

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Raymond Proctor a prisoner at HMP Littlehey on 27 April 2019

**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 Raymond Proctor died of chronic obstructive pulmonary disease on 27 April 2019 at HMP Littlehey. He was 79 years old. I offer my condolences to Mr Proctor's family and friends.

The clinical reviewer was satisfied that the standard of healthcare Mr Proctor received at Littlehey was good and equivalent to that which 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.

**Elizabeth Moody**

**Deputy Prisons and Probation Ombudsman**

**October 2019**

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# Summary

## Events

1. On 12 January 2018, Mr Raymond Proctor was sentenced to seven years and four months in prison for sex offences. On 18 October, he was moved to HMP Littlehey.
2. Mr Proctor had several medical conditions including chronic obstructive pulmonary disease (COPD – an umbrella term for a group of serious lung conditions). The nurse who carried out Mr Proctor’s reception health screen noted that he was elderly, frail, became out of breath easily and had reduced mobility.
3. On 30 October, Mr Proctor had his annual COPD review. The nurse agreed a COPD clinical management plan with him. The following day, Mr Proctor said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
4. Between January and March 2019, Mr Proctor was admitted to hospital five times because of a deterioration in his condition. On 25 March, he was diagnosed with emphysema (damage to the air sacs in the lungs). A nurse noted that he now had end-of-life COPD.
5. On 27 April, Mr Proctor died in his cell.

## Findings

6. The clinical reviewer found that the care Mr Proctor received at Littlehey was equivalent to that which he could have expected to receive in the community. Mr Proctor’s COPD was assessed and reviewed in a timely manner. He was provided with social care and support. He had regular reviews for nutritional status, mobility and pain control.
7. We make no recommendations.

## The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Proctor's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Proctor's clinical care at the prison.
11. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.
12. One of the Ombudsman's family liaison officers, wrote to Mr Proctor's daughter to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. She did not respond to our letter.
13. We shared the initial report with the Prison Service. There was one factual inaccuracy and this report has been amended accordingly.

# Background Information

## HMP Littlehey

14. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.
15. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. 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

16. 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. They noted that lifelong conditions were effectively identified and that there was an appropriate range of clinics, led by specialist nurses. They found that hospital appointments for prisoners were rarely cancelled but that risk assessments for allowing prisoners to keep and administer their own medications were not always appropriately reviewed and recorded.

## Independent Monitoring Board

17. 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.
18. In its latest annual report for the year to January 2019, the IMB noted that almost 50% of prisoners at Littlehey were aged over 50 and almost 20% were aged over 65. The Board was positive about the standard of healthcare and social care. However, it was concerned at the limit imposed on the number of prisoners able to attend hospital appointments each day (four in the morning and four in the afternoon) and the impact this had on the provision of suitable healthcare for those requiring attendance at hospital. The IMB noted that around 25 hospital appointments per month were cancelled due to lack of availability of escort staff.

## Previous deaths at HMP Littlehey

19. Mr Proctor was the 18th prisoner to die at HMP Littlehey since April 2017. Of the previous deaths, 16 were from natural causes and one was self-inflicted.

