Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Christian, a prisoner at HMP Littlehey, on 18 August 2022

A report by the Prisons and Probation Ombudsman

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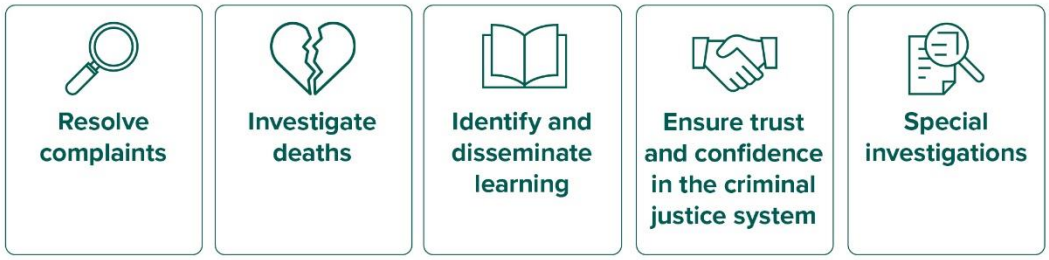
OUR VISION

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

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.

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

Mr Anthony Christian died in hospital on 18 August 2022 of multi organ failure and necrotising pancreatitis (when tissue in the pancreas dies), while a prisoner at HMP Littlehey. He was 42 years old. I offer my condolences to Mr Christian's family and friends.

Mr Christian had complex medical needs which were challenging to meet in a prison setting. His condition stabilised when he transferred to HMP Littlehey. However, when he transferred to HMP Wandsworth temporarily, healthcare staff at the prison found it difficult to manage his condition, which worsened during his time there.

The Chief Inspector of His Majesty's Inspectorate of Prisons considered that healthcare provision at Littlehey was good and found that prisoners were positive about the quality of healthcare they received. The Independent Monitoring Board at Littlehey noted that most clinics for physical health were up and running and provided a good service.

The clinical reviewer concluded that the clinical care Mr Christian received at Littlehey was equivalent to what he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. In 2013, Mr Anthony Christian was convicted of sexual offences. He was released from prison in April 2019, but was recalled in December and faced further sexual offences charges. He was sent to HMP Highdown. On 6 January 2020, Mr Christian transferred to HMP Littlehey.

2. Mr Christian had a complicated and significant medical condition called ulcerative colitis. He was under the care of hospital specialists and received treatment which included eight weekly hospital-administered medication infusions to help ease his condition. Healthcare staff saw him regularly to review and adjust his medications.

3. On 7 September 2021, Mr Christian was temporarily transferred to HMP Wandsworth to attend court. He was allocated a cell was that was in poor condition, which caused him stress and anxiety. Mr Christian had a flare up of ulcerative colitis while at Wandsworth and felt the treatment he received there contributed.

4. In November, Mr Christian returned to Littlehey. Healthcare staff noted that his colitis had worsened. They conducted a medication review and made further changes to his medication and referred him to hospital to stabilise his condition.

5. In March 2022, Mr Christian was admitted to hospital to treat another flare up of his condition. On his return to Littlehey, the doctor changed his prescribed medication. Mr Christian was unhappy about this. Hospital staff submitted a safeguarding concern to Littlehey as a result.

6. On 22 May 2022, Mr Christian's condition deteriorated further. Healthcare staff sent him to hospital. Mr Christian remained in hospital and, on 18 August, died of multi-organ failure caused by necrotising pancreatitis.

Findings

7. The clinical reviewer concluded that the clinical care Mr Christian received at Littlehey was of a good standard and at least equivalent to what he could have expected to receive in the community.

8. The clinical reviewer found that there were some issues with Mr Christian's care when he temporarily transferred to Wandsworth for his court appearances, which impacted on the management of his ulcerative colitis.

Recommendation

- The Heads of Healthcare at Littlehey and Wandsworth should ensure that when a prisoner with complex medical needs transfers, relevant medical issues are discussed with the receiving prison.

