The death of a man, who was a prisoner at HMP Leeds, in January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

December 2006

This is the report of an investigation into the death of a man who was a prisoner at HM Prison Leeds. The man died on 11 January 2006, at a hospital close to the prison. The cause of death was recorded as a gastrointestinal haemorrhage from a bleeding duodenal ulcer. He was 73.

I offer my sincere sympathy and condolences to the man's family for their sad loss.

The investigation was carried out on my behalf by one of my investigators. An independent review of the man's medical care in prison was carried out by the Leeds West Primary Care Trust. I am most grateful to them for their assistance.

I would also like to thank the Governor and staff of HMP Leeds for their full and ready co-operation during the course of the investigation.

The investigation has revealed shortcomings in the recording of prisoners' medical history at Leeds.

This report was sent in draft to the Governor of Leeds and to the man's family. I received a number of comments from the family in response, and have included these where appropriate. I have also added a further three recommendations, making eight in total, as well as highlighting one example of good practice.

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Prisons and Probation Ombudsman **December 2006**

Contents

Summary

Investigation methodology

HMP Leeds

Key events

Consideration of issues arising from the investigation

Family response to the draft

Recommendations and good practice

Summary

The man who is the subject of this report was initially remanded into custody at HMP Leeds on 1 June 2005, having been convicted, but not sentenced, on the same day. He had changed his name on a number of occasions through the course of his life, and went by a different name at the prison to that by which his family knew him.

At his reception health screening on 1 June, the man reported no concerns about his health, other than asthma and recent high blood pressure. He also signed a declaration to say that he was happy for his GP to be contacted. A fax was subsequently returned from his GP's surgery detailing his medical history, including a history of ischaemic heart disease and a duodenal ulcer. It appears that the fax was placed on the man's file and the contents not recorded elsewhere.

The man was released on bail on 8 July, before being sentenced to one year's imprisonment on 29 July when he returned to Leeds. At his reception health screening, he now said that he was unable to climb stairs because of pain in his legs. He was transferred to HMP Hull on 11 August, and repeated these concerns at an assessment on the following day.

The man was released on 20 December, but was recalled three days later after breaking the terms of his licence. At his health screening, he said he was registered disabled, and at an assessment on 29 December his level of mobility was described as poor.

On 4 January 2006, having complained of nausea and loss of appetite, the man was seen by a nurse. He was seen again two days later when he was suffering indigestion-like symptoms for which he was given milk of magnesia. At lunchtime on 9 January, the man saw a nurse for a third time. His symptoms had not receded despite the milk of magnesia and he was therefore sent 'special sick' to see the doctor that afternoon.

At around 2pm that afternoon, whilst making his way to healthcare, the man was seen by a nurse to be "slumped" on the centre. The nurse moved him to the chapel for treatment and called for assistance. His condition deteriorated and he began to have difficulty breathing. An ambulance was called, and the man was taken to a local hospital.

The man was unconscious on arrival at hospital, but his condition improved considerably over the next 48 hours. Sadly at around 10.20pm on 11 January, despite the earlier improvement, his condition deteriorated rapidly and he was pronounced dead at 10.55pm.

I make eight recommendations and highlight one example of good practice.

Investigation methodology

The investigation was opened on 13 January 2006 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the death to make themselves known to my investigator. No prisoners came forward. My investigator interviewed nine members of staff during the course of the investigation.

My investigator visited HMP Leeds on 15-16 March 2006 and met with the deputy Governor. He toured the prison and was therefore able to familiarise himself with the healthcare centre and the wing on which the man had lived. My investigator was also given access to his prison files, including the medical record.

An independent clinical review of the man's health needs whilst he was in custody at Leeds was carried out by the Leeds West Primary Care Trust.

On 28 February 2006, one of my Family Liaison Officers wrote to one of the man's daughters, to ascertain whether she had any concerns for the investigation to address. My investigator and another of my Family Liaison Officers subsequently met with the man's two daughters on 10 May 2006. At the meeting, they expressed the following concerns about their father's care at Leeds:

- That the prison were not fully aware of their father's health problems when he was received.

