Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Douglas Gray, a prisoner at HMP Leeds, on 23 November 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 Douglas Gray died in hospital of global ischaemic bowel (inflammation and injury to the bowel caused by an inadequate blood supply) on 23 November 2018 while a prisoner at HMP Leeds. He had peripheral vascular disease (a blood circulation problem that causes the blood vessels outside the heart and brain to narrow, block or spasm) which contributed to but did not cause his death. He was 60 years old. I offer my condolences to those who knew him.

I am concerned that there were significant deficiencies in the healthcare that Mr Gray received at Leeds. Healthcare staff did not provide a good standard of care to manage his Crohn's disease and his associated malnutrition. Although Mr Gray did not collect his medication on 27 occasions, healthcare staff took no action until he brought it to their attention and he did not receive his medically required diet for around two months.

When Mr Gray was discharged from hospital without a discharge summary, healthcare staff failed to contact the hospital for a verbal handover or to put a care plan and reviews in place. When administrative staff were asked to chase his hospital discharge summary, they did not do so for 13 days, by which time Mr Gray was back in hospital.

I am concerned that although a nurse asked for healthcare staff to review Mr Gray three times, they never did.

Mr Gray was also restrained when he was transferred to hospital for the last time and his restraints were not permanently removed until a few hours before he died.

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 2020**

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Summary

Events

1. On 17 August 2018, Mr Douglas Gray was sentenced to 18 months in prison for sexual offences and sent to HMP Leeds. It was his first time in prison. He had a number of pre-existing medical conditions, including asthma, Crohn's disease, hypertension, angina and acute coronary syndrome, and he had had his large intestine removed.

2. Healthcare staff managed Mr Gray's long-term conditions but a care plan was not put in place for his Crohn's disease.

3. On 30 August, a prison GP wrote to the prison's catering department about Mr Gray's dietary requirements but there is no evidence that Mr Gray received the right food until the end of October. Between 17 August and 19 November, Mr Gray's weight dropped from 62kg to 53kg.

4. Mr Gray was due to see a Crohn's disease specialist on 10 October but the prison did not have enough staff to take him to hospital and the appointment was rearranged for 6 November.

5. On 24 October, Mr Gray told a nurse that he had been struggling to get to the medication hatch at weekends to collect his prescribed medication for his Crohn's disease. By this point, he had missed his medication on 27 occasions.

6. On 2 November, a nurse asked healthcare staff to review Mr Gray that weekend for signs of deterioration as he had had diarrhoea and vomiting. There is no evidence that he was reviewed.

7. On 6 November, Mr Gray saw a Crohn's disease specialist and was admitted to hospital for a scan as he continued to have diarrhoea and vomiting. He returned to Leeds on 7 November without a discharge summary.

8. On 9 November, a nurse asked administrative staff to chase the hospital for his hospital discharge summary. They did not do so until 22 November, by which time Mr Gray was in hospital again. A nurse also asked that healthcare staff review Mr Gray regularly but he was not reviewed again for ten days.

9. On 19 November, Mr Gray was booked in to see the GP as he had diarrhoea and vomiting and was in severe pain. A GP did not see him, however, as there were not enough prison officers to bring Mr Gray from the wing.

10. The following morning, on 20 November, a nurse decided that Mr Gray should be transferred urgently to hospital for an assessment. He was taken to hospital, escorted by two prison officers and restrained by an escort chain.

11. At about 12.40am on 23 November, Mr Gray's condition deteriorated, and he was moved to the intensive care unit. At 1.30am, Mr Gray's restraints were removed permanently and, at 3.55am, he had surgery for a bowel obstruction.

12. Mr Gray died shortly after surgery at 8.45am on 23 November.

Findings

13. The clinical reviewer concluded that although the care that Mr Gray received for his asthma and cardiovascular disease was equivalent to that which he could expect to receive in the community, the care he received for his Crohn's disease was not of a good standard and was not equivalent.

