Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Guy Paget, a prisoner at HMP Leeds, on 16 March 2021

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*

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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 Guy Paget died on 16 March 2021 of throat cancer at HMP Leeds. He was 73 years old. I offer my condolences to Mr Paget's family and friends.

The clinical reviewer concluded that the clinical care Mr Paget received at HMP Leeds was good and equivalent to that which he could have expected to receive in the community.

My investigation found that when the emergency ambulance attempted to leave the prison to take Mr Paget to hospital, the main prison gates would not open and there was also confusion about what paperwork was required. Mr Paget's health then suddenly deteriorated and he died in the ambulance in the prison grounds.

As Mr Paget was terminally ill and had a Do Not Attempt Resuscitation order in place, we consider that it was in his best interests to be allowed to die while the ambulance was parked in the prison grounds, rather than dying while being rushed to hospital. However, we are concerned that the confusion about the paperwork and the failure of the prison gate to open immediately could make a critical difference in future medical emergencies. The Governor will need to address these issues.

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 **February 2022**

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Summary

Events

1. On 17 October 2017, Mr Guy Paget was sentenced to 14 years in prison for conspiracy to supply Class A drugs and was sent to HMP Leeds. Mr Paget had no significant medical issues when he arrived in prison.

2. On 19 November 2020, Mr Paget was diagnosed with cancer of the oesophagus (throat). His condition was terminal and a palliative care plan was created for him.

3. On 16 March 2021, Mr Paget became unwell with suspected urinary sepsis and needed hospital treatment. At 1.23pm a nurse called a medical emergency code and the control room called an ambulance immediately.

4. There were no ambulances immediately available to attend the call which caused a 30-minute delay. At approximately 2.00pm, paramedics arrived at Mr Paget's cell. Healthcare staff gave the paramedics a full handover and at 2.35pm the ambulance left the prison's healthcare unit with Mr Paget.

5. As the ambulance was about to leave the prison grounds, the main prison gate failed to open and the ambulance could not leave the prison. Mr Paget's health started to deteriorate and there was some discussion between paramedics and prison staff as to whether Mr Paget should be taken to hospital. Mr Paget then had a cardiac arrest and died in the ambulance at 3.06pm while it was parked in the prison grounds.

Findings

6. The clinical reviewer found that, overall, the care Mr Paget received at Leeds was of a good standard and equivalent to that which he could have expected to receive in the community.

7. There was confusion about whether a gate pass was needed for the ambulance to leave the prison. The main prison gate malfunctioned when the ambulance attempted to leave the prison grounds to take Mr Paget to hospital. These issues caused a delay in the ambulance leaving the prison. Although the delay does not appear to have affected the outcome for Mr Paget, it could make a critical difference in other medical emergencies.

Recommendations

- The Governor should ensure that:
    - the prison gate is in working order; and
    - all staff who are involved in emergency escorts are aware of what paperwork is required for an ambulance to leave the prison, including whether a gate pass is required.
- The Governor should ensure that this report is shared with those named in it, in line with Prison Service Instruction 58/2010.

The Investigation Process

8. 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.

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

10. The investigator interviewed four members of staff by telephone on 28 June, 30 June and 6 July.

11. NHS England commissioned an independent clinical reviewer to review Mr Paget's clinical care at the prison. The investigator and clinical reviewer jointly conducted one interview on 30 June 2021.

12. We informed HM Coroner for West Yorkshire of the investigation. The Coroner gave us the record of inquest, concluded on 23 April 2021. There was no post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Paget'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 respond to our letter.

Background Information

HMP Leeds

14. HMP Leeds is a local prison holding a maximum of 1,218 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group (previously known as Care UK) provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

15. The most recent full inspection of HMP Leeds was in November/December 2019. This inspection found that health services were generally good and governance was robust. A range of health care services was provided by a skilled staff group, and waiting times were reasonable. Prisoners with long-term conditions and those with social and complex care needs received good support.

16. HMIP carried out a short scrutiny visit to Leeds in June 2020 to assess how well the prison had responded to the COVID-19 pandemic. Inspectors reported that Leeds was calm and well-ordered, despite the severe restrictions on the regime. The prison had experienced a significant outbreak of the virus but had controlled it effectively. Prisoners reported being kept well informed.

