

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James O'Brien, a prisoner at HMP Littlehey, on 18 July 2023

A report by the Prisons and Probation Ombudsman

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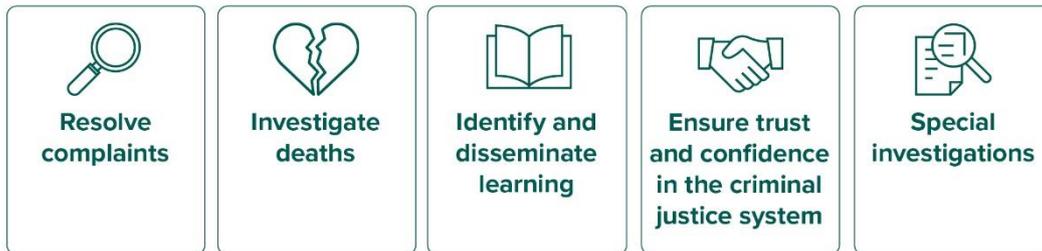
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OUR VISION

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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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 process failures.
3. Mr James O'Brien died at HMP Littlehey on 18 July 2023, of mixed vascular disease (reduced blood flow to the brain, which damages and eventually kills brain cells) and Alzheimer's dementia. He was 83 years old. We offer our condolences to Mr O'Brien's family and friends.
4. The PPO family liaison officer wrote to Mr O'Brien's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
5. NHS England commissioned independent clinical reviewers to review Mr O'Brien's clinical care at HMP Littlehey. They interviewed seven healthcare staff as part of the PPO investigation.
6. The clinical reviewers concluded that the clinical care Mr O'Brien received at Littlehey was of a very good standard and equivalent to that which he could have expected to have received in the community. While the clinical reviewers did not make any recommendations, they identified that Littlehey was an inappropriate environment for Mr O'Brien, given his dementia and deteriorating health. Considerable effort was made to transfer Mr O'Brien to a prison with 24-hour healthcare facilities, but this was not possible due to a lack of beds. Healthcare staff also considered that a transfer might increase Mr O'Brien's agitation and confusion and that he might therefore benefit from remaining at Littlehey.
7. The clinical reviewers identified several areas of good practice, including multidisciplinary working between healthcare and custodial staff to provide overnight care for Mr O'Brien. They also identified several positive actions taken since Mr O'Brien's death, including the provision of dementia training for staff.
8. The PPO investigator investigated the non-clinical issues relating to Mr O'Brien's care. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

9. The inquest into Mr O'Brien's death concluded on the 14 May 2024. The coroner confirmed that Mr O'Brien died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

July 2024

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