

**Circumstances surrounding the death of a man
at Leeds General Infirmary on 4 March 2006,
whilst a prisoner at HMP Leeds**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES**

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Contents

Summary	4
The investigation process	5
Background HMP Leeds	6
Key findings	7
Issues arising from the investigation	12
Recommendations and good practice	15

This is a report into the circumstances surrounding the death of a man at Leeds General Infirmary on 4 March 2006. Prior to his transfer to hospital, the man was a life sentence prisoner at HMP Leeds. He was 69 years of age.

The death of a loved one is always distressing. I would like to offer my condolences to the man's family for their loss.

The man had spent time on remand at Leeds, HMP Doncaster and HMP Hull before returning to Leeds in May 2004. He suffered from a multitude of health problems throughout his time in prison: chronic breathlessness being the most troublesome. In January 2006, his breathing difficulties became so acute that he was admitted to Leeds General Infirmary, where he remained for more than three weeks before being returned to the prison. Sadly, less than 24 hours after his return, he fell in the Healthcare Centre and broke his hip. He was admitted to Leeds General Infirmary again and his hip was operated on during the morning of 23 February.

Having made good progress following his operation, the man inexplicably started coughing up blood during the early hours of 4 March. He was treated by hospital staff who stabilised him for a period of six hours before he deteriorated suddenly around 10.20am. On this occasion, the emergency response team was unable to resuscitate him and he died at 10.40am.

This investigation has been undertaken by a member of my team. I would like to thank the Governor of Leeds prison and his team for their co-operation with the investigation.

I make one recommendation as a result of the investigation into the man's death and cite two examples of good practice. I also highlight one area of concern which relates to the man's lack of progress through the prison system. This links into a wider issue about the shortage of appropriate prison places for life sentence prisoners. However, as I am aware that the Lifer Release and Recall Section of the Home Office, which is responsible for managing life sentenced prisoners through the prison system and beyond, is currently looking at how this impasse can be resolved, I make no specific recommendations on this matter.

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2006

Summary

1. The man who died was remanded into custody on 4 April 2003. He was sent to HMP Leeds where he disclosed to the receiving medical staff that he was suffering from a multitude of health conditions, including chronic breathlessness. After moving between various prisons, he returned to Leeds on 26 May 2004.
2. In January 2005, some months after receiving a life sentence, the man suffered two attacks of acute breathlessness. The second of these was so serious that he was taken to the Accident and Emergency Department of the local hospital. After being stabilised, he returned to Leeds prison early the next morning. He did not experience any further episodes of breathlessness until November, when he was once again taken to outside hospital. As in January, he was not admitted to hospital, but returned to Leeds where he was located in the Healthcare Centre so that oxygen could be given.
3. On 18 January 2006, the man was seen twice by medical staff after complaining of shortness of breath. He was relocated to the Healthcare Centre for overnight observation where his breathing and blood pressure improved. He returned to A Wing the next day.
4. On 21 January, he was seen three times by Healthcare staff because of his breathing difficulties. These persisted the following morning when a decision was made to send him to hospital. He left the prison in an ambulance at midday, and was admitted to Leeds General Infirmary shortly afterwards.
5. Over the next few days, the man's condition deteriorated and the prison arranged for his next of kin, a prisoner in another prison, to visit him. However, his condition slowly improved and, on 15 February, he was discharged from the hospital to prison where he was again located in the Healthcare Centre.
6. At 11.50am on 16 February, the man who later died fell on the ward whilst attempting to collect his lunch. He was treated by staff and seen by a doctor who identified that he had broken his left hip. He was subsequently taken to Leeds General Infirmary by ambulance, and was admitted a short time afterwards. A hip operation was conducted on 23 February.
7. At 3.35am on 4 March, the man started coughing up blood, a condition apparently unrelated to his fall on the ward of the Healthcare Centre. He was treated by hospital staff and was stabilised but, at 10.20am, he suddenly deteriorated. On this occasion, the emergency response team was unable to resuscitate him and he died at 10.40am.