The Investigation Process

9. HMPPS notified us of Mr Christian's death on 18 August 2022.

10. 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. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Christian's prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Christian's clinical care at the prison and conducted joint interviews with the investigator.

13. The investigator interviewed six members of staff over Microsoft Teams on 22 September and 30 November 2022.

14. We informed HM Coroner for Cambridgeshire and Peterborough Office of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Christian's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She said that she had a number of concerns about the way Mr Christian's health conditions were managed and his deterioration. She said that he had deteriorated when he had transferred to HMP Wandsworth and that she had raised her concerns about his living conditions and diet with the prison. These issues have been addressed in the clinical review and in this report.

16. Mr Christian's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Littlehey

18. HMP Littlehey is a medium security training prison, holding more than 1,200 adult male prisoners. Primary Care services are provided by Northamptonshire Healthcare NHS Foundation Trust (NHFT). Nurses are on duty between 7.30am and 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.

HMP Wandsworth

19. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,628 male prisoners in eight residential wings. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison.

HM Inspectorate of Prisons

20. The most recent full inspection of HMP Littlehey was an unannounced inspection in August 2019. Inspectors reported that Littlehey was a calm and safe prison with very little record of violence. The prison was generally clean and well maintained, but there were ongoing problems with overcrowding and the heating system caused significant issues. Healthcare was considered to be good and prisoners were positive about the quality of healthcare they had received.

21. HMIP also conducted a short scrutiny visit to Littlehey in June 2020 to look at how the prison was responding to the COVID-19 pandemic. Inspectors reported that the prison had adopted clear plans to manage the pandemic at the start of the lockdown. Littlehey was an official outbreak site between March and April 2020. HMIP reported that the prison, in conjunction with Public Health England (PHE), had taken swift action to control the spread of the virus and managed to bring infection rates down to a manageable level. However, inspectors found that, although health and safety protocols were in place, social distancing was difficult to maintain in small offices and corridors despite best efforts.

22. The most recent inspection of HMP Wandsworth was an independent review of progress in June 2022, after unannounced inspections in 2018 and 2021 made 12 key recommendations. They noted the prison remained very overcrowded with many prisoners living in very poor conditions. They said it was concerning that staff and managers were not doing everything they could to notice or address the issues that were in their control. Inspectors assessed that there were still very high rates of non-effective staff since the inspection. Prisoners lived in dirty, graffiti covered cells, some of which had no windows. The built environment was in disrepair in places. There was no credible plan to make sustainable improvements across the wings as oversight of the environment was weak and needed better coordination.

Independent Monitoring Board

23. 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 31 January 2022, the IMB reported that for the entire reporting period the prison was subject to severe restrictions in its normal regime and activities due to the necessary response to the coronavirus pandemic. Routine clinics recommenced from mid-May 2021 for most healthcare services with GP clinics recommencing slightly later in June 2021 and continued without problems.

Previous deaths at HMP Littlehey

24. Mr Christian was the 37th prisoner to die at Littlehey since August 2020. Of the previous deaths, 34 were from natural causes, one was self-inflicted and one was drug related. There have been nine natural causes deaths and one self-inflicted death since Mr Christian's death. There are no significant similarities between our findings in the investigation into Mr Christian's death and the findings of the previous deaths at Littlehey.

Safeguarding

25. Prison Service Instruction (PSI) 16/2015, *Adult Safeguarding*, sets out the duty of care and requirements on prisons to protect adults, particularly vulnerable adults. Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect. Prison staff have a common law duty of care to prisoners that includes taking appropriate action to protect them. Prisons should have a range of processes in place to ensure that this duty is met.

26. These processes should ensure that prisoners who are unable to protect themselves as a result of care and support needs are provided with a level of protection that is equivalent to that provided in the community. Definitions of abuse and neglect are based on those used in the Care and Support Statutory Guidance issued by the Department of Health in October 2014.

