Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Haldane, a prisoner at HMP Littlehey, on 16 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

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.

If my office is to best assist HM 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.

Mr Alan Haldane died of hemoperitoneum (internal bleeding between the abdominal wall and the internal abdominal organs) on 16 May 2023, at HMP Littlehey. He was 69 years old. I offer my condolences to Mr Haldane's family and friends.

The clinical reviewer concluded that the healthcare Mr Haldane received at HMP Littlehey was of a good standard and equivalent to that he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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Summary

Events

1. On 19 December 2015, Mr Alan Haldane was charged with sexual assault and sent to HMP Lewes. On 7 April 2016, he was sentenced to six and half years in prison.

2. Mr Haldane had pre-existing medical conditions, which included COPD and hypertension.

3. On 18 August, Mr Haldane was transferred to Littlehey.

4. On 13 September 2017, Mr Haldane was sentenced to a further 15 years in prison for rape. He remained at Littlehey.

5. On 11 May, a GP at Littlehey saw Mr Haldane after he had been experiencing dull, achy, abdominal pain for the past few days. The GP examined him and gave him another appointment the next day, but Mr Haldane did not attend.

6. On 14 May, Mr Haldane told prison staff that he was feeling discomfort when he urinated. Prison staff called the healthcare unit but they got no response. Mr Haldane said that he was happy to wait to go to the healthcare drop-in session, the next morning.

7. At around 9.30am on 16 May, a prisoner told prison staff that Mr Haldane was in pain. An officer attended his cell and asked Mr Haldane where his pain was, and he pointed to his lower stomach. Mr Haldane was drifting in and out of consciousness. The officer called a medical emergency code and healthcare staff responded. Mr Haldane was grey and had no pulse so healthcare staff started cardiopulmonary resuscitation (CPR).

8. Two ambulance paramedics and one air ambulance crew arrived. The paramedics took over Mr Haldane's care but, at 10:10am, they confirmed that Mr Haldane had died.

Findings

9. The clinical reviewer concluded that the care Mr Haldane received at Littlehey was of a good standard and equivalent to what he could have expected to receive in the community.

10. The clinical reviewer was satisfied that Mr Haldane had received a good level of care for the management of his long-term conditions.

The Investigation Process

11. HMPPS notified us of Mr Haldane's death on 16 May 2023. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Haldane's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Haldane's clinical care at the prison.

14. We informed HM Coroner for Cambridgeshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Haldane'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.

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

Background Information

HMP Littlehey

17. HMP Littlehey is a category C male prison. It holds up to 1,220 male prisoners convicted of sexual offences. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Littlehey was in August 2019. Inspectors reported that there was a wide range of good and responsive primary care clinics and services. Systems to identify and support patients with long-term conditions and complex health needs were impressive, this included a range of specialist clinics and a well-developed response to patients with social care needs.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to January 2022, the IMB reported that the health services continued to work cooperatively with the prisoners, who benefitted from seamless healthcare services. Throughout the year, the healthcare team worked well with the prison staff to respond rapidly to keep prisoners as safe as possible.

Previous deaths at HMP Littlehey

20. Mr Haldane was the 45th prisoner to die at Littlehey since May 2020. Of the previous deaths, 41 were natural causes, two were self-inflicted and one was a drug-related death.

Key Events

21. On 19 December 2015, Mr Alan Haldane was remanded to HMP Lewes charged with sexual assault of a child. On 7 April 2016, he was sentenced to six and half years in prison. He remained at Lewes and transferred to Littlehey on the 8 September 2017. On 13 September, Mr Haldane was sentenced to a further 15 years in prison for rape. He remained at Littlehey.

22. Mr Haldane had several pre-existing medical conditions, which included a right inguinal hernia repair, emphysema (damage in the lungs that causes breathlessness), hypertension (high blood pressure) and chronic obstructive pulmonary disease (COPD- a long-term, incapacitating respiratory disease). Healthcare staff prescribed appropriate medications to manage his conditions.