Independent Monitoring Board

17. 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 the year ending December 2020, the IMB reported that, in respect of healthcare, the pandemic saw a greater use of in-cell phones for initial consultations with doctors and nurse practitioners. A number of key face-to-face contacts continued to be undertaken to meet patient needs such as wound management and the delivery of social care. This had the benefit of prisoners not having to be moved from their wing and a reduction in face-to-face contact, both of which were important in preventing the spread of COVID-19.

Previous deaths at HMP Leeds

18. Mr Paget was the 24th prisoner to die at Leeds since March 2019. Of the previous deaths, 14 were from natural causes eight were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Paget's death and our investigation findings in previous deaths.

Key Events

19. On 17 October 2017, Mr Guy Paget was sentenced to 14 years in prison for conspiracy to supply Class A drugs and was sent to HMP Leeds. Mr Paget had no significant medical issues on entering prison.

20. On 16 October 2020, a nurse saw Mr Paget because he had been complaining of frequent vomiting. The nurse booked appointments for Mr Paget to have a blood test, weight checks and a GP review.

21. On 9 November, a prison GP saw Mr Paget. Due to Mr Paget's significant weight loss, the GP made an urgent gastroenterology referral for suspected cancer.

22. On 19 November, Mr Paget was diagnosed with cancer of the oesophagus. Further investigations showed that his condition was terminal and healthcare staff created a palliative care plan.

23. On 3 December, Mr Paget was moved to the prison's Complex Care Unit. On 11 December, Mr Paget said he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Resuscitate (DNR) order to that effect.

24. On 20 January 2021, Mr Paget fell in his cell. He was taken to hospital and treated for dehydration. He returned to Leeds on 30 January.

25. On 5 March, a Palliative Care Consultant spoke with Mr Paget about hospice care. Mr Paget said he was still undecided on his preferred place of death.

Events on 16 March 2021

26. On 16 March, Mr Paget had pulled out his catheter overnight. A nurse went to review him. Mr Paget was passing urine, so the nurse decided to leave the catheter out for a while to let his discomfort subside before inserting a new one.

27. At approximately 1.00pm, a healthcare assistant went to Mr Paget's cell to carry out routine observations. She saw he was naked and trying to get out of bed. She went into the cell to help him and asked an officer to ask a nurse to come and assist her.

28. A nurse arrived and assessed Mr Paget. He was very agitated and confused. She suspected that he had urinary sepsis. She consulted a prison GP and they agreed that Mr Paget needed urgent hospital treatment. The nurse asked an officer to call a medical emergency code blue - a request for an emergency ambulance - over his radio. Control room logs show that the emergency call was made at 1.23pm.

29. There was no ambulance immediately available, so the nurse continued to treat Mr Paget, medicating him to make him as comfortable as possible and monitoring his vital signs.

30. At 1.59pm, an ambulance arrived at the prison gate and was with Mr Paget within minutes. At approximately 2.35pm, Mr Paget was put in the ambulance. He was accompanied by two escort officers. The vehicle was escorted back to the prison

main gate by an Operational Support Grade (OSG). At 2.38pm, the control room recorded, ‘Ambulance did not leave.’

31. In their written statements, the escort officers said that the prison gate malfunctioned, which meant that the ambulance was unable to leave the prison and had to reverse into the area behind the prison gate.

32. The officers said that they were asked by an OSG searching the vehicle for a gate pass. They did not name the OSG. They did not have one as this was an emergency escort, so advised the OSG to seek permission for the ambulance to leave the prison from the duty governor.

33. The OSG who was working on the gate that day did not recall asking the escorting officers for a gate pass. In interview she said that emergency escorts do not need a gate pass and that the paperwork can be completed later.

34. Mr Paget’s health began to deteriorate quickly in the ambulance. One of the escort officers said that the paramedics treating him knew he had a DNR order in place and began to question whether Mr Paget should be taken to hospital. He left the vehicle twice to speak to the duty governor, who said that Mr Paget must be taken to hospital. The officer said that when he returned to the vehicle a second time, Mr Paget was actively dying.

35. As she was leaving the prison at the end of her shift, the nurse noticed that the ambulance was parked in the area behind the prison gate. She got into the ambulance and held Mr Paget’s hand and offered words of comfort to him as he was dying.

