INVESTIGATION INTO THE DEATH OF A MAN ON 21 JANUARY 2005 WHILST IN THE CUSTODY OF HMP LEEDS

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

SEPTEMBER 2005

This is the report of an investigation into the death of a man who died from natural causes at the Leeds General Infirmary on 21 January 2005.

The man who is the subject of this report had been remanded into custody on 16 December 2004. He was held at HMP Leeds and it was there that he was taken ill on 29 December and then transferred to hospital.

This investigation has been undertaken by one of my investigators. I would like to thank the Governor of HMP Leeds and his staff for their participation in this investigation. A doctor from Leeds (West) Primary Care Trust was commissioned to undertake a review of this man's care, and I appreciate his assistance. I was pleased to learn that the man's clinical care was appropriate and his transfer to hospital timely.

The loss of a loved one is always distressing. I would like to add my condolences to the man's family to those already expressed by my Family Liaison Officer.

This report includes one recommendation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **September 2005**

CONTENTS

Summary	**3**
Background	**4**
HMP Leeds	**5**
Conduct of investigation	**6**
Key findings	**7**
Recommendations	**9**

Summary

1. The man was born in 1963 and was 41 years old when he died from natural causes in Leeds General Infirmary on Friday 21 January 2005.

2. He arrived at Leeds on 16 December 2004. He was remanded into custody after committing a robbery, while released on licence. At his First Reception health screen, it was noted that he had a number of health problems and that he had recently suffered a cerebro-vascular accident (a stroke).

3. On arrival at Leeds, he was admitted to the healthcare centre and it was there that he was discovered collapsed in his cell during the morning of 29 December. Later that day, when his condition deteriorated, he was transferred to Leeds General Infirmary where he was later diagnosed as having a malignant brain tumour.

4. Whilst an in patient at the hospital, a bedwatch was carried out by prison officers. Due to the seriousness of his medical condition, and as it was considered he was no further risk to the public, physical restraints were not used. In the light of his physical deterioration, the prison were investigating whether he could be granted early release. They were in the process of liaising with probation and social services to try to achieve this, but unfortunately he died in the hospital before this could be achieved.

5. The clinical review carried out and concludes that the man's care whilst in prison was appropriate and of a good standard. The doctor who carried out the review also considers that the man's referral to Leeds General Infirmary was appropriate and timely.

6. My office was not informed about the man's death until 23 May 2005. This was after the prison received an enquiry from the Coroner's officer about progress on the investigation. My investigator immediately made contact with the prison and formally opened this investigation.

7. On 17 June 2005, one of my Family Liaison Officers contacted the man's family. This was to give them the opportunity to meet with her and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that they would like explored and addressed.

Background

8. The man was born in Yorkshire in 1963. He was one of three children. He had an older brother and younger sister. In 1965 his family moved to the United States of America and lived in Brooklyn, New York.

9. The man returned to the United Kingdom in 1994, married two years later and lived a settled life with regular employment. After his marriage broke down, he started to have debt problems. This resulted in him getting into trouble with the police and led to him serving a custodial sentence of three years.

10. He was released on licence in April 2004 and went back into employment. During the following summer, he started to become ill. He had seizures and subsequently suffered a cerebro-vascular accident in October.

11. On 14 December, when the mental health crisis team visited him at home, he disclosed that he had been involved in a serious criminal incident. As a result, the police were called and he was arrested. He appeared at Bradford Magistrates' Court on 16 December and was remanded into custody at Leeds.

HMP Leeds

12. The main part of Leeds prison was built in 1847. It is one of the largest local prisons in the country. The prison comprises six wings and a healthcare centre. It takes all adult male prisoners remanded from the West Yorkshire area until trial, and convicted prisoners for short periods following sentencing.

13. The healthcare centre at Leeds can accommodate 55 patients. It provides a 24 hour comprehensive primary care service and has provision for secondary care and treatment in a range of hospitals in the surrounding area. The relationship between patients and staff is described as good.

14. It should be noted that the man was transferred to the Leeds General Infirmary on 29 December and only spent fourteen days in the prison before he was transferred to hospital as an in-patient.

Conduct of the investigation

15. There was a delay before the Prisons and Probation Ombudsman's office was notified of this man's death and so the investigation was not opened until 25 May. My investigator studied all the relevant prison records relating to the man. These included his main prison record, Inmate Medical Record and the Bedwatch Logs covering the period he spent in hospital between 29 December and 21 January. My investigator also studied instructions at Leeds on the arrangements to be followed when prisoners are escorted outside the prison.