## Key Events

20. On 12 January 2018, Mr Raymond Proctor was sentenced to seven years and four months in prison for sex offences and sent to HMP Bedford. On 18 October, he was moved to HMP Littlehey.
21. Mr Proctor had several medical conditions including chronic obstructive pulmonary disease (COPD – an umbrella term for a group of serious lung conditions including chronic bronchitis and emphysema), epilepsy and asthma. He also had skin cancer, osteoporosis (weak bones) and age-related frailty.
22. On 18 October, a nurse carried out Mr Proctor's initial and secondary health screens. She noted that Mr Proctor was elderly, frail, became out of breath easily and had reduced mobility. She completed a falls risk assessment and noted that he had an appointment at the chest clinic at a hospital on 28 January 2019.
23. On 30 October, a nurse carried out Mr Proctor's annual COPD review. He refused to have chest physiotherapy because he said that he did not feel well enough to do the exercises. His blood oxygen saturation was slightly low (95%). She noted that his breathlessness on the Medical Research Council (MRC) scale was 3 (walks slower than most people on the level, stops after a mile or so, or stops after 15 minutes walking at own pace) due to his reduced mobility rather than his respiratory problems. She noted that he had good inhaler technique. The nurse agreed a COPD clinical management plan with Mr Proctor and gave him a British Lung Foundation booklet.
24. On 31 October, Mr Proctor said that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
25. That same day, a pharmacist noted that Mr Proctor was prescribed antibiotics and steroids because of a flare up of his COPD.
26. On 13 November, a nurse noted that Mr Proctor had an appointment on 26 November for a computerised tomography (CT) scan of his chest (a scan that uses X-rays and a computer to create detailed images of the inside of the body) at the hospital. There is no record of the result of the scan.
27. On 2 January 2019, a prison GP saw Mr Proctor because he said he was chesty, had a cough and was short of breath. He prescribed him antibiotics and steroids.
28. On 24 January, a prison GP saw Mr Proctor because his mobility was much worse over the last three days and he looked frail. He noted that he should be treated for a urinary tract infection and an exacerbation of COPD. He said that if his condition deteriorated he should go to hospital. At 4.40pm, a nurse said that his condition had deteriorated further and arranged for a non-emergency ambulance to take Mr Proctor to hospital. He was not restrained for this hospital visit or for any subsequent visits.
29. Mr Proctor had treatment for a possible lower respiratory tract infection. He also had a chest X-ray which showed a 'suspicious lesion' on his lungs. Hospital staff gave him antibiotics and steroids. On 27 January, he went back to Littlehey.

30. On 29 January, a prison GP saw Mr Proctor who said that he was feeling good. His blood oxygen saturation was normal (96%) and she noted that his chest was clear.
31. On 5 February, a prison GP decided that Mr Proctor should go to hospital because he had difficulty standing and had pain in his right hip. Staff called an ambulance and paramedics took him to hospital. The appointment booked for Mr Proctor at a hospital was cancelled. Hospital staff did a CT scan which showed that he did not have a hip fracture and referred him to the orthopaedic team.
32. On 11 February, the Head of Healthcare, saw Mr Proctor in hospital. He noted that he was going to have another X-ray, that he had not been out of bed while he was in hospital and that he was having social care twice a day. On 13 February, a clinical services manager spoke to a physiotherapist at hospital who said that Mr Proctor's mobility was much worse and that he needed a hoist to get him out of bed. She said that before he could go back to Littlehey she needed the reablement team (a sub-contracted company who manage social care) to carry out a full assessment so that the correct equipment was ready.
33. On 14 February, the clinical services manager held a multidisciplinary team meeting. The disability liaison officer, said that she would complete a Social Care Adult Risk Framework (SCARF) assessment for the reablement team. The clinical services noted that they had to get a hoist because, they did not currently have one at the prison, that they would have to increase Mr Proctor's social care and arrange for him to be moved to a larger cell so that he could have a hospital bed and the hoist in the room.
34. On 19 February, the clinical services manager held another multidisciplinary team meeting and said that social care staff saw Mr Proctor in hospital to complete the assessment. On 21 February, an occupational therapist went to Littlehey and looked at the cell which was ready to take Mr Proctor. She said that she would order a profiling bed, an air mattress, a standing hoist and thoracic sling, a canter lever table and a soft chair and raisers. On 26 February, Mr Proctor went back to Littlehey.
35. On 3 March, Mr Proctor's health deteriorated. He looked very frail and refused to get out of bed. At 3.38pm, a nurse noted that he was grey in colour, that his breathing was rapid and that he had low blood oxygen saturation (88%) which went up to (92%) when they gave him oxygen. He was slow to respond to questions and had a rattling chest. The nurse said that he should go to hospital. Staff called an ambulance and paramedics took him to hospital.
36. Mr Proctor recovered in hospital and on 5 March, he went back to Littlehey. Two nurses saw him in his cell. He was sat up in bed and looked comfortable and well. On 14 March, a nurse saw Mr Proctor because he had fallen on the floor. He told her that he had pain in his hip. His condition worsened during the morning and his blood pressure was low so the nurse asked for an ambulance and he went to hospital.
37. On 18 March, hospital staff said that Mr Proctor was ready to go back to Littlehey but they were concerned that healthcare staff at Littlehey would not be able to meet his care needs. The clinical services manager went to the hospital and

spoke to a ward nurse manager who said that Mr Proctor did not want to do anything himself and was reluctant to get out of bed. She arranged for rails to be fitted to his bed and for social care staff to see him four times a day. She arranged with prison staff for him to have a buddy (a prisoner who assists another prisoner in their daily life) to give him drinks every hour to prevent him getting dehydrated.