The investigation process

8. My investigator considered the man's prison documentation, including his clinical records, before formally opening the investigation on 19 April 2006. Unfortunately, one potentially important piece of documentation, the bedwatch records covering the period 25 February to 1 March, was missing, and Leeds has subsequently been unable to trace its whereabouts.
9. Prior to my investigator arriving at Leeds, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themselves known to the investigator. In the event, nobody came forward. However, two prisoners who were on the ward when the man fell on 16 February were interviewed. Six members of staff, most of them based in the Healthcare Centre, were also interviewed.
10. One of my Family Liaison Officers contacted the man's next-of-kin to offer them the opportunity to participate in the investigation process. I hope that this report addresses any concerns they may have about the circumstances surrounding his death.
11. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.
12. West Leeds Primary Care Trust conducted a review of the care the man received whilst in prison and I thank him for his report and contribution to the investigation.

HMP Leeds

13. Leeds is a category B local prison, built in 1847. 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.
14. 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.
15. Leeds was last visited by HM Chief Inspector of Prisons in August 2005. She identified that the prison faced a number of difficult challenges because of chronic overcrowding and a high turnover of prisoners. Of relevance to this investigation, she expressed concerns about the length of time life sentence prisoners spent at Leeds before being transferred to establishments more suited to their needs. She also found that clinics held by the locum General Practitioner were beset by problems which resulted in unacceptable delays for prisoners.
16. Prisoners who need to leave the prison in order to receive hospital treatment are usually sent to Leeds General Infirmary. They are escorted by prison staff. Before a prisoner leaves the prison, or as soon as possible afterwards in the case of emergencies, the Security Department decides whether the prisoner needs to be handcuffed. Every day that a prisoner is in hospital, a member of the prison's management team visits to ensure that the restraint protocols are being followed by the bedwatch staff. Prior to conducting the 'daily management check', the designated manager is provided with a Bedwatch Risk Assessment / Management Check form by the Security Department, which sets out the arrangements.
17. Since the Prisons and Probation Ombudsman assumed responsibility for investigating deaths in prisons in April 2004, there have been 16 deaths at Leeds. Six of these have been attributed to natural causes.

Key findings

18. The man who is the subject of this report was remanded into custody by Calderdale Magistrates' Court on 4 April 2003. He was sent to HMP Leeds where he disclosed to the receiving medical staff that he suffered from a number of health conditions, including bronchitis, arthritis, thyroid disease and chronic obstructive pulmonary disease (COPD). These, and his various other health problems, were subsequently managed by a combination of prescribed medications which the clinical reviewer has deemed to be appropriate to his needs.
19. On 6 January 2004, the man successfully applied to the Court to be released on bail, and he spent the next nine days at Ripon House Bail Hostel in Leeds. He was remanded back into custody on 15 January and spent the next month at HMP Hull. He returned to Leeds prison on 16 February and remained there until 6 May, when he was transferred to HMP Doncaster. On 26 May, he returned to Leeds once again where he remained until his death.
20. On 19 July, Bradford Crown Court imposed a life sentence and specified that the man was to serve a minimum of five years and nine months in custody. He appears to have accepted the indeterminate sentence handed down to him and complied with the expected standards of behaviour.
21. On the morning of 18 January 2005, the man's chronic obstructive pulmonary disease flared up and he suffered from a prolonged attack of breathlessness. Staff removed him from his usual place of work and oxygen was administered. He was seen by a doctor but refused to be admitted to the Healthcare Centre, signing a disclaimer to this effect. After 50 minutes' use of the nebuliser his breathing improved and he was allowed to stay on A Wing.
22. At 11.30am on 20 January, the man who later died suffered another attack of breathlessness and on this occasion was admitted to the Healthcare Centre. Oxygen was administered and he was prescribed prednisolone, a steroid used to control inflammatory disorders. He was also monitored regularly but his breathing did not improve over the course of the day. He was therefore sent to the Accident and Emergency Department of Leeds General Infirmary but was not admitted and returned to the prison around 12.45am on 21 January. Oxygen was once again administered, and stabilised his condition. Over the next few days, his breathing improved significantly and he was discharged back to A Wing on 26 January.
23. Throughout 2005, the man's chronic obstructive pulmonary disease continued to cause acute breathing difficulties and he came to the attention of medical staff on more than one occasion. Usually he refused to be admitted to the Healthcare Centre and medical care was

administered on the wing, but at times of acute distress he agreed to be relocated temporarily so that observations could be carried out.

