

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Leeds,
on 7 January 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

January 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Leeds. The man died in his cell on 7 January 2009, shortly after having been found collapsed by his cell mate. He was 68 years old. The cause of death was found to be ischaemic heart disease (a lack of oxygen to the heart muscle) and cardiomegaly (an enlarged heart) with a secondary condition of fibrosing lung disease and bronchopneumonia.

I offer my sincere sympathy and condolences to the man's family and all who have been affected by his loss. I must, however, apologise to his family for the delay to issuing this report.

The investigation was carried out by my colleague. An independent review of the man's medical care in prison was carried out by the local Primary Care Trust. I am most grateful to the clinical reviewer for his assistance.

I would also like to thank the Governor and staff of Leeds for their co-operation during the course of the investigation. My particular thanks go to the safer custody team for their work in liaising with the investigator.

My investigation found that the man who died received a high standard of medical care whilst at Leeds. However, it is apparent that there were occasions in which his medication was not available to collect when he needed it. Although this would not have adversely affected his health whilst in prison, I recommend that a review of dispensing is undertaken. I make one further recommendation, regarding the appointment of family liaison officers at Leeds.

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

Jane Webb
Deputy Prisons and Probation Ombudsman

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SUMMARY

The man who died was remanded into custody at HMP Leeds on 7 July 2008. He had several long standing health problems affecting his heart and lungs, for which he took various types of medication. On account of these problems, he spent his first two months in prison living in the healthcare inpatients' wing for observation and assessment.

Following an exacerbation of his symptoms, the man was admitted to the local hospital for a week in mid August. In the month after discharge his condition stabilised and, by mid September, he was well enough to move to a ground floor cell on A wing.

The man's first three months on A wing were largely uneventful. However, he found it difficult to walk the long distance from A wing to healthcare and became out of breath quickly. Both the man and his personal officer spoke to healthcare staff in December to enquire whether he could be seen in his cell rather than in healthcare, to spare him the walk. However, prison doctors thought it was better for his heart and lung conditions that he continue to exercise where possible.

On 17 December, the man submitted a complaint form in which he said that his warfarin (medication he took to prevent blood clots) was never ready to collect when he needed it. He therefore missed a day of medication when he was due a new batch of warfarin. The healthcare manager asked a member of staff to investigate this complaint. However, due to an apparent breakdown in communication, the complaint never reached the assigned investigator. The man's records indicate that there were some occasions in which he did not receive new warfarin until a day or two after his previous batch was due to expire. My report recommends that the arrangements for dispensing medications are reviewed.

Shortly after 8.00am on 7 January 2009, the man was found collapsed by his cell mate. Over the next 20 minutes, staff attempted to resuscitate him. Sadly, their efforts were unsuccessful and he was pronounced dead by a prison doctor at 8.22am. The main cause of death was later established as ischaemic heart disease and cardiomegaly.

In the weeks following his death, one of the man's daughters complained to the prison about the conduct of the appointed family liaison officer, Senior Officer (SO) A. She said that SO A was not returning her calls and had made several promises to contact her that she had not kept. In order to protect relations with the man's family, a new family liaison officer was appointed by the prison in April 2009. SO A's usual place of work at the prison is reception, a very busy and demanding environment in a large local prison such as Leeds. I recommend that the Governor consider appointing family liaison officers who work in areas in which they can contact the bereaved family more easily.

THE INVESTIGATION PROCESS

1. The investigation was opened on 7 January 2009 when the investigator, issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to the investigator. No prisoners or staff came forward as a result.
2. The investigator was given access to the man's prison files, including the medical record. He visited Leeds on 21 April and 28 April, interviewing four members of staff and one prisoner during the course of the investigation.
3. An independent clinical review of the man's health care whilst he was in custody was carried out by a doctor on behalf of the local Primary Care Trust. A doctor accompanied the investigator on 28 April, a visit which included an interview with a prison doctor.
4. One of the Ombudsman's family liaison officers contacted three of the man's daughters to inform them of the investigation and give them the opportunity to raise any questions or concerns they had about their father's death. The family liaison officer spoke to the first of the man's daughters on 3 February 2009. She told the family liaison officer that she had seen her father just before Christmas recalled that he was "fine" but had lost some weight.
5. The family liaison officer spoke to another of the man's daughters on 4 February. She raised the following issues with the family liaison officer:
 - Her sister had visited their father in December 2008. During the visit, the man said that he had collapsed on 11 December and had to be resuscitated.
 - She had heard several different versions of the events of the morning of 7 January 2009, when her father died. The man's daughter asked that the report tells her what happened that morning, including how her father was discovered and the timings of events.
6. The family liaison officer spoke to the third daughter on 6 February. She raised the following issues that she wished the investigation to address:
 - Her father wrote to her in December 2008 and said he had collapsed on a Thursday on the way to hospital. He had keeled over on the way to the ambulance and had to be resuscitated before he got there.
 - On a visit in December, the man was "visibly puffing and panting". He used a spray more than once on the visit. His daughter asked

