

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Wilkins a prisoner at HMP Littlehey on 4 April 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Steven Wilkins died on 4 April 2016 of lung cancer while a prisoner at HMP Littlehey. He was 63 years old. I offer my condolences to Mr Wilkins' family and friends.

I am satisfied that, after his diagnosis, the prison delivered a standard of care equivalent to that Mr Wilkins could have expected to receive in the community. However, prior to that point there are areas where the standard of care delivered by the prison fell short of what should have been expected, in particular I repeat for the third time in recent investigations that urgent referrals must be treated more expeditiously at Littlehey.

I also repeat a concern that the decision to restrain Mr Wilkins during part of his final admission to hospital did not properly take into account his poor health and mobility. Finally, I am concerned by the delay in appointing a family liaison officer and that the family were not given enough private time with Mr Wilkins in his final hours.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2016

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Summary

Events

1. Mr Steven Wilkins was convicted in 1979, in Scotland, of murder and robbery and subsequently, in 1980, in England, for rape and arson. He was sentenced to life imprisonment. He spent time at a number of prisons before arriving at HMP Littlehey in January 2015 (although he had been there before). When he arrived at Littlehey in 2015, a nurse noted that Mr Wilkins had chronic obstructive pulmonary disorder (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), thyroid issues and osteoarthritis. She also noted he smoked 10-20 cigarettes a day.
2. In July, a nurse created a COPD care plan but did not conduct a respiratory risk assessment as Mr Wilkins had undergone one the year before and she did not consider he COPD was a problem at the time. Mr Wilkins refused advice on giving up smoking.
3. In December, Mr Wilkins had an exacerbation (acute episode) of his COPD which staff treated with medication. In January 2016, he suffered another exacerbation which healthcare staff treated with medication.
4. Mr Wilkins did not improve and on 1 February 2016, he was admitted to hospital. A CT scan revealed a possible tumour, pneumonia and severe emphysema (lung disease). Hospital physicians planned a meeting to decide on the next steps and Mr Wilkins returned to the prison on 3 February. The discharge summary was unclear about the dose of pain relief for Mr Wilkins and prison GPs did not check with the hospital before prescribing various doses.
5. Prison clinicians waited to hear from the hospital about the planned care for Mr Wilkins. Eventually, on 19 February, a prison GP made an urgent referral to a specialist; however this was delayed at the prison until 24 February.
6. On 11 March, while attending the chest clinic, a respiratory consultant told Mr Wilkins that he had lung cancer that might have spread. Five days later, the hospital informed the prison that Mr Wilkins' tumour was inoperable and would not respond to chemotherapy.
7. Healthcare staff implemented appropriate care plans, including for pain management. Despite this, Mr Wilkins frequently complained of pain and doctors reviewed and amended his pain relief. On 28 March, a nurse was concerned about Mr Wilkins' condition and sent him to hospital. He remained in hospital where he deteriorated. Mr Wilkins moved to a hospice on 1 April and died peacefully on 4 April.

Findings

8. The clinical reviewer was concerned that, although healthcare staff implemented a COPD care plan, no one carried out a respiratory risk assessment in line with community practice. A doctor did not clarify a prescription dosage with the hospital. We are also very concerned that an urgent referral to a specialist was delayed for five days by administration at the prison, and note this is the third

time we have found this in recent investigations. After his diagnosis, we are satisfied that healthcare staff looked after Mr Wilkins well, there were good care plans including for pain management, although he often complained of being in pain.

9. We are concerned that the prison delayed appointing a family liaison officer or other suitable member of staff to support Mr Wilkins. We are also concerned that a manager approved the use of restraints when Mr Wilkins went to hospital on 28 March, despite his poor condition and already low risk of escape. We do not consider it was appropriate for escorting officers to remain with Mr Wilkins in his last hours, a time when some privacy should have been given to him and his family.

Recommendations

- The Head of Healthcare should ensure that staff manage COPD in line with national guidance, to include regular respiratory assessment.
- The Head of Healthcare should ensure that staff clarify information on hospital discharge summaries when it is not clear, so that there is good continuity of care.
- The Head of Healthcare at HMP Littlehey should ensure that all urgent referrals are sent within 24 hours.
- 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 and are reviewed when the prisoner's condition deteriorates. Families should also be given appropriate privacy with a prisoner in the final hours of life.
- The Governor should ensure that an appropriate member of staff is appointed to engage with the prisoner and his family when a prisoner is diagnosed with a terminal or serious illness in line with Prison Service Instructions.

