Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr Sidney Thorpe, a prisoner at HMP Littlehey, on 16 July 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Sidney Thorpe died of widespread cancer while a prisoner at HMP Littlehey on 16 July 2015. He was 81 years old. I offer my condolences to Mr Thorpe's family and friends.

Mr Thorpe was an elderly man, with a number of health problems and a physical disability, which affected his mobility. I am satisfied that Mr Thorpe generally received a standard of healthcare equivalent to that he could have expected to receive in the community. However, the clinical reviewer considers the deterioration in his condition should have led to an earlier hospital referral. Given the advanced stage of the cancer, this would not have altered the outcome for Mr Thorpe.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. In March 2011, Mr Sidney Thorpe was sentenced to 14 years in prison for sexual offences and was sent to HMP Lewes. In February 2015, he transferred to HMP Littlehey. He was 81 years old and had a number of health problems, including heart disease, diabetes and haemophilia. Healthcare staff monitored and treated his conditions and he attended hospital appointments as necessary. He had a prisoner carer to help him with everyday tasks.

2. On 2 July, Mr Thorpe told a nurse that he had been feeling unwell for three weeks; he had fallen twice in the previous three days and had bumped his head. The nurse suspected he might have had a mild stroke or a bleed on the brain. A GP reviewed him that day and referred him for an urgent referral CT scan but did not consider that Mr Thorpe needed to go to hospital immediately.

3. On 5 July, Mr Thorpe's family visited him and raised concerns about his health. A nurse reviewed him and Mr Thorpe said that he had fallen again the previous night. A GP examined him the next day, who considered his falls were possibly due to low blood pressure. She decided to wait for the outcome of the CT scan, which was due in three days, in case his deterioration was due to a stroke. On 8 July, a scan did not show anything significant.

4. On 10 July, another GP assessed Mr Thorpe after he complained of chest pain. The doctor considered Mr Thorpe might have fractured a rib and prescribed antibiotics for an infection. He arranged to review Mr Thorpe the next week.

5. The next morning, Mr Thorpe told a nurse he had fallen again. The nurse monitored Mr Thorpe that afternoon and again the next day. In the evening of 12 July, Mr Thorpe appeared very unwell. A nurse attended and found Mr Thorpe's oxygen levels were low. He gave Mr Thorpe oxygen and requested an emergency ambulance, which took him to hospital. In hospital, Mr Thorpe's condition deteriorated further and he died on 16 July. A post-mortem examination found that he had widespread cancer, which had not been detected before his death.

Findings

6. Mr Thorpe received a good standard of care at Littlehey until July, when we consider that he should have been referred to hospital more promptly, after he developed new symptoms, including several falls. However, the clinical reviewer noted that despite this concern Mr Thorpe's death would have been inevitable, due to underlying undetected cancer, the extent of which was not established until after his death.

Recommendation

- The Head of Healthcare should ensure that prisoners who report ongoing acute symptoms are examined and referred to hospital for further investigation without delay.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

8. The investigator obtained copies of relevant extracts from Mr Thorpe's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Thorpe's clinical care at the prison.

10. The investigator and the clinical reviewer interviewed four members of staff at Littlehey on 20 August.

11. We informed HM Coroner for Cambridgeshire and Peterborough district of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Thorpe's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked the following:

    - Did Mr Thorpe receive an adequate level of healthcare throughout his time in prison? She was concerned that the symptoms he displayed when she visited on 5 July had not previously been identified and acted on by prison or healthcare staff.
    - Should the prison have given Mr Thorpe's family more information about his condition? Mr Thorpe's daughter said it was difficult to obtain information about her father.
    - Did the prison give the hospital adequate information about Mr Thorpe's medical history, including his haemophilia?

13. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

14. Mr Thorpe's daughter received a copy of the initial report. The legal advisor representing her wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the legal advisor.

Background Information

HMP Littlehey

15. HMP Littlehey in Cambridge is a medium security prison holding approximately 1200 men. A large proportion of the population are men convicted of sexual offences.

16. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison healthcare centre is open from 7.30am to 5.00pm, Monday to Friday, and from 8.00am to 12.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that following a significant change in late 2014, when the young offenders section of the prison had been replaced with adult sex offenders, the prison had adapted well to the needs of a larger population of older prisoners and those with disabilities. The inspection found that there were good arrangements for safeguarding vulnerable adults. Prisoner carers complemented the work of staff in supporting prisoners in a variety of areas. Older prisoners felt well supported. Inspectors described health services at the prison as very good.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2015, the IMB reported that a significant proportion of the population was elderly and staffing levels did no take into account the needs of an ageing population in terms of health and social care, as well as the increased requirement to take prisoners to hospital. The IMB questioned why there was no national Prison Service strategy to manage an increasingly elderly prison population.

Previous deaths at HMP Littlehey

19. Mr Thorpe was the third person to die from natural causes at Littlehey since July 2013. There were no significant similarities with the circumstances of the other deaths.

