Investigation into the death of a man in hospital in January 2007 whilst in the custody of HMP Littlehey

Report by the Prisons and Probation Ombudsman
for England and Wales

August 2008

This is the report of an investigation into the death of a man at HMP Littlehey, who died in hospital in January 2007. The day before, the man was taken to hospital by ambulance for investigation after he had vomited a significant amount of blood in his cell. He had not suffered similar episodes previously and did not complain at the time of any pain. In the early afternoon on the day of his death, the man again vomited significant amounts of blood and then went into cardiac arrest. Efforts by medical staff to resuscitate him were sadly unsuccessful.

The post mortem indicates that the man, who was 75 years old, died of a ruptured aortic arch aneurysm that resulted in bleeding into the lungs. This was caused by atherosclerosis (blocking of the arteries). I offer my condolences to the man's family and friends.

The investigation was conducted on by behalf by one of my colleagues. I am grateful to the Governor of Littlehey and his staff for their co-operation. I must also thank the medical practitioner from the Cambridgeshire Primary Care Trust for providing the clinical review into the man's care and treatment in custody.

The man was one of what seems to be a growing number of elderly prisoners who enter custody in poor physical health. He had been a lifelong smoker and suffered with osteoarthritis in his knees, ischaemic heart disease, high blood pressure and dermatitis on both legs that had progressed to venous ulcers. The clinical reviewer concludes that the man had a high standard of clinical care in prison. Nevertheless, he judges that the man's death was unavoidable, accelerated as it was by years of heavy smoking prior to his imprisonment.

I make no recommendations in this report, but would like to commend the sensitive way in which the prison liaised with the man's daughter (his next of kin) following his death. She has praised the prison in warm terms, and this reinforces for me the huge steps forward the Prison Service has taken in recent years in respect of family liaison when a death in custody takes place.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man died in hospital in January 2007. He was 75 years old. The post mortem report indicates that he died of a ruptured aortic arch aneurysm that resulted in bleeding into the lungs. This was caused by atherosclerosis (blocking of the arteries).

The man was a sentenced prisoner who had been in prison since June 2004. He arrived at HMP Littlehey in October 2004, having previously been held in HMP Chelmsford and HMP Wayland. This was his first experience of prison.

Staff and fellow prisoners described the man as in poor physical condition. His medical records show that he suffered from arthritis in both knees, ischaemic heart disease and dermatitis on his legs that led to venous ulcers. He also experienced breathlessness on exertion but continued to smoke heavily despite staff advice to give it up. During initial health screening it was established that the man had suffered a heart attack some years previously. The clinical review carried out as part of this investigation says that his death was unavoidable, and accelerated by years of heavy smoking prior to his admission to prison. The review finds that the man's clinical care was of a high standard and entirely equitable with that he would have received outside prison.

On 24 January 2007, an officer discovered the man vomiting up a significant amount of fresh blood into the washbasin in his cell. A nurse was called and, on the advice of the prison doctor, he was taken by ambulance to the local hospital for investigation. He was described as fully conscious but did not complain of any pain. Whilst in hospital, he was handcuffed and escorted by two prison officers in compliance with standard security procedures designed to ensure public safety.

The man experienced a restless but pain-free night. By the early afternoon on the day of his death, he was sitting in a chair and chatting to staff. However, at about 2.20pm the man began to cough up more fresh blood. Medical staff were alerted and his handcuffs were removed to facilitate treatment. The man then lost consciousness and cardio-pulmonary resuscitation began. Despite the efforts of staff to resuscitate him, he was pronounced dead soon after.

The man's daughter, his next of kin, has asked why she was not told that her father had been referred to hospital for investigation. The man had declined to make contact with his family whilst he was in prison, but my investigation has found that reasonable attempts were made to contact his daughter when his condition deteriorated. Since the man's death, his daughter has praised the prison for their sensitivity and support. I have been pleased to highlight this as good practice in my report.

THE INVESTIGATION PROCESS

1. The investigation into the circumstances surrounding the man's death was opened by one of my investigators when he visited HMP Littlehey on 13 March 2007. He spoke to a number of staff and to one prisoner. Notices were also issued to staff and prisoners to tell them about the investigation and giving them the opportunity to speak with the investigator. No responses were received to my notices.

2. The Governor and his staff produced the man's prison records for review. These included his medical record and bed watch logs.

3. Cambridgeshire Primary Care Trust was commissioned to conduct a clinical review into the care and treatment that the man received at Littlehey.

4. One of my Family Liaison Officers (FLO) had telephoned the man's daughter (his nominated next of kin) on 14 February. The FLO offered her and the family the opportunity to meet to discuss the purpose of the investigation, and to raise any concerns or questions they would like to be addressed. The man's daughter had nothing but praise for the way in which the prison has supported her following the death. However, she was concerned that she had not been told that her father had been taken to hospital, although she appreciated that no one knew how seriously ill he was or anticipated his rapid deterioration.