what the spray was used for and stressed that the investigation should look at the standard of healthcare received by the man.

- Her father had received a threat from his sister's husband. This may have added to his stress levels.
 - She had been told by the prison's family liaison officer that she would contact her after her father's funeral to arrange a visit to the prison. This never happened. She also said that she had left messages for the prison's family liaison officer but had received no response. The man's daughter contacted the Ombudsman's family liaison officer again several weeks later and said that she was still having problems with the prison's family liaison officer not returning her calls.
7. I hope that this report helps to clarify any issues that might remain unclear for the man's children and helps them to better understand what happened in the time leading to his death.

HMP LEEDS

8. HMP Leeds is a category B local prison serving courts in West Yorkshire. At the time of the man's death, the prison had an operating capacity of 1,004 across six wings. The man lived on A wing, the vulnerable prisoners' unit (VPU, a wing for those who request to be separated from other prisoners for their own safety), for most of his time at Leeds.
9. During his first two months at Leeds, he lived as an inpatient in the prison's healthcare centre. There are 24 beds in the healthcare centre, with provision for those with both physical and mental health needs. Healthcare at Leeds is provided by the local Primary Care Trust.
10. Leeds was last inspected by HM Chief Inspector of Prisons, in December 2007. She found that Leeds had some significant problems and was underperforming in several key areas. However, there had been progress in all areas and managers were seeking to introduce further improvements.
11. Half of those prisoners surveyed by the Inspectorate felt that health services at Leeds were either good or very good. However HM Chief Inspector of Prisons identified several areas for improvement. Among these, she felt that waiting times to see a prison doctor were too long. She also noted that not all healthcare staff had received resuscitation training in the last 12 months.
12. In their annual report for 2009, the prison's Independent Monitoring Board commented that the healthcare team had improved the service provided to prisoners over the course of the previous year. They reported that healthcare was a "well managed and forward thinking department".
13. The Ombudsman investigated four deaths in custody at Leeds in 2008, of which three were due to natural causes. There have been a further three deaths at the prison since the man died, one of which was due to natural causes. One of the investigations in 2008 involved a man who collapsed and died suddenly whilst living on A wing. The clinical review in that case was also conducted by Dr J. He recommended that prisoners identified as being at high risk of cardiovascular disease should be managed in line with nationally agreed standards of care. This recommendation was accepted by the Prison Service, to be taken forward as an element of the prison's chronic disease management plan.

KEY FINDINGS

14. At the time of his imprisonment, the man had an extensive medical history. This included a condition known as congestive cardiac failure, whereby the heart struggles to cope with any strain put on it (caused by an insufficient oxygen supply to the heart), which usually leads to shortness of breath on exercise. The man was taking the medications frusemide and spironolactone to treat this condition.
15. As a result of the lack of oxygen to his heart, the man also suffered frequent angina pains. He therefore carried GTN spray (glyceryl trinitrate spray) with him, which is used by angina sufferers to relieve pain. As well as this he suffered from an irregular heartbeat (a condition known as atrial fibrillation). This particular condition can lead to the formation of a blood clot in the heart and therefore increase the risk of a stroke. As a result of this the man took warfarin. Other medications taken by the man in relation to his heart disease were digoxin (to control the heart rate) and simvastatin (to reduce cholesterol).
16. The man also suffered from chronic obstructive pulmonary disease (COPD, a disease of the lungs in which the airways are narrowed), as a result of which he regularly used inhalers and a nebuliser (a device similar to an inhaler whereby medication is breathed in as a mist through a mouthpiece or mask. Nebulisers are used to treat more severe symptoms than an inhaler). Additionally, the man had previously been exposed to asbestos, which also affected his lungs and led to increased shortness of breath.
17. Following his arrival at HMP Leeds on 7 July 2008, the man was assessed by a nurse for a first reception health screen (a routine health screen for all new arrivals into prison). His medical history, as outlined in paragraphs 14-16, was recorded. The nurse also recorded that he had reduced mobility and had previously used a scooter to travel. On account of his numerous health problems, the nurse arranged for him to be admitted to the healthcare centre's inpatients' wing for observation and assessment.
18. The man who died attended court the following day. In his absence, his medication was confirmed with his pharmacist in the community and the prescription chart was written and signed by a prison doctor. He remained on the inpatients' wing following his return from court. Various blood tests were carried out on 9 July, none of which showed anything unusual.
19. On 11 July, the man was reviewed by a prison doctor. His International Normalised Ratio (INR, a blood test used to check the effectiveness of warfarin) was taken and found to be slightly lower than the normal range. As a result the prison doctor increased the dose of warfarin from 5mg to 5.5mg.
20. A week later, the man was sick in his cell and said that he felt dizzy. The following day he had to use a nebuliser to help him breathe. It was also

