

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Murray, a prisoner at HMP Littlehey, on 24 December 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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Summary

1. 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.
2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Peter Murray died on 24 December 2022, from bronchopneumonia and a lung abscess, while a prisoner at HMP Littlehey. He was 61 years old. We offer our condolences to Mr Murray's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Murray received at Littlehey was equivalent to that which he could have expected to receive in the community. The clinical reviewer makes no recommendations.
5. We found that the non-clinical care provided to Mr Murray was of a good standard and make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Murray's clinical care at HMP Littlehey, in conjunction with her colleague. The clinical reviewer's report is attached as Annex 1.
7. The PPO investigator investigated the non-clinical issues relating to Mr Murray's care.
8. The PPO family liaison officer wrote to Mr Murray's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
9. We shared the initial report with HM Prison and Probation Service. They identified one factual inaccuracy which we have amended in this report.

Previous deaths at HMP Littlehey

10. Mr Murray was the 43rd prisoner to die at HMP Littlehey since December 2019. Of the previous deaths, 41 were from natural causes, one was self-inflicted and one was drug-related. There are no significant similarities between our findings in the investigation into Mr Murray's death and our investigation findings for the previous deaths.

Key Events

11. On 19 December 2007, Mr Murray was sentenced to life imprisonment with an eight year minimum term for sex offences.
12. On 8 July 2014, Mr Murray was transferred to HMP Littlehey. During his time at Littlehey, Mr Murray was regularly monitored by the mental health team because of a diagnosis of paranoid schizophrenia.
13. Due to Mr Murray's cardiovascular history and diabetes, he was referred to Coronary Heart Disease (CHD) and diabetic clinics at the local hospital. His medications were reviewed and prescribed.
14. On 20 April 2015, Mr Murray spoke to a GP at Littlehey about pain to the left side of his throat. On 13 May, he was seen by an Ear Nose and Throat (ENT) consultant at Hinchingsbrooke Hospital. On 30 June, Mr Murray was diagnosed with squamous cell carcinoma to the base of the tongue. Mr Murray was referred to Addenbrookes Hospital for treatment and surgery.
15. On 3 February 2016, Mr Murray had a review at Addenbrookes ENT Clinic and, on examination, his oral cavity, nose and neck were all clear. Between 2016 and 2022 he attended regular ENT follow up appointments.
16. On 26 July 2022, a consultant in palliative medicine assessed Mr Murray for hip pain. He diagnosed a musculoskeletal injury and referred Mr Murray for physiotherapy.
17. On 8 August, Dr A, a GP at Littlehey reviewed Mr Murray due to him having difficulty bearing weight on his left leg and apparent weight loss. The doctor ordered blood tests and urgent X-rays of Mr Murray's hip, pelvis and chest.
18. On 15 August, Mr Murray attended Hinchingsbrooke Hospital for his X-rays. They showed a large mass, suspected to be cancer, in his left lung. The X-rays also found a mass in Mr Murray's pelvic area that was suspected to be cancerous.
19. On 17 August, Nurse A, a Specialist Palliative Care Prison Nurse reviewed Mr Murray. She noted that Mr Murray had a new lung cancer diagnosis and created a lung cancer care plan. The nurse also recorded that they were awaiting the results of an urgent CT scan.
20. On 22 August, a Consultant Specialist in Palliative Medicine for Cambridgeshire, covering HMP Littlehey, reviewed Mr Murray. She told Mr Murray that he had fractured his hip and it was likely that this was due to cancer in his hip and lungs. With Mr Murray's consent, the doctor telephoned Mr Murray's sister and informed her of the diagnosis. Mr Murray also had an orthopaedic assessment of his hip. Due to his diagnosis, there was no treatment available for the fracture.
21. On 30 August, the doctor visited Mr Murray to discuss his diagnosis and told him that the prognosis was poor. She advised that due to the type of cancer that Mr Murray had, they needed to wait for the Specialist Respiratory Consultant to review treatment options. Mr Murray was supported by a prison carer who was also a friend on his house block.

