

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Laurence Oliver a prisoner at HMP Littlehey on 3 June 2018

**A report by the Prisons and Probation Ombudsman**

## 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 Laurence Oliver died on 3 June 2018 in hospital of oesophageal cancer while a prisoner at HMP Littlehey. He was 60 years old. I offer my condolences to Mr Oliver's family and friends.

The investigation found that Mr Oliver missed his first chemotherapy treatment because a prison escort had not been arranged. It also found deficiencies in the emergency response when he collapsed in his cell the day before he died. However, the clinical reviewer considered that overall Mr Oliver received a high standard of care at the prison.

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

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**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**

**December 2018**

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# Summary

## Events

1. Mr Laurence Oliver was sent to prison in December 2011 and moved to HMP Littlehey in June 2013.
2. In December 2017, Mr Oliver complained about difficulties when swallowing food and a prison GP prescribed medication for excess stomach acid and indigestion which improved his condition.
3. In February 2018, Mr Oliver said his swallowing difficulties had returned and a prison GP made an urgent referral to a gastroenterologist (a specialist who deals with disorders of the stomach and intestines). He had an appointment on 13 March.
4. On 6 April, a gastroscopy (an examination of the oesophagus, stomach and small intestine) revealed a tumour in Mr Oliver's oesophagus. The results of a CT scan on 18 April revealed further tumours in Mr Oliver's lymph nodes and liver.
5. On 20 April, a prison GP told Mr Oliver that his condition was terminal. On 23 April, a hospital consultant told Mr Oliver he had a life expectancy of approximately 12 months. Mr Oliver's condition was suitable for palliative chemotherapy and he had his first treatment on 10 May. He missed a chemotherapy session on 4 May because the prison had forgotten to arrange an escort.
6. On 15 May, Mr Oliver was admitted to hospital with chest pain. Hospital doctors diagnosed a coronary vasospasm (a sudden constriction of a blood vessel which reduces its diameter and flow) which was caused by chemotherapy medication. On 29 May, a hospital consultant told Mr Oliver he was unable to continue with chemotherapy treatment because of the effect on his heart.
7. At 10.56am on 2 June, Mr Oliver collapsed in his cell. Healthcare staff attended and tried to give him oxygen but the cylinder was empty so there was a short delay while staff collected another one. An air ambulance took him to hospital. Mr Oliver's condition continued to deteriorate and at 11am on 3 June he had a cardiac arrest. Mr Oliver died at 11.10am with a prison nurse present.

## Findings

8. The clinical reviewer found that healthcare staff worked closely with the hospital to ensure Mr Oliver's care was seamless. Nurses supported Mr Oliver throughout his illness and the clinical reviewer considered that this aspect of his care was exemplary.
9. We are satisfied that the missed chemotherapy appointment had no impact on the outcome for Mr Oliver but it is important that the prison facilitates attendance at hospital appointments, particularly when prisoners are due to receive treatment.

10. We are concerned that on 2 June, nurses did not thoroughly check the emergency equipment to ensure it was ready for use.
11. Overall, we are satisfied that Mr Oliver received an appropriate standard of care at the prison, equivalent to that which he could have expected to receive in the community.

## **Recommendations**

- The Governor should ensure that appropriate arrangements are in place so that prisoners are able to attend hospital appointments.
- The Head of Healthcare should ensure that emergency equipment is thoroughly checked and is ready to use at all times.

## The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Oliver's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Oliver's clinical care at the prison.
15. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
16. The investigator wrote to Mr Oliver's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
17. The investigation has assessed the main issues involved in Mr Oliver's 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.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS 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 Littlehey

19. HMP Littlehey in Cambridgeshire is a medium security prison holding approximately 1,200 men. A large proportion of the prison's population have been convicted of sexual offences.
20. Northamptonshire Healthcare NHS Foundation Trust commissions healthcare services at Littlehey. The prison healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.00am to 5.30pm 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

21. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were effectively identified and there was an appropriate range of clinics, led by specialist nurses. Inspectors found that hospital appointments for prisoners were rarely cancelled. Prisoners with palliative and end-of-life needs received excellent care from the prison and health care staff.

