

**INVESTIGATION INTO THE CIRCUMSTANCES
SURROUNDING THE DEATH OF A MAN IN
HOSPITAL ON 4 JUNE 2005 WHILST IN THE
CUSTODY OF HMP LITTLEHEY**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2005

This is a report into the circumstances of the death of a prisoner in an outside hospital in June 2005. The man who died was a prisoner at HMP Littlehey and, at the time of his death, he was 30 months into an eight-year sentence. He had been taken to hospital in the morning and died later that day.

The man's post mortem recorded the cause of death as a ruptured abdominal aortic aneurysm.

A doctor from the Huntingdonshire Primary Care Trust carried out a clinical review and I am very grateful for the promptness of his report. The doctor reports that four per cent of elderly men are thought to have an aortic aneurysm and that there are usually no obvious symptoms.

The investigation was carried out by one of my colleagues. One of my family liaison officers spoke on the telephone to the man's daughter, who said her contact with the prison after the death of her father had been helpful. The exception to this was the way in which she learnt about his death. I have concerns about the failure to notify the man's family of his emergency admission to hospital in a timely manner. I make a recommendation in relation to this matter.

I would like to extend my sincere condolences to the man's relatives and friends for their loss. I would also like to thank the staff at HMP Littlehey for their help during this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man who died was a 69 year old man serving an eight year sentence at HMP Littlehey. He died in June 2005 in an outside hospital having been admitted earlier that day. The man died from a ruptured abdominal aortic aneurysm.

The man suffered from hypertension which had been diagnosed just prior to going into custody and was controlled by medication. He had been very healthy for most of his life and had not seen a doctor for 30 years when he went into custody. For most of the time he was at Littlehey, he was well.

In April 2005, the man collapsed in his cell. He underwent a thorough examination and was told to bed rest for seven days. Although his private diaries appear to indicate that he suffered from dizziness, he does not seem to have told staff about these episodes.

The day he died, the man was unable to get out of bed and was found to be suffering from severe abdominal and back pains. He had gone to bed early the night before having not felt well. After an assessment by the nurse, an ambulance was called at 9.45am and he was taken to hospital, arriving at 11.15am. Unfortunately, his condition worsened during the day and he died at 9.33pm that evening.

Contrary to HMP Littlehey's own policy, the man was not asked about his next of kin and attempts were not made to contact his daughter until it was evident that he was very ill. Staff were then unable to locate the man's daughter for some hours because the prison had not updated its records with her change of address. She learnt of her father's death in a telephone call from a member of prison staff at 11.30pm the day he died.

The clinical reviewer made no criticism of the medical care that the man received in respect of his final illness. However, he concluded that there were aspects of his care which could have been improved in relation to the chronic management of hypertension, smoking cessation and renal disease detection.

I make four recommendations and note one area of good practice.

The investigation

My practice in cases of death from apparently natural causes is to conduct an initial review to determine the extent of investigation required.

There had been a regrettable delay in contacting my office after the man's death and, although in June, I did not learn of it until July. The investigation began, therefore, on 15 July 2005 when my investigator contacted the prison. The same day, notices were issued to staff and prisoners announcing the investigation and inviting anyone with information relevant to the man's death to contact my office.

The man's prison records and other documentation were sent to my office following the contact made by my investigator.

Having reviewed the documentation my investigator visited Littlehey on 1 September and spoke with a number of wing staff, a prisoner and friend of the man who died. A clinical review of the man's health care was requested and undertaken by Huntingdon Primary Care Trust.

One of my Family Liaison Officers (FLOs) made contact with the man's daughter and next of kin to establish what concerns, if any, she had regarding her father's care in custody. She did not want the FLO to visit her at home at that time but did want to be kept informed about the investigation and to see the report.

HMP Littlehey

HMP Littlehey is a category C training prison holding up to 706 adult male prisoners. It was opened in 1988 with four wings A - D. Two other wings, E and F, were added some years later and a further 'quickbuild' wing, G, has since been put in place. There is also a drug rehabilitation wing, H wing. About 10 per cent of the population are life sentence prisoners and a high proportion (about 30 per cent) are sex offenders, but the regime encourages integration of all categories of prisoners throughout the prison.

