

**The death in custody of a man
who died in hospital
in February 2005**

Report by the Prisons and Probation Ombudsman for England and Wales

December 2005

This report concerns the death from apparent natural causes of the man.

The man had been discharged from the hospital to Littlehey prison on 8 February following an admission, which commenced on 30 January, for treatment of a chest infection. He was unwell on return to the prison and on the morning of 10 February, his condition gave sufficient cause for concern for him to be returned to hospital by emergency ambulance. Between 9.10pm and 9.20pm that evening, his condition suddenly deteriorated and he required resuscitation. Despite the efforts of the hospital's cardiac team, he died.

A subsequent post mortem on 14 February concluded that the cause of death was cardiac arrest, ischaemic heart disease, recent myocardial infarct, coronary atheroma and chronic obstructive pulmonary disease.

I would like to extend my condolences to his family for their sad loss. I would also like to thank the Governor of Littlehey and the Governor's secretary, who was duty governor on 10 February, and the other staff members who assisted my investigators with their enquiries. We found everyone very helpful and co-operative.

The investigation was carried out by my Investigator and her assist. We are very grateful to Huntingdon Primary Care Trust for their review of the clinical care of the man.

I make two recommendations and commend the professionalism of Littlehey in respect of communication, record keeping and prisoner care as consistently very good practice. I hope the Governor will share that finding with her staff.

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Contents

Summary

The Investigation

Littlehey prison

Events leading up to and following 10 February 2005

Events of 10 February 2005

Events after the man's death

Key Findings and Conclusions

Recommendations

Summary

The man was quite disabled by the effects of a serious injury to his leg that had taken place as a child, and by longstanding lung disease. He was convicted of sex offences in November 2002, aged 61. It was his first conviction. He was sentenced to nine years imprisonment on 18 December. He transferred from Norwich to Littlehey on 4 June 2003.

The man did not admit his offences and therefore refused to participate in treatment programmes. Records show that he was a very quiet prisoner, compliant with the regime and never breaching prison rules. He was on the standard level of the incentives and earned privileges scheme (IEP). He undertook light work and participated in education classes which enabled him to improve his literacy skills. He had regular visits and correspondence from his wife and two of his daughters while at Littlehey.

Records show that the staff were concerned about the man's frailty. He was admitted to hospital on 30 January 2005 for treatment of a chest infection. He was discharged on 8 February. He was unwell on return to the prison and, on the morning of 10 February, his condition gave further cause for concern and he was returned to hospital by emergency ambulance. That evening, his condition suddenly deteriorated and he passed away despite the efforts of the hospital's cardiac arrest team.

A post mortem on 14 February concluded that the causes of death were cardiac arrest, ischaemic heart disease, recent myocardial infarct, coronary atheroma and chronic obstructive pulmonary disease. A clinical review by Huntingdon Primary Care Trust concluded that he had received care and attention whilst in custody comparable to that available in the community.

This report makes two recommendations and commend's Littlehey for good practice.

The investigation

The investigation began on 11 February when my investigator, contacted the Governor's secretary. The Duty Governor had made contact with the man's widow to inform her of his death and make funeral arrangements according to her wishes. On 11 February, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to his death to contact my investigator.

One of my Family Liaison Officers (FLO), made contact with his wife on 22 February to establish what concerns, if any, she would wish my investigator to follow up on her behalf. His wife did not want the FLO to visit her at home at that time but she did want to be kept informed about the investigation and to see the report.

My investigators visited Littlehey on 9 March, familiarising themselves with the prison, particularly A wing where he had resided. They returned on 1 April 2005. Three staff were interviewed. On 13 May, a final visit was made and three more staff were interviewed. Records of the interviews were forwarded to Littlehey for staff to check, amend as necessary and sign.

An independent clinical review of his health care was undertaken by Huntingdon Primary Care Trust.

The investigation was completed on 31 May 2005.

HMP Littlehey

HMP Littlehey is a purpose built Category C training prison for men. The certified normal accommodation is 664. The operational capacity is 706 with a typical occupancy around 690. The prison was opened in 1988 on the site of the former Gaynes Hall Youth Custody Centre. It has been extended by the addition of two 'ready to use' units, one in 1997 and one in 2003.

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 a sex offender treatment programme as well as extensive industrial work and education opportunities.

Records show that three Littlehey prisoners died in custody in the six months prior to his death. The circumstances of all those deaths were investigated by my office and all were from natural causes.

