

**The Death in Custody of a man at
HMP Littlehey – September 2004**

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

November 2005

This is the report of an investigation into the circumstances of the death of a man at HM Prison Littlehey on 29 September 2004. The man, who was 46 years old, died as a result of asphyxia following an epileptic fit. He had suffered from epilepsy for a number of years. This followed a road traffic accident in 1981 during which he suffered head injuries needing surgery to replace a piece of his skull with a plastic plate. He was under medication for his epilepsy until his death.

I would like to extend my condolences to his mother, and to the rest of his family and to all those touched by his death. I regret that this report has taken so long to complete.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the prisoner's medical care in prison was commissioned by the local Primary Care Trust and Prison Health Regional Development Team. On all their behalves, I would like to thank the management and staff at HMP Littlehey for their assistance and co-operation during the course of this investigation.

The death of this man was from natural causes but, whilst it was apparently straightforward, the circumstances were not documented by clinical staff as fully as would be expected. I make two recommendations in respect of this. Furthermore, as he was not fully compliant with his prescribed treatment I recommend that systems are developed to manage non-compliant patients.

I note the way in which the news of her son's death was broken to the mother and commend the practice adopted by the Governor. This sad duty was handled in an entirely appropriate and sensitive manner.

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Prisons and Probation Ombudsman

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Summary

The man was a 46 year old man serving a mandatory life sentence at HMP Littlehey. He was located on B wing, designated as a Lifer wing. He lived here from his reception into Littlehey on 23 December 2003 until the time of his death.

Following a serious road traffic accident in 1981, he suffered head injuries resulting in an operation to replace a section of skull with a plastic implant. The injuries suffered resulted in long term epilepsy and a degree of personality change and some facial disfigurement. He was given a life sentence in May 1985.

The man died on 29 September 2004 from asphyxia as a consequence of epilepsy. His death was not connected to his imprisonment or to the level of care he received whilst in prison. Death due to natural causes was recorded at the inquest on 20 April 2005.

The post mortem report was prepared by, a consultant pathologist at Hinchbrook Hospital Huntingdon, for Huntingdon South and West Cambridgeshire Coroner. The report indicates that he died as a result of asphyxia as a consequence of epilepsy. The conclusion that the Coroner's Inquest came to on 20 April 2005 was death due to natural causes.

The clinical review was carried out in response to a request made by Huntingdon Primary Care Trust and the Prison Health Regional Development Team. No major concerns were raised by the clinical review regarding the medical care that the man received during his time in prison. However, a number of recommendations are made by the clinical reviewer regarding the levels of compliance for clinical record keeping by HMP Littlehey. The clinical reviewer also mentions that throughout his sentence, the prisoner was documented as being non compliant with the taking of his prescribed anti-epileptic medication.

The reviewer recommends that health care staff should be reminded of the requirement for accurate and contemporaneous record keeping in accordance with General Medical Council guidelines. She also recommends that a policy should be implemented for the management of prisoners who refuse to comply with prescribed treatment. I make a separate recommendation designed to ensure that all staff involved in an incident, including medical staff, should write and sign a statement as soon as possible after the event and before they leave the prison at the end of their shift.

I also conclude that the actions taken by Littlehey in the aftermath of this death were examples of very good practice.

Investigation Process

My practice in investigations into a death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

My colleague, visited Littlehey following the death. She was given a full briefing about the circumstances surrounding his death and the situation regarding family contact and actions instigated by the establishment. A notice to staff and a notice to prisoners were published in the prison, inviting anyone who might have information relating to this death to make themselves known to the inquiry team. Three prisoners who knew him came forward and spoke to my investigator.

My investigator took away with her files and records relating to the prisoner. A clinical review was later commissioned. A post mortem report and information about the inquest were requested from HM Coroner for South and West Cambridgeshire.

The mother of the deceased, was informed that her son had died by way of a personal visit from the Governor, and the prison chaplain. They visited her home on the day that he died. The mother expressed her thanks for the support offered by them and appreciated their visit. The Governor followed her visit with a letter of condolence and support.

HMP Littlehey

HMP Littlehey is a category C training prison holding up to 706 adult male prisoners. It was opened in 1985 with four wings A - D. Two other wings, E and F, were added some years later and a further 'quickbuild' wing, G, has since been put in place. There is also a drug rehabilitation wing, H wing. About 10 per cent of the population are life sentence prisoners and a high proportion (about 30 per cent) are sex offenders, but the regime encourages integration of all categories of prisoners throughout the prison.

