

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Maxwell Clifford a prisoner at HMP Littlehey on 10 December 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*



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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.

Our 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 Maxwell Clifford died on 10 December 2017 of a heart attack while a prisoner at HMP Littlehey. Mr Clifford was 74 years old. We offer my condolences to Mr Clifford's family and friends.

While the clinical care Mr Clifford received at Littlehey was largely equivalent to that which he could have expected to receive in the community. We are concerned that Mr Clifford was given incorrectly labelled medication on at least two occasions, and that staff did not monitor his medication compliance adequately at other times.

We are also concerned that there was a delay in his transfer to hospital, even though the GP requested an emergency ambulance.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

November 2018

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Summary

Events

1. On 2 May 2014, Mr Maxwell Clifford was sentenced to eight years imprisonment for sexual offences. On 13 May, he was transferred to HMP Littlehey.
2. A reception health screen revealed that Mr Clifford had a history of prostate cancer and was on prescribed medication for hypertension (high blood pressure). Mr Clifford had no relevant health concerns for the next couple of years but had annual hypertension reviews, and regular prostate check-ups.
3. In July 2017, a prison GP reviewed Mr Clifford after a period of breathlessness. The GP requested blood tests and an electrocardiogram (ECG). In August a prison GP suspected heart failure and consulted a cardiology specialist. He referred Mr Clifford to the hospital, and prescribed heart failure medication. A week later, a consultant cardiologist reviewed Mr Clifford and referred him for further tests.
4. During the next few months, Mr Clifford started avoiding some medication because of its side-effects but prison GPs kept this under review. His condition steadily deteriorated, and he became increasingly breathless. In October, a consultant cardiologist advised a staged increase in one of his medications but a week later, another prison GP noted that he had neither deteriorated nor improved since this change. On 28 November, a consultant cardiologist varied Mr Clifford's medication ahead of an upcoming CT scan.
5. On 6 December, a prison GP reviewed Mr Clifford following reports that his condition was worsening. The GP examined him but did not feel he needed an acute admission to the hospital at that point.
6. On 7 December, prison staff informed Mr Clifford that he had an urgent CT scan appointment that afternoon. He declined this appointment in order to attend a legal visit he already had booked and signed a disclaimer to this effect. That afternoon, a prison GP reviewed Mr Clifford as an emergency case but noted that he was clinically stable. That evening, a nurse saw Mr Clifford in his cell and noted that he did not appear unwell.
7. On the morning of 8 December, a nurse saw Mr Clifford. She felt that a hospital admission was unnecessary but requested a GP review. Later that morning, a nurse saw Mr Clifford in his cell because he was too unwell to make a healthcare appointment. He told her that he had collapsed in the shower that morning but was not sure how long he had been unconscious. At midday, a prison GP reviewed Mr Clifford and asked the prison to call an emergency ambulance. At 12.45pm, an urgent but non-emergency ambulance was called. At 3.00pm, Mr Clifford was transferred to hospital. He was initially restrained but the restraints were removed in the ambulance after a review.

8. Mr Clifford was initially located on a standard ward. After a cardiac arrest, he was relocated to the intensive care unit. Over 9 December, he remained stable, but began to arrest during the evening. On 10 December, at 1.37am, Mr Clifford was pronounced dead.

Findings

Clinical care

9. The clinical reviewer concluded that, overall, the care Mr Clifford received was equivalent to that which he could have expected to receive in the community. His health issues were appropriately managed and he was referred to external specialists as required.
10. However, there was confusion with his medication being incorrectly labelled on at least two occasions, and it was clear that Mr Clifford was not taking his medication as prescribed.

Emergency response

11. We are concerned that there was both a delay in calling for an ambulance, and that an emergency ambulance was not called, as specifically requested by the prison GP.

Contact with Mr Clifford's family

12. We are satisfied that the prison acted sympathetically and diligently in its contact with Mr Clifford's daughter. The family liaison officers informed her in person of his death and continued to support her afterwards.

