Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Wayne Spreckley, a prisoner at HMP Leeds, on 27 January 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Spreckley died from a bilateral pulmonary embolism (a blocked blood vessel in the lungs), whilst a prisoner at HMP Leeds. He died unexpectedly in hospital on 27 January 2022. He was 53 years old. I offer my condolences to his family and friends.

The clinical reviewer was satisfied that the standard of healthcare that Mr Spreckley received at Leeds was equivalent to that which he could have expected to receive in the community. However, she was concerned that staff did not radio a medical emergency code blue when he reported feeling unwell. This caused a delay in calling an ambulance and I share the clinical reviewer's view that the emergency response was not equivalent to that which Mr Spreckley could have expected to receive in the community.

I am also concerned that the prison did not notify Mr Spreckley's family of his condition when he was sent to hospital on 26 January and that a family liaison officer was not available during the night state to speak to Mr Spreckley's family after he had died.

I am also concerned that despite numerous requests, the prison did not provide the investigator with statements from healthcare staff in a timely manner. Statements are significant in understanding the timeline of events as fully as possible and are critical to our investigation.

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 **October 2023**

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Summary

Events

1. Mr Wayne Spreckley was sentenced to life in prison on 2 October 1998 for sex offences. He was released on licence in January 2020 but was recalled on 7 May for breaching his licence conditions. He was sent to HMP Leeds on 10 May.

2. At around 11.30am on 26 January 2022, prison staff radioed healthcare staff to tell them that Mr Spreckley was short of breath and had chest pains. They did not call a medical emergency code blue. A nurse attended to Mr Spreckley and took observations. His oxygen saturation levels when sitting were acceptable but showed a decrease to unacceptable levels when walking. She carried out an electrocardiogram (ECG, a test to detect heart problems and monitor the heart's health) and sent this to the prison GP later that day.

3. At 2.10pm, the prison GP reviewed Mr Spreckley's medical notes and the ECG. He considered that Mr Spreckley looked very unwell and asked the nurse to call an emergency ambulance to take him to hospital. The nurse requested an ambulance at 2.30pm and ambulance paramedics attended the prison.

4. Mr Spreckley was taken to hospital and died at 12.37am the next day.

Findings

5. The nurse carrying out Mr Spreckley's observations showed excellent clinical skills when she monitored his oxygen saturation levels both when he was walking and sitting. This meant that his low oxygen saturation levels were not missed.

6. There were missed opportunities to call a code blue when Mr Spreckley reported chest pains and difficulty breathing. This caused an unnecessary delay to Mr Spreckley receiving emergency medical treatment. While we cannot say if this would have affected the outcome for Mr Spreckley, in other emergencies, it could be critical.

7. When Mr Spreckley was taken to hospital on 26 January, a prison GP suspected that he had a pulmonary embolism or serious cardiac event. We are disappointed that Mr Spreckley's family was not informed of his serious condition.

8. We are concerned that a family liaison officer was not available during the night to speak to Mr Spreckley's family when he died.

9. We are disappointed that the statements of healthcare staff were withheld from the investigator, one for three months and one was not provided at all. This meant that it was difficult to determine the timeline of events when Mr Spreckley left for hospital on 26 January.

Recommendations

- The Governor and Head of Healthcare should ensure that where there are serious concerns about the health of a prisoner, staff should use an emergency code to

alert control room staff to call an ambulance immediately, in line with Prison Service Instruction (PSI) 03/2013.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.
- The Governor and Head of Healthcare should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with Prison Rule 22 and PSI 64/2011.
- The Governor should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.
- The Governor and Head of Healthcare should ensure that all evidence about a death in custody, including statements and electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

The Investigation Process

10. 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.

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

12. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Spreckley's clinical care at the prison.

13. The investigator, another PPO investigator, and the clinical reviewer interviewed three members of staff at Leeds on 2 March 2022.

14. We informed HM Coroner for West Yorkshire of the investigation. No post-mortem examination was carried out. He confirmed the cause of death was bilateral pulmonary embolism. We have sent him a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Spreckley's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no questions but asked about a payment to the chaplain for Mr Spreckley's funeral. We have addressed this query with Leeds and sent a letter to the family.

16. Mr Spreckley's sister received a copy of the draft report. She did not make any comments.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies, however they did request that some additional information was added to the report. The report has been amended accordingly.