14. Mr Gray was not assessed using the malnutrition universal screening tool (MUST) in line with National Institute for Health and Care Excellence (NICE) guidance. This would have shown that he was at high risk of malnutrition and needed a management plan.

15. There is no evidence that Mr Gray received his prescribed diet for around two months.

16. Before 24 October, Mr Gray did not attend for his medication on 27 occasions but healthcare staff did not take any action until Mr Gray told them that he could not get to the medication hatch.

17. On 7 November, healthcare staff did not contact the hospital or put a care plan and clinical reviews in place when Mr Gray was discharged from hospital without a discharge summary.

18. Administration staff were asked to chase Mr Gray's hospital discharge summary on 9 November, but did not do so until 22 November, by which time Mr Gray was in hospital again. Despite three requests, healthcare staff failed to review him.

19. We consider that Mr Gray was inappropriately restrained when he was transferred to hospital on 20 November 2018.

Recommendations

- The Head of Healthcare should ensure that all patients with Crohn's disease have a management plan in place, in line with NICE guidelines.
- The Catering Manager should ensure that there are arrangements in place to record when a request for a medically required diet is received and what action has been taken to ensure it is provided.
- The Head of Healthcare should ensure that all healthcare staff use the MUST tool, where appropriate, in line with NICE guidance.
- The Head of Healthcare should ensure that healthcare staff identify and take action when prisoners do not collect their medication, in line with Care UK policy.
- The Head of Healthcare should ensure that when a prisoner is discharged from hospital without a discharge summary, healthcare staff put a care plan in place and review the prisoner at least twice a day within the next 48 hours, in line with Care UK policy.
- The Business Support Manager should ensure that requests for hospital discharge summaries are made promptly.

- The Head of Healthcare should ensure that:
  - all requests for healthcare staff to complete observations are completed and documented; and
  - there is a contingency plan in place when prisoners require a GP review which cannot be provided at the time.
- The Governor should ensure that all staff who undertake and review risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

The Investigation Process

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

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

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

23. The investigator and the clinical reviewer jointly interviewed six members of staff at HMP Leeds on 7 January 2019.

24. We informed HM Coroner for West Yorkshire Eastern District of the investigation. He gave us the cause of Mr Gray's death and told us that a post-mortem examination was not conducted. We have sent the Coroner a copy of this report.

25. Mr Gray did not have a recorded next of kin, and the investigator was unable to contact anyone about the investigation.

26. 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.

27. The initial report was shared with the clinical reviewer, who pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Leeds

28. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

29. In August 2018, Leeds was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the prison and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

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

Independent Monitoring Board

31. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for 2017, published in April 2018, the IMB reported that prisoners were generally satisfied with the delivery of healthcare but frequently reported difficulty in accessing the service in a timely manner and, as they had reported the previous year, the healthcare system regularly had missed appointments. They were concerned that prison officers were far too frequently not available to escort prisoners to their hospital appointments. They noted that this threatened the ongoing care of prisoners, caused difficulties at the hospitals, and had a knock-on effect for the medical care in the prison (as routine problems could turn into emergencies, requiring urgent action).

Previous deaths at HMP Leeds

32. Mr Gray was the seventeenth prisoner to die at HMP Leeds since August 2016, and the eighth to die from natural causes. At the time of writing this report and since Mr Gray died, one more prisoner has died at Leeds from natural causes.

33. The PPO has made recommendations to address the inappropriate use of restraints four times. In January 2019, we escalated the issue to the Prison

Group Director for Yorkshire to satisfy himself that the Governor has taken effective action to address the continuing inappropriate use of restraints for hospital escorts at HMP Leeds.

34. We have previously made a recommendation about prisoners who return from hospital not having appropriate healthcare plans in place.

35. We have also previously made a recommendation about the need for healthcare staff to identify when prisoners do not collect their medication.