noted that minimal exertion left him breathless. On 24 July, he had to use the nebuliser twice to help him breathe. It was reported on the same day that he was able to walk around by himself and could care for himself without assistance. The following day, the man's INR was higher than the normal range. The prison doctor therefore reduced his dose of warfarin to 4.5mg.

21. Towards the end of the month the man developed oedema (swollen legs due to fluid retention), a condition that often develops in patients with congestive cardiac failure. As a result the prison doctor increased the man's dose of frusemide, the medication he took to control oedema. The swelling in his legs caused him difficulty walking so it was decided that he should remain an inpatient for the time being.
22. The man continued to experience swollen legs in early August. He asked for a wheelchair to move about the wing, but was advised by healthcare staff that it was better for him to try to keep walking as much as he could. His warfarin dose was reduced further, to 4mg, on 8 August.
23. In the early hours of the morning of 12 August, the man experienced chest pain for several hours. He used his GTN spray, but this had no effect. Later that morning he was reviewed by a prison doctor, who queried whether he may have suffered a heart attack. She arranged for the man to be admitted to the local hospital for investigation and monitoring.
24. The man was discharged from hospital on 18 August. He had been diagnosed with an exacerbation of his heart and lung disease. The discharge letter sent to the prison reported that he had "responded to standard treatment". His warfarin prescription was increased to 5mg by the consultant cardiologist (heart specialist).
25. In the month following his discharge from hospital, the man's health stabilised. He still experienced some breathlessness and was advised to stop smoking and walk round the exercise yard during association. He started to use nicotine patches on 7 September, and occasionally used his nebuliser if he was feeling breathless.
26. By 16 September, his condition had stabilised to the extent that he was able to move out of healthcare to a cell on A wing. He was allocated a cell on the ground floor of the wing and staff were advised that he did not need any assistance to care for himself. A risk assessment was carried out which concluded that he would be given his medication on a weekly basis to keep in his possession and use as prescribed.
27. The man attended education classes during his time on A wing. He was reported by the tutor to co-operate very well in class, work hard and communicate well with the group. His cell mate said that the man got on well with other people on the wing and would usually come out during association and either sit and chat or play pool.

28. After ten days on A wing, the man's INR reading was higher than previously. His warfarin prescription was therefore reduced to 4mg by the prison doctor. Over the following weeks, his INR was checked regularly. Each reading was within normal limits and the prescription therefore remained at 4mg.
29. He attended an asthma clinic on 25 November, at which the nurse observed that he had a poor technique with his inhaler. She advised him how to use it properly. A week later, he refused to attend for an INR reading. The reason for this refusal is not recorded.
30. On 12 December, Officer A spoke to a prison nurse, about the man's mobility. Officer A was his personal officer on A wing. (Each prisoner is assigned an officer on their wing who they can approach first with any problems.) He told the prison nurse that the man became very breathless when he walked back from healthcare, and asked if there was any other way he could be seen. The prison nurse said that she would discuss this further with her colleagues.
31. Officer A described to the investigator the route that the man who died took to healthcare. It involved walking up three flights of stairs to the top floor of A wing, across to C wing, down three flights of stairs on C wing and then a walk of around 250 yards to the healthcare centre. He recalled that on one occasion he was "really, really struggling ... he was really gasping" on his return from healthcare. It was this that prompted Officer A to speak to the nurse.
32. The man submitted a complaint form on 17 December. He complained that his warfarin was never ready to collect when he needed a new batch. This meant, he said, that he always missed a day of treatment when his warfarin ran out. He said this had been going on throughout his time at Leeds.
33. The following day, he spoke to the prison nurse to follow up Officer A's query of 12 December. He asked if he would be allowed to have medical staff visit him in his cell, rather than having to walk to healthcare and back for appointments. He was told that the situation had been discussed with the prison doctor, whose view was that it would "do him good" to walk over to healthcare. The man queried this and said he was becoming breathless and dizzy on the walk to and from healthcare. The prison nurse said she would discuss the situation further with the prison doctor.
34. Later that morning, the prison nurse spoke to the prison doctor and another prison doctor. They both agreed that, in view of his COPD, the man should continue exercising, but should be encouraged to go at his own pace. At interview with the investigator, the prison doctor explained the reasons behind his decision:

