

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Hammond, a prisoner at HMP Littlehey, on 15 August 2015

**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 George Hammond died of respiratory failure due to lung disease on 15 August 2015, while a prisoner at HMP Littlehey. He was 69 years old. I offer my condolences to Mr Hammond's family and friends.

Mr Hammond had suffered from a number of chronic health conditions for a number of years. The investigation found healthcare staff at the prison managed his conditions well, with regular reviews and appropriate care plans. When Mr Hammond's health deteriorated, staff assessed him promptly and sent him to hospital. I am satisfied that Mr Hammond received a good standard of care at Littlehey, equivalent to that he could have expected to receive in the community.

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

March 2016

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Summary

Events

1. In September 2008, Mr George Hammond was convicted of sexual offences and sent to HMP Albany (now HMP Isle of Wight). He had a number of health problems including, severe chronic obstructive pulmonary disease (COPD), chronic joint pain and hypertension (high blood pressure). In August 2011, he was diagnosed with type 2 diabetes. Healthcare and hospital staff frequently reviewed and managed Mr Hammond's health conditions. In 2012, he began continuous oxygen therapy for his deteriorating COPD.
2. On 30 March 2015, Mr Hammond transferred to HMP Littlehey. On 5 June, a prison GP reviewed Mr Hammond after he complained of chest pain and breathing difficulties. The GP sent him to hospital, where doctors diagnosed suspected pneumonia and a chest infection. Mr Hammond remained in hospital until 8 June.
3. In the early hours of 15 August, Mr Hammond's COPD deteriorated. He was short of breath and experiencing pain when breathing. An out of hours GP reviewed Mr Hammond and sent him to hospital where Mr Hammond's condition continued to decline. At 9.45pm on 15 August, hospital staff stopped active treatment. Mr Hammond died at 10.45pm.

Findings

4. We are satisfied that the standard of care Mr Hammond received at Littlehey was equivalent to that he could have expected to receive in the community. He had clear well-documented care plans and his conditions were managed well by healthcare staff at specialist clinics in the prison. When his condition deteriorated, he was assessed promptly and taken to hospital quickly. Officers handcuffed Mr Hammond when they took him to hospital as an emergency in the early hours on 15 August. However, these were removed very shortly after he arrived, which was appropriate and humane. We make no recommendations.

The Investigation Process

5. 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.
6. NHS England commissioned a clinical reviewer to review Mr Hammond's clinical care at the prison.
7. The investigator obtained copies of relevant extracts from Mr Hammond's prison and medical records. He and the clinical reviewer interviewed four members of staff at Littlehey on 2 November 2015.
8. 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.
9. One of the Ombudsman's family liaison officers wrote to Mr Hammond's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We received no reply.
10. The initial report was shared with the Prison Service. They identified no factual inaccuracies.

Background Information

HMP Littlehey

11. 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.
12. 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

13. 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

14. 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 not 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

15. Mr Hammond was the fourth person to die from natural causes at Littlehey since January 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

16. On 4 September 2008, Mr George Hammond was convicted of sexual offences and was sent to HMP Albany (now HMP Isle of Wight). On 30 September, he received a sentence of 15 years in prison.
17. Mr Hammond had poor health before he was sent to prison. He suffered from severe chronic obstructive pulmonary disease (COPD - the name given to a group of lung diseases, including chronic bronchitis and emphysema), chronic joint pain and hypertension (high blood pressure). In August 2011, Mr Hammond was diagnosed with type 2 diabetes. Prison healthcare staff and hospital staff saw Mr Hammond frequently to review his medication and treatment. His health gradually deteriorated throughout his time in prison.
18. In April 2012, a respiratory consultant at hospital reviewed Mr Hammond's COPD and noted that the only treatment available was his prescribed medication. In August 2012, Mr Hammond's condition deteriorated to the extent that he started long-term oxygen therapy to help alleviate his symptoms. His condition continued to deteriorate over time.
19. On 30 March 2015, Mr Hammond transferred to HMP Littlehey. At an initial health screen, a nurse noted that he had COPD and that he needed continuous oxygen therapy. She also recorded that he needed a wheelchair to get about.
20. On 7 April, a prison GP reviewed Mr Hammond, noted his severe COPD and referred him to the respiratory clinic at hospital. (The referral was subsequently changed to another hospital, as the appropriate area.) On 21 April, a nurse reviewed Mr Hammond and noted he had appropriate care plans for his mobility, COPD and respiratory care.
21. On 1 May, a prison GP discussed Mr Hammond's condition with him. Mr Hammond said that he thought he was dying as he had cared for his wife, who had died from a similar condition, and was aware of the signs. The GP referred him to the respiratory clinic at hospital again.
22. On 5 June, a nurse referred Mr Hammond to the GP, as he had chest pain and shortness of breath. The GP examined Mr Hammond, noted his condition was very poor, and arranged for him to be admitted to hospital. In hospital, doctors diagnosed Mr Hammond with suspected pneumonia and a chest infection. He was discharged from hospital on 8 June.
23. On 16 July, a consultant respiratory physician at hospital reviewed Mr Hammond. He noted that, although Mr Hammond's COPD was severe, his chest sounded relatively clear. The consultant referred him for an urgent CT scan to establish the extent of his condition and to check whether there were any signs of lung cancer.
24. On 28 July, Mr Hammond had the CT scan. The consultant wrote to the prison GP the same day and diagnosed severe emphysema (a long-term, progressive lung disease causing shortness of breath). He advised the GP that there was no active treatment available.