Key Events

36. On 17 August 2018, Mr Douglas Gray was sentenced to 18 months in prison for sexual offences and sent to HMP Leeds.

37. That day, a nurse saw Mr Gray for an initial health screen. She noted his pre-existing medical conditions, including asthma, hypertension, angina, acute coronary syndrome, iron deficiency anaemia and Crohn's disease, and that he had had his large intestine removed. He was under the care of specialists at Bradford Royal Infirmary for his Crohn's disease. The nurse recorded Mr Gray's weight as 62kg (about 9 stone 10lbs).

38. The nurse referred Mr Gray to a long-term conditions nurse to manage his long-term conditions of asthma and cardiovascular disease. The nurse assessed that Mr Gray should live in a single cell due to his Crohn's disease and in line with his wishes.

39. Later, a prison GP saw Mr Gray who had brought his medication to prison with him. He was allowed to keep his medication in his cell for one night, but the prison GP asked for another prison GP to review his medication.

40. On 18 August, a nurse saw Mr Gray for a second health screen. He referred him to a prison GP to review his medication, as a prison GP had requested.

41. On 30 August, a prison GP reviewed Mr Gray and noted that he had diarrhoea, severe Crohn's disease, took steroid medication and was not having the appropriate food to manage his Crohn's disease. The prison GP wrote to a hospital consultant gastroenterologist for an opinion about his steroid medication and made a plan to monitor his blood and change his medication. She wrote to the prison catering team about his dietary needs. She noted that his weight had not changed.

42. A catering manager told us that she received the letter from the prison GP within a couple of days, but could not recall the date.

43. Mr Gray had an appointment to have his blood taken on 30 August and 30 September but did not attend. (There is no evidence to explain why not.)

44. On 11 September, the long-term conditions nurse saw Mr Gray to review his asthma and cardiovascular disease, and put care plans in place. The long-term conditions nurse noted that he was still having problems receiving the right food for his Crohn's disease and sent a prison GP's letter to the catering team again. She recorded Mr Gray's weight as 61kg and told us that she did not find it concerning.

45. The catering manager told us that she did not receive the letter that the long-term conditions nurse sent her on 11 September.

46. Mr Gray's medical records show that on 13 September, healthcare staff were still waiting for a response from the specialist and that Mr Gray's steroid prescription had not been changed.

47. The consultant gastroenterologist responded to a prison GP on 18 September. She said that she had seen Mr Gray over the summer, and a colonoscopy showed that he had ongoing Crohn's disease in his small bowel, despite taking immunosuppressant medication (to stop the immune system from attacking the bowel). She recommended that if Mr Gray was struggling with symptoms and loose bowels, he should stay on the same level of steroid medication until she saw him again in October.

48. Also on 18 September, an officer, Mr Gray's key worker, noted in Mr Gray's prison record that he was still having difficulties getting the right diet for his Crohn's disease and said that he would speak to catering staff about this. (There is no evidence of whether he did so.)

49. On 20 September, a prison GP saw Mr Gray as he had painful diarrhoea after meals. She had not received the letter from the specialist and reduced his steroid medication, with effect from 24 September. The prison GP noted that Mr Gray had a forthcoming appointment with the specialist, and planned to chase a response. The prison GP also recorded Mr Gray's iron levels and made a plan to take a blood sample the following week.

50. On 25 September, Mr Gray did not attend his appointment to have his blood taken. The reason for his non-attendance is not recorded.

51. On 10 October, Mr Gray had an appointment to see the consultant gastroenterologist but the prison did not have enough staff to take him as another prisoner had to be urgently transferred to hospital. Mr Gray was put back on the waiting list for another hospital appointment and his steroid medication was not reviewed.

52. On 19 October, a prison GP reviewed Mr Gray and recorded his weight as 58.5kg (about 9 stone 3lbs). He noted that Mr Gray had lost weight and was unable to eat and he prescribed him a dietary supplement drink. The prison GP told us that Mr Gray presented well with no diarrhoea and vomiting. He said that he did not put a plan in place to monitor Mr Gray's weight as he was aware that he had a hospital appointment soon and he would expect the hospital clinic to monitor his weight. The prison GP noted that Mr Gray felt that he was still not receiving the correct diet so he re-sent a prison GP's letter to the catering team. The catering manager told us that she did not receive this letter.

