Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Gathercole, a prisoner at HMP Littlehey, on 8 February 2024

A report by the Prisons and Probation Ombudsman

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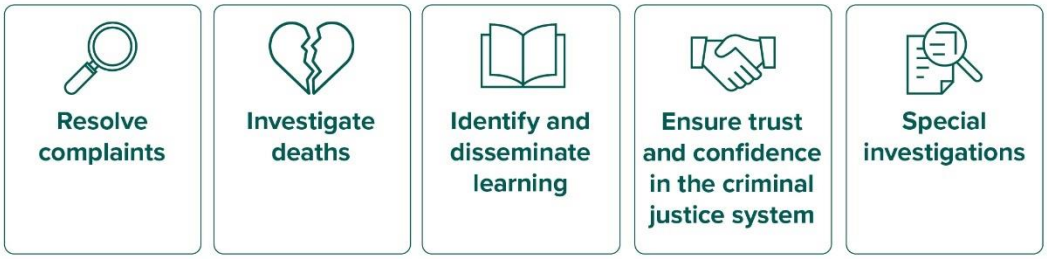
OUR VISION

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

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. In 2018, Mr Dean Gathercole was sentenced to 17 years imprisonment for sexual offences. He died of ischaemic heart disease (with underlying diabetes, hypertension and hypercholesterolaemia) on 8 February 2024, at HMP Littlehey. He was 59 years old. We offer our condolences to Mr Gathercole's family and friends.

4. The Ombudsman's office wrote to Mr Gathercole's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not reply.

5. NHS England commissioned an independent clinical reviewer to review Mr Dean's clinical care at Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Gathercole received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. She noted that he had an extensive and complex medical history, care plans were in place for all his healthcare needs and regular blood tests were completed, in line with the guidelines for each of his conditions. She made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Gathercole's care.

8. We did not find any non-clinical issues of concern and make no recommendations.

9. The initial report was shared with HMPPS. They found no factual inaccuracies.

10. An inquest, held on 14 October 2024, concluded that Mr Gathercole died from natural causes.

Good practice

11. In August 2021, Mr Gathercole began to ignore medical advice and took actions which could have been severely detrimental to his health. The prison assigned a family liaison officer, who encouraged him to cooperate with his treatment and engaged the support of his family. Over the following two and a half years, the family liaison officer consistently maintained clear and comprehensive records of actions and contact. We are pleased to note the timely appointment of a family liaison officer and the considerable support provided.

Governor to note

Emergency response

12. There appears to have been a significant delay in requesting an ambulance when Mr Gathercole reported chest pains at 3.30am on 8 February 2024. Although the time of the initial telephone call was recorded as 3.32am on the incident log, the ambulance service records show it was 3.40am. In addition, the paramedics noted a delay when they arrived at the prison gate and were waiting to be taken to the houseblock. The delays did not affect the outcome for Mr Gathercole, but prison managers will wish to ensure there are no performance issues in this area.

Security risk assessments and the use of restraints

13. The investigation found inconsistencies in the use of restraints on Mr Gathercole for hospital visits between November 2023 and January 2024, with him sometimes attending hospital appointments unrestrained and other times restrained, with little evidence for the different assessments of risk.

14. In response to the findings in another recent investigation at Littlehey, HMPPS' Operational Security Group Director implemented several measures to monitor compliance with the policy on the use of restraints and so I make no further comment.

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

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