

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Leslie Bryan, a prisoner at HMP Littlehey, on 8 November 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*



© Crown copyright 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Leslie Bryan died in hospital on 8 November 2020 of vertebral osteomyelitis (a spinal infection) and empyema (where pus gathers between the lungs and the chest wall), while a prisoner at HMP Littlehey. He was 66 years old. I offer my condolences to Mr Bryan's family and friends.

I am satisfied that the standard of care Mr Bryan received at Littlehey was equivalent to that he could have expected to receive in the community.

I make 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

July 2021

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	8

Summary

Events

1. In April 2018, Mr Leslie Bryan was sentenced to 18 years in prison for sexual offences. In August 2019, he was moved to HMP Littlehey.
2. Mr Bryan had significant medical issues including hypertension (high blood pressure) and heart disease. When he arrived at Littlehey he was waiting for surgery for an abdominal hernia but needed to lose weight first. He was prescribed medication and was appropriately referred for his ongoing care.
3. In July 2020, Mr Bryan reported abdominal pain and blood in his stools, and a prison GP referred him urgently to colorectal services. The appointment did not go ahead, however, as the hospital postponed all outpatient appointments because of COVID-19.
4. In August and again in October, Mr Bryan's appointments for a colonoscopy (an examination of the bowel) were cancelled because he had not stopped taking blood thinning medication in time. In between those dates he spent two weeks in hospital where he was treated for rectal bleeding and pneumonia. The colonoscopy was done on 30 October and revealed a large hernia and a twisted bowel. His consultant said he was not suitable for surgery.
5. On 3 November, a prison GP examined Mr Bryan after he complained of abdominal pain and found his clinical observations were acceptable. On 6 November, a nurse sent Mr Bryan to hospital by emergency ambulance after he again reported abdominal pain. He died in hospital on 8 November.
6. A post-mortem examination showed that Mr Bryan died of vertebral osteomyelitis (a spinal infection) and empyema (a condition in which pus gathers between the lungs and the chest wall).

Findings

7. The clinical reviewer considered that the care Mr Bryan received at Littlehey was equivalent to that he could have expected to receive in the community.
8. She found that overall, Mr Bryan's complex medical issues were well managed by the healthcare staff at Littlehey and they could not have predicted his sudden death.
9. We have made 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 Bryan's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Bryan's clinical care at the prison.
13. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. The coroner 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 Bryan's next of kin, a friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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. This includes GP services and a range of nurse-led clinics. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

18. The most recent full inspection of HMP Littlehey was in July and August 2019. Inspectors reported that healthcare provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. Innovative means of increasing secondary care consultation slots, such as Skype, were being introduced where demand outstripped escort availability. Palliative care, led by a specialist consultant and advanced nurse practitioner, was highly developed.
19. In June 2020, Littlehey was subject to a short scrutiny visit following the outbreak of COVID-19. Littlehey was declared an official outbreak site in March. Three prisoners had died from COVID-19 related illnesses and there was a spike in the number of staff and prisoners testing positive. Inspectors reported that the prison took swift action to control the spread of the virus and in a relatively short time brought the infection rate down to a low and manageable level. Understandably, in the early days of the crisis the prison adopted a very cautious approach to shielding but, having successfully taken hold of the situation, inspectors concluded the prison was slow to improve the very restricted regime.

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, overall, healthcare waiting times had improved and were broadly comparable with those in the community.
21. The Board reported that the prison only scheduled four morning and four afternoon external hospital appointments (increases were allowed where there were emergencies) which they considered inadequate. Overall however, the Board considered that the majority of prisoners experienced a quality of care comparable to that in the community, a finding supported by a recent Care Quality Commission inspection.

Previous deaths at HMP Littlehey

22. Mr Bryan was the 16th prisoner to die at Littlehey since November 2018. Of the previous deaths, 14 were from natural causes and one was self-inflicted.