27. Responsibility for safeguarding in prisons rests with the Governor, who must appoint a prison manager to lead on safeguarding. The PSI encourages Governors to be proactive in engaging with the relevant local authority's Safeguarding Adults Board, both at a strategic level and as a source of advice and assistance in safeguarding prisoners.

Key Events

28. On 14 April 2012, Mr Anthony Christian was remanded to HMP Wandsworth. On 29 October 2013, He was sentenced to 14 years in prison for sexual offences. Mr Christian spent time in several prisons as he progressed through his sentence.

29. Mr Christian had a complex medical history of pancreatitis (a condition where the pancreas is inflamed), depression, rectal polyps, and ulcerative colitis (a potentially serious condition causing inflammation of the lower end of the digestive system). He was under the care of hospital specialists.

30. On 12 April 2019, Mr Christian was released on licence, having served seven years in prison. On 12 December, he was recalled to HMP High Down and faced further sexual offence charges.

HMP Littlehey

31. On 6 January 2020, Mr Christian was transferred to HMP Littlehey.

32. On arrival, a nurse completed Mr Christian's reception screen. She noted that he had received infusions of medication every eight weeks at a hospital in London to treat his chronic pancreatitis and ulcerative colitis. His next appointment was scheduled for the end of the month. A pharmacist at the prison conducted a medication review to ensure that Mr Christian continued to receive the medications he needed to manage his conditions. At this point, Mr Christian was prescribed pain relief medication, a range of medications to help manage symptoms of the ulcerative colitis and antidepressants.

33. The next day, a GP at the prison completed a review and noted that the scheduled appointment at the hospital should be kept and then arrangements made for Mr Christian's care to be transferred to a hospital in Cambridge.

34. In October, Mr Christian tested positive for COVID-19. Staff monitored him as he completed his COVID-19 isolation period.

35. In December, Mr Christian was charged with three sexual offences.

36. On 26 February 2021, Mr Christian tested positive for COVID-19 again. After a period of isolation and completing a course of antibiotics, he tested negative on 19 March.

37. Pharmacy services and GPs at the prison saw Mr Christian regularly and adjusted his medication and pain relief to manage his ulcerative colitis.

Events at HMP Wandsworth

38. On 7 September 2021, Mr Christian was transferred to HMP Wandsworth to attend his court hearing. There was no medical handover from Littlehey to Wandsworth. The reception nurse noted that although he was not having a flare up of his ulcerative colitis, he was experiencing bowel problems and his condition was being managed at the hospital.

39. Mr Christian was allocated a single cell to maintain his dignity due to his frequent need to use the toilet. However, the cell had a water leak. Water leaked from the toilet and around the wall and had flooded the cell (records indicate that the leak had begun from at least 1 September). Mr Christian's mother complained to the prison and said he was living in stagnant water.

40. On 8 September, healthcare staff referred Mr Christian to the local hospital to organise his next medication infusion (which was due in October). Healthcare staff made some changes to his medication. For his pain control they prescribed co-codamol. They commenced him on a steroid reduction of 5mg every five days. They placed him on a withdrawal programme for pregabalin as they noted this had been prescribed for his mental health and not pain control. His enemas were changed from a pressurised foam cannister applicator (pressurised containers were not allowed at Wandsworth due to flammability and safety risks associated with a pressurised can) to a liquid cannister enema and were dispensed on a monthly basis. Mr Christian complained that these were less effective.

41. On 10 September, Mr Christian's mother emailed staff at Wandsworth outlining his medical conditions because she was concerned that he had been allocated a flooded cell and his medical needs were not being addressed. In response, staff told her that Mr Christian was "ok" and "the issues had been forwarded to the relevant party".

