

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Carson, a prisoner at HMP Leyhill, on 15 December 2019

A report by the Prisons and Probation Ombudsman

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*



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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 Darren Carson died in hospital of an intracerebral haemorrhage (a bleed on his brain) on 15 December 2019, while a prisoner at HMP Leyhill. He was 49 years old. I offer my condolences to Mr Carson's family and friends.

In 2010, Mr Carson was diagnosed with grand mal seizures caused by arteriovenous malformation (AVM - a congenital disorder of the blood vessels in the brain, brainstem or spinal cord which results in a restriction of the blood flow). He initially declined treatment but then agreed to undergo surgery, which he had in July 2019. He was told it could take up to two years for it to have any effect on his AVM.

On 14 December 2019, after suffering his second seizure in a week, Mr Carson was taken to hospital by emergency ambulance. He died the next day.

The clinical reviewer found that prison healthcare staff made prompt referrals to secondary care providers to diagnose, treat and manage Mr Carson's condition. She was satisfied that Mr Carson received a good standard of clinical care, equivalent to that he could have expected to receive in the community.

I make no recommendations.

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

September 2020

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Summary

Events

1. On 22 December 2006, Mr Darren Carson was given an indeterminate sentence for public protection (IPP), with a minimum tariff of 18 months, for sexual offences.
2. In 2010, Mr Carson was diagnosed with grand mal seizures (seizures that cause unconsciousness and violent muscle contractions). He was later diagnosed with arteriovenous malformation (AVM - a congenital disorder of the blood vessels in the brain, brainstem or spinal cord which results in a restriction of the blood flow). He was offered a non-surgical radiation therapy but declined because he thought it may interfere with his parole application.
3. On 17 May 2012, Mr Carson was moved to HMP Leyhill.
4. Mr Carson later agreed to undergo surgery, which he had in July 2019. He was told it could take up to two years for the surgery to have any effect on his AVM.
5. On 8 December 2019, a prison nurse reviewed Mr Carson after he suffered a seizure, his first in almost a year. He told her he thought the seizure may have been due to him feeling stressed about an upcoming parole hearing. She told him to rest and to contact healthcare staff if he had any further symptoms.
6. At 9.00pm on 14 December, Mr Carson suffered another seizure and was taken to hospital by emergency ambulance. He was sedated and placed on a ventilator to help him breathe.
7. Mr Carson's condition continued to deteriorate and at 11.00pm on 15 December, he died. A hospital doctor confirmed his death at 11.11pm.
8. A hospital doctor gave Mr Carson's cause of death as intracerebral haemorrhage (a bleed on his brain) caused by AVM.

Findings

9. The clinical reviewer found that healthcare staff at Leyhill appropriately reviewed Mr Carson, and when necessary referred him to secondary care providers. She concluded that the care he received was equivalent to that he could have expected to receive in the community.
10. We make no recommendations.

The Investigation Process

11. 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.
12. The investigator obtained copies of relevant extracts from Mr Carson's prison and medical records.
13. NHS England commissioned an independent clinical reviewer to review Mr Carson's clinical care at the prison.
14. We informed HM Coroner for Avon of the investigation. The coroner gave us Mr Carson's cause of death. We have sent the coroner a copy of this report.
15. We wrote to Mr Carson'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 have any questions or raise any concerns about Mr Carson's care.
16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Leyhill

17. 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.
18. 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, 8.00am to 4.00pm. A local NHS centre, Hanham Health, provides GP and out of hours services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Leyhill was in September 2016. Inspectors reported that Leyhill was, overall, a safe and decent establishment. They 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

20. 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 community. However, the Board noted that there was a strain on the healthcare department caused by staffing vacancies.

Previous deaths at HMP Leyhill

21. Mr Carson was the third prisoner at Leyhill to die since December 2017. The previous two deaths were from natural causes. There are no similarities between Mr Carson's death and the previous deaths.

Key Events

22. On 22 December 2006, Mr Darren Carson was given an indeterminate sentence for public protection (IPP), with a minimum tariff of 18 months, for sexual offences.
23. In 2010, Mr Carson had a series of seizures. He was taken to hospital, where he was diagnosed with grand mal seizures (seizures that cause unconsciousness and violent muscle contractions.) The hospital subsequently diagnosed arteriovenous malformation (AVM - a congenital disorder of the blood vessels in the brain, brainstem or spinal cord which results in a restriction of the blood flow).
24. Mr Carson was placed on a waiting list for stereotactic radiosurgery (a non-surgical radiation therapy used to treat functional abnormalities and small tumours of the brain).

HMP Leyhill

25. On 17 May 2012, Mr Carson was moved to HMP Leyhill. At his initial health screen, staff noted his pre-existing medical conditions and prescribed medications, updated his care plans and made referrals to secondary care providers to ensure continuity of his neurological care.
26. On 6 August, Mr Carson was reviewed by the neurosurgery department at a hospital in Sheffield. Hospital staff told Mr Carson he required gamma knife surgery in order to treat his condition (a form of stereotactic radiosurgery). However, Mr Carson told hospital staff he did not want to undergo the procedure until the following year, as it may interfere with his parole application. He was discharged from the care of Royal Hallamshire Hospital and told to ask to be rereferred once his parole application had been processed.
27. Healthcare staff regularly reviewed Mr Carson and sought advice from secondary care providers. He continued to have regular seizures.
28. In January 2014, following an increase in the frequency of his seizures and a persistent feeling of dizziness and numbness in his left arm, a prison GP made a referral to the neurosurgery department at a hospital in Bristol. However, hospital staff told the prison GP the procedure Mr Carson required was not available at the hospital at that time, but may be at some point in the future.
29. They advised that for Mr Carson to be able to have the procedure in the near future, he would have to be referred back to a hospital, which would require a transfer to a prison closer to the hospital. Mr Carson told healthcare staff he did not want to transfer prisons and would wait until the procedure was available at the hospital.
30. Mr Carson was a heavy smoker. Despite repeated attempts by healthcare staff, Mr Carson continued to refuse smoking cessation advice.
31. In the months that followed, healthcare staff continued to regularly review Mr Carson, appropriately updating his care plans, reviewing his medications and

