Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Whitehouse, a prisoner at HMP Oakwood, on 21 October 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

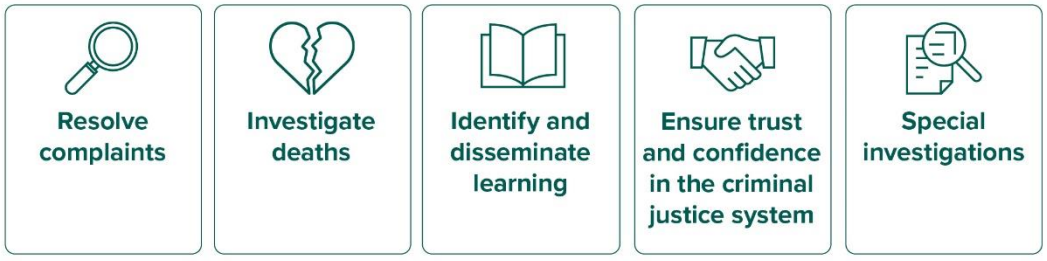
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 August 2021, Mr Roy Whitehouse was sentenced to ten years imprisonment for sexual offences. He died in hospital of severe thyrotoxicosis on 21 October 2023, while a prisoner at HMP Oakwood. He was 76 years old. We offer our condolences to Mr Whitehouse's family and friends.

4. The PPO family liaison officer wrote to Mr Whitehouse's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. The PPO investigator investigated the non-clinical issues relating to Mr Whitehouse's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Whitehouse's clinical care at HMP Oakwood.

7. The clinical reviewer concluded that the clinical care Mr Whitehouse received at Oakwood was partially equivalent to that which he could have expected to receive in the community. She made two recommendations related to his death.

8. We make the following recommendations related to the clinical care Mr Whitehouse received:

    - **The Head of Healthcare and the provider's Lead GP must be assured that all staff are fully aware of the local operating procedure related to "GP referrals to hospital" and that this is followed at all times.**

    - **The Head of Healthcare and the Lead GP should review the terms of reference of the multi-professional complex case clinic/conference (MPCCC) process to ensure that:**

        - **crucial information is appropriately reviewed and shared at meetings, and**

        - **patients receive continuity of care.**

9. We shared our initial report with HMPPS and the healthcare provider at Oakwood. They found no factual inaccuracies in this report. The healthcare provider pointed out some minor factual inaccuracies in the clinical review report which has been amended. The healthcare provider provided an action plan which is annexed to this report.

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

Inquest

The inquest, held on 30 October 2024, concluded that Mr Whitehouse died from natural causes. The medical cause of death recorded was hypoxic brain injury caused by chronic obstructive pulmonary disease (COPD – lung disease), congestive cardiac failure (heart failure), chest infection and sleep apnoea (when breathing stops and starts during sleep).

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