Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Laurence Hughes, a prisoner at HMP Littlehey, on 1 April 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Laurence Hughes died in hospital on 1 April 2023 of bronchopneumonia while a prisoner at HMP Littlehey. He was 81 years old. We offer our condolences to Mr Hughes' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Hughes received at HMP Littlehey was equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found no non-clinical issues of concern.

The Investigation Process

6. On 1 April 2023, HMPPS informed us of Mr Hughes' death.

7. NHS England commissioned an independent clinical reviewer to review Mr Hughes' clinical care at Littlehey.

8. The PPO investigator investigated the non-clinical issues relating to Mr Hughes' care.

9. The PPO family liaison officer wrote to Mr Hughes' daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked about Mr Hughes' clinical care in prison, and why she was not informed that Mr Hughes was going to hospital within 72 hours. We have answered her questions in the clinical review and our report. Mr Hughes' daughter also asked about the care Mr Hughes received in hospital and we have responded in separate correspondence.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. Mr Hughes family received a copy of the initial report. They did not make any comments.

Previous deaths at HMP Littlehey

12. Mr Hughes was the forty fifth prisoner to die at Littlehey since April 2020. Of the previous deaths, 41 were from natural causes, two were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Hughes' death and our investigation findings for the previous deaths.

Key Events

13. On 16 March 2022, Mr Laurence Hughes was remanded to HMP Elmley for sexual offences. He was 80 years old. On the 10 June, he was sentenced to eight years in prison and remained at Elmley.

14. Mr Hughes had some medical conditions when he arrived in prison. He had an ulcer on his left foot which needed dressing weekly, type 2 diabetes, but was not taking any medication, a damaged vertebrae and gout.

15. On 10 August, Mr Hughes was transferred to HMP Littlehey.

16. Following his arrival at Littlehey, a nurse completed Mr Hughes' initial health screen. She recorded that he had poor mobility and noted that this needed to be followed up at his secondary health screen the next day.

17. On 11 August, a nurse completed Mr Hughes' secondary screen. Mr Hughes said that he was diabetic but was in remission and was no longer taking his medication, metformin (used to treat type two diabetes). She recorded Mr Hughes as being elderly, frail and using a walking stick. Mr Hughes denied any previous falls and could walk well with his stick.

18. In September, Mr Hughes developed ulcers on his toes. Healthcare staff dressed and treated him, but as the ulcers healed, he developed an ulcer on his left ankle and had pressure damage to his heels and toes.

19. In November, Mr Hughes was diagnosed with neuropathy (nerve damage which can cause loss of sensation, pain and weakness) and was prescribed a buprenorphine patch (strong pain relief) to help manage his pain. (He did not use the patches consistently.)

20. On 21 November, a palliative care consultant met with Mr Hughes for an 80 year old plus review, and to discuss symptom management and pain relief for his neuropathy diagnosis. They also discussed an advance care plan (ACP – where clinicians have conversations with patients and make decisions about future care and support requirements).

21. On 12 December, Mr Hughes had a scheduled hospital appointment and was escorted to hospital. Mr Hughes had some X-rays and the results showed that he had osteomyelitis (inflammation and swelling in the bone). When he returned to Littlehey, healthcare staff saw him and advised him to keep taking his pain relief, gently mobilise when he could and to continue to change his dressings when necessary.

22. On 19 December, the palliative care consultant and an occupational therapist visited Mr Hughes in his cell. Mr Hughes said that he was struggling to stand and complained of pain in his feet, ankles and knees. Mr Hughes was non-compliant with medication and did not want additional aids or support from social care. Mr Hughes agreed to use the buprenorphine patches to try and get his pain under control and it was agreed social care would visit him daily for additional support.

23. On 20 January 2023, the prison appointed a Family Liaison Officer (FLO), due to Mr Hughes' decline in health.

24. On 30 January, a GP at the prison saw Mr Hughes about his ulcers. Mr Hughes agreed to take amitriptyline (a medication used to manage neuropathic and nerve pain) at night.

25. On 6 February, the palliative care consultant saw Mr Hughes. He told her that he had not been taking amitriptyline at night because he thought the dose was too high. She advised him that this medication would help him with the pain at night. She noted that Mr Hughes had deteriorated since the last visit and showed increased frailty.

26. On 14 February, a new FLO was appointed.

27. On 24 February, Mr Hughes' carer pressed the emergency cell bell because Mr Hughes had fallen over. Two officers attended the cell and found Mr Hughes under his desk, but he was conscious and breathing. One officer told a nurse that Mr Hughes had banged his head during the fall. The nurse said he would come and check on Mr Hughes before officers assisted him up with the air bag (which is used to assist people with getting up off the floor).

28. The nurse attended Mr Hughes' cell and assessed him. Mr Hughes had a NEWS2 Score (a scoring system that detects the deterioration in patients - a score of 7+ requires emergency response) of 7, a very high temperature of 38.2, a very high pulse rate of 135 beats per minute and a very low blood pressure at 87/71. Staff called an ambulance to take Mr Hughes to the hospital and the nurse said his vital signs needed to be monitored every 15 minutes until the ambulance arrived.

29. An ambulance arrived and took Mr Hughes to hospital. Two officers escorted him, and he was not restrained.

30. The hospital staff confirmed that Mr Hughes needed to stay in hospital for more tests and observations. Mr Hughes did not return to Littlehey.

31. Mr Hughes still had the ulcer on his ankle when he was taken to hospital. He had been supported by the healthcare team with regular dressing changes and ulcer reviews and management, but the ulcer would not heal.

32. On the 1 March, the FLO contacted Mr Hughes' daughter and informed her that her father was not well and had been admitted to hospital. Arrangements were made for Mr Hughes' family to visit him. Mr Hughes' daughter raised concerns that the prison had not told her Mr Hughes was in hospital until six days after his admission. The FLO explained that Mr Hughes had not been assessed as seriously ill when he was sent to hospital on 24 February but had been admitted for on-going monitoring. He said that he had informed Mr Hughes' family as soon as it became clear that Mr Hughes was seriously unwell, and he had been able to identify the correct next of kin details.

33. On 7 March, the palliative care consultant informed prison healthcare staff that Mr Hughes was being treated for sepsis, which had occurred from the ulcers and wounds on his feet.

34. On 14 March, Mr Hughes was diagnosed with COVID-19. His health began to deteriorate, and he became less responsive to treatment. Staff started an application for compassionate release on Mr Hughes' behalf. Mr Hughes died before the application was completed.

35. On 24 March, hospital staff told a nurse at Littlehey that Mr Hughes was not taking his medication, he was also not allowing staff to check his pressure areas and change the dressings.

36. On 29 March, a prison manager approved an application for a special purpose licence, so that Mr Hughes could receive palliative care at hospital. This meant that one prison officer remained with him.

37. That day, a palliative care nurse at the hospital contacted the healthcare team at Littlehey, to inform her that Mr Hughes had deteriorated, and they were making a referral to a hospice. Mr Hughes died before the application was made.

38. On 1 April, it was confirmed that Mr Hughes had died in hospital.

Post-mortem report

39. The post-mortem report gave Mr Hughes' cause of death as bronchopneumonia. Hypertensive heart disease was also listed as a contributory factor.

Adrian Usher
Prison and Probation Ombudsman **January 2024**

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