Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terrance Dass, a prisoner at HMP Littlehey, on 20 September 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

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 Terrance Dass died on 20 September 2022 of acute airway obstruction at HMP Littlehey. He was 68 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the healthcare Mr Dass received at Littlehey was equivalent to that which he could have expected to receive in the community. The clinical reviewer did not make any recommendations.

5. An Operational Support Grade did not radio a medical emergency code when Mr Dass collapsed in his cell, instead she radioed for urgent assistance. While we do not think this warrants a recommendation, the Governor of Littlehey should ensure staff are aware of the correct procedure when involved in a medical emergency.

6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

The Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Dass' clinical care at the prison. The clinical reviewer's report is annexed.

8. The PPO investigator, investigated the non-clinical issues relating to Mr Dass' care, including Mr Dass' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. We informed the 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.

10. Mr Dass had not identified a named next of kin.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not identify any factual inaccuracies.

Previous deaths at HMP Littlehey

12. Mr Dass was the 35th prisoner to die at HMP Littlehey since September 2020. Of the previous deaths, 33 were from natural causes and one was drug related. There are no similarities between our findings in the investigation into Mr Dass' death and our investigation findings for the previous deaths.

Key Events

13. On 8 August 2007, Mr Terrance Dass was remanded to HMP Brixton charged with multiple sexual offences. He was 53 years old. Over the years that followed, Mr Dass transferred between prisons on several occasions. His final transfer was on 13 October 2020, to HMP Littlehey.

14. Mr Dass had pre-existing medical conditions, including COPD (the name given to a range of respiratory conditions), type 2 diabetes and joint pain caused by arthritis.

2020-2021

15. When Mr Dass arrived at Littlehey, a prison nurse carried out an initial health screen. She noted his medical conditions and updated his care plans. She also referred him to the prison's long-term clinics to manage his care.

16. The next day, the pharmacist reviewed Mr Dass' prescribed medications. She noted that in previous prisons, there had been occasions when Mr Dass had not used his inhaler as prescribed. She made sure that he understood how to use his inhaler and explained to him the importance of using his medications as prescribed.

2022

17. On 12 January 2022, Nurse A carried out a respiratory review. She checked Mr Dass' inhaler technique and recorded his level of breathlessness; oxygen saturation level and respiratory rate and they were all within a normal range. However, Mr Dass told the nurse that he felt that his fostair inhaler (used to open the airways) was not effective. He agreed to try a different type of inhaler.

18. On 2 February, Nurse B saw Mr Dass after he reported a shortness of breath. He told her that he was struggling with the change of inhaler. She checked that he was using the inhaler correctly, and noted that following her review, his condition had improved.

19. On 4 February, Nurse C saw Mr Dass after staff raised concerns about his health. Mr Dass said that he had developed a persistent cough and had noticed traces of blood in his phlegm. The nurse took a note of his observations and recorded his oxygen saturation level as 91% (95-100% is a normal oxygen saturation level). She noted that he appeared generally unwell and considered that he may have developed pneumonia. Mr Dass was taken to hospital by emergency ambulance for further review.

20. In hospital, Mr Dass was diagnosed with a chest infection. He was admitted to hospital as an inpatient and prescribed a course of antibiotics. He was discharged from hospital and returned to the prison on 6 February.

21. On 9 April, Nurse A saw Mr Dass after he again reported shortness of breath. She discovered that despite regular support from healthcare staff, he had not been using his inhaler as prescribed. She reminded him of the importance of using his inhaler correctly. Healthcare staff reviewed Mr Dass regularly over the months that followed.

Events of 20 September

22. At 4.25am on 20 September, Mr Dass pressed his emergency cell bell and told Operational Support Grade (OSG) that he was experiencing shortness of breath. The OSG went to the wing office and telephoned the prison control room to inform them of Mr Dass' condition, and to ask for the other staff on duty to attend his cell. She then left the wing office and made her way back to Mr Dass' cell to wait with him.

23. However, as soon as she arrived at his cell, Mr Dass collapsed face upwards onto the floor. The OSG radioed an urgent message and asked for assistance. She did not radio a medical emergency code blue (indicating that a prisoner is unconscious or is having breathing difficulties). At 4.27am, staff in the control room telephoned for an emergency ambulance.

24. Prison staff arrived at the cell shortly afterwards. They immediately entered the cell and checked Mr Dass for signs of life, but there were none. They commenced cardiopulmonary resuscitation (CPR) and attached a defibrillator to Mr Dass' chest, but it did not find a shockable rhythm.

25. At 4.46am, paramedics arrived. They noted that the defibrillator pads were still attached to Mr Dass' chest and that the officers were continuing with CPR. The paramedics checked for signs of life, but there were none. They advised staff to stop CPR. At 5.27am, the paramedics confirmed that Mr Dass had died.

Post-mortem report

26. The post-mortem report concluded that Mr Dass died of acute airway obstruction. He also had coronary artery disease, which did not cause but contributed to his death.

Lisa Burrell **October 2023**
Assistant Ombudsman

Inquest

12. The inquest, heard on 13 December 2023, concluded that Mr Dass died from natural causes.

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