Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Rogers, a prisoner at HMP Holme House, on 7 August 2020

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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 Lee Rogers, who was 27 years old, died of pneumonia caused by hepatitis on 7 August 2020, while a prisoner at HMP Holme House. We offer our condolences to Mr Rogers' family and friends.

The clinical reviewer concluded that, overall, the care that Mr Rogers received at HMP Holme House was not equivalent to that which he could have expected to receive in the community. She was particularly concerned that requests made by healthcare staff to administrative staff were not actioned nor was Mr Rogers included on the complex care pathway when he should have been. This had an impact on the timely management of Mr Rogers' ongoing medical condition. However, the clinical reviewer was satisfied that the care Mr Rogers received as his condition deteriorated was appropriately managed and his transfer to hospital was timely.

I am concerned that when Mr Rogers was taken to hospital his medical condition was not adequately considered when deciding to use an escort chain to restrain him.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **February 2023**

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Summary

Events

1. Mr Lee Rogers was sentenced to three years imprisonment for sexual offences on 24 May 2019 and transferred to HMP Holme House on 6 June. He had auto immune hepatitis (a liver condition), a heart murmur and mental health concerns.

2. Mr Rogers was seen by a gastroenterologist on 24 July 2019, after coughing up blood two weeks before. Following abnormal blood test results on 28 August, a prison GP asked healthcare administration staff to schedule a follow up appointment for Mr Rogers with the gastroenterologist. Healthcare administration staff did not action this until 11 October. Mr Rogers was eventually seen by a consultant gastroenterologist on 29 January 2020.

3. On 1 July 2020, Mr Rogers' condition got worse and healthcare staff noted that his skin was yellow. The prison doctor spoke to a gastroenterologist and agreed to change his prescription. On 15 July, a nurse asked a prison doctor to review Mr Rogers because of his yellow skin. The doctor reviewed Mr Rogers later that afternoon and arranged for him to be transferred to hospital.

4. On 24 July, Mr Rogers was transferred to a specialist hospital for a liver biopsy following multiple gastrointestinal bleeds.

5. On 7 August at 4.10pm, Mr Rogers died of pneumonia caused by decompensated auto-immune hepatitis (a disease where the immune system attacks the liver).

Findings

6. The clinical reviewer concluded that the clinical care that Mr Rogers received was not equivalent to that which he could have expected to receive in the community. She was particularly concerned that requests made by healthcare staff to administrative staff were not actioned, and that Mr Rogers was not immediately put on the complex care register. She considered that this had an impact on the timely management of Mr Rogers' ongoing medical condition.

7. However, the clinical reviewer found that the care that Mr Rogers received in relation to his deterioration and management just before going into hospital for the last time was timely and responsive. The Head of Healthcare will also want to consider the additional recommendations in the clinical review.

8. We also concluded that Mr Rogers' medical condition was not adequately considered when deciding to restrain him when he was taken to hospital.

Recommendations

- The Head of Healthcare should ensure that all healthcare and administrative staff understand their responsibility for the implementation and follow up of healthcare tasks and tests.

- The Head of Healthcare should ensure appropriate patients are put on the Complex Case Register for overview of clinical care and the effective management of long-term health conditions.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

10. NHS England commissioned an independent clinical reviewer to review Mr Rogers' clinical care at Holme House. The clinical reviewer interviewed the prison's Head of Healthcare with the PPO investigator.

11. Our family liaison officer wrote to Mr Rogers' 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 Holme House

13. HMP Holme House is a Category C training prison holding over 1,200 men. G4S provides health services at the prison. There is a 24-hour healthcare inpatient unit with 16 beds.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Holme House was in March 2020. Inspectors reported that, although there was no lead nurse for long-term conditions, two senior nurses were being trained to take on this role. Healthcare staff liaised with the GP and external specialists to ensure a coordinated approach. There was a range of nurse-led clinics, and patients with long-term conditions or complex needs were monitored and reviewed appropriately. There was an effective process for monitoring external hospital referrals.

15. They also reported that there was a high rate of non-attendance at some clinics, and prisoners suggested that this was due to extended waiting times in the healthcare area, where waiting rooms were uncomfortable.

