

**Investigation into the circumstances surrounding the
death of a man
at HMP Littlehey in April 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2010

This is the report of an investigation into the death from natural causes of a man at HMP Littlehey in April 2009. He was 33 years of age.

I extend my sincere condolences to the man's family and friends and all those affected by his loss.

A clinical review of the man's care and treatment was carried out by the local Primary Care Trust.

The man died suddenly and unexpectedly. His cause of death was pulmonary embolus¹ secondary to deep vein thrombosis. The possible cause of the thrombosis was that he had been using a wheelchair for some months past. There is some evidence that his need for a wheelchair was feigned.

The clinical reviewer found that it would not have been possible to anticipate the man's cause of death. He also found that his clinical care was equitable with that which he would have received in the outside community.

I make one recommendation about the use of translation services at clinical consultations and brought a similar issue to the Governor's attention.

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

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Deputy Prisons and Probation Ombudsman

February 2010

¹ A blood clot obstructing a blood vessel supplying the lung.

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SUMMARY

The man was born in Poland in April 1975. He came to England in around 2000, with his partner and her young son.

The man was remanded into HMP Bedford in January 2007 to await sentencing following his conviction of assault occasioning actual bodily harm. He was subsequently given a five year extended sentence comprising a three year custodial period followed by a two year period on licence (during which period he could be recalled to prison if he breached his licence conditions). He spent time at two further prisons during 2007 before being transferred to Littlehey later that same year.

During reception health screening on arrival in Littlehey, the man was asked whether he had any physical or mental health problems. The only problem he reported was that he suffered from epilepsy, although he also reported he was receiving prescribed Olanzapine (an anti-psychotic medication).

The man's parole eligibility date (the earliest date he could be released) was July 2008. He applied for parole but his application was unsuccessful. From around this time onwards he began complaining repeatedly that his sentence had been miscalculated. He seemed to be under the impression that he was entitled to release once he had served a set part of his sentence – it seems he thought the two thirds stage – without the need for approval by the Parole Board.

Not long after this, a number of incidents occurred that might have been related to the man's frustration at remaining in prison custody. He began to complain about a loss of strength in his legs and, from around September 2008, was provided with a wheelchair. Despite this, he was still considered fit for work, although he disagreed with this assessment. When told that if he did not go to work he would remain locked in his cell, he both threatened to harm himself and then did so by cutting his arms. There is some evidence that his need for a wheelchair was feigned: on a number of occasions staff saw him both standing, as well as walking, around his cell. Additionally, on examination he was found not to have suffered any muscle wastage in his legs.

On an afternoon in April, an officer looked into the man's cell and saw him lying on his bed with his bed clothing wrapped around his stomach. The officer went into the cell to investigate and could not get a responsive from the man. The officer summoned assistance but despite all efforts to save him, the man was pronounced dead at 6.15pm. His cause of death was initially unclear but at post mortem he was found to have suffered a pulmonary embolus secondary to a deep vein thrombosis. The pathologist has said that his chances of a thrombosis were increased through his reduced mobility.

The medical care that the man received was reviewed by the local Primary Care Trust. The clinical reviewer found that the man's cause of death could not have been anticipated. The reviewer has, however, made one suggestion about how healthcare services at Littlehey could be improved.

THE INVESTIGATION PROCESS

1. The Ombudsman's investigator first visited HMP Littlehey in April 2009 when he met the prisons governing Governor. The investigator did not conduct any formal interviews, but he had informal discussion with a number of staff including the Residential Manager for B wing and one of the prison's Family Liaison Officers.
2. The local Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Littlehey prison.
3. One of the Ombudsman's Family Liaison Officers contacted the man's brother. to inform him of the scope of the investigation and to gave him the opportunity to ask any questions or to raise any concerns he wished to be considered as part of the investigation. The man's brother did not raise any specific issues that he wished to have explored although he did express an interest in seeing a copy of the investigation report.

HMP LITTLEHEY

4. HMP Littlehey is a modern prison in Cambridgeshire holding just over 700 adult convicted males. The prison has eight residential wings. Health services are commissioned by the local Primary Care Trust (PCT). A community based practice provides six GP sessions each week. Nurses provide primary care during day time hours. After 5.00pm, primary care is available through an out-of-hours service.

5. The most recent inspection of Littlehey by Her Majesty's Chief Inspector of Prisons was a full announced inspection in July 2007. The Chief Inspector's findings included:

"... This full announced inspection confirmed [previous inspection findings] that Littlehey remained an impressively safe prison, with mutually respectful staff-prisoner relationships, a reasonable amount of purposeful activity and an appropriate focus on resettlement.

