Circumstances surrounding the death of a man, who was a prisoner at HMP Littlehey, in January 2008

Report by the Prisons and Probation Ombudsman for England and Wales

April 2008

This is the report of an investigation into the death of a man. The man was a prisoner at HMP Littlehey and died from natural causes in January 2008. He was 64 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. He and I would like to thank the Acting Governor of HMP Littlehey and her staff for their assistance. A doctor was asked by Cambridgeshire Primary Care Trust to undertake a review of the man's clinical care and I also much appreciate his help.

The man had long-standing health problems and there is no reason to suppose that his death was in any way related to the fact that he was in custody. The clinical review assesses that his treatment was equivalent to what he would have received had he been at liberty.

I believe that the man was well looked after by staff at Littlehey. I make no recommendations in this report.

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.

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

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SUMMARY

The man was born in 1943 and he was 64 years old when he died at HMP Littlehey. He died from natural causes as a consequence of acute ventricular failure (heart disease).

The man had been remanded into custody in January 1996. He was sentenced to life imprisonment at Leeds Crown Court in September 1996. He arrived at HMP Littlehey in July 2005 after previously being held at Leeds, Wakefield and Parkhurst prisons. During his time in custody, the man developed arthritis and was also diagnosed as suffering from hypertension (high blood pressure).

Around 5:00pm on 14 January 2008, the man was locked in his cell for the night. During the early hours on 15 January, an Operational Support Grade (OSG) noticed that the man was in an unusual sleeping position. At 7:10am the OSG conducted a handover with a Prison Officer. The OSG told his colleague about the man. They both then went to the man's cell. The officer unlocked and entered the cell. He could not find evidence of life so immediately contacted the prison communications section. He informed them of the situation and asked for an ambulance to be called. The OSG and officer were joined shortly after by other prison staff and a paramedic. The paramedic confirmed at 7:48am that the man had been dead for some time and the prison doctor later pronounced death at 8:51am.

The clinical review concludes that the man's clinical care was good and comparable to that available in the community. I have made no recommendations.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 18 January 2008. He issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. In the event, nobody came forward. My investigator also studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.

2. My investigator visited Littlehey on 10 March 2008 and discussed aspects of the man's treatment with staff at the prison. He met the Acting Governor, the Residential Manager and the Head of Healthcare at Littlehey. He also interviewed the man's personal officer who was able to provide background information concerning the man and his activities whilst in custody.

3. The Cambridgeshire Primary Care Trust (PCT) commissioned a doctor to carry out a review of the man's clinical care. I am grateful to him for undertaking the review.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries into the man's death.

5. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions they would like explored or addressed. The man's family did not wish to raise any specific concerns about the treatment he received while in custody. I hope that my report helps the family better understand the events leading up to the man's death.

HMP LITTLEHEY

6. HMP Littlehey is a category C prison. It has the capacity to hold 706 male offenders, but has a typical occupancy around 690. It first opened in 1988 and has eight residential wings. Three additional units have been added since the prison was originally built, and all the rooms on these units have privacy locks and en suite 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 outside the prison. The prison offers sex offender treatment programmes, as well as extensive industrial work and education opportunities.

8. The prison was most recently inspected by HM Chief Inspector of Prisons on an announced visit between 2-6 July 2007. In her subsequent report, the Chief Inspector commented:

> "We have previously applauded the way that the prison has been able to integrate all prisoners safely into a single population. This full announced inspection confirmed 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. Health services were adequate, although some waiting lists were long. Mental health in-reach services were particularly well integrated into the work of the establishment. Health service managers needed to continue to work with the local primary care trust to ensure that problems with the over-prescribing of some medications were properly addressed and progress monitored. Littlehey remains an impressive and improving prison, able to work effectively with some very high risk prisoners. It provides a fundamentally safe and respectful environment, in which prisoners are generally occupied purposefully. Some impressive interventions are available for sex offenders. Inevitably, there is scope for improvement but, overall, staff and managers are to be commended on what they have achieved so far."

9. Provision of healthcare is the responsibility of Cambridgeshire Primary Care Trust with the General Practitioner service being provided by a local GP practice. A wide range of health promotion clinics are available, with Mental Health Nurses available on a daily basis. A psychiatrist also visits. Healthcare staff run nurse-led chronic disease clinics.

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

KEY EVENTS

11. The man arrived at Littlehey on 26 July 2005 after previously being held at Leeds, Wakefield and Parkhurst. On first reception in prison, the man did not have any medical complaints of note. During his time in custody, the man developed arthritis in his shoulder and neck and hypertension (high blood pressure). A range of medications was prescribed for his condition and he was allowed to keep these in his possession for self administration.

12. On 14 February 2006, the man was seen by the prison doctor in the medical centre at Littlehey. The man was diagnosed with indigestion and also had pain in his lower back. The prison doctor prescribed acupan to act as pain relief for the man. It was noted in the medical record that the man refused to have his blood pressure checked on 4 September.

13. The man went to the healthcare centre on 14 June 2007 as he was experiencing pain in his joints. Paracetamol was prescribed and this was to be taken in combination with acupan.

14. On 25 July, the man assaulted another prisoner. He was confined to his cell after the altercation pending an adjudication (a disciplinary hearing). The adjudication was carried out on the following day. The man admitted the assault and he was given a punishment that was suspended for three months.

15. The man attended an optometric assessment on 29 October at the local hospital. Cataracts were identified in both of his eyes and a referral was made for surgery. An eye clinic appointment was made for the man on 10 December but he refused to attend and signed a medical disclaimer. On 10 January 2008, the man's medication was reviewed by another prison doctor and a repeat prescription was issued.