- Whether any action was taken following the receipt of a fax from their father's GP outlining his medical history?

- Whether their father was diagnosed with an ulcer at the prison or at hospital?

HMP Leeds

Leeds is a category B local prison. It accepts adult male prisoners from courts in West Yorkshire. It has 680 cells, plus rooms and wards for 26 in the Healthcare Centre. A new gate complex opened in September 2002, providing staff facilities and an improvement to the entry point for all visitors and staff.

Leeds has an operational capacity to accommodate a total of 1,254 prisoners. The prison always functions at or near this figure which is the maximum population level. It was expanded from four to six wings in 1994.

Leeds was last visited by HM Chief Inspector of Prisons in August 2005. Her report identified that the prison faced a number of difficult challenges because of chronic overcrowding and a high turnover of prisoners. She also found that clinics held by the locum General Practitioner were beset by problems. They resulted in unacceptable delays for prisoners, and she recommended a complete overhaul of the application and waiting list system to minimise these delays.

In April 2004, responsibility for the provision of healthcare transferred from the prison to the local Primary Care Trust.

Key Events

At his first reception health screening on 1 June 2005, the man said that he had seen a doctor recently for high blood pressure and had asthma, for which he used an inhaler. He reported no other concerns about his health.

At the same time, the man signed a declaration that he was happy for his GP to be contacted and for his medical history to be disclosed to the prison Medical Officer (MO). An undated fax was returned from the Rooley Lane Medical Centre, Bradford, to the Head of Healthcare at Leeds. The fax said that, amongst other ailments, the man had a duodenal ulcer and a history of ischaemic heart disease. It appears that the fax was placed on the man's medical record, and there is no documentary evidence that the contents were noted or the information entered on the electronic clinical record.

The man was seen in healthcare by a nurse on 6 June. He said that he had had vascular surgery to his legs around three years earlier, and complained of difficulty in walking. He was therefore put forward for a doctor's review. He was also given advice on the correct techniques for using his inhaler.

The man was seen by a prison doctor later that day. He again complained of painful legs and was prescribed Tramadol (an analgesic for moderate to severe pain). The man was then released on bail on 8 July 2005, having made no further request to see a doctor or member of healthcare staff in this time.

On 29 July, the man was sentenced to one year's imprisonment and returned to Leeds. At his health screen update of the same day, he reported that he was unable to climb stairs because of the pain in his legs. He was then transferred to HMP Hull on 11 August, having been passed fit to travel the previous day.

At his reception health screening at Hull on 11 August, it was noted that the man walked with a slight limp but was otherwise fit and healthy. He had a further assessment the following day at which he now said that he had painful legs and could not walk up stairs. He also said at this assessment that he had high blood pressure.

On 3 September, the man reported to a Healthcare Assistant that his Tramadol had been stolen. An appointment was therefore made for him to see the doctor on 7 September. An entry on 5 September states that the "policy is not to replace [stolen medication]". This entry states that the options available are to convert the man to once daily supervised medication (as opposed to 'in possession' as had been the case prior to 3 September), or to convert to ibuprofen or paracetamol that he could keep in possession. He was subsequently prescribed paracetamol in possession, on the same day.

The man failed to attend his scheduled appointment with the doctor on 7 September. He continued to repeat his prescription for paracetamol until his release on licence from Hull on 20 December.

The man was recalled to Leeds on 23 December after breaking the terms of his licence. As previously, a health screening took place on reception. At the screening, the man told the nurse that he was registered disabled, although no detail of his disability was given at the time. He also said that he used an inhaler for his asthma and that he was taking Kapake (usually known as co-codomol) for his painful legs, back pain and headaches.

Later that day, he was seen by a prison doctor. On examination, the doctor noted widespread bronchospasm (a contraction of the lungs, as occurs with asthma), but no sign of a respiratory tract infection. The doctor instructed the man to continue with his salbutamol inhaler. He made no note of any examination of the back or legs.