Events leading up to and following 10 February 2005

The man was convicted of sex offences at Bury St Edmonds Crown court and was received into custody. On reception, his healthcare needs were assessed and he was noted to have a history of hypertension (high blood pressure), asthma and back pain. His medication was noted and he was admitted to the healthcare centre for assessment. Throughout his time in Norwich, there is documentary evidence of regular healthcare and medication reviews, including requests for information from his general practitioner (GP).

On 18 December, he attended Norwich Crown Court where he was sentenced to 9 years imprisonment. He returned to Norwich and was transferred to Littlehey on 4 June 2003. On arrival at Littlehey, a reception health screen was carried out and his treatment plan was noted.

He remained in generally poor health throughout his time in Littlehey. He was quite disabled by his longstanding lung disease and spent eight days as an in-patient in hospital in December 2003. He had periods where he was unable to leave his cell due to shortness of breath and it was reported that other prisoners would help by bringing his food to his cell and spending time talking to him.

He attended the Chronic Obstructive Pulmonary Disease (COPD) clinic at the hospital as an out-patient in January and February 2004. During these appointments he was reviewed by the Respiratory Nurse Specialist for COPD and by the Consultant Physician.

In January 2005, he developed a chest infection for which he was prescribed antibiotics. It was noted that he sometimes forgot to take his medication and wing staff were instructed in writing to check that he had taken his medication and to inform the healthcare centre of any problems. On 30 January 2005, he was still unwell and was taken to the Accident and Emergency Department (A&E), complaining of shortness of breath. He was diagnosed with a chest infection and admitted as an in-patient.

He was discharged from this period in hospital on 8 February. The officer, who was on bed watch the previous evening, stated at interview that the man had been told by the doctor that he could be discharged the following day provided his test results were fine. There is also an entry in the bed watch record to this effect. As far as the officer on bed watch was aware, the man had diarrhoea up until the evening of 7 February but the next morning he was not complaining of any illness. The bed watch officer and another officer then escorted him back to the prison on the morning of 8 February. During the journey, he was quiet, which was not unusual for him and he seemed alright.

An entry in his wing record on 8 February, however, stated that he had returned from hospital and 'has diarrhoea and feels unwell'. This entry was made by the

senior officer although, from his interview it appears that the entry was made on the basis of information passed to him by another officer. The other officer confirmed at interview that she had been concerned that the man was still very unwell on his return from hospital. She stated that he was in his bed, he looked ill and said he felt unwell. He was sick and he had diarrhoea. The other officer stated that the healthcare staff were aware that the man was still unwell and that he was being monitored.

The officer who wrote an entry in the observation book dated 9 February 2005 stated that the man was quite ill and requested wing staff to observe him overnight and during the day. At 4.50pm, wing staff contacted the health care centre and asked Healthcare Officer (HCO) to see him. The HCO confirmed at interview that he saw the man, who was complaining of diarrhoea and vomiting. HCO monitored his blood pressure, gave him some medication and advised him about taking his medication and eating and drinking. He said at interview that he scheduled a follow-up visit for the next morning.

Events of 10 February 2005

The nurse confirmed at interview that she saw the man in his cell at 9.20am on 10 February. Wing staff were concerned that the man was still unwell. He had refused breakfast and was complaining of pains. An officer had been concerned and had telephoned for healthcare staff to attend.

On arrival at the wing, the nurse was immediately concerned for the man's health. She could smell vomit in the room and the man described the vomiting as black in colour and increasing in frequency. She carried out a physical examination, which was fully documented. She informed the prison doctor, who was in the health care centre and who was familiar with the man's condition. The doctor advised an ambulance be called and the nurse remained with the man until the ambulance arrived. According to the nurse, the ambulance crew remained with him for some time and he was taken to hospital at 9.58am.

The man was anxious about going into hospital as his wife was due to visit the following day (11 February). An entry in his record indicates that his wife was informed that he was being taken to hospital and advised to contact the prison before visiting.

The bed watch record indicates that the man arrived in A&E at 10.40am. A risk assessment was carried out by the prison with regard to the level of security appropriate for the man's escort. During his treatment, permission was requested and given for restraints to be removed so that a drip could be inserted. The man was told by the doctor that he would be staying in and that they were not sure what was wrong.

The man remained poorly and on intravenous fluids. The officer, who was with him, said at interview that he was coughing a lot and seemed in a lot of pain. At 9.10pm he was moved to a side ward, in his bed and with drips attached. The bed watch report stated that there was no change and there were no concerns.

The next entry in the bed watch record is at 9.20pm and states that the cardiac team were with the man and were attempting cardio-pulmonary resuscitation (CPR). At interview, another officer said that when the man was moved to the side ward the hospital staff made him comfortable and started to do some tests. The officer said he then 'took a turn for the worse' and staff present began CPR. The officer remembers equipment being brought in and several attempts to resuscitate were made. CPR continued until 9.30pm when doctors made the decision to stop and pronounced that the man had died.