24. On 8 November, he suffered an asthmatic episode that necessitated a visit to outside hospital. Upon his return to Leeds, around 1.00am the next morning, he was located in the Healthcare Centre so that oxygen could be given. He returned to the wing when his breathing stabilised.
25. On 18 January 2006, the man was seen twice by medical staff after complaining of shortness of breath. He remained on the wing but at 9.20pm Healthcare responded to a 'blue call' (breathing-related medical emergency) and found the man in considerable distress. His blood pressure was taken and was found to be extremely high – 220/100 mmHg compared to a 'normal' reading of 120/80 mmHg for the general population. He was relocated for overnight observation to the Healthcare Centre where his breathing and blood pressure improved. During the medical examination at 9.30am on 19 January, the man requested to return to the wing and, because his condition had improved significantly, this was authorised.
26. On 21 January, the man was seen on three occasions by Healthcare staff because of his ongoing breathing difficulties. They persisted into the following morning when a decision was made to discharge him to hospital. He left the prison in an ambulance at midday, accompanied by prison staff, and arrived at the Accident and Emergency Department of Leeds General Infirmary at 12.10pm. He was admitted shortly afterwards.
27. Over the next few days, the man's condition deteriorated and, at 8.55am on 23 January, authorisation was given for his handcuffs to be removed. Due to the seriousness of his condition, the prison arranged for his next-of-kin, a prisoner at another prison, to visit him under prison officer escort. The visit took place on 25 January and lasted around 40 minutes. This is an example of good practice and shows that Leeds was sensitive to the man's needs at what must have been a most distressing time for him and those close to him.
28. On 27 January, his condition started to improve and, by 29 January, he was well enough for restraints to be re-applied. However, on 30 January, a bedwatch officer noticed that his arms were swelling up around the handcuffs. The officer contacted the prison in order to ask a member of the Healthcare staff to assess the situation. A Healthcare officer visited the man at 11.00am on 31 January and, at 11.40am, the restraints were removed.
29. The man's breathing and general health continued to improve in the days that followed and, on 4 February, handcuffs were re-applied as the swelling had gone down. However, at 6.15pm on 5 February, his health deteriorated once more and his restraints were removed to facilitate

treatment. He was stabilised and re-handcuffed again at 5.50pm on 6 February.

30. At 4.00am on 7 February, the man was given a blood transfusion after it was discovered that he had developed a gastro intestinal bleed. His handcuffs were removed at 9.00am because of his chronic state of ill-health, although he steadily improved over the next few days and they were re-applied on 11 February.
31. On 13 February, he had a session with a physiotherapist in order to teach him how to use a zimmer frame. He was observed to be able to walk short distances with the aid of the frame.
32. By 15 February, Leeds General Infirmary felt that the man's improved health and short-range mobility made him suitable for discharge. He left the hospital at 5.17pm and arrived back at Leeds at 5.40pm. In order to obtain a better sense of his mobility and general health, he was located in the Healthcare Centre rather than on A Wing.
33. The night of 15 February was uneventful and, when the man was seen by a nurse at 10.30am on 16 February, she noted that he was using his nebuliser, interacting with fellow prisoners and that his blood pressure, pulse and body temperature were all normal.
34. At 11.50am, was one of three prisoners on the in-patient ward in the Healthcare Centre waiting for lunch to be served. One of the prisoners told my investigator that the man was lying on his bed when he attempted to get up and collect his meal. The other prisoner said the man was actually in his chair when he attempted to get to his feet. Notwithstanding this inconsistency in their accounts, the two prisoners agree that the man only managed to stay upright with the aid of his zimmer frame for a couple of seconds before he fell to the floor, landing on his left side.
35. The two prisoners promptly summoned staff, the former using the emergency alarm and the latter shouting for assistance. A nurse arrived on the ward within seconds, followed almost immediately afterwards by a Senior Healthcare Officer (SHCO). Upon their arrival they noticed that the man was lying on the floor, next to his bed. After asking him what had happened, to which the man responded "I've fallen", the SHCO and the nurse asked the man whether he could get up. His response was that he could not and that it hurt his left hip when he attempted to do so. After making certain that the man was not suffering from any pain elsewhere in his body, the SHCO and a male colleague lifted him onto his bed so that the nursing staff could make him more comfortable and examine him more easily.
36. At this point, another nurse was delegated the task of conducting baseline observations on the man. She found that his blood pressure and pulse were "satisfactory", whilst a colleague judged that he was both

lucid and responsive. On the basis of these assessments, the medical staff involved concluded that the man's condition was not a medical emergency and that it was not necessary to call an ambulance. However, they did contact Leeds's locum General Practitioner who was conducting a clinic in the out-patient department, and asked him to examine him. This request was made at approximately 12.00pm.