"... Language issues [for foreign national prisoners] were identified on induction ... but although a list was kept about levels of written and spoken English, this was not always reflected in prisoners' wing files. Most staff knew which prisoners on their wings struggled with English, although this information was not readily available ... We were told about a number of prisoners whose English was very poor, but translations services were seldom used ...

"[We recommend that] information for foreign nationals about ... translation services should be displayed in a range of languages in residential areas."

6. The only matter contained in Independent Monitoring Board's report for the year 2008/2009 that is relevant to the man relates to prisoner complaints. Their report shows that during the previous four years, the number of sentence related complaints have risen year by year. Only one other of the 14 complaint categories reflects such a trend.
7. Prior to the man's death, there had been nine other deaths from natural causes at Littlehey since April 2004. No matters arising in those cases were of direct significance to the circumstances surrounding the man's death.

KEY FINDINGS

8. The man was born in Poland in April 1975. After leaving school he started work as a motor mechanic. Between 1999 and 2003 he had several brain scans after suffering head injuries. It seems that he first suffered injuries in a motor accident and subsequently during an assault. At some point around this time he moved to England with his partner and her young son.
9. In January 2007, the man was remanded into HMP Bedford having been found guilty of an offence of assault occasioning actual bodily harm. At that time he was still awaiting sentencing. A month later, he received a five year extended sentence. This comprised a three year custodial period to be followed by a two year period on licence. His parole eligibility date (the earliest date he could be released) was July 2008. His conditional release date (when his time on licence in the community would start) was January 2010.
10. Having spent time in three other prisons during 2007, the man transferred to HMP Littlehey in December 2007.
11. During reception health screening on arrival in Littlehey, the man was asked whether he had any physical or mental health problems. The only problem he reported was that he suffered from epilepsy which he said had arisen from the head injuries he had sustained when in Poland. (He was receiving prescribed medication – Carbamazepine – for this condition.)
12. With the mid point of the prison part of his sentence approaching, the man made an application for parole. (Had he been successful he would have been released in July 2008.) In June 2008, the Parole Board wrote to him refusing his application. The Board explained that the basis of their decision was that:

“[You] committed a violent offence against [your] partner, whilst subject to a community order for a very similar offence. [You continue] to demonstrate very little insight into [your] violent behaviour and [have] expressed a clear wish, in [your] representations, to resume [your] relationship with [your partner] despite having been informed that this will not be possible or acceptable. In the absence of firm evidence that the ‘high’ risk of harm to [your] partner has decreased the Panel is unable to share [your] confidence that [you are] a changed man ...”
13. The Board also explained in their letter that the man would be entitled to a further review. (If there were to be a further review, it would consider his eligibility for release in July 2009.)
14. In July, the man was visited by a consultant psychiatrist who wrote that:

“[The man] remains very distressed and upset, principally now about the separation from his ex-partner and [step son]. He also seems to be poorly occupied at present. He is approaching the halfway point of his sentence and tells me he is seeking a hearing in relation to the Parole Board decision

that he should not be released. He threatened to cut himself if he is not successful.”

15. The man had a mental health review with a community psychiatric nurse (CPN) in July which again explored the stress he was feeling about his young step son now that his parole application had failed. The CPN noted that he was being monitored through the ACCT² process at that time although he denied to her having any thoughts of suicide or self-harm.
16. From around this time onwards the man had very frequent healthcare consultations. The main problems he reported were fits or epileptic seizures and the loss of strength in his legs. The latter problem ultimately led to him being provided with a wheelchair. He continued to be prescribed medication for his epilepsy although he remained in a single cell.
17. In August, one of Littlehey’s doctors wrote a letter of referral to a consultant neurologist at a nearby NHS hospital. The doctor mentioned in his letter that the man had reported recurrent epileptic fits but that none of these had been witnessed by staff. The doctor also noted that he had denied experiencing any of the symptoms that can sometimes follow an epileptic fit, such as confusion or incontinence. The doctor listed his current anti-epileptic medication and asked the consultant neurologist to advise.
18. The man’s records over the following weeks and months contain repeated references to his complaints about the lack, or absence, of strength in his legs. His clinical records show that he was examined by a physiotherapist in September. She noted that on returning to his cell after collecting some analgesia for him she saw him standing completely unaided. She gave him a programme of exercises.
19. It has not been possible to establish the precise date, but at some time in September, the man was supplied with a wheelchair for his exclusive use. His records nevertheless contain frequent references to staff witnessing him standing or walking around his cell at times when he did not realise he was being observed.
20. Towards the end of October, the man was examined by the consultant neurologist at the NHS hospital following the referral from Littlehey six weeks earlier. The neurologist noted that there appeared to be no change in the frequency of the man’s seizures and she recommended that there be no change to his medication regime. However, the neurologist also remarked that the man was not accompanied by a Polish translator which made it difficult for her to obtain a clear history from him.
21. As a convicted prisoner, the man was required to do some work or to attend education. Prisoners may, however, be excused if a prison doctor finds them to be medically unfit. If a prisoner is not able to go to work he will usually remain

² ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners at risk of self-harm or suicide.

locked in his cell. In January 2009, wing staff called for a nurse to examine the man as he was claiming to be unwell. The nurse assessed that he was fit for work and that he did not require medical intervention. A member of the wing staff then made the following note:

“[The man] appeared to become unwell when not opened up this morning. Seen by [healthcare who] said nothing wrong with him and [that he was] not medically unfit for work so is to stay locked in [in] the day time. When told he was not coming out this afternoon, he stated he would cut his wrists. ACCT opened.”

22. The ACCT form was closed three days later.

23. In February, an officer made the following entry in the man’s records:

“[An officer] had counted the [first] landing at tea time lock up ... I went to check the landing not knowing it had been done – so [the man] wasn’t expecting another check. [The man] was standing by the sink (for a while) he then walked perfectly to the window and then looked out then when he turned round I knocked and said “You can walk”. [The man] looked surprised I had seen him he immediately sat on the bed and said “No I’m not walking.” This inmate is supposedly “Wheelchair bound.” [Healthcare] informed.”

24. Towards the end of March, an officer noted that the man claimed to be unfit for work but he was told that healthcare considered that he was fit. He responded by inflicting some shallow cuts to his arm. The officer opened another ACCT form. The levels of observations were set at once per hour until he had been assessed.

25. At an ACCT assessment interview later that same afternoon the man said that he cut himself as an expression of his frustration. It seems he was frustrated that he was still in prison when he believed that he should have been released once he had served two thirds of the custodial part of his sentence. He was also frustrated that he had been deemed to be fit for work. Observations were maintained at once per hour during the day time with a reduction to once every two hours during the night and during periods such as lunch time when prisoners are locked in their cells.

26. At just before 9.00pm on 2 April, Littlehey called for an ambulance as the man was complaining about chest pain. When the ambulance paramedics examined him they found that he was hyperventilating (breathing rapidly). He was advised to slow his breathing but he would not do so. As well as complaining about chest pain, he also complained to the paramedics that he wanted help for the problem with his legs. The paramedics left the prison having advised the man to take up his issues with the prison doctor.

27. The man continued to complain about his sentence calculation and in April, Littlehey’s Head of Discipline spent around half an hour trying to explain his

sentence to him. She ended the meeting as he would no longer listen and started calling her a liar.

28. On a morning in April, the man was visited in his cell by a doctor. In a report about the visit and in a separate entry in the man's clinical records, the doctor wrote that the main reasons for visiting him were to review his chest symptoms and his continuing use of a wheelchair. The man said that he had received some penicillin from another prisoner and his chest was now feeling better. On examination, the doctor found no problems with the man's breathing. The doctor examined his legs and found no evidence of muscle wastage or other changes expected in a person who was wheelchair bound. The doctor asked the man to lift his legs and he did so by using both hands – indicating that he had no strength in his legs. The doctor noted that he asked the man how, in the circumstances, he was managing to use the toilet and to transfer in and out of bed. The man said that he was managing without any problems. The doctor told the man that he was concerned for his safety by remaining in a single cell so would be moved to a double cell.
29. The next morning the Clinical Nurse Manager (CNM) made the following entry in the man's clinical records:

