Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Kimmins, a prisoner at HMP Littlehey, on 27 March 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Kimmins died in hospital on 27 March 2020 from COVID-19 while a prisoner at HMP Littlehey. He was 77 years old. I offer my condolences to Mr Kimmins' family and friends.

Mr Kimmins had advanced Parkinson's disease and in the last six months of his life he regularly fell in his cell overnight. Early on 20 March, prison staff found Mr Kimmins on the floor of his cell. It appears that he had been there for several hours following a fall. He was taken to hospital with suspected aspiration pneumonia and died a week later.

The investigation found that Mr Kimmins' clinical care was equivalent to that which he could have expected to receive in the community. He did not display any symptoms of COVID-19 in prison and tested negative for the virus when he first went to hospital on 20 March. It, therefore, appears likely that he contracted COVID-19 in hospital and not in prison, although we cannot be certain.

However, I am very concerned that such a frail elderly man lay on the floor of his cell overnight without being found by prison staff. I have recommended that the Governor commissions a fresh investigation into how this happened.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2021**

Contents

Summary

Events

1. Mr Anthony Kimmins was serving a sentence of 11 years and six months for sexual offences and had been at HMP Littlehey since September 2018.

2. Mr Kimmins had several long-term health conditions, including Parkinson's disease. He often experienced 'freezing' (a symptom of Parkinson's), which prevented him from being able to move and he regularly fell over in his cell during the night.

3. In September 2019, Mr Kimmins said his 'freezing' episodes had increased and prison staff were finding it difficult to support him during the night. Mr Kimmins told a prison GP that he did not want to move to a prison with 24 hour healthcare.

4. On 3 March 2020, healthcare staff provided Mr Kimmins with a commode and a personal emergency alarm. A prison manager noted in the wing observation book that prison staff should monitor Mr Kimmins hourly overnight.

5. On 19 March, Mr Kimmins fell over in his cell at about 10.00pm and was not found by prison staff until 5.20am the next day, 20 March. Healthcare staff were not informed of the fall until around 10.00am. They examined Mr Kimmins and arranged for him to be admitted to hospital with suspected aspiration pneumonia.

6. Healthcare staff subsequently completed a safeguarding incident form and recorded information about a lack of overnight observations and the failure to report to healthcare staff the injuries Mr Kimmins had sustained when he fell.

7. A routine test for COVID-19 in hospital on 20 March was negative. On 26 March, Mr Kimmins tested positive for COVID-19. He died on 27 March.

8. The Coroner accepted Mr Kimmins' cause of death as COVID-19, with advanced Parkinson's disease and frailty of old age as contributing factors.

Findings

9. The clinical reviewer concluded that the clinical care Mr Kimmins received in prison was of a good standard and equivalent to that which he could have expected to receive in the community.

10. Mr Kimmins did not display any symptoms of COVID-19 at Littlehey. He tested positive for COVID-19 six days after his admission to hospital. Although we cannot say for certain where or when he contracted the virus, it seems likely that it was in hospital.

11. We are, however, very concerned that it was possible for Mr Kimmins to lie on the floor of his cell for several hours overnight without being found by prison staff, despite being known to be at high risk of falls and despite a prison manager having said he should be monitored at hourly intervals at night. We are also concerned that prison staff did not inform healthcare staff about Mr Kimmins' fall until more than three and a half hours after Mr Kimmins was found.

12. We consider that the prison's internal investigation into these failings was inadequate and that the Governor needs to conduct a further investigation into what happened.

13. We are satisfied that since Mr Kimmins' death, the prison has introduced measures to ensure that prisoners who are at an increased risk of falling are identified and appropriately monitored.

Recommendations

- The Governor should commission an investigation into the failure to put hourly observations in place for Mr Kimmins during the night and the failure to contact healthcare staff promptly on 20 March, with a view to considering whether disciplinary action is appropriate.
- The Head of Healthcare should ensure that healthcare staff are aware of Northamptonshire Healthcare NHS Foundation Trust's policy for safeguarding responsible adults and that staff adhere to the policies, procedures and guidelines.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her.

