Investigation into the death of a man at a local hospital on 13 June 2005, whilst a prisoner at HMP Leicester

Report by the Prisons and Probation Ombudsman for England and Wales

June 2006

This is the report of the investigation into the death of a man who was aged 55. He died at the local hospital on 13 June 2005 after having been found hanging in his cell at HMP Leicester the previous day. The man was on remand at the time of his death and had been in custody for just a few days.

This investigation was conducted by two of my investigators. In addition, the Eastern Leicester Primary Care Trust was asked to carry out a Clinical Review into the medical care that the man received

I would like to extend my thanks to the Governor, and his staff at Leicester for their help and co-operation during this investigation.

This is a report that raises serious concerns about the sharing and use of information relating to a prisoner's risk of suicide or self-harm. Although a definite link cannot be made, it also draws attention to the special dangers that are faced by prisoners who are detoxifying from drugs. In this man's case, he was withdrawing from prescribed dexamphetamine elixir; my report suggests he had been using possibly the highest prescribed dosage of that drug in the UK.

In addition to the recommendations in the clinical review, I make five recommendations of my own.

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Prisons and Probation Ombudsman **June 2006**

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Summary

1. The man was remanded in custody by Leicester Magistrates' Court on 9 June 2005, and taken to HMP Leicester. A number of risk factors were highlighted both to the court and on his transfer documentation. These included the fact that he was using a very high prescribed dose of dexamphetamine as part of a drug detoxification regime, and that he was at risk of self-harm.

2. His case worker from the Community Drug Team telephoned HMP Leicester and spoke at length to the Reception Nurse. He noted her concerns about the man's physical and mental health. She was concerned especially about the effects on his mood from withdrawing from the dexamphetamine. All of her concerns were noted on the Medical Record by the nurse.

3. A short while later the man was seen by a doctor as part of the new receptions procedures. He was prescribed lofexidine for opiate detoxification along with a local standard 'detox' symptom pack. A F2052SH booklet was not opened. He was then located in a double cell on the First Night Centre with another prisoner.

4. The following day, the man refused to be assessed by the Substance Misuse Nurse. She recommended that he be moved to the Detoxification Unit, but he refused to go and remained in his double cell. That evening, the doctor saw the man again and made a slight change to his medication as he was complaining of stomach pains.

5. The man apparently remained in his cell, apart from going to collect his medication. His cell mate brought him his food and made sure that he took his medication. On the morning of 12 June, the man's cell mate left the cell and went to exercise. It was the first time that he had been alone.

6. When the cell mate and another prisoner returned to the cell at about 11 am, they noticed the man hanging from the window bars. Staff entered the cell and cut him down. Cardio Pulmonary Resuscitation was performed until paramedics arrived. A heartbeat was established, and at 11.38 am he was transferred to the local hospital. Sadly, the man died at 6.41 pm the following day (Monday, 13 June 2005). He was aged 55.

7. This report raises questions about the transfer of information relating to a prisoner's risk of self-harm, and draws attention to the dangers faced by those withdrawing from prescribed medication.

Investigation methodology

8. The investigation was opened at HMP Leicester on 20 June 2005. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were distributed around the prison notifying staff and prisoners of the investigation.

9. A number of prison staff were formally interviewed, as was the cell mate. My investigators met with the investigating officer from Leicester Police to discuss issues of mutual interest.

10. The Eastern Leicester Primary Care Trust was contacted, and they agreed to carry out a clinical review of the medical care that the man received whilst he was in custody. The Medical Director carried out the review.

11. The lead investigator attended a meeting at Paget House, where the Leicestershire Community Drug Team is based. He spoke with the man's drug treatment practitioners about the drug treatment he had been receiving, and the concerns that they had about the circumstances of his death.

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

13. One of my family liaison officers, contacted the man's daughter. He explained the purpose of my investigation and arranged to visit with her to discuss her father's death. That meeting took place on 2 September. His daughter explained how she learned of what had happened to her father. Her husband had gone to visit her father at his flat. After receiving no reply, he visited her uncle who told him that the man was in hospital. The man's daughter and her husband then went to the local hospital where they found her father with two prison officers. She thus learned at the same time that her father was in custody and that he had made an attempt on his life.

The subject of this report

14. The man was born in Leicester in 1949. He had two brothers and two sisters, and was father to a daughter. Although he kept in touch with one of his brothers, he lived alone in a council flat in Leicester.

