Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Little, a prisoner at HMP Isle of Wight, on 21 October 2020

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*

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 Steven Little, who was 70 years old, died in hospital from pneumonia on 21 October 2020, while a prisoner at HMP Isle of Wight. I offer my condolences to Mr Little's family and friends.

Mr Little had several serious health conditions and arrived at Isle of Wight with significant medication prescribed for these. He was allowed to hold his medication in possession. However, in June 2020, staff discovered a vast hoard of medicines in his cell. This included warfarin which was prescribed to prevent dangerous blood clots.

Mr Little's non-compliance with his medication had unfortunate consequences. On 3 July, he was admitted to hospital with a blood clot in his leg and on 4 July, his lower left leg was amputated. His health deteriorated rapidly from this point and he became increasingly confused. Mr Little returned to hospital on 16 October, and he died there from pneumonia on 21 October.

The clinical reviewer concluded that, with the exception of the medication compliance issue, the standard of Mr Little's clinical care was equivalent to that which he could have expected to receive in the community. This follows several other recent PPO investigations at Isle of Wight in which hoarding of medication was a factor.

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 **October 2021**

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Summary

Events

1. On 13 September 2019, Mr Steven Little was sentenced to 12 years imprisonment for sex offences. On 19 November, he was sent to HMP Isle of Wight.

2. Mr Little had several serious health conditions including heart disease, diabetes and hypertension (high blood pressure).

3. In June 2020, Mr Little had a sudden deterioration in his health, and it was discovered that there was a large stockpile of medication in his cell which he should have taken. This included warfarin which was prescribed to prevent dangerous clots in his blood.

4. On 26 June, Mr Little was sent to hospital where he underwent treatment for atrial fibrillation (AF - a heart condition which causes it to beat irregularly) and a urinary tract infection (UTI). He returned to the prison two days later with a suggestion from the hospital that he be referred to the hospital vascular team for investigation of problems with his legs.

5. For the next few days Mr Little complained about painful legs and said he could not stand up. On 3 July, concerns about the circulation in his left leg resulted in him being sent back to hospital for assessment. His condition deteriorated rapidly and on 4 July, his lower left leg was amputated above the knee because he had developed a blood clot.

6. Mr Little returned to prison on 4 August, but his health continued to deteriorate and he was often confused and frequently rang his cell bell for staff assistance. Hospital staff had raised the possibility of dementia, but an anticipated assessment by the Isle of Wight Memory Service at the hospital was not possible because of COVID protocols. An assessment at the prison when he returned there was not possible either, as at that time there was no contract in place between the Practice Plus Group and the Isle of Wight NHS Memory Service.

7. On 4 October, Mr Little was taken to hospital where he was treated for heart failure and pneumonia. He returned to prison on 9 October, but was taken back to hospital again on 16 October. He died there on 21 October.

8. A post-mortem examination showed that Mr Little died from pneumonia caused by heart failure.

Findings

9. The clinical reviewer concluded that, with the exception of the medication compliance issue, the care that Mr Little received at Isle of Wight was equivalent to that which he could have expected to receive in the community.

10. Until June 2020, Mr Little kept his medication in his cell, and despite assurances to staff, he was not taking his medication as prescribed. The clinical reviewer considered that Mr Little's non-compliance with his medication had a significant role in the deterioration of his health.

11. Clues about Mr Little's non-compliance with his medication were either missed or not followed up quickly enough, although the exceptional circumstances created by the COVID-19 pandemic had a bearing on this.

12. Mr Little assured staff that he was taking his medication and did not explain why he had not done so when his hoarding was discovered in June 2020. Although he became increasingly confused after that time, he had not presented as having dementia prior to his amputation in July, when hospital staff raised the question.

13. It would have been desirable for Mr Little to have been assessed by the Memory Services, but this was not possible at the hospital because of COVID isolation protocols, or at the prison because Isle of Wight did not have any provision at the time. It is a concern that with a significant elderly population at the prison, there was no access to the Memory Service for more than a year.

Recommendations

- The Head of Healthcare should consider ways to assess medication compliance promptly and frequently in prisoners, especially in those with 'in possession' status and who are on medications with a narrow therapeutic range, such as warfarin.
- The Head of Healthcare should consider an auditing protocol for medications with narrow therapeutic margins (such as warfarin, lithium, and methotrexate) to ensure the local operating procedure on these is applied as intended.
- The NHS Healthcare Commissioner should satisfy themselves that prisoners at Isle of Wight will continue to have appropriate access to memory services in the future.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Isle of Wight informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Little's prison and medical records.