22. On 31 August, Nurse A discussed a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) order with Mr Murray. This is a document that is issued and signed by a doctor which tells a patient's medical team not to attempt CPR in the event of their heart stopping. On 1 September, a DNACPR was put in place for Mr Murray.
23. During an appointment with Nurse A on 1 September, Mr Murray lost control of the left side of his body. A GP documented a sudden onset cerebellar (sudden inability to coordinate muscle movement due to disease or injury to the area in the brain that controls muscle movement). Mr Murray was admitted to Hinchingsbrooke Hospital by ambulance. After assessment at the hospital, he returned to prison. Biopsy appointments were scheduled within a fortnight.
24. On 8 September, Mr Murray was due to attend a biopsy appointment in hospital at 7.30am, but officers could not be redeployed to escort him. Nurse A brought this to the attention of the operational managers at Littlehey, highlighting the importance of enabling Mr Murray to attend his appointments. There were no further such issues.
25. On 13 September, Mr Murray attended an appointment at Hinchingsbrooke Hospital with a respiratory consultant. They told him that the cancer was in his bones and that he now had enlarged nodes (lumps of tissue) in his lungs.
26. On 22 September, a consultant oncologist at Hinchingsbrooke Hospital confirmed that palliative care was now the only treatment option. Mr Murray would receive radiotherapy.
27. On 13 October, a nurse reviewed Mr Murray, who said that he was in pain and felt very nauseous. Healthcare staff called a GP, who advised that Mr Murray would need to be admitted to hospital for pain and symptom control, because 24 hour healthcare was not available at the prison. Healthcare staff administered diamorphine pain relief and Mr Murray was taken to hospital by ambulance. Handcuffs were not applied while Mr Murray was a hospital or hospice inpatient.
28. Mr Murray was granted Release On Temporary Licence (ROTL) between 17 October and 2 December 2022, so that he could receive palliative care in hospital and at a hospice. Over this period, he was allowed regular contact with his family via visits and phone calls.
29. On 24 October, Littlehey submitted an application for Mr Murray's early release on compassionate grounds (ERCG) to the Public Protection Casework Section (PPCS) of HMPPS.
30. On 1 November, a specialist palliative care bed referral was submitted to Sue Ryder St John's Hospice for end-of-life care for Mr Murray.
31. On 8 November, Mr Murray was transferred to the hospice. Nurse A visited him there regularly.
32. On 11 November, PPCS rejected Mr Murray's application for ERCG. They noted that an independent medical adviser, on reviewing the prognosis, considered that it was three to six months and that his health needs could be met in his current setting.

33. On 2 December, Mr Murray returned to Littlehey in order to spend his remaining days with friends on the wing, in line with his wishes. Nurse A completed several assessments with Mr Murray to manage the risks associated with his condition, including a falls assessment. She also created care plans to manage his various health needs, which were updated as necessary. Arrangements were put in place for three-hourly overnight welfare checks on Mr Murray and nursing staff administered his medication to him on the wing during the daytime.
34. On 5 December, a GP visited Mr Murray. Mr Murray said he did not want to be given any medication to prolong his life.
35. On 6 December, the Healthcare Manager visited Mr Murray to check that he was comfortable. He had previously declined an air mattress but changed his mind and the healthcare manager made arrangements for him to be given one.
36. On 7 December, Mr Murray reiterated that he wanted to remain at Littlehey if his symptoms could be managed there, so that he could be among his friends.
37. On 19 December, healthcare staff created a care plan for managing Mr Murray's final days.
38. During the morning of 23 December, Nurse A visited Mr Murray. His health had deteriorated considerably, and he was given medication to make him more comfortable. The nurse stayed late into the evening until she was satisfied that Mr Murray did not need any more medication.
39. At 1.00am on 24 December, Mr Murray died.

Liaison with Mr Murray's family

40. On 22 August 2022, a Custodial Manager (CM) was appointed as the family liaison officer. Over the following months, he provided Mr Murray's family with updates when relevant.
41. On 14 November, Mr Murray's family told the CM that they wanted to receive the news of his death by telephone. They also discussed funeral arrangements and the dispatch of Mr Murray's property from the prison.
42. On 24 December, the CM telephoned Mr Murray's family to inform them that he had died.

Post-mortem report

43. The post-mortem report concluded that Mr Murray died from bronchopneumonia and lung abscess, caused by disseminated carcinoma (where cancer migrates to a secondary growth site) of the lung. Ischaemic heart disease was listed as a contributory factor.

Findings

44. We have found that the clinical and non-clinical care that Mr Murray received was of a good standard.

Good practice

45. There were examples of good practice, such as allowing Mr Murray's nurse to accompany him to appointments with the consultant. Prison and healthcare staff created comprehensive care plans to allow Mr Murray to spend his final days in line with his wishes and the care offered by Nurse A demonstrated notable compassionate and kindness.
46. Mr Murray was able to attend hospital without being handcuffed. The support provided by the family liaison officer also demonstrated good practice.

Governor to note

47. Mr Murray missed a biopsy appointment on 8 September.

Inquest

48. The inquest into Mr Murray's death was held on 14 December 2023, and returned a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

September 2023

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