15. His first conviction was in 1967. Since that time, he had accrued a total of 48 convictions for which he had served numerous terms of imprisonment.

16. He had been under the care of the Leicestershire Community Drug Team (CDT) for 18 years. He had been prescribed a high dose of dexamphetamine by the CDT for over ten years, as well as being prescribed benzodiazepines by his GP.

17. In May 2005, the man received a sentence of 18 months imprisonment suspended for two years for two offences under the Theft Act.

18. On 9 June, he appeared before the courts charged with a further offence, allegedly committed on the same day he had received the previous suspended sentence. This time the magistrates chose to remand the man into prison.

19. The man was 55 years old when he died.

HMP Leicester

20. HMP Leicester is an early Victorian prison. The main living accommodation is a long rectangular cell block with four landings. Most cells have two occupants, although some have been converted into dormitories. In cell electricity is currently being installed in all living units. Whilst this investigation was taking place, some alteration work and electrification was taking place in the First Night Centre.

21. The prison was last inspected by Her Majesty's Chief Inspector of Prisons in July 2003 when it was noted that Leicester was three months into a five year action plan.

22. Since April 2004, there have been six deaths at Leicester, four apparently self inflicted, one from natural causes and one homicide. Action plans drawn up as the result of the investigations into two of the deaths have not yet been fully implemented. Insufficient healthcare staff was cited as the main reason for the delay in implementation.

23. In the Prison Performance Ratings for the first quarter 2005/06, Leicester rated level 3 of 4. That level is defined as 'Meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime.'

Events prior to the man's death

24. The man who is the subject of this report had been due to appear before Leicester Magistrates' Court on a charge of burglary on 2 June 2005. However, he failed to attend. He visited his solicitor's office and explained that he had failed to attend court due to his ill health. His solicitor arranged for him to surrender voluntarily to the court on 9 June.

25. His solicitor spoke with the man's Community Drug Treatment Practitioner, who explained the man's health in detail, drug detoxification and mental health problems. She told of his amphetamine reliance and that he was currently being prescribed 300 mls a day of dexamphetamine elixir, possibly the highest prescribed dosage of that drug in the UK. She also said that he was in constant pain from bladder stones and had been diagnosed as having hepatitis B and C. Additionally, she said that in recent weeks he had been having suicidal thoughts. She said that, if he did not receive his dexamphetamine, he would probably sleep for a 48 hour period and then suffer depressive moods.

26. When the court was informed of the above, they decided not to pursue the matter of his failing to appear on 2 June. The prosecutor then addressed the court regarding bail, as the man and his co-defendant had pleaded not guilty and elected trial at the Crown Court. In the man's case, she sought a remand in custody, explaining that the current offence had allegedly been committed on the same day he had received a suspended sentence (18 May). There were also concerns about him committing further offences whilst on bail and about his previous conviction history.

27. The magistrates remanded the man into custody until 16 June (his co-defendant was released on unconditional bail). His solicitor went to the holding cells area and advised the escort officers of her client's ill health. The solicitor completed the risk section of the Prisoner Escort Risk (PER) form, ticking the medical condition and suicide/self harm boxes. The further information section was completed as follows, 'Hepatitis B & C, bladder stones (constant pain, urinary problems), on 300mls daily of dexamphetamine elixir, awaiting surgery for bladder stones, suicidal, depression.'

28. The man was taken to HMP Leicester, and was in reception when his community drug treatment practitioner rang and spoke with the nurse on duty in reception. She explained the man's various conditions and her concerns in very similar terms to those expressed to the court. The nurse made a comprehensive note of the conversation and told her that the man was actually with him at the time.

29. A consultant with Paget House likewise telephoned HMP Leicester and left a message on the Medical Officer's voicemail, asking that he be contacted to talk about the man. The consultant was never contacted.

30. The reception nurse told my investigators that, when he saw the man, he believed him to be in his early 70s and obviously an ill man. He saw that he had an injury to his right ear lobe. The nurse was not in possession of the man's PER form (which he acknowledged sometimes happens), but he had the information from the community drug treatment practitioner. He was surprised that the court had remanded someone as ill as the prisoner was to prison. The nurse said that he contacted Healthcare with a view to getting the man admitted, but there was no room. There is no record of that request. In his interview the nurse said that in future he would record any such request and the outcome on the prisoner's Medical Record.