Escorts, security and restraints

13. Mr Clifford was initially restrained when he was taken to hospital but, after a review, restraints were removed in the ambulance prior to his admission. We are satisfied the prison acted appropriately in reviewing its earlier decision promptly.

Recommendations

- The Head of Healthcare at Littlehey should review pharmacy services to ensure that labelling errors on medication do not occur;
- The Head of Healthcare at Littlehey should ensure that there are effective processes to ensure that prisoners take their medication, and that staff monitor this; and
- The Governor and Head of Healthcare at Littlehey should ensure that staff respond with greater urgency and clarity to emergency situations.

The Investigation Process

14. 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. One prisoner responded and the investigator spoke to him during his visit to Littlehey.
15. The investigator visited Littlehey on 14 December 2017. He obtained copies of relevant extracts from Mr Clifford's prison and medical records. The investigator also interviewed two members of staff and a prisoner during this visit.
16. NHS England commissioned a clinical reviewer to review Mr Clifford's clinical care at the prison. During the week commencing 23 January, the investigator and the clinical reviewer jointly interviewed six members of staff.
17. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The investigator wrote to Mr Clifford's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked us to consider the clinical care Mr Clifford received at Littlehey. In particular, she asked:
 - whether Mr Clifford should have been referred sooner for his underlying condition;
 - whether he received the appropriate treatment; and
 - whether the deterioration in his health was properly monitored.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.
20. Mr Clifford's daughter received a copy of the initial report. Other than those points set out above, she did not raise any further issues or comment on the factual accuracy of the report.

Background Information

HMP Littlehey

21. HMP Littlehey in Cambridgeshire is a medium security prison housing approximately 1,200 men. A considerable proportion of the prison's population are men who have been convicted of sexual offences.
22. Northamptonshire Healthcare NHS Foundation Trust commissions healthcare services at Littlehey. Before April 2015, Cambridgeshire and Peterborough NHS Trust provided healthcare services. The prison healthcare centre is open from 7.30am to 7.00pm, 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. Lloyds Pharmacy provide medication services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Inspectors found that hospital appointments for prisoners were rarely cancelled but that risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

Independent Monitoring Board

24. 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 prison's working agreement with the local hospice to provide decent and dignified end of life care was recognised in the local hospital's Care Quality Commission report as an outstanding initiative. The IMB noted that end of life and audiology clinics had been introduced. It reported that the End of Life suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

25. Mr Clifford was one of three prisoners to die of natural causes that weekend, and the eighth over the previous year. There were no similarities between his death and these other ones.

Cardiac AL amyloidosis

26. Amyloids are proteins that build up in the body and replace the normal body tissue. When they replace the tissues in organs, this can lead to the failure of that organ. Cardiac amyloidosis is the name given to this condition when it affects the heart and is sometimes referred to as 'stiff-heart' syndrome. Its prognosis is generally very poor.