15. The investigator obtained copies of relevant extracts from Mr Kimmins' prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Kimmins' clinical care at the prison.

17. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. The coroner gave us the cause of death. A post-mortem examination was not carried out. We have sent the coroner a copy of this report.

18. We wrote to Mr Kimmins' son, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any specific issues for the investigation to consider.

19. We shared our initial report with HM Prison and Probation Service. They did not find any factual inaccuracies. They provided an action plan which is annexed to this report.

20. We sent a copy of our initial report to Mr Kimmins' son. He did not notify us of any factual inaccuracies.

Background Information

HMP Littlehey

21. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men convicted of sexual offences.

22. Northamptonshire Healthcare NHS Foundation Trust (NHFT) commissions healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm Monday to Friday, and from 8.00am to 5.30pm at weekends. A local practice provides GP services and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

23. The last inspection of HMP Littlehey took place in August 2019. Inspectors found that prisoners were generally positive about health services and there was a wide range of good and responsive primary care clinics and services. The prison responded proactively to the needs of the large population of prisoners aged over 50.

24. HMIP conducted a scrutiny visit to Littlehey in June 2020 (in line with its COVID-19 methodology) and reported that the prison had adopted clear plans to manage the COVID-19 pandemic at the start of the lockdown. Littlehey had been declared an official outbreak site in March. HMIP reported that the prison, in conjunction with Public Health England (PHE), took swift action to control the spread of the virus and managed to bring infection rates down to a manageable level.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2019, the IMB reported that the opportunities and facilities for older prisoners had decreased. Prisoners with poor mobility were unable to access the healthcare unit because it was located on the first floor. The Board noted that external healthcare appointments were capped, and no routine appointments were kept for prisoners. They concluded that this was not equivalent to healthcare in the community.

Previous deaths at HMP Littlehey

26. Mr Kimmins was the 15th prisoner to die at Littlehey since March 2018. Of the previous deaths, 13 were from natural causes (including one from COVID-19) and one was self-inflicted. There have been eight deaths from natural causes since, including one COVID-19 related death, and one self-inflicted death.

COVID-19 (Coronavirus)

27. COVID-19 is an infectious disease that affects the lungs and airways. On 11 March, the World Health Organisation declared COVID-19 as a worldwide pandemic.

28. COVID-19 can make anyone seriously ill, but the risk is higher for some people. People at high risk include those who have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

29. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March, respectively). Public Health England (PHE), HM Prison & Probation Service (HMPPS) and NHS England worked together to devise measures to contain the outbreak, achieve social distancing, reduce the risk to the most vulnerable in prisons in England and protect the NHS (by reducing the number of people requiring specialist care in community-based hospitals).

30. On 13 March, PHE's National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks. The guidance set out the importance of effective preventative measures and that methodical cleaning would help prevent infection spread.

31. On 24 March, HMPPS issued an instruction to all prisons to implement a restricted regime and to enforce social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were to be identified and put into protective isolation.

32. On 31 March, HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation' were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included protective isolation units to accommodate known COVID-19 cases and shielding units to protect the most clinically vulnerable prisoners.

Key Events

33. On 3 July 2015, Mr Anthony Kimmins was sentenced to 11 years and six months in prison for sexual offences and sent to HMP Lewes. He spent time in several prisons before he transferred to HMP Littlehey on 6 September 2018.

34. Mr Kimmins had several long-term health conditions. He was diagnosed with Parkinson's disease in 2012 and had a pacemaker fitted in 2013. He also had hypertension (high blood pressure), thoracic back pain and bladder muscle dysfunction. In September 2018, Mr Kimmins signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to say that he did not want to be resuscitated if his heart stopped beating.

35. Mr Kimmins had poor mobility due to the progression of Parkinson's disease and used a wheeled walking frame. He had numerous falls and healthcare staff noted that he tended to fall over in his cell overnight when he was using the toilet.

36. On 28 August 2019, a prison GP assessed Mr Kimmins. She noted that he lived in a disability cell and often got up during the night to walk around. She considered that Mr Kimmins did not need 24 hour healthcare support and that his needs were related to his social care. Mr Kimmins said that he did not wish to move to a prison with 24 hour healthcare.