"We try to encourage people to come to us if it's at all possible because there's good evidence in the long term management of obstructive lung

disease that exercise is good for you, prolongs life and maintains respiratory function. It's also well documented in cases of heart disease to get regular exercise ... We felt that [walking to healthcare and back from A wing] was overall beneficial for him, certainly having seen him on his arrival in healthcare he didn't seem to be performing too badly."

35. On 22 December, the healthcare manager replied to the man's complaint form submitted five days previously. His reply consisted of the following:

"I feel that this situation does need to be reviewed and you should be given an explanation as to why this apparently keeps happening. Therefore I have asked the matron to investigate this complaint and offer you an explanation."

The investigator spoke to the matron about the man's complaint. She said she had no recollection of being asked to carry out an investigation.

36. At an appointment with the prison doctor on 24 December, the man repeated his complaint that he did not get warfarin every day. The previous day, his INR reading had been lower than usual although he told the doctor that he did not want to increase his warfarin dosage. The prison doctor noted that they would try to get warfarin to him every day and check this in a week. (There is no record of any check taking place, nor of the man making any further complaints about missing medication.)
37. The next INR reading was taken on 6 January 2009. The level was normal and no change was made to his prescription. At around 4.30pm that afternoon, an officer unlocked the man's cell for the evening meal. He told the officer that he did not feel very well and was not hungry. He did not say what symptoms he had. The officer told the investigator that he looked the same as usual and was able to hold a normal conversation. She added that she had no concerns about his health and did not think it was necessary to call healthcare. It does not appear as though the man raised any further concerns about his health during the night.
38. At around 7.30am the following morning, Officer A unlocked the man's cell so that his cell mate could collect his own medication before going to work. Officer A spoke briefly to the man's cellmate and added that he did not see the man, but had no reason to be concerned about him.
39. Around half an hour later, Officer B returned to the cell to let the man's cellmate out to go to work. He shouted to the man's cellmate that it was time to go to work and moved onto the next cell. Officer B told the investigator that he did not open the door and therefore did not see the man.
40. The man was sitting in the cell toilet when his cell mate got up. His cellmate went in and realised that the man was not moving. He told the investigator that he touched him and thought that he was dead. The

man's cellmate left the cell and shouted to the nearest member of staff, Officer C, that the man was "sat on the toilet dead".

41. Officer C went into the cell, followed by Officer A, and shook and spoke to the man. He got no response and therefore left the cell and shouted to Nurse A to assist. The nurse was on duty on A wing that morning to distribute medication to prisoners. She went to the cell immediately.
42. The two officers moved the man to the floor and Nurse A made a 'code blue' call for assistance on her radio. (Code blue is an emergency code used in several prisons to indicate that urgent assistance is required for a prisoner who is having severe breathing difficulties or who has stopped breathing.) The control room log records that this call was made at 8.05am.
43. Nurse A then checked the man for a pulse, but could not find one. She also observed that he was not breathing. Nurse A immediately began cardio pulmonary resuscitation (CPR) with the assistance of Officer Y, who had arrived at the cell shortly after her. At the same time, she asked the other officers present to request an ambulance. Officer A made the call. The control room log records that an ambulance was called at 8.08am.
44. Shortly afterwards, Nurse B arrived at the cell in response to the earlier 'code blue' call for assistance. After assessing the situation, she left to go to the centre (a central area from which the main wings lead off) to collect the emergency bag, containing resuscitation equipment and a defibrillator. On her return, Nurse B took over CPR from Nurse A, who attached the defibrillator to the man. The defibrillator advised that they should continue with CPR and give no shock, as there was no electrical activity in the heart.
45. At around 8.12am, another officer and two prison doctors arrived at the cell. The officer took over CPR and applied an oxygen bag and mask. The nurses took turns to give chest compressions. The prison doctor administered adrenaline and, shortly afterwards, atropine (medications used to try to start the heart beating).
46. The defibrillator was attached again and, as previously, the advice was that no shock could be given. After concluding that their resuscitation attempts were going to be unsuccessful, the prison doctor pronounced the man's death at 8.22am. The paramedics arrived in the cell around one minute later and confirmed this. A post mortem report later found the cause of death to be ischaemic heart disease (a lack of oxygen to the heart muscle) and cardiomegaly (an enlarged heart) with a secondary condition of fibrosing lung disease and bronchopneumonia.
47. As the man had not provided details of his next of kin to reception staff, his visits record was used to establish to whom the news of his death should be broken. His most recent visitor was one of his daughters, who