As noted, B wing is one of the original wings at Littlehey and holds around 40 life sentence prisoners. The other lifers are dispersed throughout the rest of the prison. The regime is relaxed and informal. Each prisoner can work in one of the workshops or attend education classes. Association is available every weekday evening and at weekends.

Healthcare has been provided by Huntingdonshire Primary Care Trust (PCT) since April 2004. All healthcare staff working at Littlehey are medically qualified. There are no in-patient beds at Littlehey. The prison has a visiting community based GP and nurses providing primary care during the day. At the time of this man's death, medical cover was provided by a locum doctor. Secondary care was available through out-patient services in the community. Appointments to see a doctor are triggered by wing application.

The man

The man was born on 21 October 1958 at Thatcham in Berkshire. He was an unmarried man living in a hostel when he committed the crime for which he received a life sentence in 1985.

He had been in prison before, but none of his previous offences had involved violence.

During 1981, he suffered head injuries as a result of a serious road traffic accident which necessitated the insertion of a plastic plate to rectify damage done to his skull during the accident. The accident left him with some brain damage and a diagnosis of "post-traumatic epilepsy". He received a substantial sum in compensation for the injuries he suffered. He bore the scars of his facial injuries, had very poor vision in his right eye and was deaf in the left ear. Medical reports have suggested that his personality changed following the accident and that he began drinking more heavily. Psychiatric reports also indicate that he suffered from a personality disorder, flew into rages, and became very difficult, with a number of complex mental health problems. He was on constant medication for his condition but was erratic in taking the prescribed medicines.

He had regularly abused alcohol, indeed most of his criminality was related to drink including the crime for which he received his life sentence. He was aware that alcohol played a large part in his offending behaviour and had made several attempts to address the problem.

In 1984, he was a manual worker with the Reading Industrial Therapy Organisation where he was described as the "best worker they had had in years". This had been his first regular employment since he was 17 years old.

He was convicted at Reading Crown Court on 10 May 1985 for murder. He was serving a life sentence with a tariff of 15 years. He began his sentence at HMP Winchester, following a period of some eight months on remand. He was transferred on a number of occasions to various prison establishments including Maidstone, Kingston and Parkhurst. He transferred from Parkhurst to Littlehey on 23 December 2003. He remained there until his death on 29 September 2004.

During his sentence and whilst at other establishments, he had not always reacted well to stressful or confrontational situations. He was prone to outbursts of temper, violence and other inappropriate behaviour. However, to his credit, he had shown none of this type of behaviour whilst at Littlehey. Indeed, he had not been reported for any misbehaviour since February 2001.

Whilst at Littlehey, he lived on B wing (as note earlier, the wing caters primarily for life sentence prisoners). His friends - mainly other lifers - described him as being liked and respected. He was also described by another prisoner who had known him since 1987 as "a last minute kind of person in the mornings" and was known to respond robustly to being roused by staff in the morning. During an annual review in March 2004, one staff member wrote of him that he was not a problem and related well to staff and was comfortable with them. The member of staff who employed him

in workshop 6 described him as a quiet but not withdrawn man, polite and who would apologise for his absence if for health reasons he could not attend work. He described him as a very steady and reliable worker who always did his best.

The man was actively participating in his Life Sentence Plan in order to reduce the risk of re-offending. He had commenced the Enhanced Thinking Skills course. Prior to his death, he was on the enhanced regime at Littlehey. His cell, 2-6 on B wing, was a single occupancy cell.

Events leading up to 29 September 2004.

The man was remanded in custody on 1 September 1984. He was convicted of murder and sentenced to life imprisonment on 10 May 1985. He first came into prison custody at Reading. During the following 18 years he was transferred on several occasions to and from various establishments. He was transferred from Parkhurst to Littlehey on 23 December 2003.

At Parkhurst, the man's medical records show the seizures from which he was suffering to be getting more frequent. He was prescribed Tegretol 600mgs twice daily and Valporate 1gm twice daily to try to control the epilepsy.

On reception into Littlehey, he told staff that he had no thoughts of self harm and his blood pressure and pulse rate were within normal bounds. His previous medical history was noted.

On 3 January 2004, the man suffered an epileptic fit in another prisoner's cell. Nursing staff attended, he was reassured and helped back to his own cell. Nothing of significance is noted between then and 4 March 2004 when he suffered another seizure from which he recovered spontaneously. There was then a series of similar entries in his medical record with increasing clinical involvement, mainly due to the minor injuries he sustained during the seizures. His prescribed medication was also changed.