37. On 4 September 2019, Mr Kimmins had a full social care review with a clinical services manager. Mr Kimmins said that he had started to 'freeze' a lot more and she noted that prison officers were finding it more difficult to support him on the wing, especially when he was freezing during the night. (Freezing is a common symptom of Parkinson's disease and patients describe it as feeling like their feet are glued to the ground. Freezing can prevent patients being able to move for several minutes.)

38. A prison GP assessed Mr Kimmins on 19 September. He noted that Mr Kimmins was freezing at night at least three times a week and he was often unable to use the toilet. The prison GP discussed Mr Kimmins with a specialist Parkinson's nurse who advised changes to his medication. Prison staff arranged for a prisoner carer to help Mr Kimmins with his daily living.

2020

39. On 29 February 2020, a nurse saw Mr Kimmins after he fell twice in his cell during the night.

40. On 1 March, a prison manager and the clinical services manager assessed him in his cell to see if there were any additional aids that would reduce his risk of falling. Mr Kimmins said that he tended to get up and walk around his cell because his bones were aching. The clinical services manager noted that Mr Kimmins was wearing appropriate footwear, had a handrail in his cell and used a walking frame. The prison manager noted in the wing observation book that staff should monitor Mr Kimmins hourly overnight.

41. On 3 March, prison staff completed a Social Care Assessment Referral Form (SCARF) and provided Mr Kimmins with a commode. He was also provided with a personal emergency alarm to alert his prisoner 'buddy' when he needed assistance.

Events of 20 March

42. At approximately 5.20am on 20 March, prison staff found Mr Kimmins slumped against his chair on the floor of his cell. He was not wearing his personal emergency alarm. Staff did not know how long Mr Kimmins had been in that position.

43. A Custodial Manager (CM) who was the night orderly manager, was called and he checked Mr Kimmins over. He was apparently able to have "a reasonably normal conversation" with him. Mr Kimmins had liquid draining from his nose and he told prison staff that he had experienced a 'freezing' episode. He said that he was not in pain. The CM concluded that it was not necessary to call an ambulance because there was no immediate risk to Mr Kimmins, and he had no visible injuries and was not in pain. Prison staff washed and dressed him and helped him into bed. A note in the wing observation book said that staff should monitor Mr Kimmins every thirty minutes until he was assessed by healthcare staff.

44. The prisoner who was appointed as Mr Kimmins' buddy (to help him with everyday care) later told the prison's internal investigation that Mr Kimmins had pressed his personal alarm during the early hours to alert him that he needed help of some kind, and he had then pressed his cell bell and alerted the night staff. However, the investigation report went on to say, "This has been checked with the night OSG [operational support grade] and the cell bell call outs and there is no evidence that the cell bell was activated."

45. At 7.42am, a CM recorded that healthcare staff had cancelled Mr Kimmins hospital appointment that day because of his ill health. At 2.13pm, a nurse made a retrospective entry in Mr Kimmins' medical record saying that that prison staff had initially asked healthcare staff to see Mr Kimmins because he was feeling unwell and had vomited in the night and had made no mention of a fall. The Head of Healthcare told the clinical reviewer that prison staff did not ask healthcare staff to see Mr Kimmins' until 10.00am on 20 March and that there was no formal handover between prison night staff and healthcare staff.

46. Two nurses examined Mr Kimmins at about 10.00am. They found that Mr Kimmins had vomited and been incontinent of urine. He could not respond verbally and communicated with a thumbs up or down sign. They recorded his oxygen saturation level as 93-94% (the normal range is 95-100%), his temperature as 36.5°C and pulse rate as 84 beats per minute. They gave him his medication and asked a prison GP to see him.

47. At about noon, a prison GP assessed Mr Kimmins, together with three nurses . The prison GP noted that Mr Kimmins was drooling, had low oxygen saturation and was unable to stand unaided. He was, however, able to speak as his Parkinson's medication had taken effect. He said he had fallen at about 10.00pm and been unable to get up or call for help. A nurse later recorded that she had asked an un-named prison officer if Mr Kimmins had been observed over night and was told that Mr Kimmins "had a bell and should have rung it".