Events after the man's death

One of the prison officers escorting the man, contacted the prison at 9.35pm to inform the Night Orderly Officer (NOO) of his death. The NOO followed Contingency Plan 5: Death in Custody, because there was no specific plan in place for dealing with a death in hospital.

At 9.45pm the officer phoned the prison to say that the hospital was having difficulty contacting the man's wife on the number they had. At 10.11pm, the NOO informed the duty governor of the problems contacting the man's wife. The duty governor eventually managed to contact his wife at around 10.50pm to inform her of her husband's death.

A post-mortem examination was carried out on 14 February and the findings were faxed to the prison on 15 February. The pathologist had concluded that the man had died of cardiac arrest, ischaemic heart disease, recent myocardial infarct (heart attack), coronary atheroma (hardening of the arteries) and chronic obstructive pulmonary disease. There was no evidence in the man's medical record to suggest a recent heart attack, nor were prison healthcare staff, prison custodial staff or his wife aware of any heart problems.

The man's cell was cleared on the 15 February and his possessions returned to his wife. His wife said that these were packed neatly and sent by special delivery. In this, as in other areas explored during this investigation, Littlehey emerges well.

Documentation was completed by prison staff after the man's death, including an incident report, information sheet and certificate of final release. However, the certificate of final release does not allow for a specific recording of a death occurring in hospital.

Key Findings and Conclusions

The man who was in poor health before coming in to custody and this continued throughout his time in prison. The evidence from my investigation indicates that the healthcare he received whilst in prison compared favourably with that he could have expected to receive if he was living at home. He had access to prison health care staff promptly when he complained of feeling unwell, or when wing staff were concerned about his health. There is good evidence to suggest that his physical and medical condition was well known to all staff in regular contact with him, and that appropriate support was given when necessary. He attended out-patient appointments to specialist services as he would have had he been living at home.

The man had spent a period in hospital between 30 January 2005 and 8 February 2005. It is uncertain how well or unwell he was when he was discharged from hospital on 8 February. Unfortunately, the clinical review carried out by the PCT does not cover this issue.

During the investigation interviews, we discovered there were some cases of diarrhoea and vomiting in the prison, although not on A wing. We were told at interview that there was diarrhoea and vomiting in hospital at the time of his illness. My investigator asked the Clinical Governance lead at the PCT to investigate that suggestion. She made no report but when pressed she said that the hospital had confirmed there were diarrhoea and vomiting cases in the hospital at that time. We asked for this to be confirmed in writing but nothing was forthcoming.

It appears that his fitness for discharge was dependent on test results and self-reporting of symptoms. We were unable to ascertain what the tests carried out were for, however it appeared from interviews with the escort staff that the man reported to the nurses that he was feeling well. It was evident that he was quite unwell at the prison on 9 February, the day after his discharge from hospital. From then until his readmission he was seen by prison healthcare staff, given medication and monitored. He was readmitted by ambulance on 10 February. I consider that the healthcare he received at the prison during this period and the action that was taken when his condition deteriorated was appropriate.

There is no evidence to suggest that, whilst in hospital on 10 February, that he did not receive the level of care and treatment that would be afforded anyone else in his condition. The prison carried out a risk assessment that was flexible enough to allow for the appropriate treatment to be carried out and good records were kept by prison escort staff during this period.

The post-mortem examination revealed a recent myocardial infarct but when this may have occurred is uncertain. There is no evidence to suggest that any form

of heart attack was suspected by prison health care or custodial staff during his time in Littlehey.

The action taken by prison staff following his death was appropriate and in line with prison policy, even though there was not a specific contingency plan for deaths occurring in hospital. I do not consider that having a specific plan would have improved the response to his death, however the current plan does not take into account recent changes in policy and the role of the Prison and Probation Ombudsman with regard to the investigation of deaths in custody. Similarly, the Certificate of Final Release does not allow for the specific recording of a death occurring in hospital.

Recommendations

1. I recommend that the contingency plan No. 5 for deaths in custody is reviewed to accommodate changes in policy and the role of the Prison and Probation Ombudsman with regard to the investigation of deaths in custody.
2. I recommend that the Certificate of Final Release is reviewed to accommodate specific recording of removal to an acute hospital. At the same time, sections referring to the Mental Health Act 1959 should be replaced by references to the appropriate sections of the Mental Health Act 1983.

Good practice

I commend the high standards of communication, record keeping and prisoner care at Littlehey which my investigation revealed.

