Prisons & Probation Ombudsman
Independent Investigations

Investigation into the death of Mr Phillip Hopkins a prisoner at HMP Littlehey on 30 August 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.

This is the investigation report into the death of Mr Phillip Hopkins from bronchopneumonia and congestive cardiac failure, a final development of blood cancer, on 30 August 2015, at HMP Littlehey. He was 63 years old. I offer my condolences to Mr Hopkins' family and friends.

I am satisfied that Mr Hopkins received a good standard of healthcare in prison, equivalent to that he could have expected to receive in the community. Mr Hopkins had been ill for some time and prison GPs appropriately referred him to a range of specialists in an effort to get a diagnosis. Leukaemia was suspected, although he had no formal diagnosis before he died. Mr Hopkins decided against further investigation or active treatment and he received good end of life care. However, I am concerned that Mr Hopkins' poor health and mobility was not adequately taken into account when making decisions to restrain him for hospital visits.

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**

Contents

Summary

Events

1. Mr Phillip Hopkins received an indeterminate sentence for public protection for sexual offences in July 2010. He had been at HMP Littlehey since October 2011. Mr Hopkins suffered a number of medical conditions including heart disease and arthritis.

2. In February 2011, Mr Hopkins had a left knee replacement. In September 2012, a consultant orthopaedic surgeon reviewed him, as he had severe pain in his leg. An X-ray did not show any fracture or orthopaedic cause for his symptoms and he continued to experience pain. In March 2013, prison healthcare staff noted Mr Hopkins had anaemia. A prison GP thought Mr Hopkins' symptoms might be a result of a chronic infection in his left knee after his surgery but the orthopaedic surgeon ruled this out.

3. Mr Hopkins' pain fluctuated and his health gradually deteriorated. Healthcare staff reviewed him frequently and he continued to have anaemia. Blood test results were abnormal and prison GPs referred Mr Hopkins to several specialists to try and find the cause of his pain. No one was able to provide a definite diagnosis.

4. In January 2015, Mr Hopkins decided he did not want any further investigation of his condition or active medical treatment and did not want to be resuscitated if his heart or breathing stopped. Healthcare staff began a palliative care plan and a palliative care specialist reviewed Mr Hopkins regularly. Mr Hopkins was presumed to have leukaemia, but never had the final tests to establish this. Mr Hopkins' health continued to decline and, on 28 August 2015, he moved to a hospice. He died on 30 August 2015.

Findings

5. The investigation found that GPs at Littlehey appropriately managed Mr Hopkins' symptoms and proactively referred him to specialists in an effort to obtain a diagnosis. Healthcare staff had a multidisciplinary approach to Mr Hopkins' end of life care and included him and his next of kin in discussions about his care. We are satisfied that the care Mr Hopkins received in prison was equivalent to that he could have expected to receive in the community.

6. The investigation found that, in most of the escort risk assessments for hospital appointments, healthcare staff did not record any meaningful or considered information about Mr Hopkins' condition and mobility. We are therefore not satisfied that managers had sufficient information on which to base their decisions to restrain Mr Hopkins for his many hospital appointments.

Recommendation

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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 Hopkins' prison and medical records.

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

10. We informed HM Coroner for the South and West Cambridgeshire District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

11. One of the Ombudsman's family liaison officers contacted Mr Hopkins' family to explain the investigation. They did not have any specific issues for the investigation to consider.

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

13. Mr Hopkins' family was informed the draft report was available, but did not make any comment.

Background Information

HMP Littlehey

14. 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.

15. 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

16. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that, following a significant change in the prison population in late 2014, 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 as very good.

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 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

18. Mr Hopkins was the fifth prisoner to die from natural causes at Littlehey since 2014. We have previously found that Littlehey had provided good standard of care to terminally ill prisoners.

Key Events

19. On 9 July 2010, Mr Phillip Hopkins received an indeterminate sentence for public protection for sexual offences, with a minimum term to serve of four years and 78 days. He was sent to HMP Peterborough before transferring to HMP Littlehey on 26 October 2011.

20. At an initial health screen at Littlehey, a nurse recorded that Mr Hopkins had been diagnosed with uticaria (a skin rash), heart disease, arthritis and type two diabetes. In February 20111, he had had a left knee replacement using a titanium prosthesis (artificial knee). Mr Hopkins was able to walk only short distances using crutches. He smoked 10 cigarettes a day, but declined help to give up smoking.

21. On 11 September 2012, a consultant orthopaedic surgeon saw Mr Hopkins to review his knee replacement, as he had been experiencing severe pain in his left leg. The consultant recorded that, in the first 12 months after the operation, Mr Hopkins had recovered well. The pain in his leg had now resulted in weight bearing problems but an X-ray did not show any signs of fracture or any orthopaedic cause. Mr Hopkins was admitted to hospital for doctors to treat the pain. He returned to the prison on 27 September.