had visited on 22 December 2008. The appointed family liaison officer, Senior Officer (SO) A, along with the deputy family liaison officer, SO B, and their manager, Governor A visited the man's daughter around three hours after his death. His daughter broke the news of his death to other family members. His sister was informed over the telephone by SO A the following morning.

48. The man's funeral was held on 28 January and was attended by SO A and SO B. The investigator found that the prison's contribution to the funeral costs was in accordance with PSO 2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).
49. As well as not naming any next of kin, the man did not leave a will. As such, it was for the Probate Service to determine who the executor of his estate should be, by issuing a letter of administration. Until this process is complete, the prison cannot hand over any of his money or property. At the time of writing this report a letter of administration had yet to be issued.
50. In April 2009, SO A was replaced as family liaison officer by Governor A. One of the man's daughter's had written to the prison to express her unhappiness at the contact she had had with SO A. She told the Ombudsman's family liaison officer that SO A had not returned her calls and had made promises to contact her which she did not keep.
51. Governor A told the investigator that the prison understood the complaint to be that SO A had been speaking to other members of the family and given out property inappropriately. She also thought that some members of the family wanted SO A to apply for the letter of administration, which was not her role. Although she supported SO A and did not think she had acted inappropriately, they felt that it was best to make a fresh start and appoint a new family liaison officer.

ISSUES

Warfarin prescription

52. On account of his heart condition, the man who died had been taking warfarin for some time prior to coming into prison. The medication was used to thin his blood and stop clots forming. During his time in custody, his INR reading was taken regularly. When this reading fell outside acceptable ranges, his warfarin dose was adjusted accordingly.
53. In December 2008, the man submitted a complaint form in which he said that his prescription was never ready to collect when he needed it. This meant that he missed a day's medication with each batch of warfarin received. He was told that a member of healthcare staff would be asked to investigate. However, due to an apparent breakdown in communication, the identified nurse was never asked to take this forward.
54. The man's dispensing records show that he was given a 14 day supply of warfarin on 1 December 2008. He was next dispensed warfarin on 17 December, the same day that he submitted his complaint form, some 16 days since his previous batch was received. There are similar discrepancies between the supply of warfarin dispensed to the man and the time until he collected his next batch in both October and November 2008. After he submitted his complaint form, he collected his warfarin every week with no further discrepancies.
55. The prison doctor told the investigator that it was a "very common problem" for prescriptions to go missing in prison. He explained the impact of missing a day of warfarin as follows:
- "I think if you miss a day of warfarin it probably won't make very much difference because it's quite a long acting drug ... [missing] a day or maybe even two is probably not going to have a massive impact clinically. Although clearly it's undesirable that anyone should miss any medication it's very, very difficult to legislate for all the things that seem to go wrong in prison practice. Due to a shortage of nursing staff who were competent to deal with warfarin I did dramatically reduce the numbers of patients who were maintained on it at some point last year. But the man, having been well established on warfarin, we kept him on it."
56. The clinical reviewer considers the man's missing warfarin:
- "I do not consider this to have been a serious problem or contributing adversely in any way to the man's health whilst in prison. I base this on the fact that he had very regular INR blood tests to monitor the effectiveness of the warfarin therapy and these results ranged between 2 and 4 – the usual acceptable standard ... The last INR dose test was entirely satisfactory at 3.2. This was measured the day before his death. My opinion is that his warfarin therapy was managed

appropriately and except for the occasional missed dose this was to a high and acceptable standard.”