The Investigation Process

10. 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. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Wilkins' prison and medical records. She interviewed one member of staff by telephone on 8 June 2016.
12. NHS England commissioned a clinical reviewer to review Mr Wilkins' clinical care at the prison.
13. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Wilkins' brother, his next of kin, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. Mr Wilkins' brother raised a number of issues:
 - He felt Mr Wilkins' cancer diagnosis had been missed and that all his symptoms were put down to his chronic obstructive pulmonary disease and osteoarthritis.
 - He felt that Mr Wilkins was not given appropriate pain relief, was unable to shower for many weeks and that staff did not care for him adequately.
 - He felt that the prison should have appointed a family liaison officer sooner.
 - He felt that it was not necessary to have escorts present during Mr Wilkins' last few hours.
15. The investigation has assessed the main issues involved in Mr Wilkins' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
16. Mr Wilkins' family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of the report and have been addressed through separate correspondence.
17. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HM Prison

18. 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.
19. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison's healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.30am to 6.15pm at weekends and bank holidays. 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

20. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that serious incidents, complaints, prisoner feedback and audits had led to service improvement. Regular GPs had significantly improved patient care and staff shortages had not affected health services. Emergency response equipment was available throughout the prison and all custodial managers and permanent night staff were trained in first aid, including use of defibrillators.

Independent Monitoring Board

21. 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 two healthcare centres, on either side of the prison, allowed easy access to healthcare services for prisoners.

Previous deaths at HMP Littlehey

22. Mr Wilkins was the ninth prisoner to die of natural causes since April 2014. Subsequently, there have been three more natural cause deaths. We have raised the issue of processing urgent referrals and using restraints without full justification before.

Findings

The diagnosis of Mr Wilkins' terminal illness and informing him of his condition

23. On 2 October 1979, Mr Steven Wilkins was sentenced to life imprisonment for murder and robbery and was sent to HMP Edinburgh. He was transferred to the jurisdiction of England and Wales on 10 January 1980 to answer further charges of rape and arson. On 16 April 1980, he was convicted of these offences and sentenced to a further life sentence. Mr Wilkins spent time at a number of prisons before arriving at HMP Littlehey on 13 January 2015. He had been at Littlehey on a number of occasions before, including for a substantial period between August 2006 and September 2014.
24. When he arrived back at Littlehey in January 2015, a nurse carried out an initial health screen. She noted that Mr Wilkins smoked 10-20 cigarettes a day, that his health problems included chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), thyroid issues and osteoarthritis in his hip and back. She also noted that he was on a number of medications, although he was not taking any for his respiratory condition. The nurse made an appointment at the respiratory clinic for 21 January.
25. Mr Wilkins did not attend the respiratory clinic appointment and a further appointment was made for 26 February. He did not attend this either (his notes show that he often chose not to attend appointments) and Nurse A recorded that, she would not make a further appointment unless Mr Wilkins requested it, but created a routine annual recall.
26. On 16 July, Nurse A created a COPD care plan for Mr Wilkins and noted that his next review was booked for 1 February 2016. She did not conduct a respiratory risk assessment and noted Mr Wilkins had one the year before and currently his COPD was not problem. She offered Mr Wilkins assistance to give up smoking, but he refused.
27. On 14 December, Mr Wilkins had an exacerbation (acute episode) of his COPD. Nurse A learned that he had not been an inhaler user as he did not believe they worked so she prescribed salbutamol to ease his breathing. The nurse saw him two days later and his condition had significantly improved.
28. On 22 January 2016, Mr Wilkins had another exacerbation and the healthcare team tried to manage it with antibiotics, steroids and nebulisers. Mr Wilkins did not improve and, on 28 January, he told a prison GP, Dr A, that he had been unwell for approximately five weeks and had lost weight. The doctor weighed him and noted he was within the normal healthy range. The doctor prescribed a different inhaler (tiotropium bromide) to aid Mr Wilkins' breathing.
29. On 1 February, Mr Wilkins had not improved so was admitted to Hinchingbrooke Hospital, Cambridge. A CT scan revealed a possible tumour on his right lung, pneumonia and severe emphysema. The hospital said that the next steps would be determined at a hospital multi disciplinary team meeting (MDT). Mr Wilkins returned to the prison on 3 February.