Key Events

27. On 28 April 2014, Mr Maxwell Clifford was convicted of sexual offences. On 2 May, he was sentenced to eight years imprisonment. He was initially sent to HMP Wandsworth but was transferred to HMP Littlehey on 13 May.
28. A nurse reviewed Mr Clifford at a health screen on his reception at Littlehey. She recorded his history of prostate cancer, and that he had had radiotherapy five years earlier. Mr Clifford was prescribed tamsulosin to treat his enlarged prostate gland. The nurse made no reference to cardiovascular disease but noted that Mr Clifford was also prescribed atorvastatin (used to lower cholesterol) and 10mg tablets of enalapril (to treat high blood pressure).
29. In June 2014, Mr Clifford was screened to check for prostate issues but no further action was found to be necessary. On 11 June, a nurse reviewed Mr Clifford due to his history of hypertension. She noted that his blood pressure was good but that his 10-year cardiovascular risk score was 21.85%. (This represents a high chance of a heart or circulation problem occurring within the next ten years.) Over the next few years, Mr Clifford had no relevant health concerns but had annual hypertension reviews, and regular prostate check-ups.
30. On 12 May 2017, a nurse conducted Mr Clifford's annual hypertension review. She noted that he occasionally experienced dizziness when getting up suddenly. The nurse advised Mr Clifford to monitor this and said they could reduce his enalapril dose if necessary, but that he should not do so of his own accord. She took blood tests, which proved unremarkable, and Mr Clifford continued to receive the same dosage, of 10mg, of enalapril.
31. On 26 July, a prison GP reviewed Mr Clifford. He noted that he was breaking up his enalapril tablets and only taking a third of the prescribed dose, so he reduced his dose to 2.5mg. Mr Clifford also reported getting short of breath following exertion over the previous few weeks. The GP noted that he had no chest pain or radiation of pain to the arm or neck. He suspected subclinical hypothyroidism (mild symptoms of an underactive thyroid) but said in interview that he did not suspect heart failure. The GP requested blood tests and an ECG to check for the root cause of these symptoms.
32. Mr Clifford had an ECG and, on 4 August, a prison GP noted that he had a first-degree heart block and should avoid strenuous exercise until reviewed by a GP. The next day, a GP reviewed Mr Clifford's blood results and noted that his brain natriuretic peptide (BNP) level was abnormally high. (BNP is a hormone released by the heart when it is stressed, often occurring during heart failure).
33. On 9 August, a prison GP discussed these results with Mr Clifford. He noted that his symptoms could be caused by heart failure and consulted a specialist cardiology registrar at the Royal Papworth Hospital. The registrar advised that Mr Clifford should be urgently referred to the cardiology department at the local Hinchingbrooke Hospital. He also prescribed perindopril (for high blood pressure and heart failure) and furosemide (to reduce swelling following heart failure). The GP issued the prescription and made the referral the same day.

34. On 16 August, Mr Clifford attended his cardiology appointment. The consultant referred him for a stress echocardiogram (where blood pressure and heart rhythms are monitored while the patient performs exercise). The consultant also prescribed aspirin (to thin his blood), bisoprolol (to slow his heart rate) and doubled Mr Clifford's atorvastatin dose to 40mg. On 25 August, Mr Clifford collected his regular 20mg dose of atorvastatin.
35. On 22 August, Mr Clifford's private GP wrote to a prison GP to express her concerns about his condition. She stated that she had seen Mr Clifford the previous day with his daughter, and felt his symptoms were indicative of heart failure. She stated that in her private practice, he would have had an exercise stress echo test followed by an angiogram. (A coronary angiogram uses a special dye, injected into the blood vessels of the heart, so these are visible by x-ray.) Mr Clifford's private GP asked the prison GP to contact her to discuss her concerns. There is no record that this happened.
36. On 23 August, a prison GP saw Mr Clifford after he reported as unwell and lightheaded over the weekend, particularly after exertion. He recorded that Mr Clifford's clinical observations were unremarkable and that he looked well. The GP advised him to seek a medical review if he felt unwell, rather than altering his medication himself. The GP took advice from the Cardiology Department at Hinchingsbrooke, and added clopidogrel to Mr Clifford's prescription (to reduce his risk of heart disease and stroke). The GP also discussed Mr Clifford's private GP's letter with Mr Clifford, and he consented to sharing a summary of his medical condition with her.
37. On 6 September, a prison GP reviewed Mr Clifford and noted that he was "taking all medication as prescribed apart from bisoprolol". Mr Clifford said that he felt this was making him feel faint and lightheaded. The GP recorded that he had none of these symptoms at the time, but agreed to stop the bisoprolol prescription and review this decision in two weeks.
38. On 13 September, a prison GP saw Mr Clifford following an abnormal liver function test result a week earlier. He placed Mr Clifford on the list for the next available liver ultrasound scan (USS). On 5 October, a nurse noted that the USS revealed some minor concerns, and advised to check for liver ascites (an accumulation of fluid). On 11 October, a prison GP reviewed these test results, and referred Mr Clifford to the Upper Gastrointestinal (UGI) Clinic.
39. On 27 September, a prison GP reviewed Mr Clifford. He noted that he had experienced a gradual increase in breathlessness but was fine when at rest and had no chest pain. He increased Mr Clifford's furosemide dose, but advised him to decrease this if he started to feel faint or lightheaded.
40. On 11 October, a prison GP reviewed Mr Clifford. Mr Clifford said that his daughter had spoken to a cardiologist who informed her that he had a 'stiff heart' syndrome rather than a 'silent MI' (a silent heart attack, with few symptoms). The GP stated that they were yet to receive the cardiologist's letter and were chasing this up.
41. The same day, a pharmacy technician noted that Mr Clifford had returned a box of 28 perindopril tablets which were incorrectly labelled. She recorded that they