57. However, the clinical reviewer goes on to make the following recommendation, which I support:

A review should be held of medicines management and the dispensing of important medications, such as warfarin, so that any missed doses are immediately recognised and that the likelihood of this happening is reduced.

58. Following the death of the man, NHS local Community Healthcare carried out an internal serious incident investigation. They made the following comment on the Ombudsman’s draft report:

“Whilst agreeing with the [Ombudsman’s] findings that the man did not always receive his medication on the date that it was due, [our] investigation found that this was due to a ‘mixture of patient and system factors’. Patient factors identified the patient had on occasions willingly not engaged with healthcare staff to pre-order a repeat prescription as per the local renewal of in possession medication process.”

Mobility

59. One of the man’s daughters told the Ombudsman’s family liaison officer that her father had said during a visit that he had collapsed on 11 December 2008 and had to be resuscitated. Another daughter told the Ombudsman’s family liaison officer that her father had written to her in December 2008 and said he had collapsed on a Thursday on the way to hospital. (11 December 2008 was a Thursday.) He wrote that he had “keeled over” on the way to the ambulance and had to be resuscitated before he got there.
60. The man’s medical record does not show any hospital appointments or emergency admissions in December 2008, nor is there any indication that he had to be resuscitated at any time before 7 January 2009. None of the staff to whom the investigator spoke were aware of him collapsing and needing resuscitation in December 2008.
61. It is likely that the events raised by the man’s daughters are linked to the request made to healthcare by Officer A on 12 December. Officer A advised that the man became very breathless on the walk from healthcare to A wing, and asked whether there was any other way that he could be seen, such as in his cell. The issue was discussed by the prison doctors, who agreed that it would be beneficial for the man to continue exercising. The prison doctor’s reasons for this decision are outlined in paragraph 34. It was not felt to be in his best interests for him to have his medical appointments in his cell.

62. The clinical reviewer makes the following comments in the clinical review, with which I agree:

“The clinical care of the man during his time in custody was to a high standard and certainly equivalent if not better to the care that could have taken place in a community setting. I have no reason to believe that anything could have been done differently prior to [his death] in terms of care of his long term conditions that would have prevented the unfortunate outcome.”

The man’s health during a visit in December 2008

63. One of the man’s daughters told the Ombudsman’s family liaison officer that he was “visibly puffing and panting” during a visit in December and used a spray on more than one occasion. She asked what the spray was used for and requested that the investigation explore the standard of healthcare received by the man at Leeds. His daughter also said that he mentioned during a visit that he had been threatened by his sister’s husband. She wondered whether this might have added to his stress levels.
64. On account of his COPD, the man regularly used inhalers and nebulisers. Given his daughter’s description of him “puffing and panting”, it is probable that it was one of these devices that he used during the visit.
65. His daughter also questioned whether a threat he had allegedly received may have contributed to his stress. There is no evidence of him reporting any threat to prison staff, nor of him saying he felt stressed for this reason.
66. The clinical reviewer comments on the standard of medical care received by the man at Leeds. He considers that he was “well assessed and cared for” during his first two months in prison, when he was an inpatient in the healthcare centre. He goes on to say that, following his move to A wing, he received “appropriate” care for his medical conditions. As I have noted in paragraph 62, the clinical reviewer concludes that the medical care received by the man at Leeds was to a “high standard”.

Collapse on 7 January 2009

67. The post mortem report found that the main cause of the man’s death was a lack of oxygen to the heart and an enlarged heart. The clinical reviewer describes the events as follows:

“The man appears to have suffered a sudden and complete loss of cardiac [heart] output causing a collapse and unconsciousness. Irreversible damage to major organs leading to death would have occurred within a few minutes of this collapse. Unless the heart can be restarted within the first few minutes, and then sufficient cardiac output maintained by further medical intervention, death is an inevitable outcome.”

68. Staff were alerted to the man's collapse by his cell mate, shortly after 8.00am on 7 January. A nurse was on the wing at the time and went immediately to his cell. On her arrival, the nurse made an emergency coded radio call for medical assistance. She then began to try to resuscitate him. Whilst it might also have been appropriate to request an ambulance at this stage, there was just a short delay of around three minutes until the nurse did so. In any case, the prison doctors arrived at his cell at around 8.12am, around ten minutes before the paramedics, and administered drugs to try to restart his heart. A defibrillator was also applied but indicated that no shock could be given at any time.
69. The clinical reviewer makes the following comments on the resuscitation attempt, with which I agree:

“It is my opinion that the procedures for dealing with a medical emergency on A wing appear to have been followed correctly and there was an adequate response in terms of appropriate numbers of the trained personnel arriving in a timely fashion to try to resuscitate the man. The manner of resuscitation was clearly appropriate and of a sufficiently high standard.”

