

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Abrahams, a prisoner at HMP Leeds, on 25 October 2020

**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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## Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr David Abrahams died in Wheatfields Hospice, Leeds, of metastatic lung cancer on 25 October 2020, while a prisoner at HMP Leeds. Mr Abrahams was 73 years old. I offer my condolences to Mr Abrahams' family and friends.
4. The clinical reviewer concluded that the care Mr Abrahams received at HMP Leeds was equivalent to that which he could have expected to receive in the community. She has made one recommendation.
5. We did not find any non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that staff are aware of, and utilise, the relevant tools in relation to recognising a deteriorating patient. This is to include the completion of clinical observations and the use of a NEWS2 score, thus increasing the likelihood of consistent escalation of care when clinically indicated.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Abrahams' clinical care at HMP Leeds.
7. The PPO investigator has investigated non-clinical issues, including Mr Abrahams' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Abrahams' next of kin, his sister, to explain the investigation. She did not respond to our letter.
9. 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

## Previous deaths at HMP Leeds

10. Mr Abrahams was the nineteenth prisoner to die at Leeds since October 2018. Of the previous deaths, nine were from natural causes, seven were self-inflicted, one was a drug-related death, one is awaiting classification. There are no similarities between our findings in the investigation of Mr Abrahams' death and the previous deaths.

## Key Events

11. On 2 February 2018, Mr David Abrahams was remanded into custody charged with sexual offences. He was sent to HMP Leeds.
12. On 23 February, he was sentenced to nineteen years imprisonment. He returned to HMP Leeds.
13. At an initial health assessment, a prison nurse noted he had been previously suffered from depression, and as a result, had been sectioned under the mental health act. She also noted he had suffered a heart attack four years previously, following which he had been diagnosed with cardiovascular disease and COPD (the name for a variety of respiratory conditions). Care plans were created to manage both his respiratory, and cardiac care.
14. Aside from regular reviews, Mr Abrahams had little significant contact with healthcare staff while at the prison.
15. On 24 September, he transferred to HMP Moorlands. A prison nurse carried out an initial healthscreen and noted his pre-existing medical conditions. His prescribed medications were reviewed, and his care plans were reviewed and updated. Referrals were made to secondary care providers to ensure continuity of his care.
16. While at Moorlands, he was regularly reviewed by both healthcare and secondary care staff.
17. On 5 May 2019, despite not having been diagnosed with a terminal illness, Mr Abrahams told healthcare staff that he did not wish to be resuscitated if his heart or breathing stopped and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. He explained it was due to him having previously suffered from a heart attack. He agreed to consider his request, and to raise it again with healthcare staff if he still felt the same. He eventually signed a DNACPR on 26 March 2020.
18. On 11 June, Mr Abrahams was reviewed by a prison GP, after he complained of experiencing worsening back pain for the previous three days, and only being to pass small amounts of urine. The GP noted Mr Abrahams was extremely pale, had a swollen stomach and pain in his right side. He considered Mr Abrahams could have developed either ureteric colic (caused by kidney stones blocking the flow of urine) or appendicitis. He considered that Mr Abrahams would benefit from a review by hospital staff, and he was sent to Doncaster Royal Infirmary by emergency ambulance.
19. Following the review by hospital staff, Mr Abrahams underwent a CT scan (computerised tomography) the results of which revealed lesions on his spine. Hospital staff considered he required an MRI scan (magnetic resonance imaging) which was booked for 7 July. Mr Abrahams was discharged back to the prison later the same day.
20. He was admitted to hospital as an inpatient on 7 July and underwent the MRI scan on 9 July. The results of the scan revealed the lesions which had been noted previously, were in fact malignant tumours in the upper lobe of his right lung which had then spread throughout his spine. Hospital staff told him that

palliative care was the only treatment option open to him. He was discharged back to the prison the same day.

21. On 30 July, he was reviewed by a specialist cancer care nurse. He told her that he wished to die in prison and did not wish to make an application for compassionate release. She considered he had the mental capacity to make decisions about his care and treatment.
22. On 12 August, Mr Abrahams transferred to HMP Leeds to enable him to have more contact with his family. A prison GP, who had coincidentally also moved to HMP Leeds from Moorlands, reviewed Mr Abrahams when he arrived at the prison. He also reviewed Mr Abrahams' DNACPR and his care plans and made referrals to secondary care providers, to ensure continuity of his care.
23. Mr Abrahams was reviewed by a prison nurse on 20 August. He told her that he knew he did not have long left to live, and that he had reconsidered his earlier decision, and did in fact wish to die in a hospice.
24. On 16 September, healthcare staff were concerned by a marked deterioration in his condition. They telephoned Wheatfields Hospice, Leeds, for advice on how best to care for Mr Abrahams. Hospice staff advised that he be transferred to them for pain management. He was transferred to the hospice on 18 September.
25. On 22 September, Mr Abrahams transferred back to the prison and was moved to the palliative care suite. However, his condition continued to deteriorate, and he returned to Wheatfields Hospice on 16 October.
26. On 23 October, Mr Abrahams condition worsened, and he was placed on a ventilator to help him to breathe. His condition continued to deteriorate and at 8.17am on 25 October, a hospice doctor confirmed his death.
27. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Abrahams' cause of death as metastatic lung cancer.

**Lisa Burrell**  
**Assistant Ombudsman**

**May 2021**