Background Information

HMP Leeds

18. HMP Leeds is a local prison holding up to 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides health services, including clinical substance misuse and mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Leeds was in November/December 2019. Inspectors found that although Leeds faced many significant challenges, there had been an improvement in many areas since their last report. They viewed Leeds as a generally competent institution.

20. HMIP also carried out a short scrutiny visit at Leeds in June 2020 to look at issues of key importance to prisoners during the Covid-19 pandemic. They found that the prison was calm and well-ordered, despite the continuing and severe restrictions to the regime.

Independent Monitoring Board

21. 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. The IMB report for the year ending December 2020 found that prisoners were treated fairly and humanely.

Previous deaths at HMP Leeds

22. There were 23 deaths from natural causes (four of which were related to COVID-19), seven self-inflicted deaths, one drug-related death and one death awaiting classification at HMP Leeds in the two years before Mr Spreckley's death. There have been three further deaths since which are being investigated.

23. Following recommendations we made, Leeds agreed in October 2020 that a named family liaison officer should be nominated at all times to provide appropriate support to a prisoner's next of kin.

Key Events

24. On 2 October 1998, Mr Wayne Spreckley was sentenced to life in prison for sex offences. He was last released on licence on 6 January 2020.

25. On 7 May, Mr Spreckley was recalled to prison after breaching his licence conditions. Mr Spreckley was sent to HMP Leeds on 10 May.

26. At around 11.30am on 26 January 2022, prison staff called the healthcare emergency response radio. A medical emergency code was not called.

27. Nurse A was holding the healthcare emergency response radio that morning. In interview, she said she had received a call from an officer on the wing to say that Mr Spreckley was complaining of chest pains. She responded to the radio call and assessed Mr Spreckley. She noted that Mr Spreckley had had chest pains and had felt short of breath when he exerted himself for seven days. She completed his physical observations and calculated a National Early Warning Score (NEWS2) of 2. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above 7 indicates the need for an emergency response.) Nurse A measured Mr Spreckley's oxygen levels when walking and noted that they had dropped but then increased when he sat down. She carried out an ECG. Although she was not trained to assess the results in detail, she did not spot any obvious heart attack signs. She asked for a GP appointment that afternoon and sent the case to the healthcare handover meeting.

28. At 2.10pm, a prison GP reviewed Mr Spreckley's medical notes and the ECG handed over from Nurse A. He noted some abnormalities in the ECG and thought that Mr Spreckley might be having a serious cardiac event or a pulmonary embolism.

29. At around 2.20pm, the prison GP rang Nurse A and asked her to call Mr Spreckley an urgent response ambulance due to the possible pulmonary embolism. She radioed a Custodial Manager (CM) to inform her that Mr Spreckley needed to go to hospital and asked for escort staff to be arranged.

30. At 2.22pm, the prison GP sent an instant message on SystmOne (the electronic database for recording medical notes) to tell Nurse A that the ambulance should be a 'blue light' and that Mr Spreckley might be 'peri-arrest' (a period of time before or after a heart attack). He asked her to stay with Mr Spreckley until he went to hospital.

31. At 2.22pm, Nurse A sent an instant message which said, 'All sorted, thank you'. The investigator cannot know which one of these instant messages came first.

32. Nurse a then went to see Mr Spreckley. While on her way at approximately 2.30pm, the CM radioed her to ask if an ambulance had been called. She stopped to have a telephone conversation with the CM. She told the CM that she would ask for an ambulance and then she called the control room to request one. She then continued to Mr Spreckley's wing and remained with him until he left to go to hospital.

33. At 2.33pm, an officer in the control room telephoned the Ambulance Service. While on the phone to the ambulance, the officer reported that the doctor was querying 'cardiac', and that Mr Spreckley had 'shortness of breath'.

34. At 2.49pm ambulance paramedics arrived at Leeds. Shortly after the paramedics arrived, an officer arrived on the wing to escort Mr Spreckley to hospital. He noted that Mr Spreckley was talking and did not appear ill, however he seemed uncomfortable and out of breath walking to the triage room. He noted that Mr Spreckley was escorted to hospital in a wheelchair from that point onwards.