31. Despite what he had been told about the man's detox and his mood, the reception nurse did not open an F2052SH booklet. (An F2052SH is an at risk of self-harm booklet, used to monitor and support prisoners who are believed to be at risk of harming themselves or of committing suicide.) Prisoners on the booklet are checked at irregular intervals based upon the perceived risk, and their cases are regularly reviewed by a multi-disciplinary team. The nurse was aware that people withdrawing from drugs were more likely to suffer a lowering of mood and have thoughts of self-harm. He said that the man did not present as a person considering self-harm and had in fact denied having such thoughts during the completion of the First Reception Health Screen. The nurse was content that the staff on the wing would know of the man's situation and keep a closer watch on him. In fact, while it may have been fairly obvious that he was unwell, the exact nature of his condition and the concerns raised by them were only documented in his Medical Record. The Medical Records are kept secure in Healthcare for confidentiality reasons.

32. A reception officer completed the Cell Sharing Risk Assessment form, used to help staff decide the risk posed by a particular prisoner in relation to cell sharing. The officer had ticked the boxes in section one of the form to indicate that he had received the man's PER form and the warrant from the Court. During interview, the officer said that he personally had not seen either document, and routinely ticked the boxes as those documents always came with the prisoner. The man was assessed as low risk and was later put into a cell with another prisoner.

33. As part of the Reception procedure, the man was seen by one of the prison doctors, on seats outside of his cell on the First Night Centre. The doctor put some flucloxacillin, an antibiotic, on the man's damaged earlobe and interviewed him for about 15 minutes about his health. The reception nurse was with them throughout. From his notes, the doctor said that the man told him he was taking 150ml of dexamphetamine, which he was collecting on a daily basis from Paget House as he had been doing for ten or eleven years. The man asked if he would be getting his dexamphetamine and was told that he would not, but that Paget House would be contacted. The doctor said that the man was

nonplussed by his answer. The man also said that he was taking one or two tablets of temazepam each evening as well as smoking street heroin.

34. The doctor asked about the man's mental health. He noted that the man was anxious but did not appear to be depressed. He asked him directly if he had any thoughts of harming himself, which he denied. The doctor prescribed lofexidine for opiate detoxification and advised the man to use the 'standard detoxification symptom relief pack', which consisted of a pack containing ibuprofen, buscopam and seven nights sleeping medication. He then told him that the Substance Misuse Nurse would review him the following morning.

35. The doctor had not seen the PER form (the reception officer said in interview that the doctors never get to see the PER forms) but, while agreeing it would have been useful, said that he would not have changed his diagnosis nor opened a F2052SH. He did note that Paget House should be contacted the next day, although there is no record of that having been done. The doctor was content that the man would receive the best care and supervision on the First Night Centre.

36. The next morning, the Substance Misuse Nurse saw the man in his cell. She had worked at Leicester for a little over three years, and had been in her current post for about 20 months. She had not had any specific training for her specialist role, but was anticipating some in the near future. She felt that she was capable of carrying out her responsibilities, but that the extra training would give her more knowledge of the drugs the prisoners were taking and more confidence to deal with detoxification issues.

37. The substance misuse nurse's intention was to carry out an assessment of the man's detoxification requirements. He refused to co-operate with her and was irritable. She did not assess him but, realising that he was struggling, recommended that he be moved to the Detox wing.

38. The man was also seen that morning by a member of the CARAT's team (Counselling Assessment Referral Advice and Throughcare). The man did not want to speak at first, saying that he was tired, although he eventually answered some basic questions. He said that he did not want support from the CARAT's team.

39. A short while later, a wing officer went to tell the man that he was going to be moved up to the Detox unit. He found him curled up on his bed and obviously unwell. The officer told the man that he was going to be moved, to which the man replied that they would have to carry him and he was not going. The officer gave him an order to move, but the man replied by swearing at the officer. The officer closed the cell door and returned to the office. He decided not to put the man on a disciplinary charge as he was obviously unwell. He told the other staff that the man

could stay on the First Night Centre until after the weekend unless they needed the space.

40. The same doctor saw the man in his cell that evening. He had been complaining of stomach pain and staff had asked the doctor to see him. He was lying on his bed when the doctor examined him. The man was told to stop taking the ibuprofen as it might be aggravating his stomach and to replace it with paracetamol for pain relief. The doctor also prescribed some antibiotics to ward off any infection. There is no record of either medication on the prescription record or in his Medical Record.