On 29 December, a Disabled Prisoner Assessment was completed for the man. This summarised his disability as “visual problems, reduced mobility [and] reduced physical ability”. His level of mobility was also described as “poor”. He was subsequently located to a cell on the ground floor, A2-24. Despite its designation, A2 is effectively the ‘ground’ floor of A-wing. It is here that the wing offices are located and where meals are served. The man was also given a lower bunk bed and advised that assistance with collecting his meals was available if he required it.

On 4 January 2006, the man was seen by the nurse who had completed his reception screening on 23 December. He complained of nausea and a loss of appetite, saying he had been unable to eat for four days. The nurse therefore made an appointment for him to see the doctor. She also felt that he seemed low in mood, and therefore made a referral to a mental health nurse.

The man was seen by a Registered Mental Nurse on 6 January. At interview, the nurse recalled that the man was not feeling depressed and had no mental health concerns. He said that the man was suffering from symptoms similar to indigestion, and therefore gave him milk of magnesia. He also made an urgent appointment to see the doctor. The nurse said that an “urgent” appointment meant that a doctor would see the patient in around three days.

The same nurse saw the man again on 9 January, at around 12.45pm, following a call on the radio asking for Hotel 3 to attend A-wing. (Hotel 3 is a healthcare response radio, and the nurse was carrying it when the call came through.) The man was still suffering from indigestion type symptoms, and said that he was now having trouble going to the toilet. At interview, the nurse said that his main concern was that the man was still experiencing the same symptoms as three days earlier, despite having taken milk of magnesia. He therefore sent the man ‘special sick’ (whereby a prisoner is sent to see a doctor at the next surgery) to see the doctor that afternoon.

At around 2pm, the man was making his way to the healthcare centre with an officer for his special sick appointment. At the time, a member of the nursing staff was in the outpatient manager’s office on B4. From the office, the nurse could see that the man had slumped when he reached the ‘centre’ (a central

area from which wings A, B and C branch off) at the end of B3, and therefore went to attend. The nurse spoke to the man, and he complained of leg and chest pain and that he was unable to walk. A folding wheelchair was fetched from the centre, and he was moved to the chapel (the nearest suitable place in which treatment could be provided).

As the man was being moved to the chapel, the nurse noticed that he was becoming paler and his consciousness levels were dropping. He therefore put out a call on the radio for healthcare staff and a doctor to attend. In the chapel, the nurse placed the man on the floor and took his blood pressure (110/80) and pulse (130). The man was still conscious, but his condition was deteriorating and he was now having difficulty breathing. The nurse therefore put out a 'code blue' call for assistance and an ambulance was called. At the same time, two officers were sent to fetch emergency equipment from the centre and the man was given oxygen.

Shortly afterwards a second nurse arrived at the chapel, followed by the Primary Care Nurse Manager and the prison doctor. The Primary Care Nurse Manager said that, on her arrival, the man was still conscious but appeared to be having trouble breathing and was only able to provide 'yes' or 'no' answers to questions asked. Observations were retaken and his blood pressure was now 124/75 and pulse 88.

The Primary Care Nurse Manager then got a printout of the man's medical record and noted from this that he was asthmatic. He was given a nebuliser with salbutamol to guard against the possibility that he was having an asthma attack brought on by the collapse. The ambulance then arrived and the paramedics commenced an ECG with no abnormalities. The man was transferred to a local hospital at 2.40pm.

The man arrived at hospital at around 3pm, with two officers on bedwatch duty. No handcuffs were applied at the time. He was unconscious on arrival, and was hooked up to a chest monitor and oxygen.

The man's condition improved in the 36 hours following his admission and, on the morning of 11 January, he was sitting up in his bed conscious and awake. He was also able to engage in conversation at this time. The man's oxygen mask had been removed when he regained consciousness. As a result of this change to his condition, the staff who were on bedwatch duty at the time decided to apply single cuffs. At interview, one of these officers said that he also consulted a nurse before making the decision to apply cuffs.

The man's condition remained the same throughout the day until, at 10.23pm, he had a fit. He deteriorated quickly and, at 10.55pm, death was pronounced. The cause of death was recorded as a gastrointestinal haemorrhage from a bleeding duodenal ulcer.