35. Before they left the prison, the paramedics recorded that Mr Spreckley was short of breath since 20 January which worsened on exertion and that he was experiencing central chest pains when mobilising. They recorded that the GP's ECG had detected abnormalities and there was a query of a pulmonary embolism. The paramedics completed their own observations and noted that Mr Spreckley was talking in full sentences and had a good colour. However, once Mr Spreckley took less than 40 steps to the medical room, the paramedics recorded that his respiratory rate increased, he became very short of breath and his oxygen levels dropped. Mr Spreckley scored as 'likely' and at 'moderate risk' of having a pulmonary embolism on an assessment they administered. The paramedics queried a diagnosis of COVID-19 or a pulmonary embolism.

36. At 3.57pm, the ambulance paramedics took Mr Spreckley to hospital.

37. On arrival at the hospital, escorting officers noted that Mr Spreckley was transported in a wheelchair. Whilst at the hospital, Mr Spreckley continued to eat and drink, and also had an x-ray and a CT scan.

38. At 10pm an officer contacted Leeds control room to explain that Mr Spreckley would be staying in hospital as the CT scan had found a blood clot in his vein. Mr Spreckley was given an injection of blood thinners.

39. Later that evening, Mr Spreckley asked to go to the toilet and stood up to walk there. On the way back at 11.43pm, Mr Spreckley became short of breath. Hospital staff attended to him. He then deteriorated further and collapsed. At this stage, the restraints were removed by the escorting officers to allow the hospital staff to administer treatment. Hospital staff began cardiopulmonary resuscitation.

40. At 12.37am on 27 January, officers at the hospital with Mr Spreckley told the control room that he had died.

Contact with Mr Spreckley's family

41. Following Mr Spreckley's death, the Head of Residence and Safety tried to contact a family liaison officer and find the contact details for his next of kin. The next of kin details in the prison records were incorrect. There was no family liaison officer available during the night and he was unable to contact anyone at home. He asked the police to visit Mr Spreckley's sister who was his next of kin.

42. At approximately 4.00am, the police arrived at Mr Spreckley's sister's address and informed her that Mr Spreckley had died.

43. Later that day, an officer was appointed as the family liaison officer and visited Mr Spreckley's sister at home to offer his condolences and support.

44. Mr Spreckley's funeral took place on 2 March 2022. Leeds contributed to the cost, in line with national instructions.

Support for prisoners and staff

45. After Mr Spreckley's death, the Head of Residence and Safety 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.

46. The prison posted notices informing other prisoners of Mr Spreckley's death and offering support. Staff did not review all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Spreckley's death. However, Listeners (prisoners trained to support their peers who are in crisis) offered support on the wing where Mr Spreckley lived.

Post-mortem report

47. A post-mortem examination was not conducted. A hospital doctor confirmed Mr Spreckley's death, and the Coroner accepted the cause of death as a bilateral pulmonary embolism.

Findings

Clinical findings

48. The clinical reviewer concluded that the care that Mr Spreckley received at HMP Leeds was of a good standard and equivalent to that which he could have expected to receive in the community. She said that the initial care he received when he said that he was short of breath allowed for the early identification of his clinical decline. She commended Nurse A on her excellent clinical skills to identify that Mr Spreckley's health was deteriorating. However, she concluded that there was a delay in requesting an ambulance due to staff not using a code blue and that this was not equivalent to that which Mr Spreckley could have expected to receive in the community.

Emergency response

49. The clinical reviewer has commended Nurse A for measuring Mr Spreckley's oxygen saturations on walking as well as on sitting as this exceeds standard practice. We support this commendation but note that if Mr Spreckley's walking saturation scores had been used to calculate his NEWS2 score, this would have increased his NEWS2 score from a 2 to 5 which would have prompted an urgent clinical review.

50. There were missed opportunities to call an emergency ambulance which caused a delay to Mr Spreckley's treatment. Chest pains and difficulty breathing are symptoms within the medical emergency protocol that require a code blue to be radioed. Witnesses described that Mr Spreckley did not appear very ill before he left for hospital, despite complaining of chest pains and difficulty breathing. His NEWS2 score was believed to be low and therefore staff did not immediately view him as someone who required a code blue. Had this been done, it would have triggered an emergency ambulance to be called earlier.