25. At 8.57pm on 14 August, Mr Hammond told a custodial manager that he had pain in his lungs when breathing. The custodial manager asked the communications room to telephone the out of hours GP service. At 9.48pm, an out of hours GP rang telephoned the custodial manager, who explained that Mr Hammond's condition. The doctor requested a non-urgent review.
26. At 2.48am on 15 August, another out of hours GP arrived at the prison and examined Mr Hammond. Because of his medical history and poor condition, she asked for an emergency ambulance to take him to Hinchingsbrooke Hospital. A first response paramedic arrived at 3.10am, followed at 3.35am by an emergency ambulance. At 4.18am, the ambulance took Mr Hammond to hospital. Two officers accompanied Mr Hammond and he was handcuffed to one of them. Shortly after arriving at hospital, the officers removed the handcuffs.
27. At 6.00pm, a prison manager took responsibility for family liaison. Mr Hammond said that he had not been in contact with his family for 30 years and he did not want them informed of his condition or that he was in hospital. Mr Hammond's condition deteriorated rapidly in hospital. At 9.45pm on 15 August, hospital staff decided to stop active treatment for Mr Hammond and he died at 10.45pm.

Contact with Mr Hammond's family

28. Mr Hammond had named his sister as his next of kin. On 16 August, a custodial manager and an officer went to the address recorded in Mr Hammond's records to inform his sister of his death, but they found that she did not live there. After further enquires, the manager found that Mr Hammond's brother lived nearby and they informed him that Mr Hammond had died. The prison arranged and paid for Mr Hammond's funeral, which was held on 2 September.

Support for prisoners and staff

29. After Mr Hammond's death, the prison care team offered prison and healthcare staff support. The prison posted notices informing staff and prisoners of Mr Hammond's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hammond's death.

Cause of death

30. The coroner concluded that the cause of Mr Hammond's death was type 2 respiratory failure (inadequate expiration of both oxygen and carbon dioxide), secondary to an exacerbation of severe chronic obstructive pulmonary disease.

Findings

Mr Hammond's clinical care

31. The clinical reviewer noted that healthcare staff frequently reviewed Mr Hammond's COPD and his diabetes in specialist clinics at Littlehey. Despite the challenges of the long-term aspects of his conditions and frequent sudden onsets of chest infections, healthcare staff managed Mr Hammond's care appropriately and in line with National Institute for Health and Care Excellence (NICE) guidelines. Doctors referred Mr Hammond to the hospital chest clinic appropriately. When his condition deteriorated, staff assessed him promptly and ensured he went to hospital.
32. We agree with the clinical reviewer that the standard of care Mr Hammond received at Littlehey was equivalent to that he could have expected in the community.

Restraints, security and escorts

33. When prisoners travel outside prison, a risk assessment is conducted to determine the nature and level of any security arrangements, including any 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. The level of restraints used should be necessary in the circumstances and based on a risk assessment, which considers the risk of escape and the risk to the public. It should take into account factors such as the prisoner's health and mobility.
34. When Mr Hammond was taken to hospital as an emergency in the early hours of 15 August, he was handcuffed and accompanied by two officers. While it is unlikely that this was necessary, taking into account his poor mobility and condition at the time, we recognise that this was an emergency and the handcuffs were removed very shortly after he arrived at the hospital. Mr Hammond was not restrained after that, which was appropriate and humane.

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