At 9.15 am on 17 June, he suffered a prolonged fit and was found unconscious and unresponsive. Twenty-seven Epilim tablets were found in his locker. An entry in his medical record stated he did not appear to be compliant in taking his Epilim. His medication was to be provided on a 'see to take' basis thereafter. At 10.20 am a further entry reads "reported to have continuous fits, refer to hospital". A blood test to establish the levels of anti-epileptic medication in the blood stream was taken on 28 June. The results of that test are not available. There then followed a number of interventions by both medical and nursing staff mainly related to reports of seizures and appropriate treatments both during and after each episode. Most of these interventions occurred during July of 2004 and then nil of note until 8 September. On that date, an entry in his medical record noted that he had "collapsed" whilst at work, but that this collapse might have been due to postural hypertension (a condition which results in the sudden drop of blood pressure when the individual stands up, made worse if they stand up quickly).

The day he died

At around 8.10 pm on 28 September 2004, an Officer spoke to the man because he had some concerns over his canteen [purchases from the prison shop]. Following this, nothing out of the ordinary was noted by the Officer.

At or just before 9 pm, another prisoner, heard someone who he believed to be the man (in whose company he had been earlier in the evening) calling out that he needed a doctor. He thought the man was speaking to a member of staff and did nothing further about it. At 4 am on the morning of 29 September, he says that he was writing a letter and again heard the voice saying "I need a doctor. I am having difficulty breathing". Again he thought the man was talking to a staff member and did nothing about it.

At around 4.40 am, the duty Night Patrol Officer, responded to a cell buzzer at B2-6, the man's cell. He reported that when he arrived at the cell the man had returned to bed and was apparently asleep. He tried to obtain a verbal response by asking the man if he was alright, but there was no answer. He said he saw him turn over in bed and pull his cover over him. He stated that he appeared to be comfortable and that he was satisfied there was no medical emergency. The Night Patrol Officer left the cell area and carried on with his normal duties for the remainder of the night, reporting nothing unusual.

Two other prisoners living opposite and next door to the man respectively reported hearing a loud banging around 5 am followed by heavy snoring. They both presumed that the noise was the man having an epileptic fit followed by loud snoring, which was not unusual for him. They said he would normally come through the fit unscathed. They both then went back to sleep.

At about 7.30 am, another Officer was on duty on B2 landing performing the early morning count of prisoners. He opened the observation panel at cell B2-6 and saw the man laying on his stomach on the floor, with his feet towards the door and his head turned to the right. The Officer knocked on the cell door but got no response and saw that the man was not moving. A prisoner confirmed that he heard a prison officer checking and asking the man if he was okay and that there was no reply from him. He said this was followed by a commotion outside the cell.

At 7.36 am, an Officer says he then ran to the Senior Officer's office and requested that, the duty Senior Officer, return to the cell with him because the man was lying motionless on the floor of his cell. The two staff returned to the cell, entered and tried to wake him. There was no response from him, and he was not conscious or breathing. The SO then instructed an Officer to telephone the Orderly Officer, Principal Officer, and tell her that there was a problem and to call an ambulance. On the way to telephone the Orderly Officer an Officer met and told the PO of the incident in the man's cell. The PO went directly to cell B2-6. The Officer contacted PO and informed her of what had happened on B wing and that an ambulance was required urgently. She then instructed him to return to the cell and assist the SO and report back. On returning to the cell the Officer, PO and SO checked for a pulse and for breathing. They turned the man on to his back and attempted to resuscitate him using Cardiopulmonary Resuscitation (CPR) techniques. The Officer states that this proved difficult because of the stiffness of the man's body and the previous injuries from the car accident. At around 7.45 am they were joined by a Nurse and another Officer. The Nurse took over chest compressions. The

staff trying to resuscitate the man periodically checked for vital signs during CPR but at no stage did they find any. CPR was continued until paramedics from the local ambulance service arrived at 7.56 am and took over the attempts to resuscitate him. An Electrocardiogram (ECG) was attached and showed no activity. A paramedic noted that rigor mortis and post mortem lividity were present, that there were no breath sounds and that the man's pupils were fixed and dilated. Resuscitation attempts were halted and he was pronounced dead at 8.04 am.

A prisoner states that, at about 8 am, a PO opened his cell door and requested a blanket from him which he supplied. A short time later, the wing was unlocked and prisoners were asked to assemble in the wing television room where they were told of a fellow prisoner's death.

At 10.40 am, the police surgeon certified the death.

The prison's response following the death.

At 8.10 on 29 September, following the pronouncement of the death by paramedics, cell B2-6 was closed and isolated. The names of potential witnesses at the scene, both staff and prisoners were noted.