Independent Monitoring Board

16. 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 to December 2020, the IMB reported that most GP appointments were held by telephone, with nurses triaging prisoners on house blocks and dealing with a high proportion of medical issues, only referring to the GP if necessary. This has resulted in there not being a waiting list to see the GP and prisoners getting a more responsive service.

17. A complex needs nurse has been put in place to offer care to vulnerable patients and those with complex needs.

Previous deaths at HMP Holme House

18. Mr Rogers' was the 12th prisoner to die at HMP Holme House since August 2018. Of the previous deaths, seven were from natural causes, two were self-inflicted and two prisoners died of non-natural causes. Six prisoners have died since Mr Rogers' death. Three of those deaths were self-inflicted, two were from natural causes and one is awaiting classification.

19. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

20. On 24 May 2019, Mr Lee Rogers was sentenced to three years imprisonment for breach of a sexual harm prevention order. He was transferred to HMP Holme House on 6 June.

21. A prison nurse saw Mr Rogers for an initial reception screening and noted that Mr Rogers had auto immune hepatitis (a liver condition), a heart murmur and mental health concerns. A prison healthcare assistant saw Mr Rogers for a secondary reception screening on 8 June. He was not put on the complex care register (a register of people with complex health needs which requires a senior nurse overview).

22. Before he arrived at Holme House, Mr Rogers had been referred to a gastroenterologist (digestive system specialist). The referral was not followed up when he transferred to Holme House. Mr Rogers was not seen by a gastroenterologist until 24 July 2019, when he was taken to hospital having coughed up blood for two weeks.

23. Following abnormal blood test results on 28 August, a prison GP asked healthcare administration staff to schedule a follow up appointment for Mr Rogers with the gastroenterologist. Healthcare administration staff did not action this until 11 October. Mr Rogers was eventually seen by a consultant gastroenterologist on 29 January 2020.

24. A follow up appointment with the gastroenterologist was arranged for 15 July, after being re-arranged from 30 April due to the ongoing COVID-19 pandemic. Before this appointment, Mr Rogers' medical records documented that he continued to cough up blood and he reported swelling in his genitals. Mr Rogers' blood tests remained abnormal.

25. On 1 July, Mr Rogers' condition got worse and healthcare staff noted that his skin had turned yellow. A prison GP examined Mr Rogers and contacted the consultant gastroenterologist. They agreed to change Mr Rogers' prescribed medication. The GP asked the consultant to see Mr Rogers two weeks later.

26. On 6 July, Mr Rogers was put on the complex case register. Mr Rogers' health continued to deteriorate. On 15 July, a nurse asked the prison GP to review Mr Rogers because he felt weak and had yellow skin. Later that afternoon, the GP arranged for Mr Rogers to be transferred to hospital with suspected progressing liver decompensation (when liver function deteriorates). On the hospital risk assessment dated 15 July, healthcare staff wrote that there were no medical objections to restraints. The prison used a single cuff restraint to escort Mr Rogers to hospital and an escort chain to restrain Mr Rogers while in hospital.

27. Mr Rogers remained in hospital and, on 24 July, following multiple gastrointestinal bleeds, he was transferred to The Freeman Hospital, a specialist hospital in the Northeast, for a liver biopsy. He was put into an induced coma. Officers removed the escort chain and continued to assess Mr Rogers' escape risk. They reapplied the escort chain on 29 July, when Mr Rogers was able to get out of bed with the help of a walking aid and a physiotherapist. On 3 August, healthcare again wrote

that there were no medical objections to the use of restraints, but the Governor authorised that restraints were not to be used on Mr Rogers.

28. On 7 August, a nurse told bedwatch officers that Mr Rogers had passed away at 4.10pm.

Contact with Mr Rogers' family

29. Due to Mr Rogers' continued deterioration, Holme House appointed a family liaison officer (FLO) who contacted Mr Rogers' next of kin on 24 July. The FLO maintained good communication with Mr Rogers' next of kin, informed them of his death by telephone as agreed and ensured that Mr Rogers' wishes were fulfilled. The prison offered a contribution to Mr Rogers' funeral expenses in line with national Prison Service instruction.