53. On 22 October, Mr Gray's missed outpatient appointment with the hospital specialist was re-scheduled for 6 November.

54. On 23 October, Mr Gray asked to see a nurse about his Crohn's disease. On the same day, the key worker noted that Mr Gray would be speaking to kitchen staff about arranging appropriate meals to prevent his Crohn's disease flaring up. He noted that Mr Gray said he was being given the same meals over and over again which was causing him agony and forcing him to take more pain relief, which he did not like doing. Mr Gray had identified 21 meals he could eat without problems and the key worker said he would speak to catering staff about this. The key worker also noted that Mr Gray would like to have his medication in possession as, over the weekend, he had had a mild angina attack due to receiving his medication over three hours late. The key worker had spoken to

the pharmacy technician who had said this was not possible. He suggested that Mr Gray ask to see the doctor about this.

55. On 24 October, a nurse saw Mr Gray and noted that he had fluctuating loose stools, constipation and abdominal pain. He told her that he had a meeting with the catering manager arranged for that week to discuss his diet, and that an outpatient appointment with the gastrointestinal team was coming up. He also told the nurse that he had been struggling to get to the medication hatch to collect his medication at weekends. (His medication administration history showed that he had not attended for his immunosuppressant medication on 27 occasions.) The nurse asked the pharmacist to assess whether Mr Gray could keep his medication in his cell.

56. The catering manager told us that she met Mr Gray to discuss his diet but could not recall the date.

57. Mr Gray's medication administration history shows that, on 30 October, his steroid medication was reduced again.

58. On 1 November, a nurse saw Mr Gray in his cell as he had diarrhoea and vomiting which had started three days earlier, and he had been struggling to eat and drink. She noted that he appeared to be weak and underweight and checked his vital signs, which were stable. The nurse asked for a GP to review him the same day, if possible, or the next day, as she was concerned that he was at risk of dehydration. She told us that she did not weigh him as she saw him in his cell and no scales were available.

59. The following day, the nurse recorded that she discussed Mr Gray's condition with a senior nurse. She noted that the senior nurse said that it was not necessary for a GP to see Mr Gray but that he should be isolated, a stool sample taken, if possible, and healthcare staff should monitor him over the weekend for signs of deterioration. She recorded that Mr Gray would be added to the healthcare list and had an appointment at the gastroenterology unit the following week, where his Crohn's disease would be reviewed.

60. The senior nurse told us that she recalled discussing Mr Gray with the nurse, but did not remember discussing his Crohn's disease or a GP review. She told us that Mr Gray's National Early Warning Score (NEWS) tool (a guide used by medical services to determine the degree of illness of a patient quickly, based on the vital signs) indicated that he was not at risk of deterioration and that he should be isolated and reviewed in 48 hours.

61. Medical records indicate that on 2 November, Mr Gray had an appointment with a GP that had been completed. However, a GP did not see him on 2 November.

62. On 3 November, it is noted in Mr Gray's medical record that he was given a stool pot by a healthcare assistant to be collected in the morning, but there is no evidence that he had a clinical review on 3 or 4 November.

63. On 5 November, a nurse reviewed Mr Gray in his cell. Mr Gray told her that his appetite had improved and he was keeping fluids down. The nurse checked his vital signs. She booked an appointment for a GP to review Mr Gray on 7

November and advised him to drink more water. Later, a healthcare assistant collected a stool sample and sent it for testing.

64. Also on 5 November, pharmacy staff assessed that Mr Gray could keep his medication in his cell. (He did not have it in possession until 15 November.)

65. Medical records indicate that on 5 November, Mr Gray had an appointment with a GP that had been completed. However, this did not happen.