30. On 4 February, Dr A recorded that the hospital discharge summary seemed to contradict itself. It said that Mr Wilkins' medication was not amended in hospital yet gave a higher co-codamol dosage than he received in the prison. The doctor did not check the dose with the hospital but prescribed the original, lower dose of co-codamol for Mr Wilkins.
31. On 5 February, Dr B noted the abnormal scan results and that a hospital MDT would discuss the scan. On the same day, Nurse B saw Mr Wilkins, who complained of pain in his lower right rib area. He gave Mr Wilkins ibuprofen to take in conjunction with co-codamol and advised him to attend healthcare if the pain continued.
32. On 6 February, Nurse B saw Mr Wilkins again. He was still complaining of pain and said that he could not take the ibuprofen because he had ulcers. The nurse examined Mr Wilkins and noted the pain described was very localised in the upper left chest wall. The Nurse spoke to Hinchingsbrooke Hospital for further guidance, but did not record this.
33. On 7 February, a nurse prescriber noted that Dr A had reviewed Mr Wilkins' medication and it was not to be altered.
34. On 8 February, Nurse C saw Mr Wilkins. He was complaining of pain and she noted that, although he had been discharged from hospital with a higher dosage of co-codamol, this had not been prescribed. Mr Wilkins showed her the hospital discharge summary and she discussed the issue with Dr C who prescribed co-codamol tablets at the higher dosage. There is no evidence that she checked with the hospital either.
35. Dr D saw Mr Wilkins on 10 February to review his COPD and booked an appointment with a GP to review his pain relief.
36. On 15 February, a prison GP, Dr E, saw Mr Wilkins who had a chesty cough. She also noted that his CT scan had highlighted a suspicious area but that the hospital had not confirmed the next steps. She kept him under review and, on 19 February, dictated a letter to Hinchingsbrooke Hospital, making an urgent two week referral (The NHS pathway requires patients with suspected cancer to be seen by a specialist within two weeks). However, the administration team did not fax this letter to the hospital until 24 February.
37. Another prison GP, Dr F, saw Mr Wilkins on 24 February for ongoing issues with his chest. The doctor telephoned Hinchingsbrooke Hospital to find out about a follow-up appointment and the arranged an appointment for 9 March.
38. On 2 March, Mr Wilkins complained of chest pain and healthcare staff sent him to hospital as an emergency. The hospital admitted him and hospital staff told him there was a strong possibility he had lung cancer. Mr Wilkins refused to stay in hospital and was returned to prison the next day. On 11 March, a respiratory consultant saw Mr Wilkins and confirmed he had lung cancer which might have spread to his lymph nodes and bones.
39. When Nurse A created a COPD care plan for Mr Wilkins, she did not conduct a respiratory assessment. The clinical reviewer considered that this was not

equivalent to the proactive respiratory disease management now expected within the community.

40. When the hospital discharged Mr Wilkins, on 3 February, there was an anomaly about his dosage of co-codamol. Dr A did not check with the hospital, but decided to prescribe the original dose for Mr Wilkins. He told us that he had made an assumption that the dose had not changed and that such discrepancies on discharge summaries were not uncommon. We consider that, where there is any confusion about any aspect of follow-up care, clinicians should clarify this with the hospital.
41. We are concerned that it took so long for Mr Wilkins' abnormal scan results to be referred to a specialist. The hospital discharge summary indicated the hospital MDT would decide on the next steps and therefore prison healthcare staff were waiting for the hospital to make an appointment. Hospital care is outside the remit of this investigation. Dr E was sufficiently concerned to make an urgent referral under the two week rule; however there was an unacceptable delay in the letter being faxed to the hospital. The Head of Healthcare told us that the administration team should have dealt with this immediately and was unable to say why there was a delay. We note that Littlehey has a clear healthcare protocol that states urgent referrals (which are dictated by the GPs) should be written up and faxed with 24 hours. While the clinical reviewer considers this delay did not affect the outcome for Mr Wilkins, it could be crucial in other circumstances. This is the third time we have raised such an issue with Littlehey in recent investigations. We make the following recommendations:

The Head of Healthcare should ensure that staff manage COPD in line with national guidance, to include regular respiratory assessment.