were labelled as 2mg when in fact they were 8mg tablets. Mr Clifford told her that he nearly passed out after taking one, and realised the error.

42. On 25 October, a prison GP saw Mr Clifford and noted that his breathing was worsening after exertion, although was fine at rest. He recorded that Mr Clifford had no chest pains and did not experience dizziness on standing. He also noted that Mr Clifford was only taking 20mg of furosemide daily. The GP suspected worsening heart failure, and consulted a specialist cardiologist, who advised a staged increase in Mr Clifford's furosemide dose. The GP also noted that Mr Clifford's daughter had been chasing up a cardiac MRI which had been requested by the cardiologist at Papworth following the prison's referral.
43. On 27 October, a nurse saw Mr Clifford at a blood clinic. She noted that he had lost a significant amount of weight from his face, and was breathless while at rest during the appointment.
44. Later that day, a pharmacy technician noted that Mr Clifford had returned a box of 40mg atorvastatin tablets which were labelled as 20mg. He told her that this was the second medication error he had experienced.
45. On 30 October, a prison GP saw Mr Clifford and observed that his condition had neither deteriorated nor improved since increasing his furosemide dose. He noted that Mr Clifford was frustrated by the delayed assessment at Papworth and said he would chase up this referral. On 10 November, a prison GP reviewed Mr Clifford who reported that he felt worse than before. Mr Clifford said he was off his food, had twinges in his stomach and was increasingly lethargic. He added that his bowel habit had changed but that he had not noticed any blood in his stool. The GP made an urgent referral to the UGI clinic at Hinchingsbrooke.
46. On 13 November, a healthcare administrator received a phone call from someone who said they were calling on behalf of Mr Clifford's private GP. The caller said that his GP had seen Mr Clifford the day before and wanted to speak to a prison GP because she was concerned that "he was 'fading away' and that he wasn't receiving adequate care". The healthcare administrator informed the caller that she could not divulge any information relating to Mr Clifford but that she would ask the prison GP to give his private GP a call. There is no record that this happened.
47. On 23 November, Mr Clifford attended his UGI appointment at Hinchingsbrooke Hospital.
48. On 28 November, a prison GP received a letter from a consultant cardiologist ahead of Mr Clifford's upcoming CT scan. The cardiologist advised that Mr Clifford's furosemide dose should be reduced from 60mg to 40mg, and that his ACE inhibitors were suspended. (Angiotensin converting enzymes (ACE) cause the muscles to contract around blood vessels – inhibitors such as perindopril and enalapril slow the production of this enzyme, allowing the blood vessels to enlarge and reduce blood pressure.) The prison GP noted that this was discussed and enacted at a multidisciplinary team meeting.
49. On 1 December, Mr Clifford had an MRI scan at Papworth.

50. On 6 December, a prison GP reviewed Mr Clifford, who told him that he was increasingly short of breath, his leg swelling was worsening, and that he had to use a wheelchair to get to the healthcare unit. The GP noted that he had had a gastroscopy and a cardiac MRI at the hospital, and was waiting for a CT scan and an ECG. The GP observed that Mr Clifford had no chest pain, no abnormal lung sounds and maintained good air throughout. He did not consider Mr Clifford for an acute admission to hospital, and said in interview that his condition was consistent with natural deterioration. He added that Mr Clifford walked into the surgery from the waiting area. The GP later discussed Mr Clifford's care at a multidisciplinary team meeting, and noted that he might need an acute admission if his heart condition deteriorated. He added that nurses were going to monitor him on a daily basis.