66. On 6 November, Mr Gray attended an outpatient appointment with the hospital consultant gastroenterologist and was admitted to hospital overnight for a scan and intravenous steroids.

67. Mr Gray returned to Leeds on 7 November, and a nurse reviewed him. She noted that Mr Gray told her that no abnormalities were found, there was no change to his medication and that he had a follow-up appointment in three weeks.

68. On 9 November, a nurse reviewed Mr Gray and noted that he appeared well and had been able to eat small amounts without vomiting and diarrhoea. She checked Mr Gray's vital signs and made a plan for healthcare assistants to check his weight and vital signs regularly. Mr Gray was not reviewed again for another ten days.

69. During the review, Mr Gray asked the nurse if he was receiving the right medication. She was unable to check as she did not have the discharge summary. She asked administrative staff to ask the hospital for the discharge summary.

70. On 11 November, Mr Gray sent a letter to the catering manager to thank the catering team for their support with his diet.

71. On 15 November, the key worker noted in Mr Gray's prison record that Mr Gray was still trying to transfer money from his bank account to enable him to buy food in line with his dietary requirements.

72. On 19 November, a long-term conditions nurse saw Mr Gray to review his asthma and cardiovascular disease. She noted that she had no concerns about these issues but that Mr Gray had been vomiting for the past two days due to his Crohn's disease. She recorded his weight as 53kg (about 8 stone 5lbs) and noted that he did not want dietary supplements as he could not keep them down. The long-term conditions nurse made a plan to discuss Mr Gray's condition at the Multi-Professional Complex Case Clinic (MPCCC) later that day. She told us that she was concerned about Mr Gray's weight loss and wanted a GP to review him.

73. Mr Gray's health was discussed at the MPCCC meeting on 19 November. It was noted in the minutes that he had Crohn's disease and a hospital appointment was planned. It was recorded that he had been vomiting since 17 November and did not want dietary supplement drinks. Mr Gray's body mass index (a measure that uses height and weight to determine if a person's weight is healthy) was recorded as 18 (which showed that he was underweight), and it was arranged for a prison GP to see him on 22 November. (The prison GP told us that 22 November was the first available appointment with him as the lead GP to

complete a full review of Mr Gray's health. He told us that Mr Gray's symptoms were not acute as his diarrhoea and vomiting had been intermittent over the past four to six weeks.)

74. Later, on 19 November, a nurse reviewed Mr Gray at the request of wing staff as he had had diarrhoea and vomiting from the day before. She told us that he had changed considerably since she had seen him on 9 November, and that he appeared desperate and distressed. The nurse noted that Mr Gray appeared to be dehydrated, with significant weight loss and that he had severe pain in his stomach. She checked Mr Gray's vital signs and completed the NEWS tool. Mr Gray scored 4 on the NEWS scale which indicated that a registered healthcare professional should assess him to decide how frequently to monitor his vital signs and whether his care needed to be escalated.

75. At 5.28pm, the nurse noted that Mr Gray needed an urgent GP assessment because the prison was currently unable to facilitate hospital escorts unless there was a threat to life. She booked him in to the evening GP clinic. She also added Mr Gray to the list of patients to be seen by a GP the following day, in case he was not seen that evening.

76. At 7.15pm, two officers found Mr Gray lying on his bed, clutching his stomach. Mr Gray told them that the GP was coming to see him. An officer told us that she did not think that GPs went to the wing so the other officer radioed a nurse for assistance. The second officer cannot recall this and there is no evidence that he contacted the nurse.

77. The two officers finished their shift at 7.30pm. Between 7.30pm to 8.30pm, another officer was the only member on staff on Mr Gray's wing. He told us that when he arrived on the wing, wing officers gave him a comprehensive handover. He was unable to recall which officers but remembered being told that Mr Gray was unwell. He said that he was made aware that a nurse had been contacted and was coming to see Mr Gray.