23. Following Mr Haldane's arrival at Littlehey, healthcare staff managed his long-term conditions using the long-term conditions pathway and he had reviews for his COPD and hypertension regularly.

24. Mr Haldane was diagnosed with an iliac aneurysm (a bulging and weakness in the wall of the iliac artery in the pelvis) in 2019, and regularly attended Cambridge University Hospital for assessments with the vascular surgeons' team. The decision was made by the vascular team that it would not be possible to attempt to repair the aneurysm due to the risk of respiratory failure. The surgeons explained this to Mr Haldane and agreed to treat the aneurysm conservatively and, if the aneurysm ruptured, they would take a palliative approach (relieving symptoms without dealing with the cause of the condition).

25. On 10 May 2023, Mr Haldane told an officer that he was having pain in his lower region. A female member of healthcare staff went to see him, but Mr Haldane said that he was happy to wait until the next day to see a male member of healthcare staff.

26. On 11 May, a GP at Littlehey completed a medical review with Mr Haldane. During this review, Mr Haldane said that he had been having dull, achy abdominal pain, all over his abdomen and back for the last few days. The GP examined Mr Haldane and prescribed him with co-codamol and made another appointment for Mr Haldane to see another GP at the prison, the next day. There is no record that the GP discussed Mr Haldane's iliac artery aneurysm with him during the appointment.

27. The next day, for reasons unknown, Mr Haldane did not attend his appointment with the other GP.

28. On 15 May, a nurse saw Mr Haldane, and he had a urine test. The result showed no abnormalities.

Events of 16 May 2023

29. At about 9.30am on 16 May, a prisoner told prison staff that Mr Haldane was in pain. An officer attended Mr Haldane's cell and asked him where his pain was and he pointed to his lower stomach. Mr Haldane was drifting in and out of

consciousness. She called a code blue (indicating a prisoner is unconscious or is having breathing difficulties).

30. Several members of healthcare staff responded. Mr Haldane was grey and had no signs of a pulse or breathing. The healthcare team took it in turns to perform CPR. They used a defibrillator, but no shock was advised.

31. The ambulance crew and air ambulance paramedics attended and took over Mr Haldane's care. Mr Haldane was given two rounds of adrenaline, but he still had no heart rhythm. After 30 minutes of CPR with no improvements, at 10.10am, the paramedics confirmed that Mr Haldane had died.

Contact with Mr Haldane's Family

32. The prison appointed a Custodial Manager (CM) as the Family Liaison Officer (FLO).

33. The FLO telephoned Mr Haldane's son and informed him of Mr Haldane's death and offered his condolences and support.

34. Mr Haldane's funeral took place on 19 June. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

35. After Mr Haldane's death, the Head of Functions debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team offered support, as well as line manager support, PAM assist (Employee Assistance Programme) and TRIM (Trauma Risk Management) support.

36. The prison posted notices informing other prisoners of Mr Haldane's death and offered support.

Post-mortem report

37. The post-mortem report gave Mr Haldane's cause of death as haemoperitoneum (internal bleeding between the abdominal wall and the internal abdominal organs). He also had a ruptured common iliac artery aneurysm and high blood pressure. The post-mortem found that the ruptured iliac artery aneurysm had resulted in a large volume of blood gathering in the abdominal cavity and pelvis. These findings were sufficient to account for Mr Haldane's sudden death.

38. At the inquest held on the 13 December 2023 the coroner concluded Mr Haldane died of natural causes.

Findings

Clinical care

39. The clinical reviewer concluded that the clinical care Mr Haldane received at HMP Littlehey was of a good standard and was equivalent to what he could have expected to receive in the community.

40. The clinical reviewer noted that the GP in the prison did not apparently discuss Mr Haldane's iliac artery aneurysm with him at the appointment on 11 May. The reviewer concluded that this was appropriate given the vascular surgery team's plan to manage the aneurysm palliatively should it rupture.

Good Practice

41. Mr Haldane received a good standard of care for the management of his long-term conditions and appropriate care plans were in place to manage these.

42. The healthcare team also delivered the emergency response effectively.

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