Prisons & Probation
Ombudsman
Independent Investigations

# Independent investigation into the death of Mr David Wood, a prisoner at HMP Littlehey, on 8 February 2016

**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 David Wood died on 8 February 2016 of a heart attack at HMP Littlehey. He was 55 years old. I offer my condolences to Mr Wood's family and friends.

I consider that the clinical care Mr Wood received in prison was equivalent to that he could have expected to receive in the community. Mr Wood's death was sudden and unexpected and I am satisfied that there was nothing prison staff could have done to prevent it.

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** **August 2016**

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# Summary

## Events

1. On 27 January 2015, Mr David Wood was sentenced to two years and six months in prison. He had been at HMP Littlehey since 9 February. At an initial health screen, a nurse noted he had diabetes, asthma, a family history of heart disease, and mental health problems. A doctor prescribed the medication he needed to manage these conditions.

2. Mr Wood attended the prison's diabetic clinic regularly, and his diabetes became better controlled. He collected his medication from the healthcare centre each day and nurses monitored him. In September, Mr Wood reported chest pain and shortness of breath. He had an ECG (electrocardiogram to check his heart rhythm) and his vital signs were normal. A GP referred him for a chest X-ray, which was normal. Blood tests at the end of November also showed no abnormalities. After that, Mr Wood did not report any further chest pain or breathlessness.

3. Around 11.40am on 8 February 2016, Mr Wood did not respond to an officer who unlocked his cell and she sought help from another officer who assessed Mr Wood quickly and called a medical emergency code. The control room called an ambulance immediately. Other staff, including nurses, arrived quickly and tried to resuscitate Mr Wood. Paramedics arrived and took over emergency treatment. Sadly, Mr Wood did not respond. At 12.23pm, a paramedic recorded that he had died.

## Findings

4. We are satisfied that Mr Wood's care at the prison was equivalent to that he could have expected to receive in the community. His diabetes and asthma were managed in line with national standards. When he reported chest pain in autumn 2015, this was appropriately investigated and no abnormalities were found. Mr Wood received quick emergency treatment when staff found him unresponsive on 8 February and we consider that prison staff could not have prevented his sudden death.

## The Investigation Process

5. The investigator issued notices to staff and prisoners at Littlehey informing them of the investigation and asking anyone with relevant information to contact her. She received a letter from a prisoner, who was a friend of Mr Wood.

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

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

8. The investigator and clinical reviewer interviewed three members of staff at Littlehey on 10 March.

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

10. One of the Ombudsman's family liaison officers contacted Mr Wood's niece to explain the investigation. She had no specific issues for the investigation to consider.

11. Mr Wood's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

# Background Information

### HMP Littlehey

13. 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.

14. 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

15. The most recent inspection of 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

16. 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 healthcare staff vacancies. The IMB considered that agency doctors had helped improve the standard of health services.

### Previous deaths at HMP Littlehey

17. Mr Wood was the seventh prisoner to die of natural causes since January 2014. Subsequently, there have been four natural cause deaths. There were no significant similarities with the circumstances of the other cases we have investigated.

## Key Events

18. On 27 January 2015, Mr David Wood was sentenced to two years and six months in prison for assault, theft, and motoring offences. He was sent to HMP Bedford. On 9 February, he was transferred to HMP Littlehey. At an initial health screen, a nurse noted that he had asthma, mental health problems, diabetes, and a family history of heart disease. A prison GP prescribed his medication, including metformin, gliclazide and insulin (for diabetes), quetiapine (an antipsychotic), and ventolin and beclomethasone inhalers (for asthma).

19. On 26 March, a nurse reviewed Mr Wood and noted that his diabetes was poorly controlled and he did not test his blood sugar frequently enough. She advised him to increase the dose of insulin and planned to monitor him monthly in the diabetic clinic.

20. On 19 May, the nurse again advised Mr Wood to increase the insulin dose, because he had consistently high blood sugars. On 19 August, she noted that Mr Wood had better control over his diabetes and reduced the frequency of his diabetic reviews to every three months. Nurses continued to monitor Mr Wood's diabetes and asthma.

21. On 17 September, Mr Wood reported having chest pains. A nurse took his blood pressure and pulse and noted that both were within normal range. An ECG showed no abnormalities and she referred Mr Wood to a GP.

