Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Currington, a prisoner at HMP High Down, on 24 May 2023

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

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 Stephen Currington died of congestive cardiac failure (when the heart is unable to pump blood around the body efficiently) on 24 May 2023, while a prisoner at HMP High Down. He was 68 years old. We offer our condolences to Mr Currington's family and friends.

4. The PPO family liaison officer wrote to Mr Currington's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Currington's clinical care at HMP High Down.

6. The clinical reviewer concluded that the clinical care Mr Currington received at High Down was partially equivalent to what he could have expected to receive in the community. She found that Mr Currington was not referred to Tissue Viability Services for wound care management in line with Central and Northwest London (CNWL) policy for 'lower limb and leg ulcer management (2019)' as he should have been. The clinical reviewer made recommendations not related to Mr Currington's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Currington's care. We found no non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

9. At the inquest held on 19 March 2024, the coroner concluded that Mr Currington died of natural causes.

Adrian Usher **April 2024**
Prisons and Probation Ombudsman

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