37. At 2.00pm, the GP went to the in-patient department as requested. When asked to account for the apparent two-hour delay between receiving the call from the in-patient staff and examining the man, the GP said that no indication had been given to him that it was a medical emergency. He said that, if it had been a medical emergency, he would have expected Healthcare staff to have called an ambulance rather than the prison doctor.
38. The GP examined the man and quickly established that he had sustained a fracture to his hip. He informed the Healthcare staff that the man needed to go to hospital for treatment, and they called an ambulance. The GP prescribed Tramadol, a recognised painkiller, before returning to his afternoon clinics. According to the Prisoner Escort Record, the ambulance arrived at the prison at 3.30pm, leaving five minutes later. The man arrived at Leeds General Infirmary at 3.45pm.
39. After being admitted later in the afternoon, the man who later died went for an x-ray at 9.30pm before being moved to Ward 34. For the next few days, his condition was stable and he had an ultrasound on 22 February, an operation on his hip on 23 February and a further x-ray on 24 February. I have been unable to ascertain what, if anything, took place between 8.15am on 25 February and 3.20pm on 1 March, because the bedwatch records covering this period have apparently been lost by Leeds prison.
40. By 2 March, Leeds General Infirmary was satisfied with the man's progress and planned to discharge him back to prison. According to the clinical review carried out on behalf of the Prisons and Probation Ombudsman, the man was recognised to be vulnerable to further falls by the hospital, but it was considered that this did not necessitate further time as an in-patient.
41. At 4.20pm on 2 March, a Principal Officer (PO) visited the man at Leeds General Infirmary to conduct the daily management check. He noticed that the Bedwatch Risk Assessment / Management Check form stated that the man was to be handcuffed. From his previous knowledge, the PO knew that the form was incorrect and that the man was not supposed to be restrained. The PO saw that the man was not handcuffed and checked the Escort Risk Assessment, which confirmed that he was not to be restrained. The PO contacted the Security Department to inform them that the information they were sending out on the daily Bedwatch Risk Assessment / Management Check form was inaccurate, and urged

them to change the information on their records. The PO also noted this discrepancy in the continuous 'bedwatch occurrence log' to ensure that all the bedwatch officers were aware that the man should not be handcuffed. This is an example of good practice and helped to ensure that any potential confusion surrounding whether the man should be restrained was eradicated.

42. At 3.35am on 4 March, the man started vomiting blood. The duty doctor was called and, due to concerns about the sudden and apparently unexpected development, medical staff asked the prison officers conducting the bedwatch whether they could provide the contact details of a relative. Regrettably, I have not been able to establish whether this took place. At 4.30am, the medical staff attending to the man asked the bedwatch officers to vacate his room so that they could treat him more easily.
43. Around 8.30am, hospital staff allowed the bedwatch officers to return to the man's bedside because they were satisfied that he had been stabilised. However, at 10.20am, the two officers were asked to leave again after his condition suddenly deteriorated. He was treated by the hospital emergency response team, but they were unable to resuscitate him. He was pronounced dead at 10.40am.
44. After the man died, Leeds activated its 'Death In Custody' contingency plan and attempted to contact his next of kin. As the named next of kin was a prisoner in another prison, he was informed in person by the chaplain at that establishment. The next of kin provided the chaplain with the contact details of other relatives, one of whom was visited by prison staff to inform him in person. Unfortunately, the address was apparently unoccupied when the staff arrived, and they were only able to pass on the sad news the next day.