16. A Clinical Review of the care of the man whilst in custody was commissioned from Leeds (West) Primary Care Trust. I am grateful to the doctor for undertaking this review in a prompt and timely manner.

17. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and my investigator requested a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

18. One of my Family Liaison Officers contacted the man's family. They did not raise any concerns about his care and treatment at HMP Leeds.

19. My investigator visited Leeds and discussed aspects of the man's care with staff. The Primary Care Trust found that his clinical care was appropriate and his transfer to hospital timely. However, I do have concerns about the completion of the Bedwatch Logs and make a recommendation concerning this.

Key Findings

20. The man arrived at Leeds prison on 16 December 2004. During his initial health screen interview he told staff that he had poor health and, as staff were concerned for his well being, they admitted him to the healthcare centre for an assessment period. As he had previously threatened to harm himself, he was placed on an open F2052SH (Self-Harm) observation regime. The cell sharing risk assessment assessed him as high risk and so he was placed in a single occupancy cell.

21. On 21 December, after being reviewed by medical staff, he was considered fit for normal location and was moved into the main prison. At this stage, the F2052SH remained open. On 24 December, he was reviewed again by medical staff and, due to his continued ill health, was subsequently re-admitted to the healthcare centre.

22. On 29 December at 8:30am, he went to collect his medication and a Nurse noticed that he appeared to be unsteady on his feet. She decided to carry out thirty minute checks on him. Later on at about 11:30am, she was doing her rounds on H3 landing in the healthcare centre. When she arrived at the man’s cell she looked through the observation hatch and saw that he was laying on the floor. He was not moving and had a cut to his right eyebrow. The nurse alerted her colleagues and the cell door was opened. He was placed back on his bed and first aid was given to his cut.

23. At 1:00pm, his blood pressure gave staff cause for concern and, as he was unresponsive, it was decided to transfer him to Leeds General Infirmary.

24. Over the next three weeks, doctors discovered that he had serious health problems and an operation was performed to alleviate pressure on his brain. His condition improved for a short time, but it was later confirmed that he had a malignant cerebral glioma (a brain tumour) and that he only had a matter of months to live. His brother, who was his next of kin, was told that even with further surgery and radiotherapy he could die at any time.

25. In light of his deteriorating health, the prison began to identify what arrangements could be made to care for this man in the community. Sadly, he passed away on 21 January 2005 before the arrangements could be finalised.

26. The duty governor was immediately informed of the death. A member of the prison chaplaincy, and a member of staff, representing the Governor, immediately went to the hospital to offer their condolences and support to the man’s brother.

27. The Reverend maintained contact with the family. The prison also offered to assist with the funeral arrangements (including financial support), but the man's family chose not to take up this offer.

28. The post mortem report states that the cause of death was natural causes as a consequence of a malignant cerebral glioma. The report added that the mortality rate from such tumours is high even with treatment.

29. The Clinical Reviewer concluded that the care while he was in prison was of a good standard and that medical issues were dealt with in a timely and appropriate manner.

30. My investigator carefully studied the Bedwatch Logs completed by prison officers during the time that the man spent in hospital. My investigator was shown a copy of the guidance made available to staff undertaking escorts outside the prison. The guidance states that, if the escort develops into a "bedwatch", they should maintain an Occurrence Log. The guidance also gave a basic list of what is to be entered into the log. There is no guidance about what the log should or should not contain or about the language and tone of the entries. The majority of the entries were appropriate and suitable, but my investigator found one that was lacking in respect and decency.

31. It hardly needs stating that entries in all prisoner records should be accurate, factual, sensitive and respectful. But all the more so in the case of a man in the final stages of a terminal illness. The Governor will wish to review and strengthen existing procedures at Leeds for management checks and the monitoring and support of staff on bedwatch duty.

32. This man entered his last term of custody with a very serious undiagnosed physical health problem. Although his condition was being monitored and assessed regularly by the healthcare centre at Leeds, the underlying malaise was not identified. It was only after his condition deteriorated that the prison referred him for further investigation at the Leeds General Infirmary, where it was established that he had a malignant brain tumour. The disease was extensive and the prognosis poor. In light of this development the prison was trying to make arrangement to assist in his release on compassionate grounds. The prison acted appropriately and sympathetically by making arrangements for him to be released back into the community.

33. I am also pleased that the prison gave permission for physical restraints not to be used. This will, I hope, reassure the man's family that he was given some privacy and dignity in the last days of his life.

Recommendations

I recommend that the Governor conducts a review of bedwatch instructions to include improved guidance and training for staff on what to write and how to write it when on bedwatch duty. The review should reflect on whether additions are required to the existing Visiting Manager's Bedwatch Checklist.