41. The man's cellmate says that the man spent the night moaning, and occasionally getting up to be sick. The man remained in the cell the whole of the next day apart from going to collect his medication. His cell mate brought him his meals and made sure he took his medication. He felt that his care was left to him although he was not specifically asked to take care of his cellmate.

42. The following morning, Sunday 12 June, the man's cellmate left the cell to go to exercise. That was the first time that the man had been alone. The cell mate told my investigators that the man had not given any indication of an intention to self-harm. At about 11 am, the cell mate and another prisoner returned from exercise and looked into the cell. The cell mate did not see anything at first, as the cell was dark, but the other prisoner saw the man hanging. Staff were alerted and ran down to the cell and opened it. A wing officer saw the man hanging by a strip of torn bed sheet from the bars in front of the window. He immediately took hold of him, and supported his weight, while another officer cut the sheet free from the bars. Once free, they placed the man on the floor of the cell and began Cardio Pulmonary Resuscitation (CPR). Neither officer was current in First Aid training but they had both been trained in the past. The general alarm bell had been sounded and a medical emergency had been broadcast over the radio.

43. Further officers arrived and locked the other prisoners away. A healthcare officer arrived after about two minutes and quickly assessed the man's condition. He did not have a pulse, nor was he breathing. An ambulance was called and the healthcare officer continued CPR with the help of healthcare colleagues who arrived at 11.10 am. He placed the defibrillator on the man. It indicated 'No shock - continue CPR', which they did until the paramedics arrived at 11.15 am. After further CPR by the paramedics, they were able to establish a heart beat although the man was still not breathing unaided. The decision to move him to hospital was taken and he left the prison at 11.38 am. The man was taken to the local hospital.

44. About two hours later, the officers involved took part in a 'hot debrief' giving them the opportunity to talk through what had happened. Some officers were allowed to go home, but the second officer on scene remained on duty.

45. After the discovery of the man in his cell, the prison chaplain visited the man's brother, who was listed as next of kin, to inform him about what had happened and that the man was in hospital.

46. As noted above, the man's daughter first became aware of her father's situation during the afternoon of the following day. Her husband had been told by her uncle that her father was in hospital. She went to the hospital and spoke to the medical staff and the prison officers who were on bed watch duty. The officers contacted the prison and the Deputy Governor arrived at the hospital shortly afterwards. He explained to the man's daughter what had happened to her father and offered to help in any way he could.

47. After his transfer to hospital, the man did not regain consciousness. He died on the evening of 13 June at 6.41 pm.

Clinical Review

48. The Eastern Leicester Primary Care Trust were notified of the man's death and agreed to carry out a clinical review of the medical and mental health care that he received whilst he was in HMP Leicester. The report highlights poor communication, the lack of any kind of detoxification or maintenance regime in respect of the man's dexamphetamine use, and the failure to open an F2052SH.

49. The report lists 13 recommendations in his report and identifies an area of good practice. All of this should be considered by the Prison Service and the Governor of HMP Leicester:

National

- Consider scheme for access to information to support complex substance misuse out of hours and at weekends.

Area

- Consider scheme for access to information to support complex substance misuse out of hours and at weekends.

Local

- Clinical leadership is not clearly in place and this needs to be addressed as a matter of urgency. This has already been highlighted to the PCT commissioning team in advance of the acceptance of this report and has been captured in the specification currently going to tender.

- A clear protocol is required for the management of patients on amphetamine maintenance.

- A more robust process is required to ensure handover of relevant information to staff.

- Clear action plans are required for the management of individuals at risk with named individuals responsible for actions.

- The support for the detox needs of prisoners at weekends and out of hours should be reviewed particularly as new receptions occur on Fridays and Saturdays that cannot access the support service until Monday.

- All detox staff should have their training needs assessed and core training delivered as a matter of urgency.

- This case should be used as a look-back exercise and used to inform ACCT training.

- A multi-disciplinary approach is essential and consideration should be given to support the integration of the healthcare detox and CARATS services.

- Establish links with CDT both as to offer expert advice when required and to manage CDT clients. This should as far as possible be consistent with process for management of any condition already receiving NHS care.

- A mechanism is required to capture non attendance for medication and feedback of this information to healthcare to form part of ongoing patient plan.