Key Events

20. On 23 March 2011, Mr Sidney Thorpe was sentenced to 14 years in prison for sexual offences and was sent to HMP Lewes. On 17 February 2015, he transferred to HMP Littlehey. He was 81 years old at the time and lived on a wing for older prisoners. Another prisoner acted as his carer and helped him with daily tasks.

21. At an initial health screen at Littlehey, a nurse recorded that Mr Thorpe had haemophilia (a blood disorder which causes problems with bleeding and blood clotting), type 2 diabetes, chronic lower back pain, high cholesterol, prostatism, ischaemic heart disease/congestive cardiac failure (causing peripheral oedema – swelling in the tissues, especially the lower limbs), leg ulcers, obesity and urinary incontinence. He had a physical disability affecting his mobility and used a walking stick and Zimmer frame. Doctors prescribed medication and healthcare staff created care plans for his health conditions. Records show that healthcare staff saw Mr Thorpe frequently to assess and manage his conditions.

22. In April and June, Mr Thorpe attended appointments at the haematology departments at hospital to monitor his haemophilia. A blood test on 29 June showed that Mr Thorpe had a mild liver dysfunction (which can sometimes indicate a malignancy). A prison GP referred Mr Thorpe for an ultrasound to investigate the cause of this (an appointment had not been received before he died).

23. On 2 July, a nurse assessed Mr Thorpe who said that he had not felt well for the past three weeks. He said that he had fallen in his cell twice in the past three days, banged his head and felt dizzy. He had noticed a tremor in his hands and the nurse noted he was dribbling from one side of his mouth, had slurred speech and that he had lost around two stones in weight in the previous month. She diagnosed him as having a mild CVA (cerebrovascular accident, or stoke) and referred him to the GP. The GP saw him that afternoon and noted his history of recent falls. The GP took basic medical observations and referred him for an urgent CT scan. He noted that there was no need for an immediate hospital admission.

24. On 5 July, Mr Thorpe's wife and daughter visited him and told a prison officer that they were concerned about his health. Because of their concerns, a nurse reviewed Mr Thorpe, who said that he had fallen in his cell during the night and he did not feel himself. The nurse suspected that this was due to a possible transient ischaemic attack (TIA - mini-stroke) and noted that he was waiting for an urgent CT scan. She arranged for a GP to see him the next morning. Mr Thorpe's daughter said that a member of staff phoned her later that day and said that he was fine. She wrote to the Governor about her father's health the next day, but did not receive a response until after he died

25. On 6 July, a prison GP saw Mr Thorpe. His prisoner carer, who went to the appointment with him, said that he was worried about how much Mr Thorpe's health appeared to have deteriorated. She recorded a diagnosis of 'collapse' and noted that this was probably due to hypotension from low blood pressure and straining when using the toilet. She reviewed his medication but made no

changes. Mr Thorpe's CT scan was scheduled for two days later, and she decided to wait for the outcome to see whether his deterioration was due to a stroke or a subdural haematoma (a bleed between the skull and the brain). On 8 July, Mr Thorpe went to hospital for a CT scan of his head. A hospital consultant reviewed the results and did not find any issues of concern.

26. On 10 July, a prison GP examined Mr Thorpe after he complained of pain in his lower chest. The GP examined him and recorded that he had fallen a few days earlier. He diagnosed a possible fractured rib with some underlying infection, as Mr Thorpe had some discoloured sputum often associated with lung infection. He measured Mr Thorpe's blood oxygen level using a pulse oximeter, which showed that this was very low. However, the doctor discounted the reading as an error, as Mr Thorpe did not look cyanosed (when the skin is blue due to low oxygen levels). The GP prescribed a course of amoxicillin (an antibiotic) and arranged to review him in a week.

27. On 11 July, a nurse went to see Mr Thorpe after wing staff reported that he had fallen in his cell again. He said he was having difficulty breathing. The nurse took Mr Thorpe's basic medical observations, which were normal. He noted Mr Thorpe was pale but had no chest pains. When he checked Mr Thorpe later that day, he said he was feeling better. Officers checked Mr Thorpe hourly throughout the night to monitor his condition, but did not note anything significant.

28. Around 11.00am on 12 July, the nurse went to check Mr Thorpe again. Mr Thorpe said he had slept well and his breathing appeared better, but he still felt weak. At 5.10pm, Mr Thorpe told an officer that he did not feel well and could not move, so she called a nurse. The nurse took Mr Thorpe's basic medical observations, found his oxygen saturation levels were low and gave him some oxygen. He requested a non-urgent ambulance but Mr Thorpe's condition deteriorated further and at 5.50pm, the prison requested an emergency ambulance. Paramedics arrived at 6.20pm. The nurse gave them a verbal and written summary of Mr Thorpe's medical history, including his haemophilia. The ambulance took Mr Thorpe to hospital, where doctors diagnosed him with pneumonia and admitted him.