5. My investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation, and to request a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist him with his inquiries.

HMP LITTLEHEY

6. HMP Littlehey is a category C prison, with an operational capacity of 706 male offenders but a typical occupancy of around 690. It first opened in 1988 with eight residential wings. Two additional units were added to the prison in 1997 and 2003; all rooms on these units have privacy locks and individual showers.

7. Approximately 10 per cent of the prisoners are serving life sentences. A small proportion of the prisoners are category D which enables them to work in the community. The prison offers a sex offender treatment programme as well as extensive industrial work and education opportunities.

8. The prison was last inspected by Her Majesty's Chief Inspector of Prisons on an unannounced visit in December 2005. HMCIP subsequently wrote that, "Littlehey is to be commended for further improvements that it has made since our last inspection. It remains a safe and respectful prison, which has successfully integrated a large population of sex offenders and other vulnerable prisoners into the general population. The prison has expanded access to purposeful activity and begun to focus on the national resettlement agenda. Littlehey is an impressive and improving prison, working with some very high risk prisoners. Staff are to be commended for establishing a fundamentally safe and respectful environment, but further expansion of purposeful activity is required, together with strengthened sentence planning work."

9. Provision of healthcare within the prison is the responsibility of Cambridgeshire Primary Care Trust, with the General Practitioner (GP) service being provided by a local NHS practice. A wide range of health promotion clinics is available.

10. Medication is dispensed on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable to hold it in their possession. It is administered on a daily basis to other prisoners when they are considered to be either at risk, or the medication is considered unsuitable to be held in their possession.

11. A wing is a small residential unit. Its population consists mainly of elderly, vulnerable prisoners who have single cells. My investigator was told both by staff and a prisoner's representative that prisoners tend to help one another out when they are not fully mobile.

KEY FINDINGS

Events leading up to the man's death

12. At about 11.40am on 24 January, prisoners were unlocked on A wing to allow them to collect their lunch from the servery. The wing officer noticed that the man had not come out of his cell to collect his food so he went to the cell to ask if he wanted any sandwiches. The man was standing at his washbasin and the officer saw that he had blood coming out of his nose and at the side of his mouth. The man then vomited into the washbasin. The wing officer said that the man was fully conscious but looked terrified. He then vomited violently again into the washbasin, bringing up dark congealed blood. The officer told my investigator that the man had vomited a considerable amount of blood.

13. The wing officer went to a nearby office to telephone the Control Room to ask for a member of the healthcare team to attend the man's cell immediately. The wing officer said that the man was fully conscious and co-ordinated. In the meantime, other prisoners were being locked up by other members of staff. The officer returned to the man's cell.

14. The Control Room contacted the staff nurse by radio to ask her to come to the man's cell. The staff nurse said that, before doing so, she contacted the prison officer who advised her that the man should be taken to hospital for further investigation. The staff nurse then attended the man's cell and was shocked at the amount of blood he had vomited in and around the toilet area. The staff nurse told the man to lie down on his bed so that she could assess him and clean him up. The staff nurse took the man's blood pressure and was surprised to find that it was relatively normal despite the apparent loss of blood. The nurse was told by the man that he was not in any pain, had not experienced previous similar episodes and did not know what all the fuss was about.

15. The staff nurse then used her radio to contact the Control Room to request an emergency ambulance. An ambulance was called at 12.25pm and arrived at Littlehey at 12.35pm. In the meantime, the nurse stayed in the cell and started to clean the blood from the man's face. She told my investigator that the man remained conscious and insisted on walking to the ambulance. The ambulance left the establishment for hospital at 1.23pm.

16. In compliance with the prison's security procedures, the man was escorted by two officers who applied handcuffs removable only in the event of medical necessity and authority from a governor. During his stay in hospital, a log of events (known as a bed watch log) was also maintained by the escorting officers. The log shows that the man's bloodstained clothing was to be taken back to Littlehey to be incinerated.

17. At 5.40pm, the man was moved from the hospital's Accident and Emergency Department to the Medical Assessment Unit. At 8.45pm, the log shows that

18. Records show that the man had a restless night and that he was moving his legs about. At about 7.45am on 25 January, he was out of bed, having a wash, but complained that he had to wear handcuffs. By 8.04am, the man was sitting in a chair. At 8.45am, he was seen by a consultant and told that he might have to spend another night in hospital for assessment. The staff nurse told my investigator that she telephoned the hospital that morning. She was given the impression that, following tests, the man would be returning to prison later that day.

19. The bed watch entry for 12.40pm records that the man had taken lunch and was talkative with his escorts. At 1.40pm, he was taken to the toilet with no concerns raised. At 2.00pm, it was noted that the man was going to be transferred to another ward later that day.

