

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Alexis, a prisoner at HMP Leeds, on 26 September 2021

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 Anthony Alexis died on 26 September 2021 of a heart attack at HMP Leeds. Mr Alexis was 54 years old. I offer my condolences to Mr Alexis' family and friends.

The clinical reviewer found that some of the care that Mr Alexis received was not equivalent to that which he would have received in the community. She was concerned about the lack of a timely care plan for Mr Alexis' heart disease, mismanagement of the Do Not Attempt cardiopulmonary resuscitation order and a lack of a formal mental capacity assessment.

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

May 2022

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Summary

Events

1. On 21 March 1990, Mr Anthony Alexis was sentenced to life imprisonment having been convicted of murder. He transferred to HMP Leeds on 18 May 2021. At the initial health screenings, healthcare staff noted that Mr Alexis had high blood pressure, a history of paranoid schizophrenia and was on medication for high cholesterol, high blood pressure and heart failure.
2. On 15 June, prisoners found Mr Alexis slumped in the shower and not responding. Mr Alexis was transferred to hospital and diagnosed with a brain injury due to lack of oxygen caused by his heart stopping.
3. On 22 July, Mr Alexis told healthcare staff that he was going to stop taking all his medication.
4. On 7 August, a psychiatrist saw Mr Alexis at his cell door. He noted that, if Mr Alexis continued to refuse medication, a capacity assessment (an assessment which looks at whether a prisoner has the mental capacity to make their own decisions) would be required followed by a best interest meeting (a meeting where staff from different areas make decisions about a prisoner's care) if he was found to lack capacity.
5. On 8 September, a nurse noted that Mr Alexis had very high blood pressure. She called the hospital cardiology registrar and asked for advice. The registrar said that a hospital admission was not needed, but that Mr Alexis should have a capacity assessment and then be referred to the hospital cardiology department for further investigation.
6. At around 3.40pm on 26 September, staff went to Mr Alexis' cell to give him his medication. They looked through the observation panel and saw him slumped on the bed. The officer and nurse waited for more staff before unlocking his door. On entering the cell, staff found that Mr Alexis was cold to the touch. Paramedics attended and declared that Mr Alexis had died.

Findings

7. The clinical reviewer was concerned about the lack of a timely care plan for Mr Alexis' heart disease and the lack of a formal mental capacity assessment. She was also concerned about staff's failure to act with sufficient urgency when reviewing the Do Not Attempt cardiopulmonary resuscitation order, and that changes were not formally recorded, meaning they were not easily accessible to staff.

Recommendations

- The Head of Healthcare should ensure that:
 - healthcare staff formally assess and record the mental capacity of prisoners who refuse care against medical advice and repeat capacity assessments regularly to ensure that their wishes have not changed;

- when a best interest decision is required, an appropriate multi-disciplinary meeting is held promptly and accurately recorded; and
 - healthcare staff treat capacity assessments as a priority when the patient's physical health is declining and/or a capacity assessment is required for the patient to access outpatient treatment.
- The Head of Healthcare should ensure that all patients with long-term conditions have timely, clear, personalised care plans, with stated aims, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.
- The Head of Healthcare should ensure that where there is a do not attempt resuscitation order in place, any requests to review this must be urgently considered and clearly recorded, including when a prisoner wishes to either give or withdraw their consent for the order.

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 contacted her as a result.
9. NHS England commissioned an independent clinical reviewer to review Mr Alexis' clinical care at HMP Leeds.
10. We informed HM Coroner for West Yorkshire Eastern District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The PPO family liaison officer wrote to Mr Alexis' next of kin to explain the investigation. They did not respond.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Leeds

13. HMP Leeds is a local prison holding up to 1,131 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Leeds was in December 2019. Inspectors reported that the management of long-term conditions was good and that the conditions were managed by a specialist nurse with GP input. Inspectors found that Leeds were slow to transfer prisoners who required hospitalisation under the Mental Health Act.

Independent Monitoring Board

15. 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 December 2020, the IMB reported that prisoners were treated fairly and humanly. They also reported that interdisciplinary teams can take many weeks to establish the needs of prisoners who may require a transfer to a secure mental health hospital.

