Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nicholas Cordery, a prisoner at HMP Littlehey, on 6 January 2021

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.

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 Nicholas Cordery died on 6 January 2021, of acute pancreatitis and cholangitis (inflammation of the bile duct) while a prisoner at HMP Littlehey. Mr Cordery was 71 years old. I offer my condolences to Mr Cordery's family and friends.

Mr Cordery had limited contact with healthcare services at Littlehey. When he was seen on 1 January 2021, he said he felt very unwell but had not wanted to bother anyone. Mr Cordery was assessed promptly and transferred to hospital following a deterioration in his physical health. It is disappointing that, while Mr Cordery was not restrained in the ambulance to hospital, his records did not clearly document when restraints were later used for compliance while he was in hospital, or whether alternative options were considered.

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 **June 2021**

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Summary

Events

1. In September 2012, Mr Nicholas Cordery was convicted of sexual offences and received an indeterminate sentence for public protection (IPP) with a minimum tariff of 5 years 6 months. He transferred to HMP Littlehey on 24 May 2018.

2. Mr Cordery had ischaemic heart disease, high cholesterol and hypertension but refused to take medication for these conditions. He had little contact with healthcare staff while at Littlehey. From March 2020, he lived in the prison's COVID-19 shielding unit because of his ongoing health issues.

3. On 1 January 2021, Mr Cordery was seen by healthcare staff after officers reported that he was unwell. He was shaking, his skin was yellow and he reported abdominal pain and vomiting. After assessment, Mr Cordery was taken to hospital by ambulance. He was escorted by two officers and restraints were not used.

4. Over the next few days, Mr Cordery behaved aggressively and assaulted hospital staff and the escorting officers. He had no history of aggressive behaviour and hospital staff thought that his behaviour was a side effect of his medical condition. Varying levels of restraints were used, from an escort chain to double handcuffs, to manage him.

5. Early on 5 January, Mr Cordery became disorientated and fell over while walking to the toilet. Restraints were briefly removed while hospital staff assisted him, and then replaced shortly afterwards. Mr Cordery's handcuffs were removed at 6.45pm that day for surgery. Afterwards, he was taken to the Intensive Treatment Unit (ITU) for recovery and restraints were not reapplied.

6. His condition deteriorated and he died at 9.05am the following morning, 6 January.

Findings

Clinical care

7. Mr Cordery had a number of long-term health conditions for which he refused treatment. The clinical reviewer found that healthcare staff attempted to manage these conditions in line with national guidance. She considered that the care Mr Cordery received in prison was equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer considered that healthcare staff acted promptly on 1 January and ensured that Mr Cordery was transferred to hospital with appropriate urgency, following a deterioration in his physical health.

Restraints

9. We are concerned that record-keeping was not accurate so it is difficult to establish the level of restraint during Mr Cordery's time in hospital or what alternatives were considered.

Recommendations

- The Governor should ensure that the use of restraints is properly documented and a senior manager should discuss the prisoner’s management with hospital staff to ensure alternative options are explored when relevant, and record the outcome of that discussion.

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.

11. He obtained copies of relevant extracts from Mr Cordery’s prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Cordery’s clinical care at the prison.

13. 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.

14. One of the Ombudsman’s family liaison officers contacted Mr Cordery’s sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any questions but asked to receive a copy of this report.

15. 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.

Background Information

HMP Littlehey

16. 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.

17. 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 (HMIP)

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

19. HMIP also undertook a short scrutiny visit in June 2020, looking at the care of prisoners during the COVID-19 pandemic. Inspectors commented that Littlehey had taken swift action to control the spread of the virus when there was an outbreak at the prison in March 2020, but that when infection rates reduced and other prisons started to ease restrictions, Littlehey were slow to follow, still providing a limited regime for prisoners.

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 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. Mr Cordery was the 20th prisoner to die at Littlehey since January 2019. All but one of the previous deaths was from natural causes. There were no similarities between the previous deaths and Mr Cordery's.

COVID-19 (coronavirus)

22. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

23. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high

risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)

24. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

25. While Mr Cordery's death was not related to COVID-19, due to pre-existing health conditions, he chose to self-isolate to reduce the risk of catching the virus. He was also subject to restrictions put in place to stop the spread of the disease.

Key Events

26. On 23 November 2011, Mr Nicholas Cordery was remanded to custody for sexual offences, and sent to HMP Winchester. In September 2012, he was convicted and received an indeterminate sentence for public protection (IPP) with a minimum tariff of 5 years 6 months. Mr Cordery transferred to HMP Isle of Wight in April 2013, before moving to HMP Littlehey on 24 May 2018.

HMP Littlehey

27. During an initial health screen, Mr Cordery said he had had depression, alcohol dependency (while in the community), ischaemic heart disease, high cholesterol and high blood pressure.

28. Mr Cordery had little contact with healthcare staff while at Littlehey. He always refused to take medication for his medical conditions and said he had no immediate healthcare concerns. In March 2020, Mr Cordery agreed to isolate in line with the healthcare team's COVID-19 guidance, due to his ongoing health conditions. He moved to the prison's shielding unit.

