Investigation into the circumstances surrounding the death of a man in November 2011 at outside hospital, while in the custody of HMP Littlehey

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Littlehey. He died at outside hospital in November 2011, having been admitted to hospital from prison the previous day. He was 45 years old. The cause of death was recorded as multiple organ failure due to pneumonia, with secondary contributors of HIV infection and Hepatitis B. I offer my condolences to the man's family, and to others affected by his loss.

The investigation was carried out by one of my investigators, with the full cooperation of the staff at Littlehey. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of Cambridgeshire Primary Care Trust.

The man was diagnosed with the HIV virus around three years before he died. He chose not to tell his family or friends about this diagnosis. A little over a week before his death, the man had returned from hospital in relatively good health. His death, therefore, was unexpected, and arose after he contracted pneumonia which developed into multiple organ failure, a recognised complication for patients with HIV.

The investigation concludes that, in general, the man received appropriate medical care after he was diagnosed with the HIV virus and that there is nothing that prison healthcare staff could have done to prevent his death. However, the clinical reviewer does consider that there was scope for the man to have received better treatment while he waited for an ambulance. It is also unfortunate that the prison did not inform the man's next of kin when his condition seriously deteriorated, so his family were not given the opportunity to visit him before he died.

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 my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man reported no significant health problems when he arrived in prison in August 2005. By the time of his move to Littlehey, almost three years later, he had developed a rash on his skin and been diagnosed with eczema. When the rash developed further in summer 2008, he was referred to a skin specialist at a local hospital. Shortly afterwards he was diagnosed with the HIV virus (human immunodeficiency virus, a virus that attacks the immune system and therefore affects the body's ability to fight disease and infection). He chose not to tell his family or friends about this diagnosis (although prison healthcare staff were aware).

2. Over the following three years, the man developed various lesions (damaged areas of skin) across his body, which were treated with different techniques. He also took anti-retroviral drugs (treatment for HIV that helps to prevent weakening of the immune system) and saw a specialist who visited the prison monthly. A biopsy in August 2011 showed that two of his skin lesions were Kaposi's sarcoma (a rare form of skin cancer). However, the cancer specialist who examined the lesions decided that he did not need treatment as the lesions in question were very small. The clinical reviewer comments that the man received good care throughout his illness.

3. On 22 November, the man told healthcare staff that he had felt unwell for four days and had been constipated for some time. He was given a laxative. The following afternoon, a prison doctor and nurse were called to the wing as the man was still unwell. His oxygen saturation levels (a measure of how much oxygen the blood is carrying) were very low and he appeared dehydrated. An ambulance was called and he was admitted to outside hospital. The clinical reviewer comments that, despite his low saturation levels, the man was not given oxygen when awaiting the ambulance. He adds that this would have been preferable although it would not have had any effect on the final outcome. We recommend that the head of healthcare should review training and procedures surrounding the care of acutely ill prisoners.

4. On arrival at hospital, the man was diagnosed with pneumonia. During the evening and overnight, he deteriorated significantly and his organs began to fail. He died the following morning. The clinical reviewer comments that the man died from a suspected overwhelming pneumonia which caused respiratory, cardiac and kidney failure. He adds that this is a recognised complication of HIV.

5. When his condition deteriorated in hospital on the evening before his death, prison staff were asked for the man's next of kin contact details. They could not be provided and, despite him being seriously ill, the man's next of kin were not aware that anything was wrong until the news of his death was broken to them by the prison's family liaison officer the next day. We recommend that the Governor ensure staff at the prison provide next of kin information promptly when a prisoner is seriously ill in hospital.

THE INVESTIGATION PROCESS

6. The investigation was opened on 28 November 2011 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. Two prisoners who were friends of the man asked to speak to the investigator.

7. The investigator and a colleague visited Littlehey on 1 December. During the visit they saw the cell in which the man had lived and spoke with the two friends who had requested to do so. They visited the healthcare centre to speak with a nurse who knew the man well. The investigator and his colleague also met the prison's family liaison officer and spoke to the chair of the prison's Independent Monitoring Board (IMB, a body of unpaid local people who independently monitor and report on the prison).

8. A clinical review of the man's time in custody was carried out by a clinical reviewer on behalf of Cambridgeshire Primary Care Trust. The clinical reviewer visited Littlehey to discuss the man's clinical care with healthcare staff who knew him, and also spoke to his consultant in genito-urinary medicine (GUM).

9. One of the Ombudsman's family liaison officers telephoned the man's cousin, his nominated next of kin, on 16 December 2011, to introduce the investigation and give the opportunity to ask any questions or raise any concerns for the investigation to consider. She followed this up in writing on 19 December. The man's cousin subsequently telephoned the family liaison officer in January 2012. She asked whether her cousin received the appropriate care in prison, and added that she visited him regularly and he always appeared to be in good health. The standard of the man's care is addressed in the 'issues' section of this report.