At the time of his death, the man had no recorded next of kin. The prison's Police Liaison Officer arranged for an advertisement to be placed in a local newspaper to publicise his death. This was seen by a relative of one of his

daughter, who alerted her to the notice. The man's daughter spoke to the Police Liaison Officer on 10 February, and was later in contact with the Family Liaison Officers at Leeds. The funeral was arranged by the prison's Family Liaison Officers, and they arranged for a wreath to be sent on behalf of the prison.

Consideration of issues arising from the investigation

Quality of healthcare provided at Leeds

The man's daughters expressed concern to my investigator that healthcare staff at Leeds were not fully aware of their father's medical history when he was first received at the prison. They also enquired as to whether any action was taken following receipt of a fax from their father's GP, and whether his ulcer was diagnosed at the prison or after his arrival at hospital.

Following his first reception to Leeds on 1 June 2005, a request was sent to the man's GP for details of his medical history. An undated proforma was returned by fax to the Head of Healthcare. This form identified a history that included ischaemic heart disease and, significantly, a duodenal ulcer.

At interview, the Head of Healthcare said that the form would have come into the medical records office and would have been dealt with by staff there rather than by herself. She also said that the information contained would not be put onto the electronic recording system (EMIS), due to a combination of staff workload and lack of training in the software which she said was some way off being completed.

The clinical review, conducted by the Leeds West Primary Care Trust, notes that the man "had a long history of vascular and respiratory disease ... [and] a history of Duodenal Ulcer (DU)." It goes on to say:

"Although a fax from the GP indicated [the man] was suffering from a number of conditions, no active problem list was produced in the notes or the EMIS record. Had this been available it may have alerted staff to the possibility of an active DU underlying the symptoms he was complaining of on 4/01/06. Had this been the case it would not necessarily have prevented the subsequent events."

The clinical review makes the following recommendations in the light of this finding, each of which I endorse:

In prisoners with complex medical histories, an active problem list should be readily available so that clinical staff may have a comprehensive overview of the prisoner's medical history.

Healthcare staff need to actively assess the benefits of managing underlying long term conditions against the difficulties of short term stay in the prison, and record decisions.

The clinical review notes that, when the man collapsed on the afternoon of 9 January 2006, "he was managed in a prompt and appropriate manner by the healthcare staff in attendance". However, it further notes that, whilst an examination was made by the doctor at the time, "there is no record of the findings of the examination entered by the doctor".

The clinical review also says that there were a number of entries written in the medical record and on EMIS which did not appear in both. The reviewer therefore makes the following recommendation, which again I endorse:

All staff taking an active part in clinical incidents should record their findings and actions. The prison should move as rapidly as possible to having a single repository of medical notes in electronic format.

Contact with the man's family

When he died, the man had no recorded next of kin in his prison records. The Police Liaison Officer arranged for an advert to be placed in a local newspaper to publicise his death and appeal for any relatives to come forward. This is an example of good practice.

The Family Liaison Officers (FLOs) at Leeds made contact with the man's daughter around 5 March. When they met with my investigator, his daughter's said that they had "been given the run around" by members of staff at the prison prior to speaking to the FLOs. They said that they had been trying to speak to someone with regard to their father's death, but had been passed from department to department, with no-one able to answer their questions. This does not reflect well upon the prison.

At interview, one of the FLOs said that when the man's family was first contacted members of staff from other departments, including the Secretariat Manager, were involved in dealing with them. She went on to say that the situation "got a bit messy" as a result of this and that the FLOs then had to take over control. The FLO accepted that things had not been handled in an ideal manner, which she said was due to the unusual situation of the man dying in outside hospital with no nominated next of kin.

Prison Service Order 2710, Follow up to Deaths in Custody, notes that following a death in custody the Governor must:

"Appoint a senior member of staff or a dedicated family liaison officer (and a deputy to cover absences) as a named point of contact for the family, to make and maintain contact with the family ... and to provide information and practical support."

It is clear that FLOs have been appointed at Leeds and I am pleased to note that the man's daughters were very complimentary about their relationship with them once contact was established. However, it disappoints me that they were unable to establish earlier contact with the FLOs at what must have been a traumatic period for them.

