

The death in of a man in custody

HMP Littlehey – 11 January 2005

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

May 2005

This is the report of an investigation into the circumstances of the death on 11 January 2005 of a man at a Hospice, whilst temporarily released from HMP Littlehey.

The man's death was caused by lung cancer, which had spread to his liver, bones and brain. He was serving a three-year sentence at the time of his death.

One of my investigators carried out the investigation, on my behalf. A clinician, also from my office, carried out the clinical review.

My colleagues and I would like to extend our condolences to the man's family for their loss. I would also like to thank the Deputy Governor of Littlehey, who ensured that all relevant information was made available to my investigator.

I draw attention to the compassionate way the man was transferred to a hospice nearer his home, so that he could be near his family. This was arranged over the festive period and showed a level of compassion that reflects extremely well on Littlehey and the Prison Service as a whole.

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Summary

The man died at the age of 69, at a Hospice, having been admitted 13 days earlier from a hospital, where he had been for eight days. The man was serving a prison sentence at HMP Littlehey.

His death was not connected to the fact that he was in prison or to the level of care that he received there.

This was not the man's first time in prison. The prison describes him as a polite and co-operative man, with positive custodial behaviour.

The man died of natural causes as a result of lung cancer that had spread to his liver, bones and brain.

The report makes no recommendations, but commends two examples of good practice on Littlehey's behalf.

Background

The man

On 12 January 2004, he was sentenced to a three-year term of imprisonment for indecent assault, and taken to a local prison. He was subsequently transferred to Littlehey.

This was not the man's first time in prison. The prison describes him as a polite and co-operative man, with positive custodial behaviour.

On 12 January 2004, the prison received a letter from the man's solicitor¹, which detailed the man's medical history and the medication he was prescribed. He had a number of medical complaints. The man also had a history of depression.

HMP Littlehey

Littlehey was opened in 1988 as a purpose-built category C male adult training prison, near Huntingdon in Cambridgeshire. The prison comprises eight residential units.

¹ This letter was written to the man's Solicitors from his GP. His solicitors referred to this letter at the sentencing hearing at the Crown Court.

Investigation process

All the indications were that this was a death from natural causes. The Ombudsman's Terms of Reference require me to decide upon the extent of any investigation, depending on the circumstances of the death. When a death occurs from natural causes, I judge that it may be sufficient for a clinical review to be carried out by an independent health care professional, rather than conducting a full investigation.

My approach in cases of apparent natural cause deaths, therefore, has been to conduct an initial review to determine if a full investigation is justified. In The man's case, I decided that the circumstances did not require a full investigation. I did so after my investigator contacted Littlehey Prison, reviewed the documentation and had a very helpful discussion with the Deputy Governor.

My investigator wrote to the Chairman of the local Prison Officers' Association (POA), and the Chair of the Independent Monitoring Board (IMB). Neither the POA nor the IMB had any issues they wished to draw to my investigator's attention.

My investigator was given access to all of the man's prison records, including his medical records, and was given copies of everything that was required.

Following a telephone call, my investigator sent a letter to the man's family, inviting them to get in touch, if they wished, to make any comments or ask questions. The man's daughter provided some very useful comments. Information supplied has been considered in this investigation.

A clinician who works for my office carried out the clinical review.

Events leading up to the man's death

Following sentencing on 12 January 2004, the man was taken to a local prison. During the health reception screening, the prison medical staff had a letter from the man's solicitor, which detailed his medical history and the medication he was prescribed. He had a number of medical complaints, which included angina, a duodenal ulcer, and prostate problems, all of which were treated. The prison doctor authorised the medication prescribed by the man's GP. The doctor described the man as "well orientated with no thoughts of self-harm". Had the doctor been concerned about the man's health, the doctor could have asked for further tests, such as sputum, blood and urine. Alternatively the man could have been referred to the local NHS hospital. In this case, the doctor had no such concerns.

The man had a history of depression, although he did not inform prison staff of this during the routine reception assessments.

The man was transferred to HMP Littlehey on 2 February 2004.

There was little of note until 11 November, when the man was treated for a urinary tract infection. The man wrote a letter of thanks to the doctor, saying that the treatment the doctor prescribed was swift and effective. He also said that he did not want to take blood tests. However, blood tests were subsequently taken as the doctor thought it appropriate.

On 21 December, he complained of generalised aches and pains, so he was prescribed Paracetamol for 14 days.

During social visits, the man's family noticed that he was losing weight, but this was not documented or noticed by the staff at Littlehey.