22. The next day, a GP examined Mr Wood, who said he had recently started to feel short of breath, and had suffered pain in his chest on the left side for two to three weeks. She took his pulse, blood pressure, oxygen levels and temperature, which were all within normal range. She noted that there were no concerning observations and it was not clear what was causing his symptoms. She referred him for an urgent chest X-ray, which showed no abnormalities.

23. On 13 November, Mr Wood told a nurse that he felt dizzy in the mornings. She took his blood pressure, blood sugar levels, and pulse, which were all within normal range. On 18 November, a prison GP reviewed Mr Wood and diagnosed postural hypotension (low blood pressure caused when a person stands up after sitting or lying down). The doctor noted that Mr Wood had lost weight after dieting and his diabetes was well controlled.

24. On 26 November, Mr Wood told a prison GP that he still had chest pain and shortness of breath. The GP noted the previous investigations and referred him for blood tests, which showed nothing abnormal. There is no further record of Mr Wood reporting chest pain or any other health concerns.

### Events of 8 February 2016

25. Around 8.00am on 8 February, an officer unlocked the cells on Mr Wood's wing. Mr Wood was sitting on his bed at the time and shortly afterwards, she saw him go to the wing laundry. About 8.30am, after prisoners had left the wing to go to activities, the remaining prisoners, including Mr Wood, were locked back in their cells. She said Mr Wood was lying on his bed at the time.

26. Some time after 11.40am, the officer unlocked the cells for prisoners to collect their lunch. When she unlocked Mr Wood's cell, he was slumped on his bed, in a different position from earlier, and looked pale. She called his name but he did not respond so she went to the nearby wing office to get help from another officer. They went quickly back to the cell. The officer shook Mr Wood and called his name, but he did not respond. At 11.47am, he radioed a code blue emergency (which indicates circumstances, such as when a prisoner is unresponsive of has difficulty breathing). The control room called an ambulance immediately.

27. The officer brought a defibrillator and a prison manager and a Senior Officer arrived. An officer cleared the wing and locked prisoners back in their cells. The staff moved Mr Wood to the floor and the prison manager began chest compressions. He quickly realised the cell was too cramped so they lifted Mr Wood to the landing outside the cell.

28. The prison manager continued with chest compressions and at about 11.50am, two nurses arrived and took over. They nurses assessed Mr Wood and found no signs of life. They attached the defibrillator, which found no shockable heart rhythm and they continued cardiopulmonary resuscitation.

29. At 11.58am, paramedics arrived and took over emergency treatment but Mr Wood did not respond. At 12.23pm, a paramedic recorded that Mr Wood had died.

### Contact with Mr Wood's family

30. At 2.10pm, two prison managers went to see Mr Wood's father, who he had named as his next of kin. They informed him and Mr Wood's niece of his death and offered their condolences and support.

31. Mr Wood's funeral was on 7 March. The prison contributed towards the cost in line with national policy.

### Support for prisoners and staff

32. A prison manager debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

33. The prison posted notices informing staff and prisoners of Mr Wood's 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 Wood's death.

### Post-mortem report

34. The post-mortem report gave the cause of death as coronary artery thrombosis (blood clot in the heart) caused by coronary atherosclerosis (a hardening and furring of the artery walls). There was evidence that Mr Wood had suffered a previous heart attack.

# Findings

## Clinical care

35. The clinical reviewer considered that the care Mr Wood received was equivalent to that he could have expected to receive in the community. His diabetic and asthma care was in line with national standards. When Mr Wood reported chest pain in autumn 2015, the clinical response was appropriate and in line with National Institute for Health and Care Excellence (NICE) guidance. Clinicians referred him for appropriate tests, all of which were normal.

36. A friend of Mr Wood's, another prisoner at Littlehey, wrote to us, and said that Mr Wood had told him that he had pains in his arms and legs in the two weeks before he died. He said the day before Mr Wood died, he appeared more tired then usual but he did not know if Mr Wood had told any member of staff about his symptoms. Records show that Mr Wood did not report any further health problems after 26 November 2015. Officers and staff we spoke to said that Wood had not shown any signs of breathlessness or complained of chest pain in the days before his death.

37. While it would have been preferable for the officer who first found Mr Wood apparently unresponsive, to have radioed an emergency code before seeking help, the delay in calling an emergency was minimal, and the control room called an ambulance immediately the code blue was broadcast. Officers and nurses started cardiopulmonary resuscitation quickly and the overall emergency response was of a good standard.

38. We are satisfied that Mr Wood received good care at Littlehey, and staff could not have predicted or prevented his death.

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