10. The man's cousin asked the family liaison officer why no post mortem examination took place. It is a matter for Her Majesty's Coroner whether to hold a post mortem and his decision is outside of the remit of our investigation. Our understanding is that HM Coroner for South and West Cambridgeshire chose not to hold a post mortem as he was satisfied that the man's death was entirely due to natural causes.

11. Finally, the man's cousin asked a question about his sentence and whether he was to be deported to the Democratic Republic of Congo. We have addressed this question in the next section of the report. We hope this report clarifies any issues that remain unclear for the man's family and helps them understand what happened in the time leading to his death.

12. As part of the consultation period the man's cousin received the draft report. She later told the family liaison officer that she remains very concerned that no post mortem examination was completed. We would like to thank her for taking the time to read and comment on the report. The report was also sent in draft to the Prison Service. Their response to the recommendations is included on page 14.

HMP LITTLEHEY

13. HMP Littlehey opened in 1988 as a category C training prison for adult males. (Category C prisoners are those who cannot be trusted in open conditions but who are unlikely to try to escape.) A Young Offender Institution (YOI) opened within it in 2010. The total capacity of the prison is 1,206, consisting of 726 on the category C side and 480 on the YOI. The man lived on C wing at Littlehey, a standard residential unit.

14. Health services at Littlehey are commissioned by the Cambridgeshire Primary Care Trust. A local community practice provides GP clinics at the prison six days a week. A nursing team works on site during the day on weekdays and on Saturday mornings. At other times, advice is available through an out of hours service. There are no inpatient beds at Littlehey.

15. HM Chief Inspector of Prisons last inspected Littlehey in November 2011. The Chief Inspector's report has not yet been published. The previous inspection in 2007 described that range of healthcare services as adequate and with generally appropriate primary care services.

16. The IMB report for 2010-11 commented on a number of difficulties that had arisen during the opening of the YOI section of the prison. They reported that healthcare "continued to operate well", despite the recruitment and transfer of various staff to the new YOI.

17. The man was the third prisoner at Littlehey to die of apparent natural causes since summer 2010. Our report into the first of these deaths found that the deceased received healthcare equivalent to that which he would expect to receive in the community. The report into the second death has not yet been issued.

KEY EVENTS

18. The man was remanded to HMP Pentonville on 6 August 2005, to await trial for offences committed earlier that year. On 28 July 2006, he was sentenced to an indeterminate sentence for public protection (IPP) with a minimum period to serve of two years before he could be considered for release. After that release could be agreed only if the Parole Board believed he was no longer a risk to the public.

19. The Court also recommended the man's deportation at the end of his sentence. (The man had arrived in the United Kingdom in 2000 and unsuccessfully claimed asylum.) The most recent assessment by the Parole Board was in April 2011, when it determined that the man's risk had not reduced sufficiently to allow his release.

20. On his arrival at Pentonville in August 2005, the man had a routine health screen. He reported no past or current health concerns. Over the following two years, he raised no significant problems with his health. He was referred to a dermatologist (specialist in the skin and its diseases) in October 2007, after complaining of an itchy rash on his skin. He subsequently attended an outpatient appointment in January 2008, at which he was diagnosed with eczema (a long term condition that causes the skin to become itchy, red, dry or cracked) and advised to use moisturising cream. He declined to attend a second appointment the following month, for reasons which are not recorded.

21. In March 2008, the man moved to Littlehey. This was a progressive move, to allow him to complete the courses required to reduce his risk of reoffending. He lived on C wing for most of his time at Littlehey. His friends described him as a humble, religious man whose first language was French but understood English well.

22. The man was referred to the dermatology department at outside hospital in August 2008. Following an appointment in September, a blood sample was taken for analysis. The result revealed that he had the HIV virus (human immunodeficiency virus, a virus that attacks the immune system and therefore affects the body's ability to fight disease and infection). The news of his diagnosis was given to the man by a prison doctor and nurse. It appears that he kept this diagnosis to himself and did not tell his family or his friends in the prison.

23. As a result of his diagnosis, the man was referred to a consultant in genito-urinary medicine (GUM). She visited Littlehey once a month for a GUM clinic. The man saw her regularly during the remainder of his life, usually attending the monthly clinics. His first appointment with her was on 24 October 2008. The consultant prescribed anti-retroviral medication (the main type of treatment for HIV, which is used to try to limit the level of HIV in the body and prevent weakening of the immune system). The specific medication prescribed was changed in January 2009 on account of side effects experienced by the man. He was reported to tolerate the new medication "extremely well".