Previous deaths at HMP Leeds

16. Mr Alexis was the 24th prisoner to die at the prison since September 2019. Of these deaths, 14 were from natural causes, seven were self-inflicted, one was drug related and one is currently unascertained. Since Mr Alexis' death, there have been a further three deaths. Of these deaths, two were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Alexis' death and our investigation findings for the previous deaths.

Key Events

17. On 21 March 1990, Mr Anthony Alexis was sentenced to life imprisonment having been convicted of murder. He transferred to HMP Leeds on 18 March 2021. At the initial health screenings, healthcare staff noted that Mr Alexis had high blood pressure, a history of paranoid schizophrenia and was on medication for high cholesterol, high blood pressure and heart failure. Healthcare staff did not put a care plan in place for Mr Alexis' cardiovascular (heart and blood vessel) conditions. He was referred to the mental health team. Since 2010, Mr Alexis had an intermittent history of refusing his medication.
18. On 15 June, wing cleaners found Mr Alexis slumped in the shower and not responding. Staff called a code blue (a radio call announcing an emergency where a prisoner is not breathing or is having difficulty breathing) and began CPR. Mr Alexis was transferred to hospital and diagnosed with a brain injury due to a lack of oxygen caused by his heart stopping. While Mr Alexis was in hospital, doctors signed a Do Not Attempt cardiopulmonary resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made). Mr Alexis returned to the prison on 15 July.
19. On 17 July, a nurse discussed the DNACPR with Mr Alexis, who did not know that it was in place. Mr Alexis said that he did want to be resuscitated in the event of cardiac arrest (when the heart stops working). She tasked the prison GP to review this decision.
20. On 22 July, Mr Alexis told healthcare staff that he was going to stop taking all his medication. Healthcare staff explained the risks to Mr Alexis because of his heart failure. Between 22 July and 17 September, healthcare staff recorded that Mr Alexis refused his medication 13 times.
21. On 27 July, a lead prison GP discussed the DNACPR order with Mr Alexis. He concluded that he thought that Mr Alexis should be resuscitated in the event of cardiac arrest.
22. On 7 August, a prison psychiatrist saw Mr Alexis at his cell door. He noted that Mr Alexis found remembering information difficult and that he needed neurorehabilitation. He suggested that staff should make a memory aid for Mr Alexis' medication, to encourage Mr Alexis to take his medication. However, he noted that, if Mr Alexis continued to refuse medication, a capacity assessment (an assessment which looks at whether a prisoner has the mental capacity to make their own decisions) would be required followed by a best interest meeting (a meeting where staff from different areas make decisions about a prisoner's care) if he was found to lack capacity.
23. On 14 August, Mr Alexis refused his medication and the nurse on duty wrote in his medical notes that she would ask the GP about his capacity.
24. A prison GP saw Mr Alexis on 20 August. They spoke about Mr Alexis' brain injury and the events that led up to that, which Mr Alexis did not remember. They also spoke about the risks of not taking medication. The GP noted that there were some concerns about Mr Alexis' mental capacity. However, he thought that Mr Alexis had enough mental capacity to make his own decisions about his

medication. He did not record what information he used to come to that decision. He also discussed the DNACPR order with Mr Alexis again. Mr Alexis decided that he no longer wanted to be resuscitated in the event of a cardiac arrest. The DNACPR order was put back in place.