The events of 7 December 2017

51. On 7 December, prison officers informed Mr Clifford that he had an urgent cardiology appointment for a CT scan that day. Mr Clifford told them that he would not be able to go because he already had a legal visit arranged for that afternoon. Mr Clifford signed a disclaimer stating that he was aware of the urgency of this appointment, and that he had freely chosen to miss it due to his legal visit.
52. That afternoon, a prison GP saw Mr Clifford as an emergency, after complaints of breathlessness, palpitations and nausea. He observed that Mr Clifford's condition was similar to the day before. In interview, the GP said that Mr Clifford "stated that he was back to his usual self", and that "his condition was stable clinically". He added that Mr Clifford mentioned taking a higher dose of his diuretic drugs on the advice of his private GP, despite the hospital advising a reduced dose. (Diuretics, or water pills, increase the amount of water and salt expelled from the body as urine). The GP noted that a hospital admission was unnecessary at this stage, but that he should be reviewed the following week.
53. That evening, two nurses saw Mr Clifford in his cell. In interview, one of them said that Mr Clifford was a little breathless but that he had walked to the door to let them in, and did not appear clinically unwell. She observed that Mr Clifford had a leg oedema (a build-up of fluid causing swelling). The next morning, she reviewed Mr Clifford, and noted that his leg was not as swollen as the previous evening, but that he had yet to get up. In interview, she said that she did not feel an acute hospital admission was necessary at that stage, but she requested a GP review.

Events of 8 December 2017

54. On 8 December at 11.10am, a nurse saw Mr Clifford in his cell after he was too unwell to attend the healthcare unit. She noted that he was sitting upright on his bed, his eyes were yellow in colour and his face was very thin. Mr Clifford told her that he had no appetite and had not yet eaten but had drunk some water. He then told her that he had collapsed that morning while having a shower. He said that one minute he was taking a shower and the next thing he remembered was being on the floor. He did not know how long he had been unconscious. Mr Clifford said that he felt okay when resting, but got light headed as soon as he

stood up. The nurse confirmed in interview that his observations were abnormal and beyond the limits set by the GP so she requested a GP review.

55. Shortly after midday, a prison GP reviewed Mr Clifford in his cell. She noted that he was clearly unwell and his clinical observations were poor. A nurse recorded that an ambulance was called at 1.15pm but, in interview, the GP said that this would have been 12.15pm. The GP asked the nurse to sit with Mr Clifford and perform half-hourly observations. The nurse remained with Mr Clifford and noted that he “remained chatty until the ambulance arrived”. At approximately 2.15pm, the GP reviewed Mr Clifford because the ambulance had not arrived. She noted that his observations were stable, and that it was better to await the ambulance than to make alternative arrangements.
56. The control log at the prison confirms that an ambulance was called at 12.45pm. At 2.16pm, the prison called again to chase this up, and the ambulance arrived at 2.19pm. The East of England Ambulance Service log records that the first call was made at 12.47pm, which was for an urgent, but non-emergency, ambulance. The Service documented that the ambulance arrived at 2.19pm, and stated that it aims to respond to such calls within 120 minutes.
57. At 3pm, Mr Clifford was taken to Hinchingsbrooke Hospital, accompanied by three officers. He was restrained with an escort chain. At 3.15pm, a prison manager authorised the removal of the restraints and this was done when the ambulance arrived at the hospital at 3.30pm.
58. On arrival at the hospital, Mr Clifford was assessed and initially located on a standard ward. Within a few hours, his condition took a turn for the worse and he had to be resuscitated. He was then moved to the intensive care unit where his condition improved. Mr Clifford remained well throughout 9 December, but in the early evening he took a further turn for the worse and again required resuscitation. He then recovered and, in interview, an officer said that he “was laughing and chatting about football and missing the scores”. Later in the evening, Mr Clifford suffered a cardiac arrest, and the emergency crash team attended to him again.
59. On 10 December at 1.37am, Mr Clifford was pronounced dead.
60. A consultant gastroenterologist wrote a letter, dated 7 December, which stated that Mr Clifford’s biopsies indicated amyloid deposits in his stomach. She added that this could indicate that the cardiac abnormality shown on his echocardiogram was due to amyloid deposits. After Mr Clifford’s death, a significant quantity of prescription medications were found in his cell. These were marked up for his use, but had not been taken.