Post-mortem report

30. The post-mortem examination confirmed that Mr Rogers died from pneumonia caused by decompensated auto-immune hepatitis (a disease where the immune system attacks the liver).

Findings

Clinical Care

31. The clinical reviewer concluded that the clinical care that Mr Rogers received was not equivalent to that which he could have expected to receive in the community.

32. It was unfortunate that it was not possible to interview three of the healthcare staff central to Mr Rogers' care since they no longer work at Holme House. At the time of interview, the Interim Head of Healthcare had only been in post for three weeks. However, she had already identified failings in Mr Rogers' care and was implementing changes to provide robust and timely healthcare for prisoners. These included ensuring only those trained to complete healthcare screenings do so and introducing an assessment sheet for prisoners who have transferred from another prison to ensure continuity of care occurs. We note the clinical reviewer's recommendation in this regard which the Head of Healthcare will want to ensure they are aware of.

Actioning healthcare referrals and tasks

33. The clinical reviewer was particularly concerned that requests made by healthcare staff to administrative staff were not actioned. This had an impact on the timely management of Mr Rogers' ongoing medical condition.

34. On 28 August 2019, a prison doctor sent a task to administration staff to organise a follow up appointment with the gastroenterologist. This was not acknowledged by healthcare staff until 11 October. Because of this delay and hospital delays, Mr Rogers was not seen by the gastroenterologist for his follow up appointment for five months. The clinical reviewer concludes that this delay could have had an impact on the management of his auto immune hepatitis, which was the condition that caused his death.

35. The clinical reviewer found multiple instances of healthcare practitioners not taking responsibility for, or following up on, tasks they had created and tests they had ordered. The clinical reviewer also found delays with administration staff actioning tasks created by healthcare practitioners. These two issues caused delays in Mr Rogers receiving hospital treatments, delays in being reviewed by hospital consultants and delays in the implementation of hospital treatment plans. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare and administrative staff understand their responsibility for the implementation and follow up of healthcare tasks and tests.

Managing the Complex Case Register

36. Mr Rogers was placed on the complex case register on 6 July 2020, but the clinical reviewer states that he should have been placed on the register earlier. The Interim Head of Healthcare acknowledged during interview that Mr Rogers should have been put on the register at the secondary health screen. If Mr Rogers had been put on the register earlier, it would have allowed for a better overview of his care and

management of his long-term health condition. We make the following recommendation:

The Head of Healthcare should ensure appropriate patients are put on the Complex Case Register for overview of clinical care and the effective management of long-term health conditions.

37. The clinical reviewer considered that the care that Mr Rogers received in relation to his deterioration and management just before going into hospital in July 2020 was timely and responsive.

Non-Clinical Care

Use of Restraints

38. 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 the 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 suffering from 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.

39. On 15 July 2021, Mr Rogers was escorted to hospital with suspected progressing liver decompensation. Mr Rogers said that he felt really weak and unwell. Healthcare completed the medical section of the hospital risk assessment, which stated that there were no medical objections to bedwatch officers using restraints. The security department wrote that there was a standard risk to the public and a standard escape risk. The Deputy Governor authorised bedwatch officers to use an escort chain unless Mr Rogers was under general anaesthetic or on a ventilator.

40. On 24 July, Mr Rogers was put in an induced coma and officers removed the escort chain. On 29 July, Mr Rogers was brought out of the coma. He was unable to get out of bed unaided, but once out, he could walk 5 meters with a walking aid. Officers reapplied the single escort chain. On 3 August, healthcare staff wrote in a new risk assessment that there were still no medical objections to the use of restraints, but the Duty Governor authorised the permanent removal of restraints.

41. We have considered the records of Mr Roger's physical condition from his medical record and the bedwatch logs between 15 July to his death and we find that the use of restraints during this period was not justified. There were clear medical objections to the use of restraints and no raised security risks which outweighed Mr Rogers' physical condition. We find that healthcare staff's assessment of his mobility was inadequate both on 15 July and 3 August, but particularly on 3 August, when he was unable to get out of bed and walk unaided. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Kimberley Bingham
Acting Prisons and Probation Ombudsman February 2023

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