2013

22. On 29 January 2013, a prison GP recorded that Mr Hopkins' pain had decreased but his leg was swollen. The doctor considered that Mr Hopkins had an infection in his leg or it was a reaction to the prosthesis. She referred Mr Hopkins to the consultant orthopaedic surgeon. The consultant ruled out an infection and said Mr Hopkins' symptoms could be vascular and asked for a vascular review. Mr Hopkins' pain continued and prison GPs prescribed strong pain relief medication.

23. On 21 March, a blood test showed Mr Hopkins was anaemic and a prison GP referred him to a consultant gastroenterologist for further investigations. The gastroenterologist examined Mr Hopkins and planned a colonoscopy and endoscopy (both procedures use a thin flexible camera tube to examine the inside of the digestive system and large intestine). The endoscopy was normal but the colonoscopy needed repeating as a full examination of the bowel had not been possible. (Prison GPs followed this up, but Mr Hopkins did not have a further colonoscopy.) A scan of Mr Hopkins' chest, abdomen and pelvis showed an abnormality of the glands (lymph nodes) in Mr Hopkins' left groin.

24. On 9 April, as requested by the orthopaedic surgeon, a vascular surgeon reviewed Mr Hopkins and arranged a vascular leg scan. On 11 April, the consultant orthopaedic surgeon reviewed Mr Hopkins again and concluded that there was no evidence Mr Hopkins had ever had an infection caused by the knee replacement. He noted Mr Hopkins was not suffering pain in his left knee and it had a good range of movement.

25. Over the next month, Mr Hopkins' health deteriorated. Prison healthcare staff continued to care for him and prescribed medication for the pain. On 17 May, a prison GP noted Mr Hopkins could not stretch out his left leg without feeling pain and now had pain in his right knee. She was very concerned that Mr Hopkins

was clearly unwell but still had no diagnosis, despite being assessed by three consultant specialities. She asked the lead consultant physician at the hospital for advice.

26. On 19 June, the vascular surgeon confirmed that Mr Hopkins' leg scan showed no obvious vascular problem and suggested Mr Hopkins' symptoms might be related to his lymphatic system. (The lymphatic system is part of the circulatory system and is a vital part of the immune system.) He arranged for Mr Hopkins to have the glands in his left groin investigated to rule out an infection or cancer. In July, tests established that Mr Hopkins' glands were swollen in response to an infection but found no evidence of cancer. Over the next month, Mr Hopkins' pain control improved and he reported feeling comfortable.

27. On 9 August, a prison GP noted that Mr Hopkins had pain in his left groin and his glands were increasing in size and referred Mr Hopkins back to the vascular surgeon. The surgeon advised her to refer Mr Hopkins to a haematologist to consider whether his symptoms were blood related. However, the consultant haematologist considered the referral was inappropriate because tests in July had shown no indication of cancer and thought a general surgeon should see Mr Hopkins first.

28. In October, the gastroenterologist informed the prison that no further gastrointestinal investigations were necessary. She considered that Mr Hopkins' anaemia was due to chronic disease and inflammation and not related to his gastrointestinal tract.

2014

29. Over the next five months, healthcare staff frequently reviewed Mr Hopkins, updated his care plan and referred him to the physiotherapy service to assist with his mobility problems. On 4 March 2014, a physiotherapist assessed Mr Hopkins and noted he was unable to walk using a stick but needed two crutches. He recorded that Mr Hopkins found it difficult to walk long distances such as from the wing to the reception.

30. On 30 May, a prison GP reviewed Mr Hopkins and recorded he had anaemia and noted evidence of blood loss and indigestion. Mr Hopkins said he was dealing well with his pain and that he was able to walk with two crutches. Mr Hopkins had lost 5kgs in eight months, had recent intermittent rectal bleeding and night sweats. Blood tests had shown further abnormalities, and the GP referred him to the consultant haematologist again.

31. On 26 June, the consultant haematologist reviewed Mr Hopkins and requested blood tests and a bone marrow aspirate (the removal of a small amount of bone marrow in liquid form for examination) to rule out blood cancers such as leukaemia. He also asked for a repeat abdominal and pelvic scan to check the size of the lymph nodes in Mr Hopkins' groin.

32. On 22 August, a prison GP reviewed Mr Hopkins and noted he had lost a further kilogram and was now 75 kilograms. Mr Hopkins reported having problems eating and said the pain in his leg continued but he did not want the pain relief to be increased. A hospital multidisciplinary team meeting noted that Mr Hopkins'

lymph nodes had marginally decreased in size, but there was still no obvious cause for his illness.

