

**Circumstances surrounding the death of a man, who was a
prisoner at HMP Littlehey, in December 2006**

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

June 2007

This is the report of an investigation into the death of a man who was a prisoner at HMP Littlehey. The man died in outside hospital from apparently natural causes on 7 December 2006. He was 66 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 Governor of HMP Littlehey and his staff for their assistance. A doctor was asked by Cambridgeshire Primary Care Trust to undertake a review of the man's clinical care and we also much appreciate his help.

In light of the findings of the clinical review, I have concluded that the medical and other care the man received from Littlehey was entirely appropriate. Indeed, my own investigation uncovered sensitive and professional practice that reflects well upon the Prison Service.

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 the investigation.

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SUMMARY

The man was born in 1940. He was 66 years old when he died on 7 December 2006 in outside hospital.

The man was first received into custody on remand. He was sentenced at Chelmsford Crown Court in 2004 to four years imprisonment. He was initially held at HMP Chelmsford, before being transferred to HMP Littlehey on 9 September 2004. During his first health screen, it was noted that the man had suffered a heart attack in 2000.

On the morning of 6 December 2006, the man fell to the floor as he was carrying out his cleaning duties. Staff from Littlehey's healthcare centre were called to assist and, after he had been assessed, an ambulance was called. The man was taken to outside hospital where doctors diagnosed that he had suffered a stroke. The man's family was advised of his condition and they were allowed to visit him in hospital.

Whilst he was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. However, after the man's clinical condition was fully assessed, a decision was taken to remove the restraints and they were not reapplied.

On 7 December at approximately 7:05pm, the escort staff noted that the man appeared to cough and his skin became very pale. They informed medical staff who asked them to withdraw. Curtains were drawn around the man's bed while attempts were made to resuscitate him. At around 7:30pm, the escort staff were told that the attempts to resuscitate the man had been unsuccessful and that he had passed away.

The clinical review, carried out by a doctor on behalf of the Primary Care Trust, concludes that the man's clinical care was appropriate and equivalent to that available in the community.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.
 2. The Cambridgeshire Primary Care Trust identified a doctor to carry out a review of the man's clinical care. I am grateful to him for undertaking the review in a most timely manner.
 3. 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.
 4. 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 that they would like explored and addressed. The family raised two particular issues relating to the man's healthcare:
 - They were concerned that, despite the man complaining of blurred vision and feeling unwell on the weekend prior to his death, he was not referred to hospital until the Monday.
 - They also expressed concern about the information they were given by the hospital about the man's condition.
- The clinical reviewer has explored these points and I hope that my report provides the family with answers to their questions.
5. My investigator discussed aspects of the man's treatment with staff at Littlehey and with the clinical reviewer.

HMP LITTLEHEY

6. HMP Littlehey is a category C prison which has the capacity to hold 706 male offenders, but has a typical occupancy around 690. It first opened in 1988 with eight residential wings. Two additional units were added to the prison in 1997 and 2003, 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 inspected by Her Majesty's Chief Inspector of Prisons (HMCIP) on an unannounced visit between 5-7 December 2005. HMCIP commented that, "Littlehey is to be commended for further improvements that it has made since our last inspection. It remains a safe and respectful prison, which has successfully integrated a large population of sex offenders and other vulnerable prisoners into the general population. The prison has expanded access to purposeful activity and begun to focus on the national resettlement agenda. Healthcare was generally good, but the prison continued to cope with prisoners with mental health problems. The mental health in reach team was stretched and under resourced and some mentally ill prisoners were still confined to the segregation unit pending transfer to a prison with adequate hospital facilities. Littlehey is an impressive and improving prison, working with some very high risk prisoners. Staff are to be commended for establishing a fundamentally safe and respectful environment, but further expansion of purposeful activity is required, together with strengthened sentence planning work."
9. Provision of healthcare is the responsibility of Cambridgeshire Primary Care Trust with the General Practitioner (GP) 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 and a visiting psychiatrist. Healthcare staff also 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 HMP Littlehey on 9 September 2004 after being previously held at HMP Chelmsford. During the health screening procedures at both prisons, it was recorded that he had previously suffered a heart attack. It was also noted that he had a problem with his hands (Dupuytren's Contractures, where a deformity develops around the fingers) and was awaiting an appointment with the plastic surgeons for this. A range of medications were prescribed to treat the man's various conditions and he was allowed to keep these in his possession.
12. In December 2005, the man's hands were causing him problems. He was referred to the local hospital where it was decided that surgery was not appropriate at that time.
13. On 12 June 2006, the man was admitted to hospital with chest pain. He was found to be suffering from worsening angina but had not suffered a heart attack as initially thought. An angiogram (an x-ray of the heart after injecting a radio-opaque substance into it) was arranged. The results of this meant no new treatment was needed.
14. Whilst the man was in hospital, a mass was discovered in his lung and a malignancy was suspected. A specialised scan was arranged and this found the mass to be pneumonia which was then treated with antibiotics. However, another mass was found in his salivary gland and the man was awaiting an ear nose and throat appointment at the time of his death. On 27 July, the man had a follow up chest x-ray which showed the pneumonia to be clearing.
15. On 9 November, the man's annual coronary heart disease review was conducted by a doctor at the prison. The review confirmed that he was on the correct medication and his blood pressure was found to be satisfactory.
16. On 22 November, the man had a further episode of angina which was settled after the use of GTN spray. He was reviewed by the prison doctor two days later.
17. On 3 December, the man experienced blurred vision and was seen by a Health Care Officer. The man was reviewed by the prison doctor the following day when he complained of tunnel vision. An immediate referral was made to the eye clinic at the local hospital. However, when the man attended his appointment at the eye clinic, he was told that there was nothing wrong with his eyes. It was explained that the problems with his vision were probably due to momentary lack of oxygen. He was discharged back to the prison.