24. A further referral was made to the dermatology clinic at outside hospital on 28 August 2009, as the man had developed various lesions on the back of his knee. The referral was made to exclude the possibility that the lesions were Kaposi's sarcoma (a rare form of skin cancer), and to determine a treatment plan. He attended a clinic in September, at which the dermatologist concluded that the lesions were the result of a viral skin infection. They were treated over the following weeks by cryotherapy (freezing).

25. At a GUM clinic on 25 September 2009, the man told the consultant that he had not taken his medication as it was prescribed because he was fasting for religious reasons. By the next clinic, on 30 October, he was taking his medication correctly and told the consultant he was feeling better.

26. The man was reported to be well at his GUM clinics during the first six months of 2010. However, he had a continuing rash on his skin which did not improve with treatment by antifungal creams. A biopsy was taken in June, which showed that the rash was acute eczema. Following a change to his anti-retroviral medication, the man's skin condition was reported to have improved over the remainder of the year.

27. By April 2011, the man's skin rash was reported to be "extensive". The GUM consultant therefore made another referral to the dermatology clinic. An appointment was made for 24 June. The man had two GUM appointments before this but missed both. He reportedly "walked out" of the first clinic, and it is not known why he missed the second.

28. Following examination at the dermatology clinic on 24 June, the dermatologist asked the man to return for a biopsy to ascertain a diagnosis for his skin condition. In the meantime, a blood test showed that he had contracted the Hepatitis B virus (an infection that causes irritation and swelling in the liver). He returned to hospital on 12 July for his biopsy. The results were available around three weeks later, and showed that he now had Kaposi's sarcoma. He was referred to an oncologist (cancer specialist).

29. The man subsequently saw an oncologist at outside hospital on 9 September. Following an examination, the oncologist concluded that there were just two small areas consistent with Kaposi's sarcoma. They were on the man's right thigh and his left calf. The oncologist decided that the man did not need treatment for these lesions as they were very small and he showed no ill effects from their presence.

30. An ultrasound scan and blood tests taken on 4 October showed nothing unusual. Over the following month, new lesions developed on the man's body. Arrangements were made for him to be admitted to outside hospital for further investigation. During his admission, from 9 November until 14 November, various tests were performed and he was reviewed by both cancer and skin specialists. Their conclusion was that the new lesions were an inflammatory dermatosis (an exacerbation of the existing skin condition) and not a skin cancer. A number of the man's organs were also examined, including the lungs, liver, and kidneys, and were reported to be normal.

31. On his return to Littlehey, a nurse discussed the findings with the man and noted that they represented good news for him. The nurse later told the investigator that the man appeared “quite bright” when he came back from hospital. Friends of the man told the investigator that, around a week later, his behaviour began to change. He became quiet, appeared to be weaker and said he had constipation. The man’s friends also said that his eyes became yellow.

32. On the morning of 22 November, the man went to the healthcare centre and said he had felt unwell for four days. He said he felt “drained” since coming out of hospital, and reported pain in his stomach. He also said that he had not opened his bowels for some time. A nurse took his blood pressure and pulse, both of which were slightly elevated. She discussed the symptoms with a prison doctor who prescribed a laxative.

33. During the afternoon, the man told wing staff that he still felt unwell. A nurse was contacted and visited him in his cell. He was described as “flushed” and complained of an uncomfortable stomach. The nurse took his blood pressure, which was again slightly elevated. The man’s temperature was normal (although the clinical reviewer notes that it was incorrectly described as raised) and his oxygen saturation levels (a measure of how much oxygen the blood is carrying) were low. The nurse examined the man’s stomach and found it to be hard, which she attributed to him not having opened his bowels. The nurse returned later in the afternoon and repeated her examinations. The man’s oxygen saturation levels had increased and were only slightly below normal levels.

34. The following afternoon, a doctor and a prison nurse visited the man as he was still reported to be unwell. A healthcare assistant (HCA) made a note of the examination, and recorded that the man’s eyes were yellow and he appeared to be dehydrated. His oxygen saturation levels were 60 per cent (the clinical reviewer comments that this is a very low level and indicates a severe illness). Following consultation over the telephone with the GUM consultant, an ambulance was called. When the ambulance crew arrived they gave the man oxygen until his saturations levels returned to normal, after which he was taken to hospital. He remained conscious during this time.

35. The Prison Service has a duty to protect the public and escort staff routinely use restraints when prisoners are taken out of the prison for any reason. An individual risk assessment is completed on each occasion and regular management checks are made. The assessment will consider the offences and the risk of further offending, as well as the prisoner’s health and mobility. It was determined that the man would be accompanied by two officers and cuffed to one of them by means of an escort chain (a long chain with a handcuff at each end).

