Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Hope a prisoner at HMP Littlehey on 6 June 2017

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter Hope died on 6 June 2017, of pneumonia, heart problems and chronic kidney disease, while a prisoner at HMP Littlehey. He was 85 years old. We offer our condolences to Mr Hope's family and friends.

The investigation found that the clinical care Mr Hope received for his chronic conditions was good, but prompt action should have been taken to replace his missing dentures.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2018**

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Summary

Events

1. On 14 October 2016, Mr Peter Hope was sentenced to two years and six months imprisonment for sexual offences and sent to HMP Bedford. Mr Hope told a nurse that he had suffered three heart attacks in the past and had an appointment for heart surgery on 2 November. He reported being partially deaf with a painful left ear, used GTN spray (to treat symptoms of angina), and had type two diabetes for which he used insulin daily.

2. On 2 November, Mr Hope attended hospital for heart surgery. He was discharged back to prison on 28 November. On 2 December, he was moved to HMP Littlehey. Mr Hope was given a dosette box to manage his medication, which was dispensed into his possession weekly. No risk assessment was conducted; it was later noted that Mr Hope was able to cope with taking his medication because his carer prompted him to do so.

3. On 6 December, Mr Hope reported that he had lost his dentures during the transfer between prisons. A nurse manager contacted HMP Bedford to see if the prison had them but they could not be found. She did not make an emergency dental appointment so Mr Hope did not see a dentist for replacements until April 2017, when healthcare staff also put him on a soft diet because his lack of teeth caused difficulty eating.

4. Mr Hope was taken to hospital twice when he was unwell. The third and final time, on 28 May 2017, he was taken because his vital signs were poor and he was unwell with a chest infection. His health deteriorated and he died in hospital on 6 June.

Findings

5. The investigation found that the clinical care Mr Hope received for his chronic conditions and general health was equivalent to that which he could have expected to receive in the community.

6. Mr Hope spent four months without dentures which caused him difficulty eating, before he was placed on a soft diet. This level of care was not equivalent to that which he could have expected to receive in the community and fell short of what would be expected in a decent regime.

Recommendation

- The Head of Healthcare should ensure that emergency dental appointments are made promptly.

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 her. No one responded.

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

9. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation and he gave us Mr Hope's cause of death. We have sent the coroner a copy of this report.

10. The investigator wrote to Mr Hope's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Littlehey

12. HMP Littlehey is a medium security prison in Cambridgeshire holding approximately 1,200 men. A large proportion of the population have been convicted of sexual offences.

13. 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

14. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that the attendance of regular GPs, rather than locums, had significantly improved patient care. Lifelong conditions were identified effectively and an appropriate range of clinics, led by specialist nurses, was held. Hospital appointments were rarely cancelled. Risk assessments for keeping medication in possession were not always conducted appropriately.

Independent Monitoring Board

15. 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 2017, the IMB reported that the ageing prison population continued to make significant demands upon healthcare services. Healthcare clinics for diabetes had been introduced during the reporting year. Visiting carers provided a significant amount of support.

Previous deaths at HMP Littlehey

16. Mr Hope was the twelfth prisoner to die of natural causes at HMP Littlehey, since January 2016. There are no significant similarities with the previous deaths.

Key Events

17. On 14 October 2016, Mr Peter Hope was sentenced to two years and six months imprisonment for sexual offences. He was sent to HMP Bedford. It was his first time in prison. During his initial health screen, Mr Hope told a nurse that he had suffered three heart attacks in the past and had an appointment for heart surgery on 2 November. He reported being partially deaf with a painful left ear, used GTN spray (to treat symptoms of angina), and had type two diabetes for which he used insulin daily.

18. Healthcare staff monitored Mr Hope, and provided him with medication for his various conditions. On 2 November, he was taken to hospital for an angioplasty of his coronary artery and had four stents inserted. (This is a procedure designed to widen a narrowed or blocked artery.) The hospital wrote to tell the prison that Mr Hope had chronic kidney disease, severe aortic stenosis (narrowing of the arteries) and coronary artery disease. He also suffered from symptoms of angina. There were medical complications after his operation and Mr Hope remained in hospital until 28 November.

19. On 2 December, Mr Hope was transferred to HMP Littlehey. At the reception health screen, a nurse noted that he walked with a stick, in addition to his ongoing health issues and recent surgery. The pharmacist noted that Mr Hope was confused about his medication and needed a weekly dosette box to help him remember to take his pills. (A dosette box is a plastic tray which separates medicines into individual compartments for different times of the day for each day of the week.) Mr Hope was prescribed atorvastatin, bisoprolol and clopidogrel (for high blood pressure and heart issues), ferrous sulphate and folic acid (for anaemia), furosemide (to treat water retention), insulin (for diabetes) and omeprazole (to reduce stomach acid).