Contact with the man's family following his death

70. It is unfortunate that I have to report that relations between the prison and some members of the man's family were strained following his death. One of his daughters told the Ombudsman's family liaison officer that the prison's family liaison officer, SO A, had made promises to contact her which she did not keep. She said SO A had said she would telephone her after the man's funeral to arrange a visit to the prison, but had not. She also said that she had left messages for SO A but her calls had not been returned.
71. SO A told the investigator that she did not recall agreeing to telephone his daughter after the funeral, nor did she think she had failed to return any calls. The prison's family liaison manager, Governor A, told the investigator that they understood the complaint to be related to SO A speaking to other members of the family and handing over property. The disagreement was apparently resolved in April 2009, when Governor A appointed a new family liaison officer. She told the investigator that she supported SO A and did not think she had acted inappropriately, but thought it was best to make a fresh start.
72. This was not an easy case for SO A to work on. She found herself dealing with a divided family and was therefore required to keep in contact with several family members. At times she found herself speaking with up to half a dozen different relatives about the same information.
73. I am unable to determine whether there were any instances when SO A failed to return calls or messages to the family. Her usual role at the

prison is as a senior officer in reception. In a large local prison such as Leeds, this can be a very busy and demanding environment. SO A does not have her own telephone and messages have to be left with other members of staff. Although I am unable to say whether this did happen, given the nature of her place of work, it would not be surprising if some messages did fail to reach their intended recipient.

74. In several prisons at which the Ombudsman has undertaken investigations, the family liaison officer carries a mobile telephone. This enables the bereaved family to contact them quickly and efficiently. For security reasons, this would not be practical in all areas of a prison. At the very least, however, I would expect a family liaison officer to have their own direct dial telephone, with voicemail service. Whilst I do not intend any personal criticism of SO A, I am not persuaded that a busy reception area is a suitable place for a family liaison officer to work.

The Governor should ensure that family liaison officers work in an environment in which they can be easily and directly contacted by the bereaved family.

CONCLUSION

75. The man who died was an older prisoner with several long standing health problems. On account of these conditions, he spent his first two months at Leeds living on the healthcare inpatients' wing. Once his health improved, he was able to take a cell on the ground floor of the vulnerable prisoners' unit (VPU). He raised two concerns about his health whilst living on the VPU. Firstly, that the walk to healthcare left him very breathless and, secondly, that his warfarin prescription was never ready to collect when he needed it.
76. My investigation found that the man received a high standard of medical care whilst in prison and that the decision of the prison doctors to continue to ask him to attend healthcare when he had an appointment was reasonable. However, it appears that there were indeed some occasions in which he went without warfarin for a day or two. Although the clinical reviewer considers that this did not adversely affect his health, he recommends that a review of medicines management is held at Leeds.

RECOMMENDATIONS

1. A review should be held of medicines management and the dispensing of important medications, such as warfarin, so that any missed doses are immediately recognised and that the likelihood of this happening is reduced.

Accepted – from a wider view of medicines management implemented by healthcare, three initiatives have been implemented that have improved access to medication services for patients:

- All prescription repeat requests are now sent to pharmacy at least 72 hours prior to the due date for renewal. This reduces the risk of the medication not being back on the wings by the date required.
 - The skills mix of staff delivering the medication administration services has been reviewed with pharmacy technicians now managing treatments on the wings. This improves governance through; clearer clinical communication pathways from treatments to pharmacy, pharmacy technicians expertise and competence in medication administration and through introducing community pharmacy systems and standard operating procedures.
 - A daily check of prescriptions not collected at the end of treatments is now carried out by pharmacy technicians, who follow up patients to ascertain the reason for non collection and initiate any clinical corrective action required.
2. The Governor should ensure that family liaison officers work in an environment in which they can be easily and directly contacted by the bereaved family.

Accepted – family liaison officers are not always on duty but there is a dedicated telephone line on which families can leave a message for the family liaison officer. This is given by the family liaison officer to the family during their first contact along with their work extension number. Messages are checked daily then passed onto the family liaison officer. Every family liaison officer now has a deputy to cover if they have to be absent for any reason.