33. On 19 September, a prison GP reviewed Mr Hopkins and recorded he was feeling tired and short of breath. The GP noted that Mr Hopkins now had a prisoner carer to help him with daily living tasks. On 25 September, the consultant haematologist reviewed Mr Hopkins again and noted that he continued to lose weight and still had anaemia. He advised an iron infusion and asked the hospital to carry out the bone marrow aspirate if the increase in white cells and platelets did not improve.

34. On 22 September, the nurse manager discussed his care with Mr Hopkins. Mr Hopkins asked if he could move to the prison's 'Dignity Suite' (a double sized cell with a hospital bed, shower and toilet and more space to move around). She arranged the move on 25 September and Mr Hopkins was pleased with the move.

35. On 23 September, the consultant haematologist reviewed Mr Hopkins again and arranged iron treatment and blood transfusions. On 26 September, a prison GP examined Mr Hopkins and noted he had had his first blood transfusion and was feeling better. On 10 October, the GP recorded Mr Hopkins had had an iron infusion and that consultants were close to confirming Mr Hopkins' underlying diagnosis. Mr Hopkins reported feeling comfortable and the pain in his leg was under control.

36. Healthcare staff reviewed Mr Hopkins frequently. On 12 November, the nurse manager noted that he needed further iron infusions before he could have a bone marrow biopsy. Mr Hopkins said he was happy with everything the hospital and healthcare staff were doing but was frustrated that he still had no firm diagnosis.

37. On 18 December, a prison GP and the nurse manager discussed Mr Hopkins' condition and treatment with him. Mr Hopkins said he felt he would reach the end of his life in prison. He said he did not feel healthcare staff could do more for him and said he was pleased with the treatment he had received at the prison. On 23 December, Mr Hopkins received another iron infusion.

2015

38. On 2 January 2015, Mr Hopkins formally agreed with a prison GP that he did not want any further active treatment and did not want anyone to try to resuscitate him if his heart or breathing stopped. He had discussed his decision with his step-brother during a recent visit and said he knew it was in his best interest. The GP was satisfied that, although Mr Hopkins did not have a clear diagnosis, he was competent to decide to withdraw from active treatment or investigation.

39. On 7 January, the nurse manager attended a complex case meeting with prison staff and Mr Hopkins. She recorded that the prison had appointed a custodial manager as the family liaison officer for Mr Hopkins. They discussed the possibility of applying for compassionate release, but he did not want to be considered for this.

40. On 12 January, the nurse manager discussed his end of life plan with Mr Hopkins and his wing liaison officer. She planned to visit Mr Hopkins at least twice weekly to ensure he had everything he needed and that he was being consulted about his care. She agreed to discuss Mr Hopkins' needs with prison staff, to ensure a multidisciplinary approach to his end of life care.

41. On 11 February 2015, a consultant gastroenterologist examined Mr Hopkins and noted he had lost 50 kilograms over the past three years. She suggested carrying out an endoscopy and colonoscopy but Mr Hopkins made it clear that he did not want any further investigations, including a bone marrow biopsy, which had still not been done. The consultant noted her regret that they had reached this point but understood that Mr Hopkins was fed up with all the investigations he had had over the previous years and disliked the attention he got for being handcuffed to officers when he went to hospital.

42. On 26 February, a palliative care specialist reviewed Mr Hopkins. She recorded that Mr Hopkins was presumed to have a diagnosis of leukaemia, although as he had not had a bone marrow biopsy, this had not been confirmed. Mr Hopkins said that he could not see the point in life-prolonging treatment. He felt he would never be released from prison and said he found it very difficult to attend hospital appointments because of the public reaction to him being handcuffed to a prison officer. The specialist reviewed Mr Hopkins' pain relief medication. Mr Hopkins told her he wanted to stay at Littlehey for as long as possible, but when and if his symptoms could no longer be managed at the prison would like to go to a hospice near his family.

43. On 28 February, the nurse manager reviewed Mr Hopkins. His step-brother was present and said that he fully supported Mr Hopkins' decision not to have further treatment. Mr Hopkins said he was very happy with the care the prison had give him, but recognised that it was becoming increasingly difficult to manage his needs and accepted that eventually he might need to go to a hospice for end of life care. Over the next months, healthcare staff reviewed Mr Hopkins every day and frequently updated his end of life care plan.

44. On 5 June, a prison GP informed the palliative care consultant that Mr Hopkins was becoming weaker, but she was satisfied that healthcare staff at Littlehey were managing Mr Hopkins symptoms and pain well. Over the next two months, Mr Hopkins' condition continued to decline.

45. On 3 August, the palliative care consultant reviewed Mr Hopkins and noted that he was very weak and thin. The pain in his legs was becoming worse and he was only able to walk a short distance across his cell before becoming tired. She suggested changing his medication for better pain control. She discussed referring Mr Hopkins to a hospice and he indicated that this was something he would like to consider as he deteriorated, but he wanted to stay at Littlehey as long as possible.