78. A prison GP was on duty that evening and told us that he was aware that Mr Gray was on the list to be reviewed. The prison GP told us that he was working in the prison's reception and, as it was extremely busy, he was unable to leave. He told us that at 7.30pm, he asked nursing staff (he was unable to recall who he asked) to contact wing officers to bring Mr Gray to reception to see him. He told us that Mr Gray did not appear, so at 8.30pm he asked a pharmacy technician manager to ask for him to be brought.

79. The pharmacy technician manager told us that she did not recall the prison GP asking for Mr Gray to be brought to reception. She told us that when she asked officers to bring prisoners to see the GP in reception, she was usually told there were not enough officers to bring them, and she would ask officers in reception to help.

80. An officer told us that on 19 November, he received a call, asking him to bring Mr Gray to reception to see a GP. He was unable to recall who asked but said that he told them that he could not escort Mr Gray as he was working alone and that the GP would have to come to the wing.

81. The prison GP told us that he was unable to review Mr Gray as he had not been brought to reception. He added Mr Gray to the list of patients who the GP would review the following day.

82. At 9.00am on 20 November, a nurse reviewed Mr Gray as he had not been seen overnight. She noted that his health had deteriorated, he was unable to keep any fluids down and was in a lot of pain. She saw that he had vomited dark-coloured blood.

83. The nurse assessed that Mr Gray needed to go to hospital as soon as possible. She left Mr Gray in his cell and went to telephone a prison manager to say that Mr Gray needed to go to hospital urgently. She asked him to arrange a prison escort. The nurse told us that she did not call a medical emergency code blue as there was not an immediate threat to his life.

84. The nurse told us that while she was waiting for the escort to be organised, she left Mr Gray in his cell so that she could record her assessment on Mr Gray's medical record and complete the paperwork for his transfer to hospital. At 9.07am, the nurse noted that she had asked for Mr Gray to be transferred by ambulance to hospital.

85. After the nurse left Mr Gray in his cell, he walked to the wing office unaided to wait for the ambulance.

86. The nurse told us that once the prison manager contacted her to say that an escort had been organised, she telephoned the control room to ask for an ambulance and returned to see Mr Gray. The ambulance service records show that an ambulance was called at 9.57am.

87. The nurse told us that Mr Gray was sitting on a chair in the wing office when she returned to see him. She told us that she was surprised that he had managed to get there as he had had been in a lot of pain, and that he looked a lot better.

88. Paramedics arrived on scene at 10.05am and attended to Mr Gray. They transferred him to hospital at 11.03am, where he was admitted. He was accompanied by two prison officers and restrained with an escort chain.

89. At 8.40pm, Mr Gray's restraints were removed temporarily for a CT scan.

90. On 22 November, administrative staff asked the hospital for Mr Gray's discharge summary from 7 November, (which the nurse had asked them to do on 9 November).

91. At 12.40am on 23 November, Mr Gray's restraints were removed for another CT scan after his condition deteriorated, and he was moved to the intensive care unit. At 1.30am, Mr Gray's restraints were removed permanently and at 3.55am, he had surgery for a bowel obstruction.

92. Mr Gray died shortly after surgery at 8.45am on 23 November.

Support for prisoners and staff

93. The prison posted notices informing other prisoners of Mr Gray'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 Gray's death.

Post-mortem report

94. The Coroner confirmed that Mr Gray died of global ischaemic bowel (a sudden decrease in blood supply to the bowel, resulting in a shortage of oxygen causing the bowel to die). Peripheral vascular disease (a blood circulation problem that causes the blood vessels outside the heart and brain to narrow, block or spasm) contributed to but did not cause his death. No post-mortem examination was conducted.

Findings

Clinical care

95. The clinical reviewer found that in relation to Mr Gray's asthma and cardiovascular conditions, his health needs and risks were appropriately assessed and reviewed in line with NICE guidelines.

96. However, she found that the care that Mr Gray received for his Crohn's disease, in terms of drug therapy and nutrition, was not of the required standard. She concluded that it was not equivalent to that which he could have expected to receive in the community.