Issues arising from the investigation

The man's location at HMP Leeds

45. As a life sentence prisoner, the man was subject to a set of procedures distinct from the rest of the prison population. This is because life sentence prisoners can spend the rest of their lives in custody unless they are able to demonstrate to the Parole Board that they no longer pose a danger.
46. Life sentence prisoners also have to show that they have dealt with the matters that caused them to offend in the first place. In practice, this is achieved by the prisoner participating in intensive offence-focussed work, usually in a group work setting, and examining their previous behaviour. This insight is then used to develop new, more socially acceptable strategies for dealing with their problems. The programmes that a prisoner is required to complete are determined by the nature of their offending and the assessments of the professionals involved in their supervision, including psychologists and probation officers.
47. As a local prison, HMP Leeds is not geared towards preparing life sentence prisoners for release back into the community. Its function in the management of life sentence prisoners is therefore limited to identifying their needs and identifying a suitable prison establishment that can meet them.
48. The man had a tariff set by the Court that he was to serve no less than five years and nine months. I am therefore concerned that, some 20 months after being sentenced, he was still being held in a prison that was unable to meet his offending behaviour needs.
49. I am aware that there is currently a lack of capacity in the Prison Service estate to locate all life sentence prisoners in establishments where they can work on their offending and develop the skills necessary to satisfy the Parole Board that their risk has been reduced. However, it would appear from the documentation at my disposal that the man's first referral to a 'First Stage Lifer Unit' (in this case HMP Parkhurst) did not happen until October 2005.
50. Whilst there is no evidence whatsoever that this apparent delay between sentencing and a referral to a First Stage Lifer Unit had anything to do with the man's death, his continued location in a "large and overcrowded local prison" (HMCIP report, October 2005) is very disappointing.
51. Although I refrain from making any recommendations in light of these findings, I draw them to the attention of the Prison Service as an area of concern.

The accessibility of the Healthcare Centre to frail prisoners

52. The Clinical Review recommends that West Leeds Primary Care Trust “consider how the environment within the Healthcare inpatient unit might be adapted to take into account the needs of frail elderly patients” such as the man who is the subject of this report. This recommendation raises questions about the in-patient unit’s ability to meet its duty of care to prisoners with mobility problems, irrespective of the efforts of the Healthcare staff.

HMP Leeds must consider how the environment within the Healthcare in-patient unit might be adapted to take into account the needs of frail elderly patients and those with mobility problems.

General Practitioner services at HMP Leeds

53. Over the course of my investigation into the man’s death, a recurrent issue has been the extent to which clinical staff report that the locum doctor is stretched to achieve even the most basic level of service delivery. Whilst there is no evidence to suggest that this situation contributed to the man’s death, it is a cause for concern.
54. Leeds West PCT, which is responsible for delivering General Practitioner services at Leeds, has considered the concerns raised by my investigator and provided the following response:

‘The prison has a relatively small practice population of 1150; this is half the average GP list size. To provide care for this population (i.e. [in] recognition of the more complex case mix) we have:

- A clinical director for substance misuse (GP – 6 sessions)
- A clinical director for general practitioner development (GP – 3 sessions)
- Sessional commitment from GP’s in the evenings and on weekends
- A GP (8 sessions per week, Monday to Friday)
- A consultant psychiatrist (5 sessions per week)

In addition there is a nursing team of 35, 15 healthcare officers, seven pharmacy staff, a psychologist (one session per week), a mental health inreach team, a practice manager with administrative support, as well as a senior management team.

We have previously investigated a suggestion that the locum GP was “stretched”. There is no evidence to support this. We have recently recruited a full-time GP and expect we will not require an additional full-time post.’

58. I thank Leeds West PCT for looking into this matter and reviewing the level of GP provision at the prison. I was pleased to learn that a full-time

GP has been recruited and that GP services are available at evenings and weekends.

The disappearance of prison records

59. I was disappointed to find out that the bedwatch records covering the period from 8.15am on 25 February until 3.20pm on 1 March have been mislaid by HMP Leeds and apparently cannot be located.
60. I refrain from making a recommendation about record-keeping as the prison is already fully aware of its importance. I do not consider that the apparent loss of the man's bedwatch notes is the result of inappropriate systems currently in place.

Recommendations and Good Practice

1. HMP Leeds must consider how the environment within the Healthcare in-patient unit might be adapted to take into account the needs of frail elderly patients and those with mobility problems.

Good practice

2. Arranging for **'s next of kin, a prisoner in another prison, to visit him in hospital is an example of good practice.
3. Principal Officer Paul Simpson should be commended by the Governor for clarifying the potential confusion surrounding the use of restraints.