The Governor should ensure that all staff are aware of the role of the family liaison officers and the procedures for family contact following a death in custody.

The man’s journey to the healthcare centre on 9 January 2006

At his reception health screening on 29 July 2005, the man reported that he was unable to climb stairs because of the pain in his legs. He repeated this statement following his transfer to Hull on 11 August. Following his recall to Leeds on 23 December, at his reception health screening, the man said that he was registered disabled. A Disabled Prisoner Assessment was therefore completed on 29 December by the Disability Liaison Officer at Leeds. He summarised the man’s disability to include “reduced mobility (and) reduced physical ability” with his level of mobility described as “poor”.

The route that the man would have had to take from his cell (on landing A2) to see the doctor on 9 January 2006 is quite lengthy. It involves climbing a set of stairs to A3 and then walking to the centre. He would then have had to walk around the centre to C3, walk across C3 and then walk down a long corridor to healthcare. Given his mobility problems, this would have been a difficult journey for the man.

The Disability Liaison Officer told my investigator that there are wheelchairs in healthcare available for use by prisoners, should either the prisoner or staff have concerns about their mobility. There is also an ‘evacuation chair’ available in the centre that is equipped with caterpillar tracks for going up and down flights of stairs. Unfortunately, I have been unable to determine which officer accompanied the man en route to healthcare on the afternoon of 9 January. I have therefore been unable to ascertain whether he asked for or was offered a wheelchair for this journey. However, given his mobility problems described above and the length of the journey involved, I believe it would have been appropriate to have offered the man the use of a wheelchair for this journey.

The Governor should remind staff that wheelchairs must be used when prisoners with mobility or significant health problems have to travel substantial distances around the prison.

Family response to the draft

I received a number of comments from the man's daughters in response to my draft report, which I have discussed below.

- The man's sensitivity to aspirin

The man's family commented that, at his health screen update of 29 July 2005, it was recorded that their father was "sensitive to aspirin". An EMIS reference number was given on the same sheet. At his reception health screening at Hull on 11 August, it was recorded that their father was allergic to aspirin. His daughters were concerned that, despite his allergy, their father was administered aspirin when he collapsed on the afternoon of 9 January 2006.

A prisoner's EMIS record contains a section for recording drug allergies. There are none recorded on the man's record. Staff attending to him when he collapsed on 9 January would not therefore have been aware that he was sensitive or allergic to aspirin.

The Head of Healthcare should ensure that all drug allergies noted in paper records are recorded on EMIS.

- Lack of access to the man's medical history

The man's daughters were concerned that neither of the nursing staff who saw him on 4 and 6 January had accessed his medical records on these occasions. The staff were not therefore aware of their father's medical history, including that of a duodenal ulcer. They also wished to know what the normal procedures should be on receipt of a prisoner's medical history.

As I have previously discussed in this report, a document outlining the man's past medical history was received from his GP on an unrecorded date. This document was simply placed on his medical record, and was not recorded on EMIS. The clinical reviewer notes that, "had this (an active problem list) been available it may have alerted staff to the possibility of an active DU underlying the symptoms he was complaining of on 4/01/06. Had this been the case it would not necessarily have prevented the subsequent events."

My investigator wrote to the Head of Healthcare at Leeds, to determine the procedures followed on receipt of a new prisoner's medical history. The Head of Healthcare said that information received is passed to the Senior Nurse, who will arrange a follow-up if required. The information is then filed in the patient's medical record.

The Head of Healthcare makes no mention of such information being recorded on EMIS. I consider it to be unsatisfactory that staff cannot have access to details of a patient's recent medical history. I repeat the previous recommendation made by the clinical reviewer.

In prisoners with complex medical histories, an active problem list should be readily available so that clinical staff may have a comprehensive overview of the prisoner's medical history.

- Care provided at around 12.45pm on 9 January 2006

The man's daughters were concerned that, if his condition was serious enough to warrant a Hotel 3 call at lunchtime on 9 January, an ambulance should have been called at the time. They were also concerned that, despite having an "urgent" appointment booked on 6 January, their father had not seen a doctor in this time.