16. The man's personal officer was interviewed as part of this investigation. He said that the man was an enhanced prisoner and he was compliant with the regime in the prison. (The Incentives and Earned Privileged Scheme (IEPS) is a scheme that is designed to encourage and reward good behaviour in prisons. There are three tiers – Basic, Standard and Enhanced. Incentives include access to in-cell televisions, more private cash to spend, wearing own clothes, more time out of cell and community visits.)

17. The personal officer said that the man had never looked a picture of health. He had very yellow fingers and smoked a lot. He recalled that, if the man could help it, he avoided reporting to healthcare. The man would prefer to go to work and soldier on rather than go to the healthcare centre. The personal officer said that the man went to work each day in the morning and afternoon in one of the prison workshops. His work involved putting items into plastic eggs. The personal officer confirmed that, when he was not at work, the man spent most of his time on the spur of the wing where he was housed. If other prisoners wanted to see the man, they visited him in his cell.

18. The personal officer explained that, although the man did not actively seek out staff, he would speak to them if they spoke to him. However, the man was reluctant to interact with staff he did not know. The personal officer said that he spoke at length to the man about his sentence and his family. He recalled that the man spoke of his daughter (whom the personal officer later met at the man's funeral).

19. The personal officer thought that the man wanted to stay in prison and was not actively interested in pursuing opportunities for rehabilitation. The personal officer recalled that he had convinced the man to consider the option of a town visit. The man had eventually agreed and the relevant paperwork and risk assessment was completed. However, as the man was not interacting with the psychology department at that time, his request was turned down. The man later started to engage with psychology and his personal officer said that he reminded him that this had been the only barrier to his town visit being refused. The personal officer did not actively push the man to apply again for another town visit. Instead, he let the man decide on his next steps. He asked the man to come back to him if he wanted to pursue the option again.

20. When the personal officer returned to the wing on 14 January 2008, after a fortnight of working on night duties, he saw the man. He said that the man appeared okay and they exchanged pleasantries. The personal officer left Littlehey at 3:00pm on 14 January as he had to escort a prisoner to hospital. When he returned to Littlehey the following day he found out that the man had passed away.

21. Around 5:00pm on 14 January, the man was locked in his cell for the night. He was then seen through the hatch in his cell door at around 8:00pm. At around 6:30am on 15 January, an Operational Support Grade (OSG) noticed that the man was in an unusual sleeping position. At approximately 6:50am, the OSG decided to return to the man's cell (B4-11) and he noted that the man was still in the same position. The OSG was joined by a Prison Officer at around 7:10am. He conducted a handover which included his concerns about the man. After the handover was finished, both men went to the man's cell. The officer switched on the light in the cell and looked through the observation panel. The officer then unlocked and entered the man's cell whilst the OSG stayed outside. The officer could not find evidence of a pulse and noted that the man's skin was pale and cold to touch. The officer immediately contacted the prison communications section (by phone from the wing office) to inform them of the situation. In his statement to the Governor, the officer wrote that he was sure that the man had died. The officer and OSG were joined shortly after by the Orderly Officer and a Senior Officer. The Orderly Officer checked for signs of life but could not find any. He instructed the Senior Officer to close the cell and to put a screen in place to prevent anyone from looking into the area.

22. A paramedic arrived at the cell at 7:38am. The Acting Head of Learning and Skills arrived two minutes later at 7:40am and the Orderly Officer briefed her about the situation. The paramedic confirmed at 7:48am that the man had been dead for some time. The prison doctor pronounced death at 8:51am.

23. Staff went to each cell on the wing to tell prisoners individually what had happened. They also asked each prisoner whether they required anything or wanted to speak to a Listener (a prisoner who has been trained by the Samaritans to give support to their peers). One prisoner asked to see a Listener and the officers immediately organised this for him.

24. A Senior Officer was appointed as Littlehey's family liaison officer. He contacted the family on the day after the man's death to offer condolences and support. He maintained contact with the family and assisted with the arrangements for the funeral. The prison provided financial assistance with funeral costs.

25. The man's personal officer told my investigator that, after the man died, the prisoners who were located in the cells next to him were very upset. The prisoners on the wing raised a collection of £130 in memory of the man. Some of the money was spent on a wreath, with the remainder being given to a local hospital. The personal officer attended the man's funeral with a Residential Governor. The Residential Governor took a photograph of the wreath purchased by the prisoners to show them when he returned to the prison. A memorial service was also held at the prison and this was well attended.

26. The post mortem report records the man's death as being due to natural causes as a consequence of acute left ventricular failure caused by ischaemic and hypertensive heart disease.

CLINICAL REVIEW

27. A review of the man's medical care was undertaken by a doctor on behalf of Cambridgeshire Primary Care Trust. The reviewer notes that the man had little interaction with healthcare during his time at Littlehey. In the past he had suffered with arthritis and also had a history of hypertension.

28. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The reviewer concludes that there were no circumstances indicating that death could have been anticipated or prevented.

29. The reviewer judges that the quality of care the man received was good and entirely equitable with that he would have received outside prison. The reviewer was not critical of any actions of healthcare staff and says that all appropriate clinical procedures were followed. The reviewer feels that the man's death could not have been avoided. The man had been placed on appropriate preventative medication and the proper clinical investigations were carried out.

CONCLUSIONS

30. The man moved to Littlehey in July 2005 and it was here that he died of natural causes in January 2008.

31. Given the generous collection following his death, and the comments made by staff at Littlehey, it appears the man was a respected and well liked prisoner.

32. In light of the findings of my investigation and the clinical review, I conclude that the care provided to the man was entirely appropriate. Indeed, I think that staff at Littlehey treated the man with sensitivity and professionalism. I make no recommendations.