Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Davis, a prisoner at HMP Littlehey, on 25 September 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*

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 Gary Davis died of pulmonary oedema and renal failure, at HMP Littlehey on 25 September 2015. He was 48 years old. I offer my condolences to Mr Davis' family and friends.

Mr Davis was reluctant to engage with health services at the prison and had decided not to continue with hospital treatment for kidney problems. I am satisfied that healthcare staff at Littlehey, in consultation with hospital specialists, provided a high standard of care and could not have prevented Mr Davis' death.

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. Mr Gary Davis was serving a life sentence for murder and had been at HMP Littlehey since 24 April 2014.

2. Mr Davis had a history of high blood pressure and kidney disease, resulting in a kidney transplant in 2013. Initially, he was under the care of cardiac and renal specialists, but in September 2014, he decided he did not want to attend any further hospital appointments. Mr Davis also refused to cooperate with treatment by prison healthcare staff, blood pressure monitoring and taking medication.

3. At about 8.20am on 22 September, Mr Davis collapsed with severe abdominal pain. An officer went to see him immediately and radioed for healthcare assistance. A nurse attended, asked for an ambulance and monitored Mr Davis until a paramedic arrived.

4. An ambulance took Mr Davis to hospital at 10.00am. Two officers accompanied Mr Davis and used an escort chain to restrain him at the hospital, where he was admitted as an inpatient. Doctors diagnosed an aortic dissection (a tear in the wall of the major artery carrying blood out of the heart), but considered that surgery to repair it was too risky and that Mr Davis was at risk of cardiac arrest. At the request of a doctor, Mr Davis' restraints were removed at 3.43pm and were not reapplied.

5. Mr Davis' condition deteriorated and he died in hospital on 25 September. His mother was with him at the time.

Findings

6. Mr Davis did not fully cooperate with his medical treatment and had declined further hospital interventions in the year before he died. Prison GPs and nurses continued to encourage him to attend healthcare appointments. They monitored his condition and prescribed medication when he agreed. Missing health appointments left Mr Davis vulnerable to complications. We are satisfied that Mr Davis had the capacity to make decisions about his health and treatment and we consider he received a good standard of care at the prison.

7. When Mr Davis was unwell on 22 September, staff responded quickly. A nurse assessed him and called an ambulance. His initial symptoms did not indicate a life-threatening condition that warranted an emergency code. The prison appropriately removed restraints when it became clear that Mr Davis' condition was critical.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners wrote to the investigator with information, which she took into account.

9. The investigator obtained copies of relevant extracts from Mr Davis' prison and medical records. She interviewed five members of staff by telephone, on 6 and 7 January 2016.

10. NHS England commissioned a clinical reviewer to review Mr Davis' clinical care at the prison.

11. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The coroner accepted the cause of death provided by the hospital consultant, which was from pulmonary oedema caused by renal failure because of renal artery disease. Aortic dissection was a contributory factor. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Davis' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Davis' mother wanted to know the timings of the emergency response on 22 September.

13. The initial report was shared with the Prison Service. They highlighted a factual inaccuracy at paragraph 15, which has been amended accordingly.

Background Information

HMP Littlehey

14. HMP Littlehey in Cambridge is a medium security prison holding approximately 1,200 men. A large proportion of the population are men convicted of sexual offences.

15. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison healthcare centre is open from 8.00am to 7.30pm, Monday to Friday, and from 8.30am to 6.00pm 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

16. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that there was effective clinical leadership and there had been a significant improvement in patient care since the previous inspection. Nurses with additional specialist training and skills ran relevant clinics for prisoners with lifelong health conditions. Each GP had an identified specialism, including chronic pain management.

Independent Monitoring Board

17. 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 the prison had used a large number of agency staff to cover vacancies in the healthcare department. They noted that the doctors provided by an agency had improved the standard of health services.

Previous deaths at HMP Littlehey

18. Mr Davis was the sixth person to die from natural causes at HMP Littlehey since January 2014. There were no significant similarities with the circumstances of the previous deaths.

Key Events

19. In 1999, Mr Gary Davis was convicted of murder and sentenced to life imprisonment, with a minimum period to serve of 15 years before he could be considered for release. He spent time in several prisons. Mr Davis had a history of high blood pressure, which had caused end stage renal failure. In 2008, he started dialysis three times a week and saw a renal consultant every three to four months. He sometimes failed to cooperate with his treatment, including refusing to attend hospital appointments and not taking medication. On 24 May 2013, Mr Davis moved to HMP Bullingdon.