“Medication taken to [the man] this morning as usual, however he said he had suffered a seizure last night and was concerned no one was available to watch him. I advised him that this was one of the reasons along with his limited mobility and chest pain that the [doctor] felt it advisable to move [him] to shared accommodation.”
30. Early one afternoon in April, the Senior Officer (SO) noted that the man had been told that he was to be moved to a double cell on E wing in accordance with medical instructions. The SO noted that the man was not happy and was refusing to move. An hour later, the CNM, attempted to explain to the man why it was in his best interests to move into a double cell. He was noted to have responded with abusive words. She noted she would discuss options with the doctor the following week.
31. Entries were made in the man's ACCT form at 4.30pm and again at 4.45pm. On both occasions it was noted that he appeared to be asleep. At about 5.30pm, an officer checked him again and saw him lying on his bed with the bed clothes around his stomach. This seemed unusual to the officer so he went into the cell. He called the man's name and then shook him. The man did not move so the officer asked two of the prisoner cleaners to call for assistance.
32. The officer checked the man for a pulse but found none. The SO and another officer arrived. The SO also checked, unsuccessfully, for a pulse and then radioed the communications room to ask for further assistance. The second officer examined the man before moving him onto his back and starting cardio pulmonary resuscitation (CPR). Another SO arrived very soon afterwards and he helped give CPR along with another officer who responded to the emergency call. Staff continued with their efforts until the ambulance

paramedics arrived at 5.50pm. All efforts to try to resuscitate the man proved unsuccessful and he was pronounced dead at 6.15pm.

After the man's death

33. A hot debrief³ was held for staff and they were made aware of the support available from the prison care team. The prisoner cleaners were also offered support.
34. A prison Family Liaison Officer, in company with the Deputy Governor, visited the man's nominated next-of-kin, his brother, to break the news. They arrived at the home at around 7.45pm. The man's mother, who was visiting from her home in Australia, was also present. The prison Family Liaison Officer told the Ombudsman's investigator that he and his colleague spent around 45 minutes with the family. They invited the family to visit the prison and the family took up that offer. The family were informed that Littlehey would contribute to the costs of the funeral in accordance with national policy instructions.

The man's cause of death

35. The man's cause of death was initially unclear. However, in his post mortem report the examining pathologist found that:

“This man died suddenly in prison. He had recently been immobile within a wheelchair. He had been found to be tachycardic recently ... Post mortem examination reveals a massive pulmonary embolus with underlying deep vein thrombosis. His risk of thrombosis would have been increased by his immobility. Small emboli more distally (distant) suggesting early episodes which may have been the cause of his underlying tachycardia are also identified. There is nothing at post mortem examination to suggest death is due to anything other than natural causes.”
36. The pathologist recorded the cause of death to be pulmonary embolus secondary to a deep vein thrombosis.

³ A hot debrief meeting is a meeting held immediately after a significant event to give those involved the opportunity to discuss the event while the experience is still very fresh in peoples minds.

ISSUES

Clinical care

37. The main findings from the clinical review included that appropriate healthcare referrals for assessment and treatment were made for the man throughout his time in Littlehey. The reviewer found that his care and treatment in prison was equitable to that which he would have received in the outside community. The reviewer also found that it would not have been possible for health staff to have anticipated the man's death, although the risks of that happening were heightened due to his immobility.
38. The clinical reviewer raised as a learning point the need, where necessary, to make use of translation services to assist during clinical consultations. He went on to say that in the case of external consultations (such as the man's neurological consultation in October 2008), it is important that interpretation services are utilised to ensure that the maximum benefit is obtained from the consultation. In the case of an outside clinical consultation, the outside hospital would be expected to provide interpretation services. But could only do so if informed beforehand in the referral letter that translation services are likely to be needed.

(Her Majesty's Chief Inspector of Prisons also commented on the limited use of translation services at Littlehey following her last inspection of the prison.)

I recommend that the PCT and Head of Healthcare ensure that translation services are used, where appropriate, to aid clinical consultations both inside and outside the prison.

The man's sentence

39. The Criminal Justice Act 2003 introduced a number of changes to prison sentencing for offences committed on or after 4 April 2005. Information about the changes was included in Prison Service Instruction 11/2005. The change that became relevant in the man's case was that:

“Dangerous offenders convicted of a ... violent offence specified in the Act which carries a maximum penalty of less than 10 years, will be sentenced to an [Extended Sentence for Public Protection]. This sentence comprises two parts: a custodial period of at least 12 months; and an extended licence period. Release is at the discretion of the Parole Board at any time between the half way point of the custodial period and the custodial end date ...”
40. The man had been given an extended five year sentence comprising a three year custodial period followed by two years on licence. He seems to have been under the impression that he would be released automatically once he had served two thirds of the custodial element of his sentence. This was a mistaken belief. He was in fact able to apply for parole at the mid point of the custodial period and he did, indeed, apply at that stage. Had his application been successful he would have been released on 21 July 2008. However, the Parole

Board did not consider him suitable for release and wrote to inform him of the reasons for their decision. He could next have applied for release in July 2009, but if that application failed he would have to serve the full three years ending in January 2010.