appropriately managing his condition. He continued to regularly suffer seizures of varying severity.

32. On 28 December 2017, a prison GP reviewed Mr Carson after he suffered a grand mal seizure. Following the review, she wrote to the hospital to ask if the gamma knife procedure was available at the hospital. While waiting for a reply, she referred him for a magnetic resonance imaging scan (MRI - a scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body) to see if his condition had worsened.
33. On 1 February 2018, Mr Carson attended a hospital in Bristol, to undergo an MRI scan. It showed there was no change in the appearance of his AVM, nor any evidence of oedema or haemorrhage.
34. On 6 July, a prison GP reviewed Mr Carson. She told him that the hospital had said that they were still unable to offer gamma knife surgery. The only hospital able to carry out the surgery was a hospital. Mr Carson told the prison GP that while he did not want to transfer prisons, he would agree to have the procedure if Leyhill would escort him and return him to the prison following his discharge from hospital. She told him she could not authorise that but would discuss it with the Head of Healthcare and the Governor.
35. On 16 November, a prison GP reviewed Mr Carson. The prison GP told him that the gamma surgery procedure was not a day case as initially thought but would be carried out over two days. However, the Governor had agreed to him being released on licence to undergo the procedure. The surgical procedure was scheduled for July 2019.
36. On 1 January 2019, Mr Carson finally accepted smoking cessation advice. Healthcare staff continued to regularly review Mr Carson.
37. On 29 July, Mr Carson left Leyhill and made his way to hospital. He was unescorted. He was admitted as an inpatient and underwent surgery the following day. He was told that despite having the procedure, it may not have a positive effect on his AVM for up to two years. He returned to Leyhill on 31 July and his follow up care, post-surgery radiotherapy and regular MRI scans were provided by a hospital.
38. On 30 September, a prison GP reviewed Mr Carson after he had complained of severe headaches. She prescribed him painkillers and referred him to hospital for an MRI scan. She noted that Mr Carson had not suffered a seizure since 27 December 2018.
39. The scan was carried out on 30 October, the results revealed no oedema, haemorrhage or obvious cause of the headaches.
40. On 8 December, a nurse reviewed Mr Carson after he suffered a seizure, his first in almost a year. He told her he thought the seizure may have been due to him feeling stressed about an upcoming parole hearing. She told him to rest and to contact healthcare if he had any further symptoms.
41. At 9.00pm on 14 December, Mr Carson suffered another seizure and was taken to hospital by emergency ambulance. Following a review by hospital staff, the

prison officers accompanying Mr Carson were told he had suffered a 'devastating brain injury'. He was sedated and placed on a ventilator to help him breathe.

42. Mr Carson's condition continued to deteriorate and at 11.00pm on 15 December he died. A hospital doctor confirmed his death at 11.11pm.

Contact with Mr Carson's Family

43. On 14 December 2019, the prison appointed a family liaison officer (FLO). The FLO telephoned Mr Carson's next of kin, his mother, to tell her that Mr Carson had been admitted to hospital but there was no answer.
44. Later that evening, a Supervising Officer (SO) spoke to Mr Carson's father. He told him of his son's condition and offered him support. Mr Carson's father told him that his wife, Mr Carson's mother, was also critically ill in hospital. The FLO spoke with Mr Carson's brother to also offer him support.
45. At 12.10am on 16 December, the SO telephoned Mr Carson's father to tell him of his son's death and to offer him support. The following day, the FLO telephoned Mr Carson's brother to offer support and answer any questions he may have. The FLO and a member of the prison chaplaincy team remained in regular contact with his family to offer them support.
46. Mr Carson's funeral was held on 3 January 2020. In line with national guidance, the prison offered a financial contribution to his funeral.

Support for prisoners and staff

47. After Mr Carson'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.
48. The prison posted notices informing other prisoners of Mr Carson'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 Carson's death.

Cause of death

49. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Carson's cause of death as intracerebral haemorrhage (a bleed in the brain) caused by AVM.

Findings

Clinical care

50. The clinical reviewer considered that prison healthcare staff made prompt, appropriate referrals, both to prison GPs, and to secondary care providers, to diagnose, treat and manage Mr Carson's condition.
51. She noted that treatment recommendations were followed up by healthcare staff, and that Mr Carson was involved in the management of his condition. The collaborative working between prison healthcare staff and hospital specialists was in line with Prison Service Order (PSO) 3050, *Continuity of care for prisoners*. She considered that Mr Carson's death was neither foreseeable nor preventable.
52. The clinical reviewer concluded that the standard of care Mr Carson received at Leyhill was of a good standard and at least equivalent to that he could have expected to receive in the community.
53. We make no recommendations.

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