## Independent Monitoring Board

22. 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 31 January 2018, the IMB reported that the ageing prison population continued to make significant demands on healthcare services. The Board was disappointed to note that the Littlehey End of Life suite, completed in 2013, continued to be unused, reportedly due to a lack of funding. However, arrangements had been made with a local hospice, which seemed to provide good care.

## Previous deaths at HMP Littlehey

23. Mr Oliver was the 24th prisoner to die at Littlehey since June 2015, which is not remarkable, given the prison's population. All were from natural causes. There have been four natural causes deaths since. There were no similarities between Mr Oliver's death and previous deaths at Littlehey.

# Findings

## The diagnosis of Mr Oliver's terminal illness and informing him of his condition

24. Mr Laurence Oliver was serving a 13-year sentence for sexual offences and had been at HMP Littlehey since 4 June 2013.
25. On 5 December 2017, a prison GP saw Mr Oliver who complained about difficulties when swallowing food and a burning sensation between his lower and mid sternum. The GP prescribed lansoprazole for excess stomach acid and mucogel suspension for indigestion and heartburn. The GP said she would refer Mr Oliver for an endoscopy (an examination of the inside of the body using a small camera) if his condition did not improve.
26. On 27 December, the GP assessed Mr Oliver who said his condition had hugely improved and he no longer had difficulty swallowing. Mr Oliver agreed to continue taking medication to reduce stomach acid and indigestion.
27. On 12 February, Mr Oliver told the GP his swallowing difficulties had returned and he had lost weight. The GP made an urgent referral to a gastroenterologist (a specialist who deals with disorders of the stomach and intestines) under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.
28. Mr Oliver attended an appointment with a gastroenterologist at Hinchingsbrooke Hospital on 13 March. The gastroenterologist referred Mr Oliver for a gastroscopy (an examination of the oesophagus, stomach and small intestine).
29. On 26 March, Mr Oliver told the GP he was unable to swallow solid food. The GP prescribed nutritional milkshakes and asked the prison's catering manager to give Mr Oliver soup.
30. On 6 April, Mr Oliver had a gastroscopy. The results revealed a tumour in Mr Oliver's oesophagus. The gastroenterologist made an urgent referral for a computerised tomography (CT) scan (which uses X-rays and a computer to create detailed images of the inside of the body). The results were received on 12 April and confirmed that Mr Oliver had a tumour in his oesophagus. The same day, the GP discussed the results with Mr Oliver. She explained that Mr Oliver's treatment would continue in his local hospital after his release from prison in June.
31. On 15 April, a prison nurse saw Mr Oliver to discuss his diagnosis. She explained that the community palliative care team would offer support with pain relief if necessary. The nurse gave Mr Oliver information books from Macmillan Cancer Support.
32. On 18 April, Mr Oliver had another CT scan. On 20 April, the GP told Mr Oliver that the results of the CT scan had revealed that the tumour had spread to his liver and lymph nodes. The GP explained that Mr Oliver's condition was terminal.
33. We are satisfied that prison GPs appropriately investigated Mr Oliver's symptoms and discussed his diagnosis with him.