On 22 December, wing staff noticed that the man was acting in a confused manner, his speech was very slurred and he had a facial droop. Healthcare staff attended the wing and he was taken to the local hospital, in an emergency ambulance. He was admitted to a ward for tests and observation.

My investigator spoke to a number of prisoners who were friends of the man and witnessed this incident. They said that the prison staff responded extremely quickly and compassionately. One of the prisoners said that he had known the man since his arrival at Littlehey. Both he and the man had been very satisfied with the way they were treated by medical and discipline staff at the prison. The man's friend went on to say that the man's symptoms appeared very suddenly, and that the man had not told him of any medical concerns in the months leading up to his death.

On 23 December 2004, the hospital told the prison that the man was undergoing investigations, and that he might have had a stroke. The hospital said that they were waiting to perform a CAT scan on and that he would need to stay in hospital over the Christmas period.

On 24 December 2004, the prison clinical manager visited and spoke to a consultant at the hospital. They said that he had not suffered a stroke, and that the CAT scan indicated that the man had cancer of the lung, which had spread to his liver, bones and brain. The prison clinical manager stayed with the man. She supported him, and discussed the possibility of commencing chemotherapy. A decision on the most appropriate treatment was to be made when the results of a biopsy taken from the man's lung were known.

On 24 December 2004, the prison considered that his condition had deteriorated to such an extent that he posed no risk of escape and released him from custody on a compassionate temporary licence.

On 29 December 2004, the Deputy Governor and the prison clinical manager visited the man and spoke to the duty house officer. He said, "following an assessment by the Oncologist, a biopsy would be unwise in view of his very poor general health, and that due to the extensive spread of the cancer and his poor physical condition, it would be inappropriate to treat with chemotherapy. The plan therefore was to treat palliatively."

The prison decided to move him to the care of a hospice closer to his home area, in order to make visits from his family easier.

On 30 December 2004, he was moved to a hospice, near to his family. Whilst the prison made regular phone calls to the hospice, staff from local prisons visited the hospice on alternate days to check on the welfare of the man.

On 10 January 2005, the hospice told the prison clinical manager that the man had suffered an episode of mini-strokes three days earlier, on 7 January 2005. She was assured that he remained comfortable, but that at times had become aggressive. This was thought to be due both to his condition and medication.

On 11 January 2005, the man passed away at 7.00am whilst in residence at the hospice.

Level of Compliance

Standards of healthcare in prison are intended to mirror those available in the outside community. The man's prison records indicate that he was given an appropriate level of care, and his medical and social needs were recognised and dealt with appropriately. The medical aspects of his care are described in the independent clinical review. The clinical reviewer also concludes that appropriate care was given to the man.

Prison Service Order 2710 sets out what action prisons must take following a death in custody. Littlehey fully complied with this order.

All necessary information was collated for the purposes of this investigation.

Findings and Conclusions

The man received appropriate treatment for a number of medical problems and died of natural causes as a result of lung cancer that had spread to his liver, bones and brain. The medical and nursing staff cared for his health and social care needs. His treatment and care appeared to be appropriate.

At the reception assessment, the doctor was given no cause to be concerned about the man's health and did not ask for further tests to be completed. The doctor was in possession of a summary of the man's medical history, and had no reason to suspect that he would later be diagnosed with cancer.

Whilst his family noticed that he was losing weight, this could have been attributed to the fact that he was in prison and not necessarily an indicator of cancer. It is also the case that subtle changes in weight are not always as obvious when a person is seen on a daily basis, as they are when the person is seen periodically.

The man appeared to be happy with his treatment for a urinary tract infection. He wrote a letter of thanks to the doctor, saying that the treatment the doctor had prescribed was swift and effective. One of the prisoners who was known to be the man's friend, said that he and the man had been very satisfied with the way they were treated by medical and discipline staff at the prison. He said that the man's symptoms appeared quickly, and that the man had no medical concerns in the period before he became ill.

Without prior warning symptoms, the man became very ill whilst he was in prison and was transferred to the local hospital where, following investigations, a cancer of the lung with metastasis was diagnosed. The man was transferred to a hospice and died on 11 January 2005.

The family liaison arrangements appear to have been effective.

When the extent of the man's illness became apparent, the prison acted quickly in releasing him from custody and transferred him to a hospice near to his family.

Recommendations

I make no recommendations in this case.

Good Practice

The man's treatment and care whilst in custody at HMP Littlehey were managed well. The input and help that he received both from prison staff and staff in the community is to be commended.

The prison acted with despatch in granting release on temporary licence. He was transferred to a hospice, so that he could be near his family. This was done during the festive period, which would have made a transfer more difficult. Taken together, these actions demonstrated compassion and sensitivity in the best traditions of public service.