42. Mr Christian's mother contacted staff at Wandsworth again on 15 September. She said that he was in a flooded cell and was using blankets to mop up the leak. When there were no more blankets, officers told him to use dirty clothes from the communal laundry basket. She also said his dietary needs (healthcare staff had recorded that that he had a wheat allergy) were not being met and pleaded for these issues to be resolved.

43. On 17 September, a member of the Safer Custody team conducted a welfare check. He noted that he had spoken to Mr Christian in his cell and that a plumber had attended to fix the leak.

44. On 21 September, a member of staff in the Business Hub emailed Mr Christian's mother to respond to her concerns. She wrote that he had been given old clothes to "manage the leak in his cell pending repairs and to address water leak issues". She also wrote that residential staff had been instructed that any leaking cells should be designated as out of use. She told Mr Christian's mother that Mr Christian had been referred to the mental health team and that healthcare staff had told him to choose food he could safely consume from the available varied menu.

45. Healthcare staff stopped Mr Christian's pregabalin medication and added a note to his medical record that this should not be prescribed without consultation with a psychiatrist. At interview, the Wandsworth healthcare managers said that their practice was robust for discontinuing pregabalin if it was not prescribed for an appropriate condition. (Pregabalin can be prescribed to treat pain but also anxiety. It is a controlled medication in prison and often illicitly traded because it can enhance the effects of other illicit drugs.) The healthcare managers had noted that Mr Christian's medical record suggested pregabalin had been prescribed for back pain and Post Traumatic Stress Disorder (PTSD) in 2017. However, pregabalin was not

licensed for use in PTSD and his psychiatric reports and communications did not recommend pregabalin.

46. They acknowledged that Mr Christian was not happy about the withdrawal of pregabalin, but the decision was revisited and re-discussed and Mr Christian reportedly understood.

47. The healthcare managers at Wandsworth said they used localised adaptions to the Safer Prescribing in Prisons as guidance, alongside NICE Guidelines and evidence bases.

48. On 13 October, Mr Christian's mother emailed the Business Hub again and raised concerns about her son's wellbeing. She said that he was very low in mood due to his medical and dietary requirements not being met. Staff from the Safer Custody Team responded and reassured Mr Christian's mother that they and healthcare staff would discuss her concerns with the wing manager and staff would liaise with healthcare staff to help manage his diet.

49. On 18 October, Mr Christian told healthcare staff that he had had 16 episodes of blood-stained diarrhoea and was supposed to have infusions at eight weekly intervals and his last one was on 10 August. He said that this was his first flare up in over two years and that he felt it was because he had not had a scheduled infusion. Hospital staff had arranged an infusion for 1 November.

50. On 21 October, Mr Christian's mother emailed the Safer Custody Team at Wandsworth and said that despite repeated requests, the GP at the prison had not authorised any pain relief for Mr Christian as he was in excruciating pain. In response, a member of staff in the Business Hub said that an infusion appointment had been made and a GP appointment and a mental health appointment had been booked at the prison.

51. After his infusion, Mr Christian said he was struggling with his diet, constipation, rectal bleeding and pain. GPs at the prison prescribed co-codamol, but Mr Christian stopped taking it because he said that it was not effective.

52. On 16 November, Mr Christian told staff that he had not received his planned diet and was in constant pain following the medication changes.

Events at HMP Littlehey

53. On 23 November 2021, Mr Christian was transferred back to Littlehey. Wandsworth healthcare staff did not provide a medical handover. At interview, healthcare managers at Wandsworth said that a standardised form detailing social care and medical needs was completed. However, there is no record of this.

54. A nurse completed Mr Christian's reception screen and noted that he needed an urgent referral to gastroenterology at the hospital for continuation of his infusions for his ulcerative colitis. A GP completed the referral and the infusion appointment was scheduled for 27 December. Mr Christian told staff that he had missed an infusion appointment and was struggling with his colitis. Healthcare staff checked his weight and noted that in seven months, he had lost 12.5 kg.