48. The prison GP found that Mr Kimmins' condition and the injuries to his hip were consistent with having been immobile on the floor for several hours. She diagnosed him with pressure area wounds and possible rhabdomyolysis (when damaged muscle breaks down very quickly) and aspiration pneumonia and arranged for him to be taken to hospital by a non-emergency ambulance (which arrived within 30 minutes). Mr Kimmins left prison by ambulance at about 1.50pm. He was accompanied by two prison officers and was not restrained.

49. Healthcare staff completed a patient safety incident form about Mr Kimmins' fall. They noted his lack of overnight observations, the failure of prison staff to report the incident at the time and the injuries Mr Kimmins had sustained. The Head of Healthcare said that he asked the prison to report the incident as a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).

50. On 20 March, Mr Kimmins was given a routine test for COVID-19 in hospital. The results were negative. He was treated with high levels of oxygen and hospital staff decided he was suitable for end of life care. On 26 March, Mr Kimmins tested positive for COVID-19. He died the next day.

Contact with Mr Kimmins' family

51. The prison appointed a Reverend as family liaison officer (FLO) and identified Mr Kimmins' son as his next of kin. Mr Kinder arranged for Mr Kimmins' son to visit him in hospital. In accordance with COVID -19 restrictions, Mr Kinder broke the news of Mr Kimmins' death by telephone.

52. The prison contributed to the cost of Mr Kimmins' funeral in line with national guidance.

Support for prisoners and staff

53. The prison posted notices informing other prisoners of Mr Kimmins' death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Kimmins' death.

Post-mortem report

54. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Kimmins' cause of death as COVID-19, with advanced Parkinson's disease and frailty of old age as contributing factors.

The internal investigation

55. After Mr Kimmins' death, the Governor commissioned a prison manager to carry out a factfinding investigation. The prison manager investigation report, dated 4 June 2020, concluded that "there is no evidence to suggest staff were negligent in their duties and commissioning of a Disciplinary investigation is not needed in this situation". He said that there had been "some confusion in communication with the handover between the day staff and the healthcare staff in regards to the healthcare

staff not understanding that [Mr Kimmins] had fallen in the night" and he made some recommendations for improvement.

Findings

Clinical care

56. The clinical reviewer concluded that the clinical care that Mr Kimmins received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community.

57. He had care plans in place to monitor his long-term health conditions, skin integrity, pain management and palliative care. He was accommodated in a disability cell with a hospital bed and a pressure relieving mattress, and he was given the opportunity to discuss a transfer to another prison if he felt he needed overnight and enhanced healthcare. When Mr Kimmins' Parkinson's disease progressed, healthcare staff assessed his social care needs and provided him with additional equipment.

Management of Mr Kimmins' risk of catching COVID-19

58. At the outbreak of the pandemic, Mr Kimmins was not identified as at high risk of contracting the COVID-19 virus and he was not required to shield. On 24 March, Mr Kimmins was identified as high risk, but he was already in hospital by this time.

59. Mr Kimmins was routinely tested when he was admitted to hospital on 20 March with a negative result. He subsequently tested positive on 26 March. Mr Kimmins displayed no symptoms of COVID-19 while he was at Littlehey and, although we cannot be sure, it, therefore, seems likely that Mr Kimmins contracted COVID-19 in hospital rather than at Littlehey.

Safeguarding

60. Mr Kimmins had regular falls in his cell overnight and on 1 March, a prison manager noted that prison staff should complete hourly observations on him during the night. We are very concerned that these observations had clearly not taken place on the night of 19/20 March, and that Mr Kimmins may have been on the floor for more than eight hours before he was found. We do not know if the overnight observations had ever taken place.