20. On 22 July 2013, Mr Davis had a kidney transplant. After the transplant doctors continued to monitor him, but he occasionally stopped taking his medication and his blood pressure fluctuated. On 5 April 2014, he had a renal angioplasty (a procedure to widen the arteries that supply blood to the kidneys).

21. On 24 April 2014, Mr Davis transferred to HMP Littlehey and a prison GP assessed him that day. She contacted Bullingdon's healthcare team and the transplant centre to clarify Mr Davis' medications and follow-up appointments. She also spoke to the renal unit at the hospital which would take over Mr Davis' renal care. During his first few weeks at Littlehey, prison healthcare staff frequently contacted the hospital and his previous renal unit for advice.

22. On 21 May, Mr Davis attended his first appointment at the hospital's renal unit. His blood pressure was within the normal range and his kidney function was stable. He attended clinic appointments approximately every six weeks, but in September, he said he did not want to attend any further hospital appointments.

23. Prison nurses tried to monitor Mr Davis' blood pressure regularly and warned him of the risks if his blood pressure remained high. In spite of this, he frequently refused to have his blood pressure taken and deliberately missed healthcare appointments. He gave a range or reasons for missing appointments, including protesting about his location or having to wear prison clothes to go to hospital. A prison GP said that Mr Davis was angry and frustrated that his kidney transplant had not resolved his health problems.

24. On 22 May 2015, the prison GP noted that Mr Davis' last blood pressure reading in January had been high and it had not been checked since then. She wrote to Mr Davis and explained the reason for the blood pressure checks and that he could have it checked by any of the healthcare staff. Mr Davis had not attended the renal clinic for eight months and she wrote to the clinic to arrange a new appointment. Mr Davis continued to refuse blood pressure checks.

25. On 2 June, Mr Davis told another prison GP that he did not want to attend any hospital appointments. He said he knew his body and when he felt he needed to see healthcare staff, he would let them know. The GP explained the need to manage his medications appropriately. He consulted the renal and cardiology registrars at the hospital, who advised the prison to take blood tests every three to four months and send the results to the hospital so they could advise of any required changes to his medications.

26. At a review with the GP on 9 June, Mr Davis agreed to have his blood tests in the prison, but signed a disclaimer refusing all hospital treatment and intervention.

27. On 30 June, Mr Davis reported having back pain to a prison GP. The GP took his blood pressure and found it was at the top end of the normal range. Another GP reviewed the results and planned to prescribe another blood pressure medication if it did not settle.

28. On 16 July, the GP again explained to Mr Davis the serious consequences of not attending renal appointments and noted that he had the capacity to make decisions about his treatment. The next week, Mr Davis' blood pressure reading was lower, so the GP did not change his medication.

29. Healthcare staff often found it technically difficult to obtain blood from Mr Davis' veins, when tests were needed. On 21, 23 and 24 July, they found his veins inaccessible. He said he was fed up with tests, so a GP decided to try again in a week. A healthcare assistant, managed to get a blood sample on 5 August. There were no other significant entries in Mr Davis' medical record over the next seven weeks. He took his medication, but continued refusing to have his blood pressure checked.

30. At about 8.20am on 22 September, a prisoner went to the wing office and told an officer that Mr Davis was on the landing, unwell, and needed help. The officer went to see Mr Davis immediately and found him on the floor, crying with stomach and back pain. At 8.25an, the officer radioed for urgent healthcare assistance.

31. A nurse responded immediately and arrived at the wing about three minutes later with an emergency bag and oxygen. Another nurse arrived shortly afterwards. Mr Davis was conscious and said he had severe abdominal pain. He was on his hands and knees, as he said this was the most comfortable position for him. A nurse asked the officer to ask for an ambulance. The prison's communications room called one at 8.28am.

32. The nurse took Mr Davis' blood pressure, pulse and temperature, but he refused to let them examine him further, because he was in pain. Mr Davis' blood pressure was high and increased while they waited for the ambulance to arrive. His pulse rate was low and became slower. He managed to sit up, but still refused to be examined.

33. At 8.46am, an ambulance service first responder arrived, carried out an electrocardiogram (ECG) test to assess Mr Davis' heart, and rechecked his clinical observations. The first responder confirmed they needed an ambulance to take Mr Davis to hospital. The ambulance arrived at 9.32am and took Mr Davis to hospital at 10.00am.

34. A risk assessment concluded that Mr Davis was a low risk of escape and hostage taking and a medium risk to the public. A prison manager decided that Mr Davis should be restrained by single handcuffs for the journey and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) if necessary in hospital.