51. We asked Leeds to identify the officer who called healthcare to report Mr Spreckley's symptoms. They have not been able to do so. The officer did not record the incident in the wing observation book. We have therefore been unable to explore the nature of the symptoms at the time, however we know that Nurse A recorded that she was asked to see him because he complained of chest pains. We therefore cannot make a decision about whether the officer should have called a code blue at the time that Mr Spreckley explained his symptoms.

52. Later, Nurse A should have requested an ambulance immediately when the prison GP asked her to do so at 2.20pm, and again on instant messaging at 2.22pm. The GP told us that he expected the ambulance to be called in the next minute or so. The nurse told us that she did not request it immediately because there was a protocol which states not to call an ambulance until healthcare staff are on scene with the patient. She did not produce this protocol for the investigator.

53. Nurse A did not request the ambulance once on scene with Mr Spreckley. She called the control room to request an ambulance when walking between the healthcare unit and Mr Spreckley's wing, after the CM asked her if she had called it

yet. She did not inform the wing staff that she was calling an ambulance for Mr Spreckley, and this meant that the wing staff were not aware of the emergency.

54. PSI 03/2013 states that 'local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called'. The healthcare department's local operating policy requires the use of a code blue to call an emergency ambulance and does not require a member of healthcare staff to be with the patient before this happens.

55. We recognise that since the incident, Leeds have sent out a staff notice to remind staff of their responsibilities during medical emergencies. Leeds had however sent one out three months before this incident. It is therefore disappointing to see that staff were unaware of the symptoms that required a code blue to be called.

56. Leeds have provided statements from prison staff who describe that Mr Spreckley did not seem too unwell on the wing, however prison staff are not clinicians. Whether or not Mr Spreckley was able to walk around the wing whilst waiting for the ambulance, the prison doctor believed he was very unwell with either a pulmonary embolism or cardiac event and required emergency access to a hospital. It is clear that this was not communicated effectively between healthcare, operational and wing staff.

57. While we cannot conclude whether earlier treatment that day would have prevented Mr Spreckley's death, it is known that early treatment of a pulmonary embolism can reduce the mortality rate. We make the following recommendation:

The Governor and Head of Healthcare should ensure that where there are serious concerns about the health of a prisoner, staff should use an emergency code to alert control room staff to call an ambulance immediately, in line with Prison Service Instruction (PSI) 03/2013.

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Contact with Mr Spreckley's family

58. When Mr Spreckley was taken to hospital on 26 January, he was seriously ill with a suspected pulmonary embolism or cardiac event. We would have expected Leeds to update his family when he was taken to hospital, in line with PSI 64/2011.

59. In October 2020, Leeds updated local contingency plans about family liaison officers to reflect the agreement that a named deputy family liaison officer should be nominated at all times so they can provide the appropriate support in the absence of a family liaison officer. While we recognise that Leeds appointed a family liaison officer who visited the family following Mr Spreckley's death, it is disappointing that there was no family liaison officer available on call at night. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with Prison Rule 22 and PSI 64/2011.

The Governor should ensure that when a prisoner dies in custody, a trained deputy family liaison officer is promptly appointed to provide continuity of contact and support in the absence of the family liaison officer.

Providing the PPO with the relevant documents

60. PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Leeds did not supply the statements from healthcare staff in a timely manner. The investigator asked for statements from Nurse A and the prison GP at the beginning of the investigation. However, she was also told that since the death of a previous prisoner at Leeds, the healthcare department would not provide statements after deaths in custody as these had to go through Practice Plus Group's legal and inquest team before they could be released to the PPO. The investigator sent many follow-up emails in an attempt to get the statements, including to the Head of Healthcare and to the legal and inquest team. The legal and inquest team never replied.

61. Nurse A's statement was received over three months later and the prison GP's statement was never received. This adversely affected our investigation and meant that we found it difficult to determine the timeline of events when Mr Spreckley left for hospital on 26 January 2022.

62. In order to obtain an accurate and timely record of events, statements should be written by anyone involved in an incident, immediately following an event or, at least, within 24 hours. Statements should be a record of events, and therefore any changes made by a third-party months after the event may render a statement inaccurate. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all evidence about a death in custody, including statements and electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

Inquest

63. The inquest into Mr Spreckley's death concluded on the 14 February 2022. The coroner confirmed that Mr Spreckley died of natural causes.

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