by discipline staff, who will check whether there is anything obviously wrong. They are not clinically trained staff. The investigator asked the healthcare assistant whether there was a specific observation plan in place for Mr Spencer, given he was withdrawing from alcohol and very unwell. She said that as he was taking chlordiazepoxide, he should probably have been observed four times a day for three days – perhaps as frequently as hourly given how unwell he was. However, there was no formal plan in place.

79. She said that she was concerned about Mr Spencer and his risk of seizures. She said she visited the Induction Unit after her shift to check on him (he was asleep) and to share her concerns with a female officer there and to check that she knew what seizures looked like. She said the officer said that she did but that she was about to go off shift and would hand that information over to other staff. The investigator could not identify on the CCTV footage that either of these events happened.

80. The clinical reviewer was concerned that no one took Mr Spencer's clinical observations after the on-call prescriber took them at 2.42pm. She considered that Mr Spencer's observations should have been taken when he was given his medications at around 4.40pm. The pharmacy technician told the clinical reviewer that he was new to the role on that day and had followed what the day book had told him to do. He dispensed Mr Spencer's medication, as prescribed by the on-call prescriber, but did not take further clinical observations or do any monitoring. He knew that the on-call prescriber had completed clinical observations when he had seen Mr Spencer.

81. The pharmacy technician said that since Mr Spencer's death his practice had changed and that he would now undertake clinical observations for a prisoner such as Mr Spencer morning, lunch and tea time, with the general healthcare staff covering the night time monitoring. He said that if he had any concerns, he would pass them to the general healthcare team for additional support. (Turning Point staff are not on duty at night, so tasks are picked up by the night general nursing staff.)

82. The on-call prescriber had made a note that Mr Spencer should be subject to five days monitoring but was not able to explain to the investigator exactly what that would entail.

83. Clearly, neither healthcare staff nor Turning Point had a robust monitoring plan in place for Mr Spencer. The pharmacy technician has said that changes have been made, and prisoners such as Mr Spencer would now have clinical observations taken on a regular basis. Nevertheless, we make the following recommendation:

The Head of Healthcare and Turning Point Manager should ensure that staff:

- **consider putting in place an observation and monitoring plan for all prisoners who are detoxing from drugs and/or alcohol and record their consideration and decision;**
- **ensure the observation and monitoring plan sets out clearly who is responsible for carrying out any observations and when; and**
- **ensure a full handover is given when there is a change of shift.**

Observations

84. All new arrivals to the Induction Unit should be checked once an hour by prison staff. Officers should record each observation on a log and sign each entry.

85. We are concerned about an officer's entries in the observations log. Mr Spencer arrived on the Induction Unit at 12.13pm on 7 December. The officer recorded in the observations log that he checked on Mr Spencer at 12.27pm, which is confirmed by CCTV. The officer's next entry says that he checked on Mr Spencer at 1.30pm and that Mr Spencer was sleeping. However, CCTV shows that the officer did not go to Mr Spencer's cell until 1.52pm, when he took him to the office for five minutes.

86. The officer's entry at 2.20pm again says Mr Spencer was sleeping, but Mr Spencer was not even in his cell at the time. Mr Spencer returned to his cell at 2.34pm and one minute later, the officer can be seen going into his cell.

87. The officer told the investigator that there should have been two staff on the unit but, as it was a weekend, the prison was short staffed and he was the only officer on the unit that day. He also said three new prisoners had arrived on the unit, so he had three sets of checks to do. When asked why he was not seen on CCTV carrying out the 1.30pm check, he said that this would have been just as he came back from his lunch break. He said that he would have seen Mr Spencer but would also have been doing other things on the wing and he would have filled out the log later and put the time that he thought he had carried out the check. He said that this would have also been the case for the 2.30pm check and that while the times may not have been 100% accurate, he knew he had checked Mr Spencer every hour and he had been okay.

88. The officer's assertion that he was doing checks every hour but updating the log later with his best guess at the time does not make sense, as his description of Mr Spencer being asleep does not correspond with his interactions with Mr Spencer. We consider that the evidence suggests he was completing the observations log to say he had carried out hourly checks when he had not done so.

89. We understand that officers may sometimes be too busy to carry out required checks because of staff shortages or emergencies, but where that is the case, it should be recorded. It is important that managers have a realistic idea of what can be done with the resources available and that recording false information about checks that have not been done is misleading and puts prisoners at risk. It is important too that that officers understand that completing the checks is not simply a tick box exercise, but an essential means of checking the wellbeing of new arrivals.