46. On 28 August, a prison GP recorded that Mr Hopkins' health had significantly deteriorated in the previous 24 hours. He was pale, breathless and very weak. He was also experiencing hallucinations and was no longer mobile. The next day, Mr Hopkins was taken to a hospice.

47. On 30 August, a hospice nurse informed the prison that Mr Hopkins had died at 8.15am that morning.

Contact with Mr Hopkins' family

48. On 3 January 2015, the prison had appointed a custodial manager as their family liaison officer. He offered support to both Mr Hopkins and his step-brother, who he had named as his next of kin. He kept in frequent contact and arranged visits.

49. When Mr Hopkins moved to the hospice on 29 August, the custodial manager could not contact Mr Hopkins' step-brother to let him know but hospice staff informed him later that day. He kept in contact with Mr Hopkins' step-brother, who asked to be telephoned when he died.

50. After Mr Hopkins died, the custodial manager telephoned his step-brother at 9.00am, although the hospice had already informed him. He offered support and assistance.

51. Mr Hopkins' funeral was on 26 October. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

52. After Mr Hopkins' death, the Head of Safer Custody debriefed the staff involved in his care and offered her support and that of the staff care team.

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

Post-mortem report

54. A post-mortem examination indicated that Mr Hopkins' cause of death was bronchopneumonia, congestive cardiac failure and B cell lymphoma (a type of blood cancer).

Findings

Clinical Care

55. The clinical reviewer concluded that Mr Hopkins' care was complex and would have been difficult to manage in any clinical setting. We agree with the clinical reviewer that healthcare staff at Littlehey appropriately managed Mr Hopkins care and pain and proactively referred him to secondary care including orthopaedic, gastroenterology, haematology, general and vascular consultants in an effort to obtain a diagnosis.

56. The clinical reviewer also said that healthcare staff appropriately treated Mr Hopkins' heart disease and diabetes, and blood results showed good control. The clinical reviewer found that Mr Hopkins' heart disease and diabetes did not affect the diagnosis of blood cancer. She noted that if a bone marrow test had been carried out when first discussed by the consultant at the end of June 2014, a firm diagnosis might have been made, which could have led to some treatment. It is not clear why this did not happen at the time. But in November 2014, a nurse noted he needed further iron infusion treatment before he could have a bone marrow biopsy. Hospital care is outside the remit of this investigation, but the clinical reviewer has brought this to the attention of NHS England.

57. The NHS document, 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers plan when and how care will be delivered and helps patients make choices about how they are cared for towards the end of their lives.

58. The investigation found that staff at Littlehey managed Mr Hopkins in line with this guidance. There was a multidisciplinary approach to Mr Hopkins' care and staff implemented a comprehensive palliative care plan. They agreed to accommodate Mr Hopkins in the 'Dignity Suite', a suitable location to manage his care. There was good communication between the prison's healthcare team, prison staff and hospitals. Staff involved Mr Hopkins and his family appropriately in his end of life care plans. We are satisfied that Mr Hopkins received a standard of healthcare at the prison equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

59. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

60. From 24 June 2013, Mr Hopkins attended hospital appointments at least eleven times, for investigation and treatment of his symptoms. The prison gave us the risk assessments for nine of these visits. Mr Hopkins was assessed as medium risk of escape up to 23 September 2014, after which he was assessed as low risk. For each of these appointments, managers decided that officers should restrain Mr Hopkins with handcuffs or an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner, the other to an officer).

61. There is a section of the risk assessment for healthcare staff to complete. This requires them to note any medical objection to the use of restraints or any medical condition likely to influence the escort, including whether the prisoner's condition affects their risk of escape. Apart from one risk assessment for 10 August 2015, healthcare staff did not record any medical objections to the use of restraints and wrote 'NIL' to any other medical condition likely to influence the risk of escape.

62. On 29 August 2015, when Mr Hopkins moved to a hospice, healthcare staff did not make any comment about his condition or any objection to the use of restraints. However a custodial manager recorded that Mr Hopkins was terminally ill, used a wheelchair and should not be restrained.

63. Mr Hopkins had limited mobility because of a knee replacement and ongoing severe pain. He used crutches to walk short distances and sometimes used a wheelchair. He became more frail and weak in the last year of his life. None of this was reflected in his risk assessments and we consider there was insufficient healthcare input to meet the requirements of the 2007 High Court judgement. We are not satisfied that prison managers had sufficient information to make an informed decision about the level of restraints or whether they were necessary for most of the times Mr Hopkins went to hospital. All those involved in making decisions about escorting prisoners to hospital appointments need to ensure that they take prisoner's health and mobility fully into account. This requires considered and meaningful input from healthcare staff. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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