18. On 6 December at around 9:21am, a prisoner on the wing, discovered that the man had collapsed on the floor while carrying out his cleaning duties. The prisoner immediately informed prison staff. A Senior Officer (SO) saw the man on the floor and noted that he appeared quite poorly. The SO contacted the healthcare centre and asked for urgent assistance. A Prison Officer supported the man in a semi-seated position whilst the SO tried to engage him in conversation. The man was trying to communicate, but was unable to do so clearly.
19. Two members of healthcare staff responded to the call for assistance and arrived on the wing within a few minutes. They were joined shortly after by another colleague from healthcare. The medical staff made the man more comfortable before assessing him. One of the healthcare staff asked for an ambulance to be called as she arrived on the landing. The SO contacted the Communications Room to arrange this. One of the healthcare staff then carried out an electro cardio gram (ECG) which did not indicate atrial fibrillation (condition where there is disorganised electrical conduction in the chamber of the heart, resulting in ineffective pumping of blood). After assessing him further, she felt that the man had suffered a stroke. The man's speech was incoherent at times and he appeared quite restless. One of the healthcare staff then asked for a pillow and made the man more comfortable while they waited for the ambulance to arrive. Paramedics arrived after approximately 25 minutes and they took over the man's medical care. After assessing the man, they gave him oxygen and carried out another ECG. The man was then taken to hospital.
20. Doctors at the hospital diagnosed that the man had suffered a stroke which had affected the left hand side of his body. His family were advised of his condition and were allowed to visit him in hospital.
21. Whilst the man was in hospital, a bedwatch was carried out by prison staff. The initial security risk assessment was that handcuffs were to be used. However, after the man's condition was fully assessed and the diagnosis made, the residential Governor at Littlehey carried out a further risk assessment. He gave permission for the restraints to be removed and they were not reapplied at any stage.
22. On 7 December at approximately 7:05pm, there were two officers on bedwatch duty. They noted that the man appeared to cough and that his skin became very pale. One of the officers immediately told medical staff. The officers were asked to withdraw and the curtains were drawn around the man's bed while attempts were made to resuscitate him. At around 7:30pm, medical staff informed the officers that the attempts to resuscitate the man had been unsuccessful and that he had died. The hospital then contacted the man's family to tell them of his death.

23. When the family attended the hospital they were met by the prison's Deputy Governor who offered condolences and support. Having been appointed as the prison's family liaison officer, the Deputy Governor maintained contact with the family and assisted with the arrangements for the funeral. In line with Prison Service policy, the prison provided financial assistance towards the costs of the funeral. The family spoke very positively of the help and support they received from the prison. The man's own popularity was demonstrated by the fact that prisoners on his wing collected over £200 after his death. This is to be used to purchase a memorial plaque to place on a bench in the grounds of the prison.
24. The post mortem report records the man's death as being due to natural causes, as a consequence of pneumonia and ischaemic heart disease (narrowing of the arteries which carry the blood supply to the heart muscle).

CLINICAL REVIEW

25. A review of the man's medical care was undertaken by a doctor on behalf of Cambridgeshire Primary Care Trust. The review found that the man had suffered from significant long-term chronic diseases.
26. 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 clinical review concluded that there were no circumstances indicating that death could have been anticipated or prevented.
27. The man's family were concerned that, on the weekend prior to his death, the man had complained of blurred vision and of feeling unwell but was unable to see the prison doctor until the following Monday. Given his medical history, the family questioned why he was not sent to hospital immediately as a precaution. As noted earlier, on seeing the prison doctor on the Monday, the man was referred to hospital. However, following an examination, he was told there was nothing wrong and the blurred vision was likely to have been caused by a momentary lack of oxygen.
28. The family questioned why the hospital did not consider this more seriously, given that blurred vision is often associated with the onset of strokes. In his review, the clinical reviewer found that the man's eyes were properly assessed. In his opinion, the stroke would have occurred whether or not the man had been discharged from hospital. The clinical reviewer noted that, although some patients may get blurred vision before a stroke, this does not mean that a stroke can be prevented.
29. The family were also concerned that, following the man's stroke, it was suggested he would need to stay in hospital in the rehabilitation ward for some weeks. This led them to believe the man was not in any immediate danger and they had returned home. However, shortly afterwards the man passed away. The family questioned whether the hospital could have provided a more accurate prognosis about the seriousness of his condition at this time. The clinical reviewer said that the outcome of patients suffering from strokes is often very unpredictable. Patients can often deteriorate suddenly, and faster than expected.
30. The clinical reviewer concluded that the man received a high standard of care and support during his time in prison. There was no indication that his care was at any time less than he would have received in the general community.

CONCLUSION

31. The man had arrived in prison with a history of chronic health problems. He moved to Littlehey on 9 September 2004 and died of apparently natural causes on 7 December 2006.
32. Given the generous collection following his death, and from comments made by staff at Littlehey, it appears the man was a respected and well liked prisoner.
33. From the bedwatch log, it was clear to my investigator that the staff involved with the man's care behaved with sensitivity. The decision to remove mechanical restraints, following a risk assessment, was entirely appropriate. The security arrangements at the hospital seem to have been suitable, and to have struck a good balance between public protection and respect for the man.
34. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical and other care was entirely appropriate. Indeed, I think that Littlehey treated the man with sensitivity and professionalism. I make no recommendations.