My investigator contacted the clinical reviewer to obtain his assessment of the care provided at 12.45pm on 9 January. The reviewer noted that the man was later seen by a senior nurse at around 1.45pm, who immediately called for assistance. He considers that, "with hindsight it may have been preferable for the initial nurse to have requested advice from a more senior colleague, but it is likely that (the man's) condition changed between 12.45pm and 1.45pm". The clinical reviewer goes on to say that, "it is not clear that this affected the final outcome".

My investigator also contacted the Head of Healthcare at Leeds. She said that an "urgent" appointment is within the same day that the patient presents. At interview, the nurse who saw the man on 6 January said that an "urgent" appointment is "around three days" after the patient presents.

The nurse who saw the man on 6 January described him as suffering from indigestion-type symptoms. It is clear from his interview that he felt that an appointment with a doctor in around three days time was appropriate. It is also clear that there is a discrepancy between his description of an "urgent" appointment and that put forward by the Head of Healthcare.

The Head of Healthcare should ensure that all healthcare staff are aware of the policies and procedures for booking different types of GP appointments.

- Availability of diamorphine and cannulas

The man's family were concerned that there was no diamorphine available in the prison when the doctor requested it on 9 January 2006.

The prison GP asked for diamorphine as he initially suspected that the man was having a heart attack. Once it was established that he was not having a heart attack then an alternative painkiller was used (see the above section on the use of aspirin).

The clinical reviewer notes that, "the incident was managed in a prompt and appropriate manner". My investigator contacted him with regard to the availability of diamorphine at Leeds. The reviewer says that, "diamorphine is available in the prison but only in small quantities and for obvious reasons is

tightly controlled by the pharmacy. Consequently it is not in the emergency bag and only available during working hours". However, "a further complication on this occasion was that the diamorphine was out of date and steps have been taken to ensure this does not occur again."

The nurse who first attended to the man when he collapsed on the centre said in his interview with my investigator that there was only one green cannula available at the time of his collapse. The man's family were concerned by this, as a cannula must be disposed of and a replacement found if insertion is not successful at the first attempt. At interview, the nurse said that the situation with the cannulas had now been addressed, following a staff debrief.

The Head of Healthcare should ensure that stock levels of medication are regularly monitored and audited.

Recommendations and Good Practice

Recommendations

In prisoners with complex medical histories, an active problem list should be readily available so that clinical staff may have a comprehensive overview of the prisoner's medical history.

Partially accepted – this is being achieved by evolution. The EMIS clinical record system produces a current problem list as inter-actions between patients and clinical staff are recorded.

Healthcare staff need to actively assess the benefits of managing underlying long term conditions against the difficulties of short term stay in the prison, and record decisions.

Accepted – this already happens, we endeavour to deal with all clinical conditions, irrespective of length of stay at HMP Leeds.

All staff taking an active part in clinical incidents should record their findings and actions. The prison should move as rapidly as possible to having a single repository of medical notes in electronic format.

Accepted – this is work in progress. The development of the electronic record system is at the next stage, awaiting funding for the required hardware (terminals) to make the system fully accessible around the establishment. Until such we must rely on a dual paper/electronic system.

The Governor should ensure that all staff are aware of the role of the family liaison officers and the procedures for family contact following a death in custody.

Accepted – the Death in Custody policy document has been updated and includes an Operational instruction specifically pertaining to FLO's.

The Governor should remind staff that wheelchairs must be used when prisoners with mobility or significant health problems have to travel substantial distances around the prison.

Accepted – Staff have been advised and are aware of the need to use wheelchairs and 'fit for purpose' chairs have been procured, located at designated points within the Establishment and are in use.

The Head of Healthcare should ensure that all drug allergies noted in paper records are recorded on EMIS.

The Head of Healthcare should ensure that all healthcare staff are aware of the policies and procedures for booking different types of GP appointments.

The Head of Healthcare should ensure that stock levels of medication are regularly monitored and audited.

Good Practice

The Police Liaison Officer placed an advertisement in the local paper to locate relatives of the man who had died.