Healthcare has been provided by Huntingdonshire Primary Care Trust (PCT) since April 2004. All healthcare staff working at Littlehey are medically qualified. There are no in-patient beds at Littlehey. The prison has a visiting community based GP and nurses providing primary care during the day. Secondary care is available through out-patient services in the community. Appointments to see a doctor are triggered by a wing application.

Events leading up to the man's death

Following sentencing on 30 January 2003, the man was taken to HMP Nottingham. At the health reception screening, the prison medical staff had a copy of a report from a doctor which had been requested by the man's solicitors for his court hearing. The report detailed the man's medical history and concluded that he was a very fit man with no past medical problems. However, at the time of the doctor's examination he was found to have raised blood pressure and the presence of protein and blood in his urine. The doctor recommended that further assessments should be undertaken to determine the significance of these as a matter of urgency. He suggested that the 'concomitant urinary abnormalities would raise questions of possible kidney disease (which may cause high blood pressure)'. Examination of his abdomen was normal.

The health screening form at HMP Nottingham makes reference to this report. The entry in his continuous medical records by the doctor during this screening process records his blood pressure and that he 'needs U & Es (routine blood screening) and PSA – prostate (test to see if he has prostate trouble)'. Later that day, the man was seen again by medical staff after collapsing in his cell. A plan outlined in the notes recommended that his blood pressure be taken daily and that bloods be taken. Bloods were taken on 3 February 2003 and medication for high blood pressure started on the same day. His blood pressure continued to be monitored. On 13 February, he was recorded as feeling well but still suffering from dizzy spells. The results of the blood tests were attached but not referred to in the continuous record.

On 20 February 2003, he was deemed fit for transfer and moved to HMP Littlehey. He was noted as suffering from hypertension upon reception. The next entry of significance is on 4 February 2004 when he reported feeling wobbly and was diagnosed with influenza and prescribed antibiotics. There are no further entries until 27 April 2005 when he saw the doctor after reporting that he had collapsed. According to the clinical review, the examination by the doctor was thorough and there was nothing of any concern. The man was told to bed rest for seven days. On 20 May, the results of his blood tests were found to be within a normal range.

Events of 4 June 2005

According to a neighbouring prisoner and friend, the man had felt poorly the evening before and had gone to bed at around 5pm. During unlock the next morning, at 8:40am, a prison officer saw him still in bed. This was not unusual as it was a Saturday and prisoners were not expected to be up early at the weekend. The fellow prisoner went to the man's cell, as he did every morning, and found him lying across the bed, half dressed. He immediately went to get the officer and they returned to the cell. The man appeared confused and the officer promptly summoned help from healthcare.

A nurse attended from healthcare at 9:30am. The man stated that he had been vomiting and was suffering from abdominal and back pain. The nurse thought it likely that the man was suffering from an internal bleed. She returned to healthcare and telephoned the on-call doctor. As it was a Saturday, the nurse was the only medical member of staff in the prison. She then phoned for an ambulance at 9.45am. Wing staff took the man to healthcare in a wheelchair at 10:10am and the paramedics arrived soon afterwards. The ambulance left the prison at 10:45am, arriving at Hinchingbrooke Hospital in Huntingdon at 11.15am. An escort risk assessment was carried out by the duty governor at 12:45pm. He concluded that two officers using a single cuff should be retained and that restraints should be removed for essential treatment. This was due to the man's length of sentence and nature of his offence.

From the escorting officers' bedwatch record, it seems that the man was taken to the x-ray department at 2:10pm and admitted to Willow Ward. At 8:06pm, his condition worsened. The restraint, a single cuff, was removed and doctors attended. At 8.55pm, he was moved to the intensive care ward. He went into cardiac arrest and resuscitation was started at 9.15pm. Sadly, this was unsuccessful and he was pronounced dead at 9.33pm.