36. Shortly after his arrival at hospital, the man was diagnosed with pneumonia. In the evening, his condition deteriorated and he began to struggle to breathe. Shortly afterwards, the escort staff sought authority from the prison to remove the escort chain. This was granted and we agree this was appropriate. At around

the same time, the escort staff contacted the prison to request contact details for the man's next of kin. They were told that the contacts were not available.

37. During his time in hospital, the man was treated with oxygen. Despite this, his saturation levels became persistently low. He lost consciousness at around 11.00pm on the day of his admission. The following morning his heart, lungs and kidneys began to fail. The man died at 7.10am.

38. The man's next of kin was recorded as his cousin. The prison's family liaison officer and a Roman Catholic Chaplain visited the man's cousin on the morning the man died to break the news of his death to her. The man's friends on C wing were seen individually by prison staff that morning and told the news. The duty governor spoke to the staff who were with the man when he died and reminded them of the support services available at the prison. The man's funeral was held on 8 December and the prison contributed to the cost. A memorial service for staff and prisoners took place at Littlehey in the same week.

ISSUES

Clinical care in prison

39. The man's cousin asked whether he received the appropriate care in prison. The clinical reviewer comments that the treatment the man received for his HIV and skin condition was "at the same standard expected for any patient". He goes on to say that the man's treatment, investigations and hospital care were "timely and appropriate". The clinical reviewer concludes as follows:

> "[The man] died from a suspected overwhelming pneumonia which caused respiratory, cardiac and kidney failure. This is a recognised complication of HIV. [The man] had good medical care throughout his illness and there was no identified failing in the care that would have contributed to his death."

Emergency clinical care

40. When he was assessed by prison healthcare staff on the afternoon before he died, the man's oxygen saturation levels were very low. The clinical reviewer comments that he was "clearly very ill" and his hospital admission was appropriate and managed promptly. However, he goes on to express concern that, given his very low saturation levels, the man was not given oxygen before the paramedics arrived. His view is that the man should have been given oxygen immediately. The clinical reviewer also comments that clinical observations (such as blood pressure, pulse and saturation levels) were not recorded and monitored to determine whether his condition was improving or worsening until the paramedics arrived. He also comments that the man was left in his cell without a medically qualified person when the ambulance was called.

41. The clinical reviewer concludes that these issues would not have had an effect on the final outcome for the man. However, he goes on to say that prison healthcare should review their training and operational procedures in such circumstances and we make the following recommendation:

The head of healthcare should ensure that health services staff are trained in appropriate procedures to care for acutely ill prisoners while waiting for the emergency services to arrive.

Contact with the man's family

42. When the man's condition began to deteriorate on the evening before he died, staff at Littlehey were asked to provide contact details for his next of kin. Despite being available on the National Offender Management Service Information System (NOMIS, a national computer database of prisoners that all staff have been trained to use), they were not provided. The senior officer whom the escort staff asked for these details unaccountably told them that they were not available, although they were found the next day. The prison's family liaison officer was able to obtain the next of kin contact details promptly from NOMIS ahead of her visit to break the news of the man's death.

43. We consider that the man's family should have been informed at the earliest opportunity when his condition began to deteriorate on the evening before he died. Although they have not raised it as a matter of concern, it is a regrettable that the man's family did not have the opportunity to spend time with him in his final hours.

    The Governor should ensure that next of kin contact details are readily available whenever a prisoner who is seriously ill is taken to hospital and provided immediately when requested.

CONCLUSION

44. The man was diagnosed with the HIV virus a little over three years before his death. He chose to keep this diagnosis to himself. However, he largely co-operated with his treatment plan and openly discussed his condition with specialists.

45. In the last days of his life, the man contracted pneumonia. This caused multi organ failure which, as the clinical reviewer notes, is a complication common for patients with the HIV virus. The man's death was unexpected and we note that a number of his organs were examined in hospital around ten days before his death and found to be normal. We agree with the clinical reviewer's finding that the man received appropriate medical care throughout his illness.

RECOMMENDATIONS

1. The head of healthcare should ensure that health services staff are trained in appropriate procedures to care for acutely ill prisoners while waiting for the emergency services to arrive.

   Accepted – review of clinical training needs carried out and no action required. The importance of emergency response has been reinforced through the line management chain.

2. The Governor should ensure that next of kin contact details are readily available whenever a prisoner who is seriously ill is taken to hospital and provided immediately when requested.

   Accepted – duty managers and orderly officers have been reminded that next of kin details are readily available on NOMIS whenever a prisoner who is seriously ill is taken to hospital and must be provided immediately when requested.