The Head of Healthcare should ensure that staff clarify information on hospital discharge summaries when it is not clear, so that there is good continuity of care.

The Head of Healthcare at HMP Littlehey should ensure that all urgent referrals are sent within 24 hours.

Mr Wilkins' clinical care

42. On 12 March, Mr Wilkins told Nurse A that tramadol was not helping him (it is not clear when this was prescribed) and he wanted pregabalin (a medication used to treat epilepsy, nerve pain and anxiety). He also said that he had taken co-codamol as well as tramadol but it had not helped. The nurse explained that pregabalin was not necessarily an analgesic (pain relief), but Mr Wilkins would not accept this. That night he complained of further pain to officers.
43. On 14 March, Dr E increased the dose of tramadol and discussed future options of a morphine based analgesic or possibly pregabalin. The doctor planned to review Mr Wilkins in a week.
44. On the same day, Nurse D created care plans including for the management of pain and nutrition. The nurse also noted that staff had arranged extra nutrition for Mr Wilkins in the form of special soups and a nutritional supplement. Also on

the same day, Nurse E spoke at length to Mr Wilkins about his diagnosis, diet and pain relief.

45. On 15 March, Mr Wilkins complained that the tramadol was making breathing difficult and he wanted co-codamol. Nurse D told him that he had to try it for a bit longer and she also opened a fatigue care plan and a palliative care plan. She noted that Mr Wilkins needed help keeping his cell clean, though other prisoners helped him with this, and she arranged with the wing officer for someone to clean his cell for him up to three times a week. She noted he had a shower in his cell and did not have a problem using this.
46. On 16 March, a hospital doctor told Dr C that Mr Wilkins' cancer was inoperable and would not respond to chemotherapy. She and Nurse D visited Mr Wilkins on the wing that day to give him the news and offer support.
47. On 18 March, Dr B saw Mr Wilkins and increased his tramadol dose. She also ordered him a supply of morphine based pain relief with a view to replacing the tramadol (it arrived on 24 March). She noted that he had been taking some co-codamol he had left on top of his tramadol and advised him against this. Mr Wilkins asked for pregabalin, but the doctor noted there had been some issues with capsules going missing when he had been prescribed this in 2011 and 2012. She was not satisfied that Mr Wilkins needed pregabalin and noted he was not consistent in his reasoning for wanting it, so would not prescribe it.
48. On 21 March, a prison GP, Dr C, spoke to Mr Wilkins about his resuscitation wishes. He said he did not wish anyone to try and resuscitate him if his heart or breathing stopped and the doctor recorded this appropriately.
49. On 24 March, a visiting palliative care doctor recorded that Mr Wilkins' prognosis was likely to be only weeks. The morphine based pain relief had been delivered and the doctor prescribed this and oramorph (liquid morphine usually used to deal with break through pain between doses of pain relief).
50. On 28 March, Nurse F saw Mr Wilkins and noted his low oxygen saturation level (80%). She noted he was unable to maintain his oxygen level without the aid of additional oxygen and arranged for him to be admitted to hospital the same day.
51. Mr Wilkins remained in hospital until 1 April, when he moved to St John's Hospice. He continued to decline and died at 1.05am on 4 April.
52. We are satisfied that the care Mr Wilkins received after his diagnosis was equivalent to that he could have expected to receive in the community. There were appropriate care plans in place, including for pain management. It is clear from the record that his pain was difficult to manage, but the clinical reviewer is satisfied that his pain relief was reviewed and adjusted regularly.

Mr Wilkins' location

53. Throughout his time at Littlehey, Mr Wilkins lived in a single cell on a normal wing. On 24 March, Nurse D suggested that he move to a larger cell with a hospital bed and shower, situated nearer to healthcare. Mr Wilkins said he wanted to stay where he was as his friends were there.