36. Mr Paget died in the ambulance at 3.06pm. The ambulance left the prison with Mr Paget’s body at 3.21pm.

Contact with Mr Paget’s family

37. The prison appointed a prison officer as the family liaison officer (FLO). Under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO. However, Government advice at the time prohibited all but essential travel and required social distancing to prevent the spread of the COVID-19 virus. The FLO therefore contacted Mr Paget’s family by telephone to break the news of his death.

38. Mr Paget’s funeral was held on 27 April. In line with Prison Service instructions, the prison contributed towards the costs of the funeral.

Support for prisoners and staff

39. After Mr Paget’s death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Paget’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 Paget’s death.

Cause of death

41. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Paget’s cause of death as oesophageal (throat) cancer. He also had urinary sepsis, which did not cause but contributed to his death.

Findings

Ambulance access and egress

42. The ambulance carrying Mr Paget left the prison wing at 2.35pm. There was no delay in the ambulance reaching the gate. However, at 2.38pm, there is a record in the control room log which says, 'Ambulance did not leave.' Mr Paget died in the ambulance in the prison grounds at 3.06pm. We have found it difficult to establish why the ambulance did not leave the prison before Mr Paget died as different people have given us different accounts.

43. At the inquest, held on 23 April, HM Coroner concluded that the ambulance had been effectively trapped in the prison because it was delayed by incorrect paperwork and the malfunctioning of the prison gate. He issued a Report to Prevent Future Deaths under Regulation 28 on both these points.

44. In interview, the two OSGs involved said that the gate consoles, which control the opening and closing of the gates, sometimes fail. However, they were both confident that this can be resolved within seconds by a member of staff on the gate calling the control room. Staff in the control room can then override the system to allow them to open and close the main gate. If this is the case, it is not clear why this fix was not applied on this occasion as the gate was not opened.

45. The escort officers also said that they were asked to provide a gate pass. A gate pass is a piece of paper with the prisoner's details on, as well as details of where they are going, and is issued by reception staff as the prisoner leaves. However, emergency escorts do not leave the prison via reception, but instead proceed to the main gate so that the prisoners can be taken to hospital as quickly as possible.

46. In interview, the OSG was adamant that a gate pass is not necessary for an emergency escort and would not have been required to escort Mr Paget to hospital. She said that it was something that would have been completed later to allow the ambulance to leave as quickly as possible. However, there does appear to have been some confusion at the time as to whether a gate pass was needed for Mr Paget or not. One of the escort officers said that this was his first emergency hospital escort and he did not know what the procedure was.

47. We are concerned that the confusion about the pass and the problem with the gate did cause a delay, and that local procedures need to be clarified to ensure similar delays do not occur in future medical emergencies. We make the following recommendation:

    The Governor should ensure that:

    - **the prison gate is in working order; and**
    - **all staff who are involved in emergency escorts are aware of what paperwork is required for an ambulance to leave the prison, including whether a gate pass is required.**

48. However, we are satisfied that in Mr Paget's case, the delay in the ambulance leaving did not affect the outcome for him. It appears that when it became clear that Mr Paget's death was imminent, the ambulance paramedics concluded that it would not be in his best interests for him to be rushed to hospital and that he would be able to die more comfortably in a stationary ambulance. They told prison staff that as Mr Paget had a DNR order in place, if they had been called to his home in the community they would not have taken him to hospital and would have let him die more comfortably at home. We are satisfied that the decision to remain at the prison while Mr Paget died was appropriate in the circumstances.

49. We also commend the compassionate action of the nurse who took it upon herself to sit with Mr Paget as he lay dying even though her shift had ended.

Clinical care

50. The clinical reviewer concluded that the general clinical care that Mr Paget received was of a good standard and was equivalent to that which he could have expected to receive in the community.

51. The clinical reviewer is satisfied that Mr Paget's care was good, that it was right to send him to hospital on 16 March, and that the care that the nurse provided was appropriate.

Learning from this investigation

52. We think it is important that staff are able to learn from our investigations. We, therefore, make the following recommendation:

The Governor should ensure that this report is shared with those named in it, in line with Prison Service Instruction 58/2010.

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