35. At 1.20pm, a doctor told the escorting officers that Mr Davis was at risk of a cardiac arrest at any time, although there was no indication it was imminent. He admitted him as an inpatient. At 2.00pm, escort officers removed Mr Davis' restraints for a CT scan. They reapplied them afterwards, at 2.20pm. At 3.43pm, at the request of a hospital doctor, a prison manager agreed that the escort officers should remove the restraints, due to the possibility of a cardiac arrest.

36. At about 6.00pm, a hospital doctor asked prison staff to notify Mr Davis' next of kin of his condition. A custodial manager telephoned Mr Davis' mother and explained he was in hospital. An assistant family liaison officer later spoke to Mr Davis's mother, who arranged to visit him the next day.

37. At 6.14pm, a doctor told Mr Davis he had an aortic dissection (a tear in the wall of the major artery carrying blood out of the heart). Although this was a serious condition, doctors decided against surgery as the risks outweighed the benefits. Prison healthcare staff kept in contact with hospital staff, who told them that they expected Mr Davis to be in hospital for some time.

38. A member of the prison's offender manager unit and the prison's main family liaison officer arranged to meet Mr Davis' mother at the hospital on 23 September. His mother, other family member and friends visited Mr Davis over the next days.

39. Mr Davis' high blood pressure caused his kidney function to deteriorate. He was conscious, but in some discomfort and did not respond to treatment. Mr Davis' condition worsened and he was unable to pass urine. At 6.00pm on 24 September, doctors started dialysis treatment. At 6.30pm, Mr Davis became distressed and said he could not breathe. Hospital staff placed him on a ventilator.

40. Mr Davis did not recover and he died at 2.44am on 25 September. His mother was with him at the time.

Contact with Mr Davis' family

41. After Mr Davis' death, the family liaison officer continued to offer support to Mr Davis' mother. In line with national policy, the prison contributed to the costs of Mr Davis' funeral, which was held on 15 October.

Support for prisoners and staff

42. A custodial manager debriefed the staff involved in the emergency response on 22 September, and offered his support and that of the staff care team.

43. The prison posted notices informing other prisoners of Mr Davis' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by Mr Davis' death.

Findings

Clinical care

44. Mr Davis had longstanding heart and kidney disease, resulting in a kidney transplant in 2013. He was under the care of cardiac and renal specialists who frequently monitored his condition, but he refused to attend hospital appointments after September 2014. Mr Davis was disappointed that after his kidney transplant he still needed a lot of clinical intervention and medication. He often refused to cooperate with his treatment and missed appointments, despite active encouragement from prison GPs and nurses. In June 2015, he signed a disclaimer refusing further hospital intervention. We are satisfied that Mr Davis had the capacity to make decisions about his care and treatment and that, within these constraints, prison healthcare staff appropriately managed and treated Mr Davis' health conditions.

45. The clinical reviewer considered that Mr Davis' collapse on 22 September was unforeseeable and that healthcare staff responded promptly. We are satisfied that the clinical care Mr Davis received at Littlehey was equivalent to that he might have expected to receive in the community.

Emergency response

46. Prison Service Instruction (PSI) 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. Littlehey's local emergency response codes protocol states that a code blue should be used if a prisoner is unconscious, not breathing, having chest pain, difficulty breathing or there are signs of a stroke. A code red should be used for loss of blood, burns and suspected fracture. Both emergency codes require the control room to call an ambulance immediately.

47. When an officer saw Mr Davis on 22 September, he complained of severe stomach and back pain. The officer did not use a medical emergency code, as he did not consider it was a life-threatening situation. A nurse responded very quickly and took emergency equipment and oxygen. After assessing Mr Davis, around three minutes after she arrived at the landing, she asked an officer to request an ambulance. We are satisfied that the officer made an appropriate decision to call for urgent healthcare assistance and that it was reasonable to wait for a nurse's judgement about whether an ambulance was required.

Escort risk assessments

48. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. The level of restraints used should be necessary in the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes account of factors such as the prisoner's health and mobility.

49. When staff completed the risk assessment for Mr Davis' journey to hospital, the nature of his illness was unknown. His symptoms included severe stomach pain,

but he was fully mobile, lucid and able to talk. The prison agreed to remove restraints as soon as a hospital doctor requested this. We consider that there was a reasonable decision to use restraints initially and a manager appropriately decided to remove them, once he was informed of the seriousness of Mr Davis' condition.

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