16. NHS England commissioned a clinical reviewer to review Mr Little's clinical care at the prison.

17. The investigator interviewed three members of staff with the clinical reviewer in November and December 2020. The interviews were conducted by telephone due to the coronavirus restrictions in place.

18. We informed HM Coroner for the Isle of Wight of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

19. The PPO's family liaison officer contacted Mr Little's wife to explain the investigation and ask if she had anything she wanted us to consider. She had several questions about her husband's medical conditions and medication. These are all addressed by the clinical reviewer in his report. She also wanted to know why she was not contacted by the prison prior to the amputation of Mr Little's leg. This is addressed in this report.

20. The initial report was shared with Mr Little's wife. She did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. Their action plan is annexed to this final report.

Background Information

HMP Isle of Wight

22. HMP Isle of Wight is an amalgamation of two former prisons, Parkhurst and Albany, and holds approximately 1,100 men, mainly convicted of sex offences. Practice Plus Group provides healthcare services at the prison. There is an inpatient healthcare unit (IHU) at the former Albany site, providing 24-hour care for prisoners. There are two palliative care suites on the IHU to accommodate end of life prisoners. The prison is opposite the island's hospital.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Isle of Wight was in April and May 2019. Inspectors reported that healthcare was very good at the prison, and that healthcare was delivered by a conscientious team who knew their patients well. They said there was good oversight of the implementation of healthcare recommendations from deaths in custody reports and evidence of learning from serious incidents. The inspectors reported that in-possession medication risk assessments were completed and reviewed, and spot checks of in-possession medication took place according to the policy. They also said relationships between prison staff and prisoners were good.

24. The report noted that 40% of the prison population were over 50 years old and that a significant proportion were elderly.

Independent Monitoring Board

25. 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 31 December 2019, the IMB agreed that healthcare at the prison was very good. They also reported that prison staff had received a general introduction to dementia training, and that each month there was dementia training for prisoner buddies and reps.

Previous deaths at HMP Isle of Wight

26. Mr Little was the 13th prisoner to die at Isle of Wight since October 2018. Of the previous deaths, four were self-inflicted and eight were from natural causes. In three of these previous cases we have noted concerns about the stockpiling by prisoners of in-possession medication.

Key Events

Background

27. Mr Steven Little was sent to HMP Lewes on remand on 22 July 2019. He was sentenced to 12 years imprisonment for sex offences on 13 September. On 19 November, he was sent to HMP Isle of Wight.

28. When Mr Little was sent to prison, he was taking a significant amount of medication for several chronic conditions, including atrial fibrillation (AF – a heart condition that causes the heart to beat irregularly), heart disease, and diabetes. He also suffered from urinary incontinence following a recent prostate operation. At both Lewes and the Isle of Wight, he said on reception, that he had no problems with taking his medication and was assessed as suitable for keeping his medication 'in possession' in his cell.

29. On 28 October, while still at Lewes, Mr Little said that he had run out of some of his medications, which did not correspond with the records if he had been taking them as prescribed. The note about this incident in Mr Little's medical records says that this was not the first occasion this had happened, and he was offered a dosette box (a tray with sections for tablets to be taken at different times on different days) as there was a doubt that he was taking the medications correctly. Mr Little refused, insisting that he had no problem managing his medicines.

30. Mr Little was at risk of developing blood clots, which can have very serious consequences. To thin his blood in order to minimise the risk of blood clots occurring, he was prescribed warfarin. This is a very widely used anticoagulant (blood thinner) and effective drug, but has a narrow therapeutic index (which means if its concentrations in the blood fall outside a narrow range, the therapeutic effectiveness and potential for harm are quickly thrown out of balance). Therefore, people taking warfarin have their blood regularly monitored, so dosage can be adjusted if necessary. This was done for Mr Little.

31. On 9 April 2020, a pharmacist sent Mr Little a letter asking him to consider swapping to a different anticoagulant. The alternative did not have such a narrow therapeutic index, and would not require the regular blood testing necessary for warfarin. Not needing to test his blood regularly would also have the benefit during the COVID-19 pandemic, of reducing Mr Little's contact with other people. He did not reply to the letter, so at the request of the pharmacist a member of the healthcare staff spoke to Mr Little about it on 21 April. He refused to change his anticoagulant, saying he preferred to stick with what he was used to.

32. Mr Little's warfarin test results began to be a bit erratic. In May, the pharmacist was concerned that he might not be taking his warfarin as prescribed. Because of the limitations on face to face contact at the time because of the COVID-19 pandemic, she tried to contact Mr Little by telephone to discuss the matter with him, but was unsuccessful.