25. On 24 August, a nurse tasked social care staff to monitor Mr Alexis' observations daily in light of his continuing medication refusal.
26. On 28 August, a nurse created a cardiovascular care plan for Mr Alexis, which followed the National Institute for Health and Care Excellence (NICE) guidelines.
27. On 1 September, healthcare staff held a multi-agency meeting and concluded that Mr Alexis needed a mental capacity assessment because of his continuing medication refusal. A prison GP asked a nurse to carry out the assessment.
28. On 8 September, the nurse took Mr Alexis' observations and recorded very high blood pressure. She called the hospital cardiology registrar and asked for advice. The registrar said that a hospital admission was not needed, but that Mr Alexis should have a capacity assessment and then be referred to the hospital cardiology department for further investigation. On 9 September, a prison GP saw Mr Alexis in his cell and discussed his very high blood pressure and the risks of not taking his blood pressure medication. He noticed that Mr Alexis did not understand the risks, did not remember his previous hospital stay and showed no interest in the conversation.
29. At the prison GP's request, a nurse printed out Mr Alexis' discharge letter to prove his last hospital stay and explained it to him. The GP was concerned about Mr Alexis' memory problem and his inability to absorb serious information regarding his health. The nurse sent an electronic task to healthcare administrative staff to discuss his case with the GP and prison psychiatrist at the multidisciplinary meeting.
30. On 13 September, the Head of Safer Custody recorded her concerns about Mr Alexis' refusal to take his medication and his increasingly aggressive behaviour. Because of his aggressive and erratic behaviour, Mr Alexis had to be supervised by three prison officers when out of his cell. She linked these patterns of behaviour to his past behaviour which led to an admission to psychiatric hospital. She raised her concerns with the Governor and the mental health manager.
31. On 17 September, a prison GP recorded that Mr Alexis had taken his medication intermittently that week and that a best interest meeting was needed, along with a long-term plan addressing Mr Alexis' medication refusal.

26 September 2021

32. On 26 September at 8.30am, Mr Alexis refused his medication. At 09.30am, the prison psychiatrist asked the physical healthcare team to clarify what their views were on Mr Alexis' capacity. He planned to share this information with the hospital's psychiatric team, along with other aspects of his recovery from his brain injury in March 2021 and his cardiovascular condition. This was part of an ongoing discussion with him and the hospital's psychiatric team about possibly referring Mr Alexis to a mental health secure unit.

33. At 11.30am, Mr Alexis had his lunch in his room and was escorted out for exercise at 1.30pm, supervised by three prison officers. While out of his cell, Mr Alexis became aggressive, and officers took him back to his cell.
34. At around 3.40pm, an officer and a nurse went to Mr Alexis' cell to give him his medication. He did not respond when called, so the officer looked through the observation panel and saw him slumped on the bed. The officer radioed a code blue and waited one to two minutes for two more members of staff before she opened the door.
35. Once in the cell, the officer found Mr Alexis was cold to the touch. The nurse did observations and found no signs of life. The emergency nurse on duty arrived and also found no signs of life. Staff did not start CPR because Mr Alexis had a DNACPR order in place. At 4.13pm, paramedics arrived and declared Mr Alexis dead at 4.22pm.

Contact with Mr Alexis' family

36. On 26 September, Leeds appointed a family liaison officer, who informed Mr Alexis' family of his death, offered their condolences and remained in contact with them in the weeks that followed. The family liaison officer offered a contribution to Mr Alexis' funeral expenses, in line with Prison Service policy.

Support for prisoners and staff

37. Due to staff restraints, an emergency debrief was not held, but prison managers spoke to staff involved individually. The staff care team also offered support.
38. The prison posted notices informing other prisoners of Mr Alexis' death, and offering support.

Post-mortem report

39. The pathologist concluded that Mr Alexis died of a blood clot in the heart caused by heart disease.

Findings

Clinical Care

40. The clinical reviewer was concerned about the lack of a timely care plan for Mr Alexis' heart disease and the lack of a formal mental capacity assessment. She was also concerned about staff's failure to act with sufficient urgency when reviewing the Do Not Attempt cardiopulmonary resuscitation order, and that changes were not formally recorded, meaning they were not easily accessible to staff.