## Mr Oliver's clinical care

34. On 25 April, a consultant oncologist (cancer specialist) assessed Mr Oliver at Hinchingsbrooke Hospital. Mr Oliver's condition was suitable for palliative chemotherapy which he would receive every 3 weeks with a review after the third cycle. The consultant gave Mr Oliver a life expectancy of approximately 12 months. The same day, the consultant wrote to Littlehey's healthcare staff and said Mr Oliver's first chemotherapy treatment was on 4 May.
35. On 3 May, the nurse created a care plan to manage Mr Oliver's treatment and to monitor his risk of side effects from chemotherapy. The nurse also created a dietary care plan to ensure Mr Oliver received a soft diet and to monitor his fluid intake.
36. On 4 May, a nurse from Hinchingsbrooke Hospital contacted a prison healthcare administrator because Mr Oliver had not attended for his chemotherapy treatment. It transpired that Mr Oliver was not on the hospital escort list.
37. On 10 May, Mr Oliver was taken to Hinchingsbrooke Hospital for chemotherapy treatment.
38. On 15 May, Mr Oliver was admitted to hospital with chest pain. Hospital doctors diagnosed a coronary vasospasm (a sudden constriction of a blood vessel which reduces its diameter and flow) which was caused by chemotherapy medication.
39. Nurses saw Mr Oliver daily in accordance with his care plans. On 29 May, the consultant saw Mr Oliver and explained he could not continue with chemotherapy treatment because of the effect on his heart. The consultant discussed with Mr Oliver alternative palliative medication. Mr Oliver arrived late for this appointment because prison staff did not make the necessary escort arrangements.
40. At 10.56am on 2 June, Mr Oliver collapsed in his cell. Prison Officers radioed an emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) and the control room called an emergency ambulance. Shortly after, a prison nurse arrived and noted that Mr Oliver was sweating profusely, and his oxygen saturation level was low (87%). The nurse attempted to give Mr Oliver oxygen but the cylinder was empty. Mr Oliver deteriorated and he lost consciousness. Paramedics arrived at 11.15am and took control of Mr Oliver's care. An air ambulance arrived at 11.25am and took Mr Oliver to Hinchingsbrooke Hospital.
41. On 3 June, a prison nurse visited Mr Oliver in hospital. Hospital doctors told her Mr Oliver's prognosis was extremely poor. At 11am, Mr Oliver had a cardiac arrest. The nurse was with Mr Oliver when he died at 11.10am.
42. The clinical reviewer commented that overall Mr Oliver's clinical care at the prison was equivalent to that which he could have expected to receive in the community. However, there were incidents where Mr Oliver's care was not to a high standard.
43. On 4 May, Mr Oliver missed a chemotherapy appointment and on 29 May, he arrived late for a consultant appointment due to prison escort arrangements. Although the clinical reviewer commented that the missed chemotherapy

appointment did not affect the outcome for Mr Oliver, it is important that prisoners attend their hospital appointments, especially when they are receiving treatment. We make the following recommendation:

**The Governor should ensure that appropriate arrangements are in place so that prisoners are able to attend hospital appointments.**

44. On 2 June when Mr Oliver collapsed in his cell, a prison nurse attempted to give him oxygen but the cylinder was empty. Standard Operating Procedure No.103 - Checking of the Emergency Bag, states that oxygen cylinders should be checked daily and replenished after each use. The Head of Healthcare at Littlehey, told the clinical reviewer that a nurse had checked the oxygen cylinders that morning and recorded that they were full. While prison officers quickly brought a full cylinder to Mr Oliver's cell, it is important that all emergency equipment is thoroughly checked and available for use when needed. We make the following recommendation:

**The Head of Healthcare should ensure that emergency equipment is thoroughly checked and is ready to use at all times.**

#### **Mr Oliver's location**

45. Mr Oliver lived in a single cell on J wing until his admission to hospital on 2 June 2018. We are satisfied that Mr Oliver was appropriately located throughout his illness and was quickly taken to hospital when his condition deteriorated.

#### **Restraints, security and escorts**

46. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
47. Staff carried out thorough risk assessments and following his diagnosis, appropriately, did not restrain Mr Oliver.

#### **Liaison with Mr Oliver's family**

48. On 13 April 2018, the prison appointed a prison officer and a prison chaplain as family liaison officers (FLO). Mr Oliver told the prison officer FLO he would inform his wife, his nominated next of kin, about his condition when she visited him with his friend on 1 May. The prison officer FLO saw Mr Oliver in his cell regularly to offer support.
49. On 2 June, the prison officer FLO visited Mr Oliver in hospital. Mr Oliver did not want him to inform his wife about his condition because her family were unaware that she was in contact with him. Mr Oliver asked the prison officer FLO to telephone his friend after his death.
50. At 12.00pm on 3 June, the prison officer FLO telephoned Mr Oliver's friend and informed her of his death. He was unable to visit Mr Oliver's wife at home. On 4

June, the prison chaplain FLO and a prison manager visited Mr Oliver's wife at his friend's home and informed her of Mr Oliver's death.

51. The prison officer FLO kept in contact with Mr Oliver's wife and friend until his funeral on 4 July. The prison contributed towards the costs in line with national policy.

### **Compassionate release**

52. 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.
53. Mr Oliver had a life expectancy of approximately 12 months. He was due to be released from prison in June 2018 and prison GPs had arranged for him to continue his treatment at his local hospital.
54. Prison staff did not consider an application for release on compassionate grounds because Mr Oliver had a prognosis of over three months. We are satisfied that Mr Oliver was not eligible for early release.

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