33. On 14 June, prison staff noted a sudden deterioration in Mr Little's health. They referred him to healthcare. On 25 June, following further deterioration in his health, staff determined that he was unable to care for himself and he was

moved out of his cell to the prison's inpatient unit. It was then discovered that he had approximately three months' supply of unused medication in his cell and also medicines that had been issued by to him at HMP Lewes. This included medicine for his heart condition and for his circulation, including his anticoagulant. It was later concluded that the circulation to his legs had been severely affected by him not taking his medication as prescribed.

34. On 26 June, Mr Little was sent to hospital, where he was treated for atrial fibrillation and a urinary tract infection (UTI). When he was discharged the hospital suggested to the prison that he be referred to the vascular team for problems with the circulation in his legs.

35. After returning to prison on 28 June, Mr Little complained about painful legs and said he could not stand up. He had worsening oedema to his legs (swelling caused by water retention). On 30 June, a prison GP recorded that staff had expressed concern about Mr Little's leg circulation and that he had spent all the previous night in a wheelchair with his bare feet on the floor. Mr Little told the prison GP that staff had not helped him into bed. The prison GP asked healthcare staff to assist him into bed that night. However, the following night, Mr Little refused to get out of his wheelchair, saying it was more comfortable there. He spent the night in it again with his legs only elevated for a short period. He was moved to a profiling bed (commonly called a hospital bed) the following day.

36. On 1 July, his medical notes recorded that he appeared to have lost all sensation in his legs and his hands and toes looked blue. A nurse recorded a National Early Warning Score (NEWS – a tool used to assess clinical deterioration) of 6 that indicated that Mr Little was acutely unwell. A prison GP examined him and thought that he might be close to a palliative care stage (when treatment cannot produce improvements and care has the focus on optimising the quality of life and reducing suffering).

37. Mr Little had hourly checks and with his legs elevated by virtue of being in a profiling bed, there seemed to be some improvement to his condition. A prison GP was unable to see Mr Little face to face on 2 July, but reviewed the information about him and he concluded that given the improvements, the plan would be to continue with elevation of his legs.

38. On the afternoon of 3 July, a prison GP examined Mr Little again, and was concerned about his swollen legs and the very poor circulation in his left leg. Mr Little was sent back to hospital for assessment that evening. His deterioration was very rapid and the option to give him anticoagulants to break down blood clots was compromised by his previous erratic compliance with his medication. On 4 July, his left leg was amputated above the knee as a result of a blood clot having formed, cutting off the oxygen supply.

39. Mr Little was in hospital for a month recovering from his amputation as well as pneumonia and acute kidney injury (AKI). While in hospital, one of the people treating him told a senior staff nurse at the prison that he thought Mr Little was getting dementia, and said that he would refer him to the Memory Service. However, as the Memory Service was external to the hospital, it appears it was not possible for an assessment to take place while he was there, because of COVID 19 restrictions on people coming onto the wards from outside the hospital.

40. Mr Little returned to prison on 4 August, and was located on the inpatient unit. He did not regain sitting balance and his behaviour was notably different from previously. He was at times inappropriate with staff and used his emergency call bell incessantly, but when staff attended, he usually had trivial requests or had no requests at all. He was often confused but could also present as very lucid at other times.

41. On 18 August, a prison GP assessed Mr Little's rehabilitation needs. He noted his tendency to confabulate (a term referring to verbal invention sometimes used by people to cover up gaps in their memory) and the need to refer him for assessment by the Memory Service once they were available again. At that time an arrangement with the Isle of Wight Memory Service had not been commissioned by the Practice Plus Group who run the healthcare services in the prison. This situation was only rectified later in October 2020, after Mr Little's death.

42. Mr Little's health continued to deteriorate, and he became increasingly frail and confused. On 4 October, Mr Little was taken to hospital where he was treated for heart failure and pneumonia. He returned to prison on 9 October, but was taken to hospital once more on 16 October when his condition deteriorated again. He died there from pneumonia on 21 October.

Contact with Mr Little's family

43. When Mr Little was taken back to hospital on 16 October, the prison contacted his wife to let her know and an officer, was appointed as the family liaison officer (FLO). Initial contact with Mr Little's wife following the death of her husband was by the FLO's deputy officer. All contact was over the phone as required by COVID-19 protocols.

44. The prison contributed to the costs of Mr Little's funeral in line with national instructions.

Support for prisoners and staff

45. The duty governor debriefed the staff involved in the hospital bedwatch to ensure that they had the opportunity to discuss any issues arising and to offer support. An officer from the Care Team was also in attendance during the debrief to offer support. Notices about the death and the availability of support were issued to prisoners and staff.

Post-mortem report

46. A post-mortem examination found that Mr Little died from pneumonia caused by heart failure. Kidney failure was listed as a contributory factor.