41. It is not exactly clear to me why the man should have been confused about his position. But he undoubtedly was confused and his records show that staff made many attempts to explain. Unfortunately, no one seemed able to satisfy him on this matter. It is not clear to me the extent to which his knowledge of English might have impeded his understanding. As I have said, the Governor may wish to satisfy himself that sufficient use is made of interpretation services to explain potentially complex matters which in the man's case also include sentencing decisions.

Opening of the ACCT forms

42. An ACCT form was briefly opened for the man in the middle of January 2009 when he threatened to cut his wrists following a dispute with an officer about work. He claimed to be unwell on a morning in January even though a nurse examined him and found him to be fit for work. He threatened to harm himself when he was told that if he did not go to work he would not be unlocked from his cell. He did not carry out his threat and the ACCT form was closed a few days later.
43. The man had a similar dispute with staff two months later. This time, when he was told that healthcare deemed him fit for work, he responded by cutting his arm. Staff opened an ACCT form and during his assessment interview he explained that his actions were a manifestation of his frustration. He told the assessor that he had reached the point in his sentence when he should be released. He also disputed the assessment that he was fit for work. A further attempt was made to explain the sentence to him but once again without success. The ACCT form was still open when he died two weeks later.
44. The evidence indicates that the man's threats, and actual acts, of self-harm were not driven by a true desire to harm himself, as is most usually the case. Instead, his actions were driven by his frustration at still being in prison. Despite his motives, it was appropriate for staff to open an ACCT form given his actions and the procedures governing the ACCT process were followed correctly.

The man's use of a wheelchair

45. From some time around September 2008, the man started to use a wheelchair. He was still using the chair by the time of his death around seven months later. His records contain a number of references to him being observed by officers either standing or mobilising around his cell. And when physically examined by the doctor on the day before his death, the doctor found no evidence of muscle wastage or constriction in his legs. The Ombudsman's investigator was told by staff at Littlehey that their belief was that the man was feigning his need for a wheelchair.

The decision to move the man to a double cell

46. The man had further disputes with staff in April when told that he was to be moved to a double (shared) cell. He was told that the reason for moving him was concern for his safety given his claims that he was wheelchair bound and that he had suffered fits in his cell. He was unhappy about having to share a cell, insisting that he was able to manage by himself. The plan to transfer him was postponed pending further advice from the doctor the following week. This seemed a reasonable decision by the staff team to take, given the man's strong feelings on the matter.

The man's cause of death

47. At post mortem examination, the man's cause of death was found to have been caused by a pulmonary embolus. The pathologist described a massive embolus with underlying deep vein thrombosis. Both the pathologist and the clinical reviewer commented that the man's risk of a thrombosis would have been increased by his immobility. The clinical reviewer has said that it would not have been possible for staff to have anticipated the man's death. The clinical reviewer also commented that the clinical care provided to the man was equal to that which he would have received in the outside community.

CONCLUSION

48. The man was convinced that he was entitled to automatic release once he had served a set portion of the three year custodial part of his sentence: two thirds of the period it would seem. He was mistaken. He was in fact eligible for release at the mid point of the custodial period, but only if agreed by the Parole Board. The man did indeed apply for parole at that stage, but the Board rejected his application. The Board wrote to him explaining their decision. Despite the explanation, the man remained dissatisfied. It was from this time onwards that the man began to complain of lost strength in his legs. He also complained about suffering fits at night time, that healthcare deemed him fit for work and that he would remain locked in his cell if he did not go to work. On a number of occasions the man was observed by staff to be standing or walking around his cell. They were convinced that the man was feigning disability. The fact that the man lost no muscle tone in his legs would support that view. The relevance of his use of a wheelchair – whether feigned or otherwise – was that this might have been the cause of the deep vein thrombosis that in turn resulted in the pulmonary embolus that caused his death. Both the pathologist and clinical reviewer confirmed the possibility of this.

RECOMMENDATIONS

1. I recommend that the PCT and Head of Healthcare ensure that translation services are used, where appropriate, to aid clinical consultations both inside and outside the prison.

RESPONSE TO DRAFT REPORT FROM THE MAN'S FAMILY

49. Before the final version of this report was issued, a version was sent in draft form to all relevant parties seeking their comments. The man's mother replied raising a number of matters about which she remained concerned. Her main concerns focussed on her son's health care needs. She pointed out that her son had been complaining about his health for some time and she questioned why he was not hospitalised. She also questioned why certain examinations were not carried out and why her son's clinical records from Poland, which were copied to Littlehey, appeared to have been disregarded.