

INVESTIGATION INTO THE DEATH IN CUSTODY OF A MALE PRISONER
AT HOSPITAL, WHILST A SERVING PRISONER
AT HMP LITTLEHEY ON 30 JANUARY 2005

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR
ENGLAND AND WALES

MAY 2005

This is the report of a short investigation into the circumstances of the death of a male prisoner aged 69 when he died on 30 January 2005 at Hospital, at the time of his death; he was a serving prisoner at HMP Littlehey. He had been sentenced to nine years imprisonment on 30 June 2000. He transferred from HMP Whitemoor to Littlehey on 22 January 2003.

The investigation was carried out by two of my staff. A separate clinical review to look into the prisoner's clinical care and treatment was requested. Given the circumstances, I did not think it sensible to delay issuing this report but will revisit my conclusions in light of that clinical review if necessary.

I would like to extend our condolences to the prisoner's partner, and other members of his family, for their loss. I would like to thank the Governor of HMP Littlehey, and staff for their ready assistance during the investigation. I have commended Littlehey's actions in arranging the prisoner's temporary release at the point his health was deteriorating. There are no other substantive findings or recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

May 2005

Contents**Page**

Foreword	2
Summary	4
Investigation Process	5
Background	6
HMP Littlehey	7
Events leading up to Prisoner's death	8
After Prisoner's death	8
Conclusion	9
Good Practice	9
Recommendations	9

Annex

A. Notice of Investigation	10
B. Terms of Reference	11
C. Letter from Dr O Akanda dated, 17 February 2005	14
D. Letter to the Coroner's Officer from Dr R J Dickinson, 4 March 2005	16

Summary

1. The prisoner was 69 years old when he died on 30 January 2005 at the Hinchbrook Hospital, Huntingdon. The Coroner directed that a post mortem was not required as the prisoner had died whilst in hospital. The prisoner's cause of death was found at inquest to be natural causes, a cerebrovascular accident (stroke). At the time of his death, the prisoner was serving a nine year prison sentence.
2. Prior to his conviction the prisoner had not come to police attention. He had undergone a heart bypass in 1984 and, although the surgery was a success, he had been in poor health ever since. At the time of his death, he was being treated as both an outpatient and inpatient at hospital for his heart condition. He had been described as a 'model prisoner' and was on an enhanced regime. He had been variously described as a hard worker, very reliable, well liked and respected by other prisoners. He worked on the servery.
3. The sad news of his death was broken to his partner, after he had died. My Family Liaison Officer has also spoken with his partner and communicated with his ex wife. The prisoner's partner was aware that he was in poor health.
4. This report makes no recommendations.

Investigation Process

5. My practice in cases of deaths from apparently natural causes is to conduct an initial review to determine the extent of investigation required.
6. To that end my investigators, visited HMP Littlehey on 9 February 2005 when they spoke informally with the Deputy Governor who outlined the facts relating to the prisoner and his transfer to hospital. The investigators were given access to the prisoner's records, including his medical records. The investigators subsequently spoke to a representative of the local Independent Monitoring Board (IMB), and the chaplain. Neither had any issues that they wished to draw to the investigators' attention. In addition, the investigators visited the wings and spoke to staff and prisoners.
7. One of my Family Liaison Officers, telephoned the partner of the prisoner. She was aware that he had been in extremely poor health. My Family Liaison Officer explained the nature and scope of my investigation.
8. The Coroner's Officer was consulted and informed the investigation team that, on the advice of the coroner, a post mortem was not required. This was because the prisoner had died whilst undergoing treatment in hospital. The cause of death was given as cerebrovascular accident (stroke).
9. No formal interviews with staff were conducted. This report is based upon a review of all relevant paperwork, including the clinical records.

Background

10. The prisoner was 69 years old at the time of his death. He was born in London.
11. The prisoner first worked as a trainee manager for a retail store mainly based in London. At 17 years of age he signed up to serve in the navy. He was discharged after 14 months. He then worked in the building trade.
12. At Littlehey he was described as a 'model prisoner' who was on the enhanced wing. He worked in the servery. The prisoners and staff who met my investigators all spoke highly of the prisoner.
13. I understand that the prisoner had been a heavy smoker.

HMP Littlehey

14. Littlehey is a category C prison for male prisoners. It was opened in 1988 and is purpose-built. It has seven residential units. HM Chief Inspector of Prisons' first inspection commended it for its imaginative regime and it has since earned a reputation for effectively integrating those convicted of sexual offences with prisoners convicted of non-sexual crimes, a process started almost as soon as the establishment was open.
15. The most recent inspection by HM Chief Inspector took place in December 2002. She found Littlehey was overall a good Category C training prison. It was characterised by very good staff prisoner relationships, based upon respect and a real sense of equality, but within proper boundaries of control. The core work of the prison was being pushed forward by a dynamic management team, committed to improving both the quantity and quality of work available. Some was already of high quality, but needed to reach more prisoners and be more closely related to identified needs and sentence plans.
16. Healthcare had improved significantly but there was a clear need for more effective liaison and support from the NHS for those prisoners with acute or chronic mental health problems.

Events Leading Up To the Prisoners Death

17. Since 1981, the prisoner had had a history of coronary artery disease with myocardial infarctions. He was referred for a coronary artery vein bypass grafting which was performed in July 1984, five grafts being constructed. This achieved a good result, and he was discharged from hospital with a follow up to General Practitioner supervision. It is clear from his prison medical records that the prisoner had a history of significant coronary artery disease, which was identified early during his imprisonment.
18. In August 2001 whilst at HMP Whitemoor, the prisoner was referred to outside hospital as he was feeling unwell and complaining of gradually getting short of breath. In November 2001 in a conversation with an officer about his release plans, the prisoner said, "It was not an issue as, due to ill health he probably wouldn't see his sentence out". He had a similar conversation with his probation officer in November 2002.
19. The prisoner was transferred to Littlehey on 22 January 2003 where he was referred to Hinchinbrooke Hospital, Huntingdon. He received treatment, both as an inpatient and an outpatient, for his heart condition. He became an enhanced prisoner and moved to F wing.
20. The prisoner complained of chest pains on 27 January 2005 and was taken under escort by ambulance at 10.15am to Hinchinbrooke Hospital. He arrived at 10.55am. It was thought he had suffered a stroke.
21. He remained in hospital and, on 28 January, owing to his deteriorating condition was released on temporary licence effective until 4 February 2005. The prisoner's condition continued to deteriorate and he passed away 30 January 2005.

After The Prisoners Death

22. The man's partner was informed of his death at 9.20am. Standards of clinical care in prison are intended to mirror those available in the outside community. The prisoner's records indicate that while at Littlehey his health care needs were dealt with appropriately. Quite clearly, the prisoner was a man who was in poor health.

Conclusions

23. The prisoner was well cared for in Littlehey and was an enhanced prisoner. The healthcare he received there was probably at least as good as it would have been had he not been in custody.

Good Practice

24. The prison should be commended for arranging to release of the prison on Temporary Licence, at the point when his health was deteriorating.

Recommendations

25. There are no recommendations to be made regarding the prisoners treatment whilst at Littlehey.