97. The clinical reviewer made a number of recommendations in her review which the Head of Healthcare will need to address.

Managing Crohn's disease

98. NICE guidelines on managing Crohn's disease state that management options for Crohn's disease include drug therapy, attention to nutrition, smoking cessation and, in severe and chronic cases, surgery. The clinical reviewer considered that the NICE guidelines were not followed in Mr Gray's case and that there were no care plans in place. We make the following recommendation:

The Head of Healthcare should ensure that all patients with Crohn's disease have a management plan in place, in line with NICE guidelines.

Nutritional support

99. The clinical reviewer found that healthcare and catering staff made efforts to address Mr Gray's diet. However, although a prison GP wrote to the catering manager about the required diet on 30 August, and although healthcare staff re-sent the prison GP's letter (dated 30 August) to the catering manager on 11 September and 19 October through the internal post, Mr Gray was still not receiving the appropriate food for his Crohn's disease on 24 October (when he told a nurse that he would be seeing the catering manager later that week). It is not acceptable that it took two months to ensure he received the food he needed. We note that he suffered significant weight loss during this period. We recommend:

The Catering Manager should ensure that there are arrangements in place to record when a request for a medically required diet is received and what action has been taken to ensure it is provided.

100. NICE guidelines on nutrition support for adults state that a nutritional screening should take place at initial registration and where there is clinical concern that a patient is malnourished or at risk of malnutrition, he should have a care management plan that aims to meet his complete nutritional requirements.

101. The clinical reviewer found that Mr Gray's MUST score was not assessed in line with NICE guidance. She concluded that this would have shown that he was at high risk of malnutrition, and that a management plan was needed. We recommend that:

The Head of Healthcare should ensure that all healthcare staff use the MUST tool, where appropriate, in line with NICE guidance.

Administration of medication

102. Care UK's policy on patients not attending for their medication, published in January 2017, states that when a patient does not attend for one or all their medications, staff should speak to the patient, hand over the information at the daily healthcare meeting and record the explanation

103. Care UK's local operating policy on managing missed medication, published in February 2018, states that all patients who have missed medications should be discussed at the daily service meeting to agree a management plan.

104. Mr Gray arrived at Leeds on 17 August and was allowed to keep his medication in his cell for one night. Between 18 August and 14 November, he had to attend the medication hatch.

105. By 24 October, Mr Gray had not attended the medication hatch for his Crohn's medication 27 times. On 24 October, he told a nurse that he had been struggling to get to the medication hatch at weekends so she asked the pharmacist to assess whether he could keep his medication in his cell. On 5 November, pharmacy staff assessed that Mr Gray could keep his medication in his cell. However, this was not implemented until 15 November.

106. The clinical reviewer identified that between 18 August and 14 November 2018, Mr Gray did not attend for his immunosuppressant medication for his Crohn's disease on 34 occasions. He had also missed taking his medication 11 times, was unable to take his tablets 7 times and they were not available once.

107. The clinical reviewer found no evidence that healthcare staff discussed Mr Gray's medication administration history at handover, as handover discussions were not logged at the time that Mr Gray was receiving care. A senior nurse told us that discussions are now logged.

108. We are very concerned that staff did not take any action when Mr Gray did not take his medication. We cannot be sure what impact this had on Mr Gray. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff identify and take action when prisoners do not collect their medication, in line with Care UK policy.

Discharge from hospital

109. Care UK's local operating policy on patients being discharged from hospital, published in August 2017, states that when prisoner's return to HMP Leeds from hospital, the escorting officer should hand over the discharge summary and any prescribed medication to the receiving nurse. If a discharge summary is not received, the receiving nurse must contact the ward for a verbal handover. The nurse will then complete a care plan, and assess and review the patient at least twice a day for at least the next 48 hours. It says that a GP or advanced nurse practitioner must review the patient at the earliest opportunity. It says that

patients should be reviewed that evening if they have been significantly unwell or the following day, if the patient is well. It notes that a full NEWS score must be recorded at every patient review.