At 8pm, having been told of the man's deteriorating condition, the duty governor requested that the next of kin be contacted. The night orderly officer (NOO) was only able to locate an address from the prison records. She contacted Lincolnshire police by fax at 8.27pm to ask them to visit the man's daughter to tell her of her father's critical condition. After visiting the address given by the prison, the police discovered that she had moved. A mobile phone number was obtained and the NOO rang her at 11.30pm to inform her of her father's death.

The prison then followed the contingency plans for a death in custody. The man's daughter was not offered any contribution towards the cost of her father's funeral.

Issues considered during the investigation

Informing the next of kin

At 8:00pm in the evening, prison staff started to attempt to contact The man's next of kin. However, a Littlehey Governor's Operational Order, dated April 2002, states that,

When a person is escorted to outside hospital as an emergency he should be asked whether he wishes his next of kin to be advised unless it is clearly a minor injury. The Orderly Officer should establish who the prisoner wishes the information to be passed on to and advise the Duty Governor. The Duty Governor will arrange for the next of kin to be informed.

It is not clear why this operational order was not followed on this occasion. If the man had been asked when he was first taken out of the prison, he might have been able to tell staff how to contact his daughter. Unfortunately, a letter that his daughter had written to the prison on 7 March 2005, informing them of a change of address, did not get passed to the right department and hence his records had not been updated. A copy of this letter was amongst the documentation given to my investigator. The man's daughter had moved from Lincolnshire to Scotland and might not have been able to make arrangements to travel to the hospital immediately. However, it is unfortunate that she was not given an opportunity to do so.

Incident reports

Given that the man died within 12 hours of being admitted to hospital, staff involved in finding and assessing him should have written a statement about their involvement. This did not happen.

Conclusions and recommendations

The man was a 69 year old man who, although suffering from hypertension, appeared to be relatively healthy. When he was found unwell on 4 June, staff acted promptly and an ambulance was called in a timely manner. Sadly, his condition worsened during the day and he died later that evening. The clinical reviewer indicates that aortic aneurysms are usually present without obvious symptoms. It is often only once the aneurysm enlarges, leaks or ruptures that the patient experiences severe abdominal pain which radiates through to the back.

When the man was first taken out to hospital, staff should have asked about his next of kin in accordance with the Governor's Operational Order.

Local recommendation 1: *The Governor should re-issue the operational order regarding notifying next of kin of emergency hospital admissions.*

The man's daughter had written to Littlehey to inform them of her change of address. This letter did not make its way to the right department and the man's computer records were not updated. My investigator discussed this with a number of administrative staff at Littlehey. She concluded that this was a very unfortunate, one-off mistake rather than indicative of a common problem.

Incident reports were not prepared by any staff members involved in discovering or assessing him for medical treatment on 4 June.

Local recommendation 2: *The Governor should remind senior colleagues that all staff, including medical staff, present at an incident should write and sign a statement.*

The man's daughter was not offered financial assistance towards the cost of her father's funeral arrangements. This is contrary to current Prison Service policy as laid out in PSO 2710 'Follow up to deaths in custody' and the advice of Safer Custody Group.

Local recommendation 3: *The Governor should consider making an approach to the man's daughter with regard to funeral costs and remind senior colleagues of Prison Service policy as laid out in PSO 2710.*

The clinical review concludes that the man's care was of a reasonable standard in that his blood pressure was effectively reduced and his complaints sympathetically dealt with. The clinical reviewer thought the history taking and influenza follow-up was impressive. However, he urges the Prison Service to review the way in which it offers chronic disease management as regards smoking cessation, management of hypertension and renal disease detection. I endorse this view.

National recommendation 1: *The Prison Service should review the instructions it provides to prisons about chronic disease management clinics,*

particularly with regard to smoking cessation, management of hypertension and renal disease detection.

Good practice

A representative from the prison attended the man's funeral and his possessions were returned in a timely manner to his daughter.