55. The next day, officers asked healthcare staff to visit Mr Christian in his cell as he was unwell. Mr Christian told the nurses that he was constipated and was passing dark red blood. The nurses checked his clinical observations and noted that they were all within the normal range and his NEWS2 score (a nationally recognised tool to monitor deterioration at specific trigger points) was 0. Nurses encouraged him to increase his fluid intake and contact healthcare staff if needed. They also contacted kitchen staff about his dietary requirements and recommended a low fibre, non-spicy diet.

56. On 29 November, a GP at the prison saw Mr Christian due to his colitis worsening. The GP reviewed his medication and referred him to gastroenterology for infusions to help get his condition under control.

57. Throughout December, Mr Christian told healthcare staff of problems dealing with his colitis flare up. He felt unwell with abdominal pains, used the toilet up to 20 times a day and had blood and mucus in his stools.

2022

58. On 5 January 2022, Mr Christian attended an outpatient appointment. Specialists arranged for him to have his infusion, and increased his steroid and pain relief medication. Mr Christian had another ulcerative colitis flare up in February. To try to stabilise his condition, he was admitted to hospital from 4 March until 6 April. Hospital staff diagnosed him with an acute and severe flare-up of his ulcerative colitis and on 12 March, he also tested positive for COVID-19. A hospital dietician recommended that Mr Christian needed to follow a gluten free, low fibre diet, avoiding red meat, pork and egg yolk. The hospital pain team prescribed pregabalin, oral morphine and buprenorphine patches (opiate medication).

59. On 7 April, Mr Christian was discharged from hospital and returned to Littlehey. On his return a GP saw him. They discussed his pain relief options with a view to reducing the opiate medication. He said these should gradually reduce and be eventually withdrawn as they were known to create intolerance to other treatments. In particular the GP was concerned about the long-term use of pregabalin and said that it was not clear if it had previously been prescribed for pain relief or to manage Mr Christian's anxiety. The GP noted that Mr Christian had agreed to the medication changes. However, on 11 April, the pharmacist at the prison noted that Mr Christian had said that he was happy to reduce and stop the pregabalin, but was not happy with the other medication changes.

60. On 13 April, Mr Christian had another review with the GP at the prison. They discussed stopping pregabalin by 3 May, while he switched to codeine for pain relief. The GP prescribed propranolol to help with his anxiety.

61. During a meeting with a mental health practitioner on 5 May, Mr Christian said that he was unhappy and angry about the pain relief decisions and wanted his upcoming appointment with the GP to be cancelled. The appointment was cancelled and another appointment booked with as different GP.

62. On 9 May, the GP saw Mr Christian. Mr Christian said that he was struggling with his colitis, his pain was not controlled, he was constipated despite taking laxatives

and had a swollen face. As the GP suspected this was from him taking propranolol, she stopped that medication.

63. On 22 May, Mr Christian was admitted to hospital with severe stomach pains. Hospital specialists noted that when Mr Christian was discharged from hospital in April, the prison had been managing Mr Christian's condition contrary to medical advice and had ignored family efforts to rectify the situation. The hospital Consultant Psychiatrist concluded that as a result, Mr Christian had deteriorated and was back in hospital. He said that the GP at the prison had discontinued the recommended hospital treatment (which had begun when Mr Christian was an inpatient and included the prescriptions for pregabalin and opiate based pain relief) and said the GP had made changes without consulting the hospital specialists. The Consultant made a safeguarding of vulnerable adults (SOVA) referral directly to the healthcare team at Littlehey. A SOVA referral is made when there are concerns that someone is facing neglect. It is an integral part of the NHS to ensure a patient receives good healthcare.

64. Two GPs at Littlehey responded to the SOVA referral and said that when Mr Christian was discharged from hospital in April, in line with prescribing guidelines in secure settings and NICE guidance to avoid misuse, and with Mr Christian's agreement, the pregabalin medication was stopped. The GPs also said that they had reviewed him frequently, and Mr Christian had seen the pharmacist when his medication had changed.