20. On 6 December, a nurse saw Mr Hope for an initial diabetes assessment. She noted that he was “covered” in bruises which were thought to be from the handcuffs used in hospital, and that his skin was thin. She recommended that no handcuffs be used on Mr Hope in future and there is nothing to suggest that any restraint was used thereafter. Mr Hope also reported having lost his dentures in the transfer and the nurse manager contacted HMP Bedford to see whether they had them. She told us that she wanted to see if the dentures could be found before she considered booking a dental appointment. However, the dentures were not found and there is no record of any appointment being booked as a result.

21. On 8 December, the hospital wrote to the prison stating that due to Mr Hope’s age and variety of illnesses, medical intervention would only improve his quality of life, rather than prolong it. They wrote that his life expectancy was less than five years.

22. On 20 December, Mr Hope went to the healthcare clinic feeling unwell and complaining of chest pain. His blood pressure was high and oxygen levels were slightly low. A nurse took an electrocardiogram (an ECG, which tests the electrical activity of the heart), and called an ambulance to take Mr Hope to

hospital. Mr Hope was not restrained. He returned to the prison the next day, after treatment for angina.

23. A pharmacist, noted on 9 January 2017, that Mr Hope was coping with using the dosette box for his medication because he had a carer who prompted him to take his medication and keep it organised.

24. On 18 January, Mr Hope again became unwell with chest pain. A prison GP took his vital signs and conducted an ECG. It showed changes, and so the doctor sent him to hospital by ambulance. On 20 January, Mr Hope was discharged with a plan to attend the cardiology department in three to four months time.

25. Healthcare staff continued to monitor Mr Hope, and to administer medication. When he went to hospital for planned appointments, he had to use a wheelchair.

26. On 6 February, Mr Hope failed to attend a routine dental appointment.

27. On 4 April, Mr Hope reported that his dentures had been lost in the move to Littlehey. An urgent appointment for a new set of teeth was made and a soft food diet recommended. On 10 April, he attended a dental appointment at which imprints were taken for a new set of dentures. There is no record of whether Mr Hope ever received these.

28. In May, Mr Hope began to suffer from a chest infection for which doctors prescribed antibiotics. There was no improvement by 28 May, when Mr Hope's vital signs were poor. His oxygen levels were low, and he had a low blood pressure. He coughed sputum. A nurse called an ambulance to take him to hospital.

29. Following his arrival in hospital, Mr Hope had a catheter inserted. His health continued to deteriorate and his family came to visit him in hospital. On 4 June, the hospital started end of life care. Mr Hope died at 6.20am on 6 June.

Contact with Mr Hope's family

30. On 1 June, a family liaison officer was appointed. He met Mr Hope's family at the hospital on the same day. The hospital discussed the withdrawal of treatment on 3 June. He offered continued support. Mr Hope's funeral was held on 30 June, and the prison contributed towards the costs in line with national policy.

Support for prisoners and staff

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

Cause of death

32. The coroner did not conduct a post-mortem. The cause of death was given as pneumonia, and ischaemic heart disease, diabetes, aortic stenosis and chronic kidney disease.

Findings

Clinical care

33. The clinical reviewer concluded that the care Mr Hope received for his chronic conditions, including diabetes, was equivalent to that which he could have expected to receive in the community.

34. However, the clinical reviewer makes a number of recommendations which the Head of Healthcare will need to address.

Dentures

35. On 6 December 2016, Mr Hope reported that he had lost his dentures in the transfer from Bedford. A nurse contacted Bedford and planned to make an urgent dental appointment if the prison could not find his teeth, but this appointment was never made. Mr Hope did not raise this issue again until 4 April 2017. He had a dental appointment to fit a new set of teeth, but it is not clear whether, they were received. From this date, Mr Hope received a soft food diet because it was difficult for him to eat without teeth.

36. It is concerning that the prison did not appreciate Mr Hope's difficulty in eating until April, after he had spent four months without teeth. The clinical reviewer was concerned that this was not identified or addressed. Mr Hope needed a controlled diet because of his diabetes, and this may have been difficult when he could not eat. In the community, an emergency dental appointment would have been made for Mr Hope. We make the following recommendation:

    The Head of Healthcare should ensure that emergency dental appointments are made promptly.

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