

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Duley, a prisoner at HMP Littlehey, on 5 June 2020

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 Russell Duley died of heart failure caused by coronary artery disease on 5 June 2020 while a prisoner at HMP Littlehey. He also had pneumonia and chronic lung disease which contributed to but did not cause his death. He was 58 years old. I offer my condolences to his family and friends.

The clinical reviewer concluded that the clinical care that Mr Duley received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community. We have made no recommendations.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2021

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Summary

Events

1. On 21 March 2014, Mr Russell Duley was sentenced to 14 years in prison for sex offences. On 26 May 2016, he was transferred to HMP Littlehey.
2. On 31 October 2016, Mr Duley had a heart attack. He went to hospital and hospital staff gave him a stent (a procedure to widen blocked or narrow coronary arteries).
3. On 29 April 2020, Mr Duley fell over in the shower. He had superficial bruising to his right leg, behind his knee, and swelling to his ankle. The bruising to Mr Duley's leg worsened and on 11 May, a prison GP sent him to hospital where an x-ray showed that he had fractured his leg. On 14 May, he had an urgent ultrasound scan to check whether he had a deep vein thrombosis (DVT). (He did not.) On 21 May, a prison GP saw that Mr Duley's right thigh was bruised, swollen, painful, hot to touch and diagnosed cellulitis (a bacterial infection under the skin) and prescribed him antibiotics.
4. On 3 June, a prison GP saw Mr Duley who said that he had had another fall. The GP noted that his blood pressure was low and that he was anaemic. The GP arranged for Mr Duley to have urgent blood tests, the results of which were abnormal. The following morning, he was sent to Hinchingsbrooke Hospital. Mr Duley had a blood transfusion, but his red blood cell levels did not significantly improve. Hospital staff decided to send him to Addenbrookes Hospital for a CT scan.
5. Just before Mr Duley left Hinchingsbrooke Hospital, he had a cardiac arrest. Hospital staff transferred him to Addenbrookes Hospital on 5 June, where he died shortly after arrival of heart failure.

Findings

6. The clinical reviewer concluded that the clinical care that Mr Duley received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community.
7. After Mr Duley fell over in the prison shower, staff appropriately arranged for a social care assessment. Although Mr Duley declined support, he was given a shower mat and grab rails were fitted to his shower.
8. Mr Duley was sent to hospital as soon as possible when he had abnormal blood test results two days before his death.
9. We make no recommendations.

The Investigation Process

10. 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.
11. The investigator obtained copies of relevant extracts from Mr Duley's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Duley's clinical care at the prison. They jointly interviewed two members of staff by video meeting on 7 July.
13. We informed HM Coroner for Cambridgeshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. The Ombudsman's family liaison officer wrote to Mr Duley's next of kin to explain our investigation. They had no specific questions.
15. We shared the initial report with Mr Duley's next of kin. She did not respond.
16. We shared the initial report with the prison service. There were no factual inaccuracies.

Background Information

HMP Littlehey

17. 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.
18. 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

19. The most recent inspection of HMP Littlehey was in July to August 2019. Inspectors reported that healthcare provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. They noted that innovative means of increasing secondary care consultation slots, such as Skype, were being introduced where demand outstripped escort availability.

Independent Monitoring Board

20. 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 2020, the IMB reported that the Governor and senior management team had spent time and effort to deal with a range of structural and facilities issues which continued to undermine the morale of prisoners and staff. They noted that healthcare provisions were of generally good quality but were restricted on a fortnightly basis because of staff training and limited by the number of hospital appointments that could be scheduled each day.

Previous deaths at HMP Littlehey

21. There were 16 deaths from natural causes (three of which were related to COVID-19) and one self-inflicted death at HMP Littlehey in the two years before Mr Duley's death. There has been one self-inflicted death at Littlehey since Mr Duley's death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

22. On 5 February 2014, Mr Russell Duley was convicted of sex offences and remanded into custody. On 21 March, he was sentenced to 14 years in prison. On 26 May 2016, he was transferred to HMP Littlehey.
23. Mr Duley had haemochromatosis (where too much iron is absorbed and damages the body's organs over time), poor mobility and hearing difficulties. In October 2016, he was moved to J wing, for elderly prisoners who need support.
24. On 31 October, Mr Duley had a heart attack, and was sent to hospital, where he had a stent procedure.