65. In hospital, Mr Christian was diagnosed with sepsis and multi-organ failure. His condition continued to deteriorate and on 18 August, Mr Christian died in hospital with his family present.

Contact with Mr Christian's family

66. When Mr Christian was admitted to hospital, the bedwatch staff were authorised to ring his next of kin (his mother) with updates and allow for family visits. The prison assigned a custodial manager as the family liaison officer (FLO) and a diversity and inclusion officer as the deputy FLO on 29 July 2022, The FLO contacted Mr Christian's mother to inform her and ensured arrangements were in place for family members to visit Mr Christian. The FLO spent several hours at the hospital with Mr Christian's family.

67. The FLO and the deputy FLO maintained contact with Mr Christian's mother and provided frequent updates. After his death, the FLO contacted his mother to offer support.

68. The prison contributed to the costs of Mr Christian's funeral, in line with national policy.

Support for prisoners and staff

69. After Mr Christian's death, a manager debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

70. The prison posted notices informing other prisoners of Mr Christian's 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 Christian's death.

Post-mortem report

71. The post-mortem report gave Mr Christian's death as multiorgan failure caused by necrotising pancreatitis (when tissue in the pancreas dies) and ulcerative colitis (subtotal colectomy July 2022 due to inflammation of the lower end of the digestive system).

Findings

Clinical Care

72. The clinical reviewer concluded that the clinical care Mr Christian received at Littlehey was equivalent to what he could have expected to receive in the community. She did, however, find that there were difficulties and inconsistencies in the management of Mr Christian's ulcerative colitis.

73. Mr Christian did not receive his infusions as prescribed when he transferred to Wandsworth. The clinical reviewer said that it was difficult to say if the delay exacerbated his ulcerative colitis. Overall, Mr Christian's ulcerative colitis was never really well controlled. Mr Christian needed a balance between pain relief and laxatives.

Continuity of care

74. Prison Service Order (PSO 3050) – *Continuity of Healthcare*, states that to ensure continuity of care, effective communication with colleagues is essential and that patients with more complex health care needs may require more detailed planning such as communicating directly with the receiving health care team in advance of transfer.

75. Healthcare staff at Wandsworth said that they had never received a handover from Littlehey detailing Mr Christian's medical needs therefore no plans were in place for him. There is no evidence that staff at Littlehey contacted Wandsworth's healthcare department to provide a full and detailed handover about Mr Christians complex medical conditions and no handover took place when he returned to Littlehey in November 2021. Given Mr Christian's complex clinical history and the requirement for frequent hospital infusions, a detailed clinical handover should have happened on both occasions. We make the following recommendation:

    The Heads of Healthcare at Littlehey and Wandsworth should ensure that when a prisoner with complex medical needs transfers to a different prison, relevant medical issues are discussed with the receiving prison.

76. The clinical reviewer made other recommendations about using a bowel monitoring chart diagnosed bowel conditions and minimising the possibility of drug diversion at Littlehey, which we do not repeat here, but which the Heads of Healthcare at Wandsworth and Littlehey will wish to consider.

Safeguarding referral

77. Hospital specialists completed a safeguarding of vulnerable adults (SOVA) referral as they had concerns about the prison's healthcare management of Mr Christian's complicated medical condition.

78. The clinical reviewer found that when the hospital made a safeguarding referral, this should have been made via the prison safeguarding team and not directly to the prison's healthcare unit. Since Mr Christian's death, Littlehey staff have put

measures in place to ensure that there is a multi-disciplinary approach to dealing with safeguarding referrals and have introduced an audit process for regular review.

79. Contrary to the hospital specialist's opinion, the clinical reviewer noted that there was good care with a patient centred approach when Mr Christian was at Littlehey. Healthcare staff involved him in decisions that affected his care and treatment.

Inquest

80. The inquest, held on 27 January 2025, concluded that Mr Christian died from natural causes.

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