- Ensure there is a robust process for message handling to support the timely discussions of clinical matters.

Good Practice

- Individual members of healthcare and CARAT service demonstrated clear concern in their actions and interactions with the man.

Findings and conclusions

50. The subject of this report was an ill man when he entered HMP Leicester on 9 June 2005. His solicitor had informed the bench at Leicester Magistrates' Court of the concerns about both his physical and mental health. It was also made clear that a forced withdrawal from the very high dose of dexamphetamine that he was currently prescribed was likely to lead to a lowering of mood and possible increased suicidal ideation.

51. Notwithstanding the representations of his solicitor, he was remanded into custody and taken to Leicester prison. The Prisoner Escort Risk form had been comprehensively completed and it highlighted the numerous concerns. Whilst the man was in Reception, the nurse received a telephone call from the man's drug case worker from Paget House, who again spelt out the concerns that she had, particularly in the area of possible self-harm.

52. It was not possible to locate the man in the Healthcare Unit and, in any case, the doctor believed that he was likely to receive more attention on the First Night Centre. Both he and the nurse were confident that the staff would keep an extra eye on the man. However, the staff had no documentation to inform them of the concerns about him. The PER form does not go to the wing, and the notes in the Medical Record are kept in Healthcare for confidentiality reasons. The staff on duty when he arrived may have heard about the particularly high level of dexamphetamine that he had been taking, but there is no evidence of that being passed on to the next shift.

53. Prison and medical staff have to make judgements about a prisoner's mental health on a daily basis, and part of that judgement needs to be based on how the prisoner presents at the time (The man denied to the doctor that he had suicidal thoughts). That said, given the concerns expressed by the Community Drug Team, I believe that there was a strong case for the man to have been placed on a F2052SH self harm document. (Leicester is currently training its staff to implement the new ACCT [Assessment, Care in Custody and Teamwork] document which is designed to be an improved 'At Risk' management system to replace the F2052SH. For that reason, I have not made any recommendation in relation to this issue as any training requirement will be addressed under the new system.)

54. In another recent investigation at Leicester, and in investigations at other establishments, I have been concerned that reception staff have indicated they were in possession of various documents when they were not. The reception officer should not have ticked the boxes on the cell sharing risk assessment to say he had seen the PER and the warrant when he had seen neither document.

55. I also note that the doctor did not see the man's PER form and that the reception officer said the doctors never see it, as it remains in reception. I think that the doctor should see any PER form that has medical or mental health concerns on it.

56. The doctor asked that Paget House be contacted the day after the man arrived at Leicester. That was not done. I would like to see the procedure for following up health requests greatly tightened up.

57. When the doctor saw the man on Friday evening (June 10), he prescribed some antibiotics and advised him to take paracetamol instead of ibuprofen. There is no record of this in the Medical Record or on the Prescription and Administration Record Chart. Any treatment given or medication issued to a prisoner should be recorded properly, and I have recommended that the record keeping procedure within Healthcare be reviewed by the Governor and the local PCT.

58. I was disturbed to learn that a nurse had been acting as a Substance Misuse Nurse for 20 months without any job specific training. Ideally, staff should receive the relevant training before taking up a post. In any event, I believe a period of 20 months without the requisite training to be excessive.

59. The subject of this report died within a few days of entering HMP Leicester. My investigation has revealed serious flaws in the way information relating to a prisoner's risk of suicide or self-harm is shared and acted upon.

60. Although the reasons for the man's apparently self-inflicted death cannot be known with certainty, this investigation has also drawn attention to the special dangers that are faced by prisoners who are detoxifying from drugs, whether illicit drugs or those which they have been prescribed in the community.

Recommendations

- The Governor should ensure that all staff working in Reception and Healthcare are aware of the importance of completing forms correctly, and do not indicate that they have seen documents when they have not.

- The Governor and the PCT should ensure that medical records are fully completed, and there is a clear record of all treatment and medication given.

- The Governor should ensure that the Reception doctor has access to any documents likely to assist him or her when making their initial assessment.

- The Governor in co-operation with the PCT should ensure healthcare staff receive the training necessary to carry out their roles.

- The Governor and PCT should ensure that, if information about a prisoner is needed from outside healthcare agencies, this is obtained promptly, and that there is a mechanism to ensure this is done.

61. The above recommendations are in addition to those made by the PCT in the clinical review.