110. On 7 November, Mr Gray was discharged from hospital and returned to Leeds. A nurse reviewed him and indicated in his medical record that a hospital discharge was not available. She noted that Mr Gray reported that hospital staff found no abnormalities, there was no change to his medication and that he had a follow-up appointment in three weeks.

111. On 9 November, a nurse reviewed Mr Gray who asked if he was receiving the right medication. She did not have the discharge summary and was unable to check. That day, the nurse asked administrative staff to ask the hospital for the discharge summary, but they did not do so until 22 November, by which time, Mr Gray had been in hospital again for two days.

112. On 9 November, a nurse made a plan for healthcare assistants to check Mr Gray's weight and vital signs regularly. The clinical reviewer found that healthcare staff did not see Mr Gray for another ten days although he should have been seen twice a day for 48 hours and a care plan put in place.

113. We are concerned that a nurse did not contact the hospital ward for a verbal handover when Mr Gray returned from hospital on 7 November, and that she did not create a care plan or arrange for him to be reviewed. Mr Gray was reviewed just once over the following 12 days.

114. We are also concerned that administrative staff did not contact the hospital for 13 days after a nurse asked them to request Mr Gray's discharge summary. We cannot say how this affected Mr Gray. We make the following recommendations:

The Head of Healthcare should ensure that when a prisoner is discharged from hospital without a discharge summary, healthcare staff put a care plan in place and review the prisoner at least twice a day within the next 48 hours, in line with Care UK policy.

The Business Support Manager should ensure that requests for hospital discharge summaries are made promptly.

Medical reviews

115. The clinical reviewer found that on two occasions, healthcare staff did not complete actions, as requested, and on one occasions, a GP did not review Mr Gray, as requested.

116. On 2 November, a nurse booked a task on the computer for healthcare staff to take Mr Gray's observations over the weekend but there is no evidence that he had a clinical review on 3 or 4 November.

117. On 9 November, a nurse saw Mr Gray for a review. She made a plan for healthcare assistants to check his weight and vital signs on a regular basis, but Mr Gray was not reviewed again for another ten days.

118. On 19 November, a nurse asked for a GP to review Mr Gray that evening. A prison GP was busy in reception so at 7.30pm and 8.30pm, he asked for Mr Gray to be brought from the wing. There were not enough prison officers to escort Mr Gray to reception, which meant that the GP did not see him. The prison GP added him to the list of patients to be seen by a GP the next morning.

119. We are concerned that on three occasions, a nurse asked healthcare staff to review Mr Gray but this did not happen. We make the following recommendation:

The Head of Healthcare should ensure that:

- **all requests for healthcare staff to complete observations are completed and documented; and**
- **there is a contingency plan in place when prisoners require a GP review which cannot be provided at the time.**

Restraints, security and escorts

120. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account a prisoner's health and mobility. 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 the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

121. On 20 November, Mr Gray was transferred to hospital by ambulance. The person escort record form shows that Mr Gray was restrained with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and escorted by two officers.

122. A prison manager approved the use of restraints but Leeds has been unable to provide an escort risk assessment to show what information medical and security staff contributed to the assessment. (We were told that it is likely that the escort risk assessment was given to the police who also investigated the death of Mr Gray.)

123. We are concerned that there is no evidence that the decision to restrain Mr Gray when he was transferred to hospital on 20 November took account of his medical condition. The Prison Service has a responsibility to protect the public but security must be balanced with humanity. Mr Gray was a 60-year old Category C prisoner with a serious medical condition causing a lot of pain when he was transferred to hospital, and this would have affected his ability to escape, particularly as he was escorted by two prison officers.

124. We are also concerned that Mr Gray remained restrained until the early hours of 23 November, when his condition deteriorated and he was moved to the

intensive care unit about seven hours before he died. We make the following recommendation:

The Governor should ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position on the use of restraints, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

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