Findings

Clinical care

47. The clinical reviewer concluded that, with the exception of the medication compliance issue, the care given to Mr Little was equivalent to that which he could have expected to receive in the community.

Mr Little's non-compliance with his medication

48. Mr Little had several serious health conditions for which he was prescribed appropriate medication. Probably the most important single factor in the deterioration in his health was his failure to take his medication as prescribed.

49. Doubts about his compliance were first raised at Lewes in October 2019, but this was not highlighted as a concern when he was transferred to Isle of Wight and so went unnoticed. Some of Mr Little's blood test results in 2020 also suggested that he may not have been adhering to his warfarin prescription properly, although variations can occur for other reasons.

50. The pharmacist tried unsuccessfully to contact Mr Little to discuss this in May. During interviews with healthcare staff, they said that although prisoners had telephones in their cells as a result of the special regime introduced for COVID-19, initially there were no direct connections to these phones from those used by healthcare staff. In order to speak to prisoners, they had to use the telephones of prison staff, which created some logistical difficulties.

51. This was a physical infrastructure problem arising out of the unexpected need to adapt to the pandemic and to keep prisoners safe by limiting movement around the prison. Although the shortcomings of the telephone infrastructure have since been rectified, this was a factor in not being able to challenge Mr Little about his reassurances that he was taking his medication correctly. Another limitation caused by the restriction of movement around the prison due to COVID-19, was the national suspension of cell searches. Although it is not suggested that Mr Little would necessarily have been the subject of a random cell search (which in normal times are carried out routinely), that possibility that his medication hoarding might have been discovered earlier was eliminated altogether.

52. It is noted on several occasions that Mr Little insisted that he was taking his medications, and a prison GP said at interview that Mr Little was very convincing in conversation. He speculated that Mr Little had particular skill in this respect deriving from his background as an actor and performer. Prison staff did not raise any concerns about Mr Little either. Quite the opposite in fact. As late as 13 June, there is a note in his prison records from an officer, praising him for having the abilities of a much younger man despite his health issues.

53. Mr Little was quite insistent in his decisions, and there were several instances of him refusing medical advice that was in his best interests. This included the refusal of a dosette box or to switch to an alternative anticoagulant. There was no evidence at that point that he did not have the mental capacity to make these decisions.

54. However, there were some missed opportunities. Mr Little's suspected non-compliance with his prescriptions at Lewes, although not highlighted when he transferred to the Isle of Wight, was recorded in his medical notes. The pharmacist at the Isle of Wight also expressed some concerns about non-compliance, which unfortunately turned out to be correct.

55. There have been other recent cases at Isle of Wight in which the hoarding of medication has played a role in a prisoner's death. The prison has said that additional safeguards have been implemented since Mr Little's death, and that there are new protocols for medication, such as warfarin, held by prisoners in their cells. To reinforce this, we make the following recommendations:

The Head of Healthcare should consider ways to assess medication compliance promptly and frequently in prisoners, especially in those with in possession status and who are on medications with a narrow therapeutic range, such as warfarin.

The Head of Healthcare should consider an auditing protocol for medications with narrow therapeutic margins (such as warfarin, lithium, and methotrexate, for example) to ensure the local operating procedure on these is applied as intended.

The absence of the provision of memory services

56. Problems with Mr Little's memory and the possibility of dementia only became apparent after his non-compliance with his medication and consequent amputation. A prison GP said at interview that mental deterioration is a known issue after an operation like the one Mr Little had. There is no suggestion that the provision of memory services would have prevented his amputation and subsequent decline, as it is unlikely that he would have fitted the criteria for referral. But he may well have benefitted from their input after his operation.

57. However, we were concerned in the course of our investigation to discover that there was no access to memory clinics for prisoners between August 2019 and October 2020. This was due to a commissioning issue by the healthcare provider, Practice Plus Group. Memory services provide specialist help for those with failing memory and dementia to cope with their everyday living and have an important place in a setting like the Isle of Wight which has a significant elderly population. We make the following recommendation:

The NHS Healthcare Commissioner should satisfy themselves that prisoners at Isle of Wight will continue to have appropriate access to memory services in the future.

Contact with Mr Little's family

58. Mr Little's amputation came as a shock to his wife. She asked the PPO why she was not informed about her husband's condition and impending amputation until she was contacted by the hospital very early in the morning on 4 July just before the operation. The prison said that the situation developed very quickly and at that point, Mr Little was in the care of the hospital rather than the prison. Given the urgent nature of his condition, the hospital contacted Mr Little's wife directly

rather than trying to communicate through the prison. The prison healthcare team regularly updated Mr Little's wife after he was hospitalised in July. We are satisfied that this was reasonable.

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