20. At about 2.20pm, the man began to cough. The senior officer (SO) offered him a drink of water which he declined. The SO then offered him the use of a spittoon to bring up phlegm. This was also declined. The man then began to vomit a large amount of blood. Medical staff were called and moved him from a chair to his bed. The SO removed the man's handcuffs to allow medical treatment.

21. At about 2.27pm, the SO telephoned the Control Room at Littlehey and notified the duty governor that the man had suffered a cardiac arrest and was receiving cardio respiratory resuscitation (CPR). Officers were given authority by the duty governor to remove his handcuffs in order to facilitate medical treatment. The duty governor also decided that, in view of the circumstances, the man's next of kin should be informed of the situation. The prison records show that, at 2.30pm, the Principal Officer (PO) left a message with the man's next of kin to contact Littlehey as soon as possible. The police were also informed of the man's condition and were asked to make contact with the man's daughter.

22. At about 2.47pm, the SO reported to the Control Room at Littlehey that CPR was continuing on the man. He also asked whether the man's next of kin had been informed. At 2.55pm, medical staff told the SO that, as the man was not responding to the resuscitation effort, CPR would be stopped. At 3.00pm, the man was pronounced dead.

Events after the man's death

23. The Senior Officer telephoned the duty governor to inform her of the man's death. Littlehey then implemented its contingency plan for deaths in custody that included informing the police, the Independent Monitoring Board and the Prison Service's National Operations Unit. The area in which the man was being treated was preserved as a potential crime scene until the arrival of the police at about 3.20pm.

24. At about 5.20pm, the man's daughter called Littlehey in response to the message which had been left on her answerphone. The PO told her the sad news of her father's death. The daughter agreed to contact other members of the family and her father's partner to tell them of his death.

25. At about 6pm, the SO and the second SO returned to Littlehey where they were debriefed by the duty governor and the PO and reminded of the support they could receive from the prison's care and support team.

26. On 26 January, the Governor sent a letter of condolence to the man's daughter and offered a contribution towards funeral costs. The Governor also invited the family to attend the prison's memorial service (this offer was declined). An SO was appointed as the prison's family liaison officer (FLO). Together with the deputy governor, they visited the man's daughter at her home. The daughter told my own family liaison officer that the prison FLO, the deputy governor and the PO were able to answer all her questions concerning her father and she was appreciative of all the support and kindness shown to her. She also said that, following her father's death, she had received a card with over 70 signatures from prisoners and staff, from which she has derived much comfort.

27. The wing officer said that the prisoners located near to the man's cell were told of his death on 26 January. The Samaritans and Listeners (prisoners trained by the Samaritans) were also told in case prisoners needed support. The wing officer told my investigator that, although staff and prisoners were aware of the man's ill health, they had been surprised at the quick deterioration in his condition.

28. A memorial service was held for the man in the prison chapel. The Governor also sent a letter to the hospital, acknowledging the efforts of medical staff in trying to save the man.

29. The deputy governor and the prison's family liaison officer attended the man's funeral.

Clinical review and post mortem

30. The clinical review found that the man's quality of care was of a high standard and equitable with what he would have received in the wider community. The clinical reviewer concluded that the man's death was unavoidable and had been accelerated by years of heavy smoking prior to his admission to prison.

31. The post mortem indicated that the man died from a ruptured aortic arch aneurysm that resulted in bleeding into the lungs. This was caused by atherosclerosis (blocking of the arteries).

ISSUES

Clinical management

32. The man entered prison with a number of health problems that were managed in an appropriate and timely manner. He was a heavy smoker. Despite concerns about his health and advice from staff to stop smoking, he showed no inclination to do so. The clinical review says that his quality of care was of a high standard and that his death was unavoidable. The man rapid deterioration was unforeseen, dramatic and not preventable.

Family Liaison

33. The man chose not to maintain contact with his family whilst he was in prison. This was despite the efforts of some of his family to sustain contact through the prison chaplain. When he was taken to hospital, the prison did not immediately contact his daughter as he was fully conscious and his condition was not considered to be critical. Furthermore, for public protection reasons, families are not usually informed when a prisoner is transferred to hospital for routine investigation or treatment.

34. When it became apparent that the man's condition was critical, it was decided to contact his next of kin. Unfortunately, a response was not received until some hours after his death. This aside, the man's daughter has praised the prison in warm terms for the support shown. She has cited in particular the deputy governor, the prison FLO and the PO. It is clear to me that that a high degree of sensitivity and compassion was shown to the family which has eased their sense of loss.

    The Governor should commend the prison's Family Liaison Officer as well as the PO and the Deputy Governor, for the supportive way in which they liaised with the man's next of kin, and the high level of sensitivity, professionalism and compassion displayed, and commented on by members of the family.

RECOMMENDATIONS

1. **The Governor should commend the prison's FLO, as well as the PO and the Deputy Governor, for the supportive way in which they liaised with the man's next of kin, and the high level of sensitivity, professionalism and compassion that has been displayed and commented on by members of the family.**