61. We are also concerned that prison staff did not report Mr Kimmins' fall to healthcare staff until some time between 9.00 and 10.00am (at least three hours after Mr Kimmins was found on the floor of his cell), even though healthcare staff were on duty in the prison from 7.30am. In addition, prison staff did not tell healthcare staff that Mr Kimmins may have been on the floor for several hours before he was found and healthcare staff only discovered this when Mr Kimmins told them. The prison's internal investigation found that there was "confusion and miscommunication around this information" and that healthcare staff would have responded more quickly if they had been aware that Mr Kimmins had fallen and been unable to get up during the night.

62. Since Mr Kimmins' death, the prison told us that they have introduced measures to monitor prisoners who are at risk of falling. Prisoners who are identified as at an

increased risk are reviewed weekly at the Safety Intervention Meeting and are provided with a fall detector. Prisoners who need to be monitored overnight are identified on the daily briefing sheet and observations are recorded in the wing observation book. The prison has also provided healthcare staff with access to the daily briefing sheet and has introduced a formal handover between prison night staff and healthcare staff.

63. We are satisfied that these measures will ensure prisoners who are at risk of falling are appropriately monitored and healthcare staff are aware of prisoners who have caused concern during the night.

64. However, we are concerned that the prison's internal investigation did not address the key question of why Mr Kimmins was not being observed on an hourly basis overnight in line with the prison manager's instructions in the wing observation book on 1 March. If observations had been taking place, Mr Kimmins would have been discovered within an hour and would not have been lying on the floor for several hours. If he had been found earlier, it is possible that his condition would not have deteriorated to the point where he needed to go to hospital.

65. The prison manager's recorded in his investigation report that on 1 March he "spoke to the staff to ask them to keep an hour [sic] eye on [Mr Kimmins] over night which was recorded in the Observation book but there was nothing formal put in place." We consider that the internal investigation should have considered whether this was an adequate way of communicating such key instructions about the care of a vulnerable prisoner, and, if it was, why staff were not conducting hourly checks.

66. We are also concerned that the internal investigation did not adequately consider whether staff should have called an ambulance or spoken to an out of hours doctor for advice when they found Mr Kimmins on the floor, given his age, medical issues and the fact that they did not know how long he had been lying on the floor. In addition, although it was recorded that staff should check Mr Kimmins every 30 minutes until healthcare staff had seen him, we have seen no evidence that such checks took place or that the deterioration in Mr Kimmins' condition before healthcare staff saw him at about 10.00am was noted. We are also concerned that no one had responsibility for ensuring that healthcare staff were told about the fall when they came on duty at 7.30am.

67. For these reasons, we do not consider that the internal investigation was an adequate investigation of what went wrong and why. We recommend:

The Governor should commission an investigation into the failure to put hourly observations in place for Mr Kimmins during the night, and the failure to contact healthcare staff promptly on 20 March, with a view to considering whether disciplinary action is appropriate.

68. The clinical reviewer said that the Head of Healthcare did not know if the prison had reported the patient safety incident to the Health and Safety Executive (HSE) and had not investigated healthcare staff's concerns about Mr Kimmins' care. The Head of Healthcare said that safeguarding was a prison responsibility and while healthcare staff sought advice and support from safeguarding teams, it was the prison's responsibility to report safeguarding incidents.

69. The clinical reviewer said that relying on another party to raise a safeguarding concern was not in accordance with NHFT's policy for safeguarding vulnerable adults which says:

> "If an adult has died as the result of abuse or neglect (whether known or suspected) and there is a concern that partner agencies could have worked more effectively to protect the adult, then Local Safeguarding Adult Boards are to commission a Safeguarding Adult Review (SAR)."

70. The clinical reviewer considered that while the application of safeguarding policy will vary between the community and a custodial setting, it was the responsibility of the Head of Healthcare to ensure that safeguarding concerns raised by healthcare staff were actioned and that staff were aware of the outcome of any investigation into those concerns. We recommend that:

The Head of Healthcare should ensure that healthcare staff are aware of NHFT's policy for safeguarding responsible adults and that staff adhere to the policies, procedures and guidelines.

Inquest

71. The inquest, heard on 2 October 2023, concluded that Mr Kimmins died from natural causes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100