Contact with Mr Clifford’s family

61. Mr Clifford’s next of kin was his daughter. On 8 December, shortly before going to hospital, Mr Clifford asked a prison GP whether she could let his daughter know he was in hospital. The GP said she could not do this personally but would pass on the message. Mr Clifford’s daughter was informed that he had been taken to hospital.

62. That afternoon, the prison asked two members of staff to act as Mr Clifford's family liaison officers (FLOs), if necessary. At 11.24pm, one of the FLOs informed Mr Clifford's daughter that her father's condition had deteriorated. Mr Clifford's daughter said she would head straight to the hospital but that it would take several hours due to its distance from her house. The FLO kept her updated during her journey. In the early hours of 9 December, the two FLOs met Mr Clifford's daughter and Mr Clifford's private GP.
63. Mr Clifford's condition had improved by the time his daughter arrived, and they spent some time together. After a few hours, she returned home, planning to return some days later. Mr Clifford's private GP had informed Mr Clifford's daughter that he was stable and safe, and that they would be briefed in full about his condition once he had been assessed by the registrar.
64. At 10.31pm on 9 December, after Mr Clifford suffered a further cardiac arrest, one of the FLOs informed his daughter, who requested an update from the hospital at midnight. At 1.52am, escort staff informed the FLO that Mr Clifford had died, but that the hospital was unable to contact his daughter. The two FLOs drove to Mr Clifford's daughter's house, through heavy snow, and at 4.40am, they informed her in person of her father's death.
65. The two FLOs continued to support Mr Clifford's daughter. They also liaised with her regarding how to handle the media interest in his death.
66. Mr Clifford's funeral was held on 10 January. The prison contributed to the cost in line with national guidance.

Support for prisoners and staff

67. After Mr Clifford's death, no formal debrief was held but the staff care team spoke to the officers involved with the bed watch for Mr Clifford, and offered their support. The care team also visited each of the wings where Mr Clifford had been located to offer support.
68. The prison posted notices informing other prisoners of Mr Clifford'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 Clifford's death.

Post-mortem report

69. The post-mortem concluded that Mr Clifford died from congestive cardiac failure. This is a chronic progressive condition that affects the pumping power of the heart muscles. This was caused by cardiac AL amyloidosis, which was in turn caused by plasma cell neoplasm, a disease which causes abnormal growth of plasma cells in bone marrow.

Findings

Clinical care

70. The clinical reviewer concluded that, overall, the care Mr Clifford received was equivalent to that which he could have expected in the community. Mr Clifford had an underlying condition which went undetected, but there is no indication that this would have been detected any sooner had he been living in the community. He was promptly referred for investigations into his heart condition, and was reviewed regularly in respect of this.
71. While we acknowledge that Mr Clifford's private GP had her own professional opinions about Mr Clifford's treatment, we are satisfied that GPs at Littlehey acted appropriately. They regularly consulted specialists and acted on their advice throughout. We recognise that both Mr Clifford and his private GP expressed their desire for him to be reviewed by specialists at Papworth but we are satisfied that it was appropriate for him to be initially referred to Hinchingsbrooke, not least as it was on Papworth's advice that he was referred to Hinchingsbrooke.
72. Littlehey confirmed that due to security considerations, it cannot disclose the details of medical appointments to prisoners in advance. It added that it was standard practice to inform prisoners on the day of an appointment, unless there was a need to prepare in advance, such as by fasting. We note that Mr Clifford missed an urgent appointment for a CT scan the day before his emergency admission to hospital, and recognise that he was only informed of this appointment on the day. However, we consider that he must have been aware that this medical appointment was due, given that his medication had been adjusted for over a week in anticipation of this scan. He was also given the option to prioritise this appointment over his legal visit, and signed a disclaimer to indicate that his decision was taken of his own free will. We are satisfied that the prison acted appropriately in respecting his decision.
73. However, we are concerned that on at least two separate occasions Mr Clifford's medication was incorrectly labelled. We make the following recommendation:
- The Head of Healthcare at Littlehey should review pharmacy services to ensure that labelling errors on medication do not occur.**
74. We are concerned that Mr Clifford did not take his medication as directed by GPs, in consultation with specialists at the hospital. We find that the prison could have done more to monitor his compliance with his medication, and to better inform him of the risks of not complying.
- The Head of Healthcare at Littlehey should ensure that there are effective processes to ensure that prisoners take their medication, and that staff monitor this.**
75. Following the issue of our initial report, we reviewed Mr Clifford's clinical care in the light of concerns raised by his daughter. We share the clinical reviewer's conclusion that these points do not affect our original findings, and that the points which were relevant to Mr Clifford's clinical care at Littlehey were addressed in