Mental Capacity

41. Mr Alexis was frequently non-compliant with his medication. Prison and healthcare staff questioned Mr Alexis' capacity to refuse medication multiple times. A prison GP assessed his capacity on 20 August. He noted that there were some concerns about Mr Alexis' mental capacity, but that Mr Alexis had enough mental capacity to make his own decisions about his medication. This was not a formal assessment and he did not record how he came to that decision.
42. After 20 August, healthcare staff continued to question Mr Alexis' capacity and staff from different disciplines recorded that an assessment was required, but no one took responsibility for carrying it out. A prison GP asked a nurse to undertake an assessment on 1 September, but there is no record of the nurse organising or carrying out this assessment, or any record of the GP checking that this task had been completed.
43. On 8 September, Mr Alexis' capacity to refuse medication became an urgent issue when his blood pressure was very high. A nurse consulted the hospital cardiology department, who required a capacity assessment before he could be referred to them for further investigation. The nurse passed this responsibility to a prison GP, who had very clear concerns about Mr Alexis' capacity and passed the responsibility to another GP.
44. On 17 September, a prison GP saw Mr Alexis at his cell door and recorded that a best interest meeting was needed as well as a long-term plan regarding his medication refusal. Although he recorded no formal assessment about Mr Alexis' capacity, this suggests that he had concerns that Mr Alexis did not have capacity to make decisions about his medication. There is no record that a best interest meeting was held before Mr Alexis died nine days later.
45. We are particularly concerned that Mr Alexis' capacity was an item of concern for multiple members of staff and the issue became urgent when Mr Alexis' blood pressure became very high. Yet still, staff failed to act and make a decision about his capacity and set up a best interests meeting. We make the following recommendation:

The Head of Healthcare should ensure that:

- **healthcare staff formally assess and record the mental capacity of prisoners who refuse care against medical advice and repeat**

capacity assessments regularly to ensure that their wishes have not changed;

- **when a best interest decision is required, an appropriate multi-disciplinary meeting is held promptly and accurately recorded; and**
- **healthcare staff treat capacity assessments as a priority when the patient's physical health is declining and/or a capacity assessment is required for the patient to access outpatient treatment.**

Care Plan for Heart Disease

46. When Mr Alexis arrived at HMP Leeds, the nurse noted that he had heart disease, high blood pressure and was overweight. These factors meant that Mr Alexis was at a much higher risk of a heart attack. At this point, no formal care plan was put in place to manage the risks and management of his long-term cardiovascular conditions.
47. Mr Alexis was rushed to hospital on 15 June after his heart stopped. He returned to the prison on 15 July and again, no care plans were put in place to manage the risks of his long-term cardiovascular conditions.
48. On 28 August, a prison nurse created a cardiovascular care plan for Mr Alexis, which followed the National Institute for Health and Care Excellence guidelines. We acknowledge that healthcare staff did eventually put the care plan in place, but it should have been put in place over three months earlier. Since there was a delay in Mr Alexis' care plan, Mr Alexis' cardiovascular condition did not benefit from overarching formal management, though it was a condition that Mr Alexis was seriously ill with in June - July 2021 and ultimately died from. Therefore, we make the following recommendation:

The Head of Healthcare should ensure that all patients with long-term conditions have timely, clear, personalised care plans, with stated aims, planned interventions and monitoring, and regular reviews of medication in line with National Institute for Health and Care Excellence (NICE) guidelines.

DNACPR Order

49. A DNACPR order was put in place while Mr Alexis was in hospital in June 2021. This was reviewed by a nurse on his return to prison, who found that Mr Alexis was unaware of the DNACPR and wanted to be resuscitated in the event of cardiac arrest. She asked the GP to review this order.
50. A prison GP did not review Mr Alexis until ten days later. At that point, he concluded that he thought Mr Alexis should be resuscitated. If Mr Alexis had gone into cardiac arrest during this time, staff may have chosen not to resuscitate, which would have been against his wishes. Therefore, we make the following recommendation:

The Head of Healthcare should ensure that where there is a do not attempt resuscitation order in place, any requests to review this must be urgently considered and clearly recorded, including when a prisoner wishes to either give or withdraw their consent for the order.

Emergency response

51. On 26 September, an officer looked through Mr Alexis' cell observation panel and saw him slumped on the bed. She radioed a code blue and waited one to two minutes for two more members of staff before she opened the door.
52. The officer said that she weighed the risk to Mr Alexis against the risk to herself. She considered Mr Alexis's recent aggressive and threatening behaviour towards staff including herself. Since she was aware of Mr Alexis' unpredictable behaviour, she decided to wait for extra staff. She also said that she would always make a dynamic risk assessment if she ever found an unconscious prisoner who required a three-officer unlock.
53. We are satisfied that the officer made a dynamic risk assessment and that waiting for officer support was an acceptable decision in the circumstances.

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