29. On 1 January 2021, a prisoner told an officer that Mr Cordery was unwell. Mr Cordery was shaking and his skin appeared yellow. He said he had abdominal pain, his urine was dark and he had vomited earlier in the day, but that he had not wanted to bother anyone. A nurse examined Mr Cordery and recorded his pulse and temperature as high. After consulting a doctor, Mr Cordery was taken to Hinchingbrooke Hospital by ambulance. He was escorted by two officers, but not restrained. Following a review by hospital staff, Mr Cordery was diagnosed with sepsis and admitted as an inpatient.

30. At 3.15am on 3 January, escorting officers restrained Mr Cordery with a single handcuff when he became confused, agitated and tried to discharge himself from hospital. Mr Cordery hit a nurse when she tried to take his blood pressure. Prison records show that Mr Cordery was normally polite and compliant, with no history of violence. Hospital staff suggested that Mr Cordery's condition may have caused a change in his behaviour and a hospital doctor confirmed that Mr Cordery did not have mental capacity. At 7.10am, after review by a custodial manager, the handcuffs were removed and replaced with an escort chain.

31. At 8.30am, escort officers put Mr Cordery in double handcuffs after he assaulted a prison officer by punching him in the face. (Double cuffing is when the prisoner's hands are handcuffed in front of them and one wrist is attached to a prison officer by an additional set of handcuffs.) An officer contacted the prison and a custodial manager agreed the level of restraint.

32. A custodial manager visited the hospital and at 9.50am it was agreed that handcuffs could be replaced by an escort chain, as a third officer would be joining the escorting officers at the hospital to assist.

33. According to hospital records, Mr Cordery did not have the mental capacity to make decisions about his care. Prison records show that, at roughly 1.45pm, a custodial manager at the hospital spoke to another manager about using force to help hospital staff administer medication. Nurses said that as "he had been

deemed medically incapable he could be sedated". Officers used double handcuffs and staff recorded that Mr Cordery placed his hands into the cuffs without resistance.

34. At 6.45pm on 4 January, the level of escort was reviewed and it was decided that only two officers needed to stay with Mr Cordery. Mr Cordery was still restrained and there were no further reported issues with his behaviour.

35. At about 2.40am on the morning of 5 January, officers helped Mr Cordery to walk to the toilet. He became disorientated and fell over. The officers removed the handcuffs to allow nurses to help him. Records show that officers used handcuffs again once he was in a stable condition.

36. Officers removed Mr Cordery's handcuffs at 6.45pm when he went into surgery. Following surgery Mr Cordery was taken to the Intensive Treatment Unit (ITU) for recovery. Officers were not allowed to remain with Mr Cordery in the ITU due to COVID-19 restrictions and he was not restrained.

37. Mr Cordery's condition deteriorated and he died at 9.05am the following morning, 6 January.

Contact with Mr Cordery's family

38. The prison's family liaison officer (FLO) contacted Cambridgeshire police at 9.30am on 6 January when Mr Cordery died. The prison did not have contact details for his sister and asked the police to help make contact. Avon and Somerset police (local to Mr Cordery's sister) spoke to Mr Cordery's niece at 12.50pm the same day.

39. The FLO contacted Mr Cordery's sister the following day, 7 January. He offered support and answered some questions she had. The prison contributed to the funeral cost in line with national policy.

Support for prisoners and staff

40. After Mr Cordery's death, support was offered to prison staff in attendance at the hospital when he died.

41. The prison posted notices informing other prisoners of Mr Cordery'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 Cordery's death.

Post-mortem report

42. The post-mortem report found that Mr Cordery died from acute pancreatitis (a condition where the pancreas becomes swollen over a short period of time) and cholangitis (inflammation of the bile duct), caused by gallstones. He also had heart disease which contributed to but did not cause his death.

Findings

Clinical Care

43. Mr Cordery had limited contact with prison healthcare at Littlehey. He had a number of long-term health conditions but declined to take medications to treat them. The clinical reviewer noted appropriate assessments of long-term conditions and concluded that the prison's healthcare team attempted to manage these in line with national guidance, taking into account his mental capacity at all times. Mr Cordery was appropriately advised to shield in line with NHS England's guidance at the time.

44. Acute pancreatitis is a condition where the pancreas becomes swollen over a short period of time. The clinical reviewer was satisfied that healthcare staff liaised with secondary services and that Mr Cordery was transferred to hospital promptly on 1 January, following a sudden deterioration in his physical health.

45. Having reviewed the clinical care extended to Mr Cordery, the clinical reviewer is of the opinion that Mr Cordery's overall care was equivalent to the care he could have expected to receive in the community.

Restraints

46. When Mr Cordery was taken to hospital on 1 January 2021, he was assessed as low risk to others, taking into account his medical condition at the time of the assessment. He was escorted by two officers and restraints were not used.

47. When Mr Cordery became aggressive and assaulted hospital and prison staff, the escort officers used varying levels of restraints, from double handcuffs to a single escort chain, to manage this behaviour. Mr Cordery had no history of violent behaviour and hospital staff said that he lacked capacity, and the change in his behaviour was probably due to his medical condition.

48. The record-keeping related to Mr Cordery's restraints was poor. We consider that a senior manager should have spoken to hospital staff about the options to control Mr Cordery's behaviour, including the use of restraints and sedation, and documented the outcome of that conversation. We are also concerned that risk assessments were not always updated by prison staff and it is not always clear from the records when restraints were used.

49. We make the following recommendation:

    The Governor should ensure that the use of restraints is properly documented and a senior manager should discuss the prisoner's management with hospital staff to ensure alternative options are explored when relevant, and record the outcome of that discussion.

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