the initial report. We maintain that the care Mr Clifford received at Littlehey was equivalent to that which any ordinary member of the public could have expected in the community. We also recognise that many of the concerns Mr Clifford's daughter raised relate to the care he received at external hospitals. This is beyond the scope of our investigation.

Emergency response

76. When the prison GP saw Mr Clifford at midday on 8 December, she requested an emergency ambulance to take him to the hospital. However, this call was not placed for a further 30 minutes, and an emergency ambulance was not deployed. This resulted in an ambulance not arriving until approximately two hours after it had been requested. The Ambulance Service confirmed that their target time for urgent, but non-emergency, ambulances is 120 minutes but clearly if this call had been logged as an emergency, the response target would have been earlier still, and an ambulance should also have arrived sooner.
77. The recording of the ambulance call indicates that a 'blue-light' ambulance was requested, but following a telephone triage by the ambulance service, this was not logged as an emergency. We are concerned that there was a failure of clear communication between healthcare staff and the control room, which led to this call not being processed as an emergency as requested by the prison GP.
78. We are also concerned that the documenting of this call lacked clarity and accuracy. The control room log simply noted that an ambulance was requested, but not the nature or urgency of this call. The entry in Mr Clifford's medical notes records that the ambulance call was made at 1.15pm rather than 12.15pm as confirmed by the prison GP. This lack of clarity made it difficult to ascertain precisely where this breakdown in communication took place.
79. Given that he spent the next 36 hours being looked after in hospital, we cannot say whether an earlier response would have affected the outcome for Mr Clifford, however, we would have expected staff to have acted with greater urgency and communicated more clearly.

The Governor and Head of Healthcare at Littlehey should ensure that staff respond with greater urgency and clarity to emergency situations.

Contact with Mr Clifford's family

80. We are satisfied that the prison conducted their dealings with Mr Clifford's daughter diligently and appropriately. The family liaison officers informed his daughter in person, despite having to make the long journey to her house in the early hours of the morning and in very difficult driving conditions.
81. Mr Clifford's daughter also praised one of the escort officers for the compassion and care he showed to her father while he was at the hospital. She expressed the wish that the officer and the family liaison officers attended Mr Clifford's private funeral service.

Escorts, security and restraints

82. 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 of 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 such 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.
83. On 8 December, Mr Clifford was restrained when he was first transferred to hospital. These restraints were removed promptly following a review, prior to him entering the hospital. The prison manager has subsequently confirmed that staff applied Mr Clifford's standard escort conditions, which he signed. He added that he was not aware of the full circumstances of his escort at the time, and signed this risk assessment as a normal escort. Once he became aware that it was an emergency, the manager sent a message to the escorting staff to remove these restraints. While we are concerned that Mr Clifford was initially restrained, we are satisfied that these restraints were promptly removed when it became clear the situation was an emergency.
84. We also recognise that Mr Clifford was subject to a three-officer escort, but we are satisfied that the prison made this decision with Mr Clifford's welfare in mind, and the need to avoid any unwelcome media or other interest.

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