29. Mr Thorpe's condition deteriorated and prison nurses liaised with the hospital for updates on his condition. On 14 July, a nurse recorded that he had multiple organ failure. He did not recover and died at 1.10am on 16 July.

Contact with Mr Thorpe's family

30. On 12 July, shortly after Mr Thorpe went to hospital, a custodial manager phoned Mr Thorpe's wife to inform her, but got no reply. He therefore called Mr Thorpe's daughter to let her know that her father had been taken to hospital. On 13 July, the prison appointed family liaison officers. One family liaison officer contacted Mr Thorpe's daughter the same day to tell her that his condition was deteriorating. She arranged for his family to visit the hospital and for the hospital to update them directly about his condition after this.

31. On the night of Mr Thorpe's death, the hospital called Mr Thorpe's family to tell them that his condition had deteriorated further. Unfortunately, Mr Thorpe died before his family arrived. At 1.45am, when Mr Thorpe's daughter was on her

way to the hospital, a family liaison officer telephoned her to let her know that he had died. A prison manager and a prison chaplain met Mr Thorpe's family at the hospital when they arrived and offered their condolences and support. The family liaison officer telephoned Mr Thorpe's daughter again later that day.

32. Mr Thorpe's funeral was on 7 August. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

33. After Mr Thorpe's death, the prison manager debriefed the staff who had cared for him on the night he was taken to hospital and offered support. The prison posted notices informing staff and prisoners of Mr Thorpe's death, and offering support if needed.

Post-mortem report

34. A post-mortem examination found that Mr Thorpe had died of a disseminated poorly differentiated carcinoma of unknown primary (widespread cancer without a known primary source). The post-mortem found that the cancer had not spread to Mr Thorpe's brain. The cancer had not been detected while Mr Thorpe was in hospital.

Findings

Clinical Care

35. The clinical reviewer concluded that Mr Thorpe's clinical care in prison before his deterioration in July 2015 was equivalent to that he could have expected to receive in the community. The medical records show that doctors prescribed medication appropriately and staff created care plans to manage his conditions. Healthcare and hospital staff saw him frequently to manage his conditions including haemophilia.

36. In early July, Mr Thorpe suffered several falls. Officers, his prisoner carer and his family were concerned about the deterioration in his health and reported this. Healthcare staff saw Mr Thorpe at least ten times between 2 July and his admission to hospital on 12 July. The clinical reviewer noted that clinicians identified symptoms, which they considered, might be due to a stroke or a bleed on the brain, but it was not clear whether they took into account Mr Thorpe's underlying haemophilia. Doctors decided to wait for the results of a CT scan and did not immediately refer Mr Thorpe for further investigation. As Mr Thorpe was elderly with multiple health conditions, the clinical reviewer considered that his additional symptoms of multiple falls and neurological symptoms should have prompted a more urgent hospital admission for investigations, in addition to the CT scan.

37. However, the clinical reviewer noted that an earlier referral to hospital would not have altered the outcome. The post-mortem showed that Mr Thorpe had advanced cancer and the primary source was unclear. The cancer would also have been advanced in early July and it was unlikely that there would have been any viable treatment options at that late stage. The pathologist commented that his breathlessness leading up to the death was most likely due to the development of oedema (fluid) in his lungs due to cancer. We found no evidence that Mr Thorpe had reported any symptoms before July 2015 or that healthcare staff missed opportunities to diagnose cancer before that.

38. Mr Thorpe's health was poor but the deterioration in his health in July appears to have been sudden. Nevertheless, we consider that he should have been referred to hospital for investigation sooner. The extent of his cancer meant that Mr Thorpe's death was inevitable but earlier hospital admission might have allowed more appropriate management of his condition and allowed Mr Thorpe and his family more time to prepare for his death. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners who report ongoing acute symptoms are examined and referred to hospital for further investigation without delay.

Family Liaison

39. A member of staff telephoned Mr Thorpe's daughter after she had raised concerns about her father during a visit to the prison on 5 July. She was concerned that no one had identified the deterioration in her father's condition until she had spoken to an officer about this. However, we are satisfied that

prison healthcare staff had already recognised his symptoms and had referred him for an urgent CT scan. Mr Thorpe's daughter told us she wrote to the prison the next day, 6 July, and arranged for next day delivery, but no one replied to the letter before Mr Thorpe died. This was unfortunate, but we recognise that, as Mr Thorpe was taken to hospital five days later, his care then became the responsibility of the hospital. Nevertheless, the Governor or the Head of Healthcare should have contacted Mr Thorpe's daughter earlier, in response to her concerns.

40. Once the hospital admitted Mr Thorpe on 12 July, we are satisfied that the prison contacted Mr Thorpe's family promptly. There was good communication between the prison and Mr Thorpe's family to provide updates on his condition and to organise visits. The prison provided appropriate support after Mr Thorpe's death.

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