54. On 27 March, Nurse D made a referral to St John's Hospice. The next day he was admitted to hospital but moved to the hospice on 1 April.
55. We are satisfied that Mr Wilkins' accommodation at Littlehey was adequate and, in line with his wishes. The move to a hospice was appropriate and allowed him a peaceful death.

Restraints, security and escorts

56. 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.
57. On 28 March, when Mr Wilkins was sent to hospital at 11.25am, a security risk assessment was carried out. The risk assessment noted that Mr Wilkins was a low risk to the public, of hostage taking and of escape, although it noted he had absconded from open conditions in 2014. The medical portion of the risk assessment recorded no objection to restraints, but pointed out that Mr Wilkins had cancer and handcuffs might bruise or produce clots. It also recorded that, although Mr Wilkins could mobilise, he used a wheelchair. Prison manager, A, authorised two officers to escort Mr Wilkins and restrain him with an escort chain (this is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer).
58. The prison manager, A, reviewed the risk assessment at 6.30pm and, after receiving more information about Mr Wilkins' condition, she authorised officers to remove the restraints which were not reapplied. The escorting officers remained with Mr Wilkins in hospital and when he moved to the hospice. They were with him when he died.
59. The prison manager, A, told us that when she made her original decision, she only had a short time in which to make it and was not aware of the gravity of Mr Wilkins' condition.
60. We are pleased that the prison manager reviewed the risk and removed Mr Wilkins' restraints the same day he was admitted to hospital. However, when he first was sent to hospital, Mr Wilkins was very ill with lung cancer. His mobility was very poor, to the extent that he needed a wheelchair. We are not satisfied that the risk assessment properly took into account how Mr Wilkins' health impacted on his already low risk of escape, a topic we have raised with the prison before. We are also concerned that the escorting officers remained with Mr Wilkins once he moved to the hospice in his final days. By this time he was known to be dying and managers should have reviewed the escorting

arrangements to allow his family private time with him in his final hours. 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 and are reviewed when the prisoner's condition deteriorates. Families should also be given appropriate privacy with a prisoner in the final hours of life.

Liaison with Mr Wilkins' family

61. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011 states that prisons must ensure that a member of staff engages with the next of kin of prisoners who are either terminally or seriously ill.
62. When Mr Wilkins was admitted to hospital on 28 March, the prison appointed a prison manager, B, as the family liaison officer. She telephoned Mr Wilkins' brother, his next of kin, that evening and arranged to meet him when he arrived at the hospital the next morning. She met Mr Wilkins' brother and other members of his family the next day, explained her role and offered them support from that point on.
63. Mr Wilkins' family were able to visit him in hospital and at the hospice. During the evening of 3 April they had spent some time with him and then went home. At 12.35am on 4 April, a hospice nurse telephoned Mr Wilkins' family to inform them that he was dying. They asked for someone to call when he died. After Mr Wilkins died, a custodial manager telephoned Mr Wilkins' brother to inform him of his death and offer his condolences and support.
64. Later that morning, prison manager, B, telephoned Mr Wilkins' brother to offer her condolences and support.
65. Mr Wilkins' funeral was on 15 April. The prison contributed to the costs in line with national instructions.
66. While we consider the prison's liaison with Mr Wilkins' family was reasonable after 28 March, we are concerned that the prison did not appoint a family liaison officer or other suitable member of prison staff to support both Mr Wilkins and his family when he was informed his condition was terminal, on 16 March, as Prison Service Instructions require. We make the following recommendation:

The Governor should ensure that an appropriate member of staff is appointed to engage with the prisoner and his family when a prisoner is diagnosed with a terminal or serious illness in line with Prison Service Instructions.

Compassionate release

67. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
68. On 14 March, Nurse E spoke to Mr Wilkins about a Parole Board hearing which was due to consider his release. She told him that if the Parole Board refused to release him she would start an application for compassionate release. However, the next day she asked the offender management unit at the prison to start an application.
69. On 23 March, the Parole Board refused to release Mr Wilkins. On 24 March, a prison GP completed a medical report but the application, but more information was needed, before it could be progressed. The application was not completed before Mr Wilkins died. We are satisfied that the prison appropriately considered compassionate release for Mr Wilkins.

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