Prisoners on B wing were asked to assemble in the wing television room where they were told of the death. The prisoner's telephone system was closed to ensure that the next of kin were informed in a dignified manner, not learning of it from a telephone call.

At 8.12 am, prison contingency plans for a death in custody were implemented. All necessary people were informed of the death. The prison chaplain arrived at cell B2-6 at 8.55 am, was allowed into the cell and said a prayer.

A police Sgt and PC attended at 9.20 am and left at 9.23 am. At 9.39, the Police Liaison Officer notified the Coroner, and at 9.50 a Detective Inspector and Detective Constable, and scenes of crime officers, examined the scene. At 10.27 am, the police surgeon arrived on B wing and at 10.40 am formally certified the man's death. At 11.10 am, he informed the prison that the death was not suspicious.

Cell B2-6 remained secure and the funeral directors removed the body at 11.42am to a local chapel of rest.

The mother was his next of kin. She is an elderly lady living in sheltered accommodation, having the support of her five children and her carers. Immediately following her son's death, the Governor, and the Prison Chaplain, travelled to her home address and informed her of the sad news. The Governor wrote to her immediately following the visit and included details of organisations offering support to bereaved families.

Staff debriefings took place and the Care Team were actively involved in supporting those staff who had been involved. The Governor issued a notice to prisoners informing them of the man's death and a memorial service was held for him in the prison chapel.

A consultant pathologist, carried out the post mortem at Hinchingsbrook Hospital, Huntingdon on 29 September 2004 and confirmed the cause of death as Asphyxia as a consequence of Epilepsy. A toxicology report was also prepared by, the Chief Biomedical Scientist for the Sheffield Teaching Hospitals, in which he states that the results are consistent with the therapeutic use of anti-convulsant drugs.

An inquest into the death of this man was held by HM Coroner for South and West Cambridgeshire on 20 April 2005. The verdict was death from natural causes.

Issues considered during the investigation.

Medical record keeping at Littlehey

The man died on 29 September 2004. Unfortunately, there is no written documentation in the Medical Record relating to the cause or events which led to his death.

Statements and Action Sheets

My investigator found the Control Room Action sheet for a death in custody was well completed. All prison staff and prisoners who had been involved made statements and these were found to carry an appropriate amount of detail. However, the nurse involved did not make a statement. My investigator made efforts to contact her but she is retired and now lives in Spain. She has not responded to requests for interviews or a statement.

Conclusions and Recommendations

The man was a 46 year old man in poor health, having suffered a serious road traffic accident in 1981. The accident left him with some brain damage and a diagnosis of post-traumatic epilepsy. His personality changed following the accident and he drank heavily. Psychiatric reports indicate that he suffered from a personality disorder and had number of mental health problems. He was on constant medication for his epilepsy but was erratic in taking the prescribed medicine.

Littlehey cared for him to the best of their abilities and that care was comparable to that which he would have received in the community. The management of his health was sensitive to his needs given his age and medical history.

Having suffered a serious epileptic episode early in the morning of 29 September 2004, He was discovered lying on the floor of his cell and not responding to stimuli. He was treated in a speedy and professional manner by staff who had the necessary skills to make a determined attempt to resuscitate him. Unfortunately, that attempt was unsuccessful. The local ambulance service paramedic attached an ECG machine, established that no activity was present, saw no vital signs, noted the condition of his body and concluded that he had died.

Following the death the response by Littlehey was speedy, effective and sensitive. The manner in which his mother was treated by the Governor and Chaplain was exemplary. The mother expressed her appreciation of the way they handled the breaking of the news to her. Within the establishment, the support of prisoners on B wing and the staff closely involved with him and those involved with the actual event of his death was good.

The death of this man was one from natural causes. But whilst it was relatively straightforward, the circumstances were not documented by medical staff as fully as would have been expected. The retirement and emigration of the nurse who attended has not made it possible to obtain a statement regarding the death from her perspective.

Recommendations

I make the following recommendations.

Health

1. Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the standards required by their professional bodies.

The prison accepted this recommendation.

2. A local policy should be developed and implemented in partnership with the local Primary Care Trust for the management of prisoners who refuse to comply with prescribed treatment.

The prison accepted this recommendation.

Operational

3. The Governor of Littlehey should remind senior colleagues that all staff including medical staff present at an incident should write and sign a statement.

The prison accepted this recommendation.

Good Practice

4. The decision of the Governor and Chaplain personally to break the news of her son's death to the man's mother was an example of good practice. I also commend the other local actions taken by the prison in the aftermath of this man's death.