90. We make the following recommendation:

The Governor should commission an investigation into the actions of an officer and his completion of the observations log on 7 December 2019, with a view to considering whether disciplinary action is appropriate.

91. An officer carried out checks at 6.22pm and 7.03pm, and at 7.40pm, an officer did the roll check and had no concerns. No further checks took place until 10.10pm, when a nurse went to give Mr Spencer his medication and realised he was unresponsive.

92. A CM said the observation checks log had been in place for at least two years (after being extended from prisoners who were new to custody to all new receptions). She said staff working on the unit for the first time would shadow another officer first and be shown how to complete the log – although it was self-explanatory. The investigator also spoke to a CM who was on duty in the evening and the highest-ranking officer in the prison that night. He was based in the rotunda (a central point in the prison) but did a handover to all staff at the beginning of the shift, toured the prison and would eat later with staff in the Induction Unit. He said that staff would sort out between themselves who was

carrying out the observation checks and only involve him if they could not agree. He was not aware of any issues that evening but thought that as an officer was working the two's landing, he would have had responsibility for the Induction Unit observation checks also.

93. The investigator spoke to the officer. He said he was new to the Induction Unit and 7 December was only the fifth night he had worked there. His shift started at 8.45pm. He said that he would do a check and then fill in the log straight afterwards unless something important like a cell bell interrupted him. He said he had not shadowed anyone on the Induction Unit before working there and was not trained on how to complete the observations log, though it was self-explanatory.

94. The officer said he had had been designated the two's landing and the Induction Unit at the beginning of the week and as such it would seem the responsibility for the evening observation checks fell to him. However, the officer also described a scenario where other officers would often do the checks for one another if they were passing a cell and that, in practice, there was a sense of it being a collective responsibility.

95. When asked to explain the lack of any check on Mr Spencer between the roll check (by an officer) and a nurse's medication visit, the officer said that he had missed the handover that would have been given from day staff to night staff and that this is something that might have reminded him about checking Mr Spencer. He could not recall any other events that night that might have distracted him or other staff from carrying out the checks but said that the checks had only been in place for a week.

96. In the CM's subsequent interview with the investigator she refuted this and said that the checks had been in place at least two years. She said that since Mr Spencer's death, which had highlighted the gap in observations that evening, she had added a new section to the form to include a handover from day to night staff to ensure no checks are missed, and that this may be the change the officer was referring to.

97. We are very concerned that no checks were carried out on Mr Spencer after the roll check at 7.40pm. There should have been at least two more checks before a nurse went to Mr Spencer's cell at 10.10pm. We make the following recommendation:

The Governor should ensure that staff on the Induction Unit carry out checks on all new prisoners at least hourly and complete the observations log accurately.

Communication

98. We are concerned that prison staff did not understand how unwell Mr Spencer was and the risks associated with alcohol withdrawal. If they had understood this, it is possible that they would not have stopped checking on him after 7.40pm.

99. The healthcare assistant told the investigator that she did what she could to alert officers on the Induction Unit to her concerns about Mr Spencer's condition. She said officers are often not fully engaged with Turning Point staff when they try to

raise issues with them. We note, however, that there was no information from Turning Point on NOMIS (the electronic prison record). A CM said that Turning Point staff can record information on NOMIS and on an induction log. We also note that the healthcare assistant did not know about the hourly monitoring in place on the Induction Unit or what those checks comprised of. Neither is there CCTV evidence that she visited the unit at the end of her shift.

100. On the custodial side, the officer did not receive an adequate handover, with no information given to him about Mr Spencer. The CM told the investigator that she has amended the observations log to include a handover section for staff to record what information has been exchanged when a shift changes. We are pleased to hear of this amendment. Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **information about prisoners detoxing from drugs and/or alcohol is shared between healthcare, Turning Point and discipline staff;**
- **healthcare and Turning Point staff alert discipline staff to any concerns about a prisoner's welfare and highlight any signs to look out for that might indicate a deterioration in their condition; and**
- **Induction Unit staff conduct appropriate handovers when shifts change and record relevant information in the observations log.**

Learning from this report

101. We consider it important that staff should learn the lessons from this report. We therefore recommend:

The Governor and Head of Healthcare should share this report with an officer, a nurse, a healthcare assistant, a pharmacy technician and an on-call prescriber and arrange for a senior manager to discuss the Ombudsman's findings with them.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141