2020

25. On 9 March 2020, Mr Duley was sent to hospital for an MRI scan of the brain because he had severe daily headaches. The scan showed that Mr Duley had chronic ischaemic changes (damage to small blood vessels) and strokes (reduced blood flow) in the brain. Hospital staff gave him migraine headache information and advice about his lifestyle and medication.
26. On 29 April 2020, a nurse saw Mr Duley after he fell over in the shower. She saw that he had superficial bruising on his right leg, behind his knee, and swelling to his ankle. She gave him pain relief medication. On 8 May, a nurse saw Mr Duley in his cell and saw that the bruising had travelled down his leg which was swollen. He told her that he could not stand on his foot. She gave him paracetamol and told him to rest and put his foot up to reduce the swelling.
27. On 11 May, a prison GP saw Mr Duley who said that he had pain in his calf which was tender and swollen. The prison GP sent him to hospital for an x-ray which showed that he had a fracture in his right fibula (lower leg bone) near to the knee. The following day, Mr Duley returned to Littlehey.
28. On 14 May, Mr Duley went back to hospital for another x-ray and an urgent ultrasound scan as there was concern that he might have a DVT (a blood clot in the deep veins of the leg). He did not have a DVT. Hospital staff told him that the fracture would heal in four to six weeks and gave him exercises for his knee and ankle.
29. On 21 May, a prison GP saw Mr Duley whose right thigh was very bruised, swollen, painful and hot to touch. The prison GP diagnosed cellulitis and prescribed antibiotics.
30. On 2 June, a prison GP saw Mr Duley who told him that his leg was still very painful. The prison GP noted that his leg was bruised all the way to the groin, that he was not elevating his leg and that he felt generally unwell. Mr Duley was able to move his toes and the prison GP saw that blood was flowing to his foot. The prison GP arranged for blood tests.
31. On 3 June, a prison GP saw Mr Duley who said that he had had another fall and felt dizzy. The prison GP noted that his systolic blood pressure was low and that he was anaemic, and he arranged for urgent blood tests. The test results were worrying according to an out-of-hours doctor who advised that Mr Duley needed

to go to hospital. Mr Duley told prison staff that he refused to go and signed a disclaimer.

32. The following morning, a nurse spoke to prison staff and persuaded Mr Duley to go to hospital. He was sent unrestrained to Hinchingsbrooke Hospital, where he had a blood transfusion. His red blood cell levels did not significantly improve, and hospital staff decided to send him to Addenbrookes Hospital for a CT scan. Just before he was transferred on 5 June, he had a cardiac arrest. He died at 7.20am soon after he arrived at Addenbrookes Hospital.

Contact with Mr Duley's family

33. On 5 June 2020, the Head of Safer Custody, appointed a Custodial Manager (CM) as the family liaison officer (FLO) and an officer as the deputy family liaison officer.
34. At 7.45am on 5 June, the FLO telephoned Mr Duley's next of kin (in accordance with national instructions on managing the risk of COVID-19 in prisons) but she did not answer. At the FLO's request, the police broke the news of Mr Duley's death to his next of kin that afternoon. The FLO also offered them his condolences. Mr Duley's funeral took place on 28 June. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

35. After Mr Duley's death, the Head of Residence debriefed the staff who were at the hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
36. The prison posted notices informing other prisoners of Mr Duley'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 Duley's death.

Post-mortem report

37. A post-mortem examination established that Mr Duley died of decompensated congestive cardiac failure (a change in the heart which leads to its inability to work normally). This was caused by atherosclerotic coronary artery disease (a narrowing of the arteries). He also had pneumonia and chronic lung disease which contributed to but did not cause his death.
38. The pathologist noted that in his opinion, Mr Duley's fall and fracture did not directly relate to his death.

Findings

39. The clinical reviewer concluded that the clinical care that Mr Duley received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community.
40. After Mr Duley fell over in the shower, prison staff appropriately arranged for a social care assessment to be carried out. Mr Duley refused assistance and said that he could move around independently. However, he was given a shower mat and had grab rails fitted because he was afraid of slipping in the shower.
41. Mr Duley was appropriately sent to hospital as soon as possible after he had very abnormal blood test results two days before his death.
42. We found that because of restrictions due to the COVID-19 pandemic, healthcare staff were not holding clinics in the healthcare department and were instead seeing prisoners in their cells. Healthcare staff did not therefore have ready access to prisoners' medical records. Although it did not affect Mr Duley's care, an entry in Mr Duley's medical records about an event that happened on 3 June was not entered in his medical records until 9 June, which is not in line with the contemporaneous record keeping code. We were told that a healthcare initiative is now being implemented at Littlehey to enable healthcare staff to view and update prisoners' medical records on hand-held computers when they are not in the healthcare department. The clinical reviewer has made recommendations about this issue which the Head of Healthcare will need to address.

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