38. On 20 March, Mr Proctor went back to Littlehey.
39. On 21 March, a prison GP updated Mr Proctor's medication to include carboceisine for COPD and an antibiotic for chest infections. Later that day a prison GP saw him because he had a coughing fit, he went blue and his blood oxygen saturation was low (83%). Mr Proctor's condition did not improve. When a nurse went to see him to dress his sores, he coughed large amounts of sputum so she arranged for him to go to hospital.
40. On 25 March, a nurse spoke to a palliative care consultant who said that scans showed that Mr Proctor did not have lung cancer but emphysema (damaged air sacs in the lungs). She said that he was no longer on oxygen or nebulisers.
41. The following day Mr Proctor went back to Littlehey. The nurse noted that he now had end-of-life COPD. She noted that he was very bright and joked with his carers.
42. On 5 April, a prison GP saw Mr Proctor and noted that he was cachectic (end-of-life) but answered questions sensibly and quickly. He understood that he was slowly getting weaker and frailer and said that he did not want to go back to hospital and wanted to stay in prison or go to a hospice. The prison GP said that she would speak to another GP about going to the hospice.
43. On 11 April, a prison GP saw Mr Proctor and felt that he had lost a large amount of weight. She said that he did not want to eat even though he was offered a variety of food. She prescribed him buprenorphine for pain relief.
44. On 15 April, a nurse spoke to Mr Proctor about an end-of-life care plan. The nurse completed the gold standards framework (GSF- to enable earlier recognition of patients with life limiting conditions to plan ahead to live as well as possible to the end). He told her that he was comfortable and not in any pain. The acting Head of Offender Management in Custody, agreed that he could have his cell door open 24-hours. On 21 April, a nurse did a psychological and emotional care plan.
45. On 27 April, Mr Proctor died. A prison GP recorded that he died of end-of-life COPD.

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

46. On 8 March, the head of safer custody, appointed an officer as the family liaison officer (FLO) and a chaplain as the deputy family liaison officer.

47. When Mr Proctor first arrived in prison, he did not give any next of kin details. After he was appointed as family liaison officer, the FLO saw Mr Proctor who told him that he wanted his daughter to be his next of kin but he had no telephone number for her. He found a telephone number for her in Mr Proctor's mobile telephone (which was in the prison's property store).
48. On 15 April, the FLO telephoned Mr Proctor's daughter and told her that he was very unwell. She said that she did not want to visit him but asked to be told when he died.
49. On 28 April, an officer telephoned Mr Proctor's daughter and told her that he had died. He offered his condolences. The following day, on his return to work, The FLO telephoned Mr Proctor's daughter and offered his condolences.
50. Mr Proctor's funeral took place on 28 May, and Littlehey contributed to its cost in line with national instructions.

### **Support for prisoners and staff**

51. After Mr Proctor's death, the Head of Offender Management, ensured that the staff who were with Mr Proctor when he died were offered the support of the staff care team.
52. The prison posted notices informing other prisoners of Mr Proctor'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 Proctor's death.

### **Cause of death**

53. There was no post-mortem examination. A prison GP recorded that Mr Proctor died of end-of-life COPD.

# Findings

## Clinical care

54. The clinical reviewer was satisfied that the standard of clinical care Mr Proctor received at HMP Littlehey was equivalent to that which he could have expected to receive in the community.
55. Mr Proctor was provided with social care and support which was reviewed and increased as needed. He had regular reviews for nutritional status, mobility and pain control. Healthcare staff frequently spoke to hospital staff, a palliative care consultant, health and social care agencies.
56. Despite frequently going to hospital in the months before he died, healthcare and hospital staff made sure that Mr Proctor's cell had a hospital bed, mattress, hoist and furniture to make him comfortable. In the weeks before he died, his cell door was unlocked 24-hours so that healthcare staff could see him at all times. The clinical reviewer said that the cell was suitable for his needs.

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