Key Events

23. On 6 April 2018, Mr Leslie Bryan was sentenced to 18 years in prison for sexual offences. On 7 August 2019, Mr Bryan was moved to HMP Littlehey.
24. Mr Bryan had several significant ongoing medical issues. Part of his stomach and bowel had previously been removed and he also had haemophilia, hypertension (high blood pressure), obesity, heart disease, a previous stroke, pancreatitis, a hernia, depression and a blood clot in the lung. At his initial health screen, a nurse noted that Mr Bryan was waiting for surgery for an abdominal hernia. His medication, which he kept in his possession, was listed and reviewed and he was appropriately referred for specialist care. This included a referral to weight loss services, in preparation for his surgery, and to the Hinchingsbrooke Hospital cardiology department.
25. On 28 October, in discussion with a consultant in palliative medicine and a nurse, Mr Bryan agreed that he did not want staff to attempt to resuscitate him if his heart or breathing stopped. A Do Not Attempt Resuscitation document was completed.
26. Healthcare staff monitored and reviewed Mr Bryan as appropriate. On 4 March 2020, at his six-monthly cardiac review, a nurse noted that he was still waiting for his cardiology appointment. On 24 March, he received a letter identifying him as high risk from COVID-19. The letter contained guidance on protection and shielding. He took a COVID-19 test on 9 June and the result was negative.
27. On 2 July, Mr Bryan reported ongoing abdominal pain which a doctor concluded was caused by his hernia and by irritable bowel syndrome (a condition that affects the digestive system). He needed surgery but had to lose weight first. The doctor prescribed mebeverine, a drug for abdominal spasms and pain.
28. On 3 July, Mr Bryan reported blood in his stools. A prison GP referred him to the colorectal surgery service under the two-week cancer referral system. However, on 10 July, healthcare staff were told that due to NHS COVID-19 restrictions, all non-essential outpatient appointments, planned procedures and operations had been postponed until further notice.
29. On 19 August, Mr Bryan had a hospital appointment for a colonoscopy (an examination of the bowel). Unfortunately, prior to the procedure, the message to stop his blood thinning medication did not reach the prison pharmacy and consequently it could not go ahead due to the risk of bleeding. The prison contacted the hospital to discuss a date for a new appointment.
30. On 30 September, Mr Bryan reported new episodes of rectal bleeding, shaking, a high temperature and dizziness. A prison GP arranged his transfer to hospital where he was treated for pneumonia. He returned to Littlehey on 9 October.
31. On 12 October, Mr Bryan was again referred to the colorectal department at the hospital under the two-week system and an appointment was scheduled for 14 October. However, due to his recent return from hospital it was too late to stop his medication. He was also required to self-isolate due to COVID-19 restrictions. The colonoscopy was rearranged to 30 October.

32. On 19 October, Mr Bryan reported chest pain. A prison GP examined him and recorded his observations. Mr Bryan was still recovering from pneumonia and his heart disease had progressed to the point where his heart was only 60% efficient. The GP took Mr Bryan's physical observations, which he recorded as 'acceptable', and noted that he was not acutely unwell. He referred him to the physiotherapist for general exercise.
33. On 30 October, Mr Bryan attended for his colonoscopy which showed a large anterior abdominal wall hernia and a twisted bowel. He was booked for a computerised tomography (CT) scan (a detailed body scan) but the consultant told him that he was not suitable to have the hernia repaired.
34. On 3 November, a prison GP examined Mr Bryan after he reported abdominal discomfort. Mr Bryan walked to the appointment and was alert and communicating. The GP noted that Mr Bryan's abdomen was soft but with no tenderness, rigidity or lumps. She recorded his physical observations as acceptable. The GP advised him to rest but to contact healthcare staff if he continued to feel unwell.
35. On 6 November, a nurse examined Mr Bryan at the request of wing staff after he reported abdominal pain in the region of his hernia. She arranged for an emergency ambulance to be called and, following examination by paramedics, Mr Bryan was taken to Hinchingsbrooke Hospital. On 7 November, he was transferred to Addenbrooke's Hospital where he died the next day.

Contact with Mr Bryan's family

36. After Mr Bryan's death the prison appointed a family liaison officer (FLO). At 8.30am, the FLO telephoned Mr Bryan's next of kin, a friend, and told her that he had died. The FLO offered his condolences and they discussed funeral arrangements.
37. The FLO and a colleague kept in contact with Mr Bryan's friend and arranged the return of his property.
38. Mr Bryan's funeral took place on 11 December 2020. The prison contributed towards the cost in line with Prison Service instructions.

Support for prisoners and staff

39. After Mr Bryan's death a senior prison manager spoke to the officers on the hospital bedwatch to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Bryan'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 Bryan's death.

Post-mortem report

41. A post-mortem examination showed that Mr Bryan died from vertebral osteomyelitis and empyema. (Vertebral osteomyelitis is a bone infection in the spine usually caused by bacteria. Empyema is a condition in which pus gathers

in the area between the lungs and the inner surface of the chest wall.)
Hypertensive heart disease was listed as a contributory factor.

Findings

42. The clinical reviewer was satisfied that the care Mr Bryan received at Littlehey was of a good standard and equivalent to that he could have expected to receive in the community.
43. The clinical reviewer found that overall, Mr Bryan's complex medical issues were well managed by the healthcare staff at Littlehey. Medical observations recorded on 2 October and 3 November 2020, did not indicate that he was unwell and healthcare staff could not have predicted his sudden death.

**Prisons &
Probation**

Ombudsman
Independent Investigations