Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Sedgwick, a prisoner at HMP Littlehey, on 25 January 2025

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 I 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

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 Jason Sedgwick died of cardiac arrythmia and ischaemic heart disease on 25 January 2025, at HMP Littlehey. He was 40 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Sedgwick received at Littlehey was only partially equivalent to what he could have expected to receive in the community. Mr Sedgwick had numerous stockpiled medications in his cell and a medication in possession assessment had not been carried out since 2021.

5. We found that a routine roll check on the morning Mr Sedgwick died was not adequately carried out.

Recommendations

- The Governor should ensure that officers record and remove night light coverings during cell fabric checks

- The Governor should introduce a robust quality assurance process to ensure officers carry out effective roll checks.

The Investigation Process

6. HMPPS notified us of Mr Sedgwick's death on 25 January 2025.

7. NHS England commissioned an independent clinical reviewer, to review Mr Sedgwick's clinical care at HMP Littlehey. The clinical review is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Sedgwick's care. She interviewed eight members of staff at Littlehey in person, by video conferencing and by telephone in March, April and July 2025.

9. The Ombudsman's office wrote to Mr Sedgwick's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

10. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.

Previous deaths at HMP Littlehey

11. Mr Sedgwick was the 42nd prisoner to die at Littlehey since January 2022. Of the previous deaths, 37 were from natural causes and four were self-inflicted. Up to the end of December 2025, there have been 10 deaths since Mr Sedgwick's death, all were from natural causes. There are no similarities between the findings in our investigation into Mr Sedgwick's death and the findings from our investigations into the previous deaths.

Key Events

12. On 29 June 2015, Mr Jason Sedgwick was sentenced to 16 years imprisonment for sexual offences and was sent to HMP Nottingham. On 24 June 2021, Mr Sedgwick transferred to HMP Littlehey.

13. A nurse carried out Mr Sedgwick's reception health screen at Littlehey. Because of COVID-19 restrictions in place at the time, the nurse carried out the first and second health screen at the same time.

14. Mr Sedgwick was prescribed naproxen and paracetamol for sciatica, lansoprazole (a stomach protecting medication) and sertraline for anxiety and depression.

15. The next day, a pharmacist carried out a medication reconciliation and recorded that Mr Sedgwick could have 28 days' worth of medication, which he could keep with him in his cell. She did not record his medication in possession risk assessment (MIPRA) score. No further MIPRAs were carried out during Mr Sedgwick's time at Littlehey and he did not often see healthcare staff.

16. On 12 January 2025, an officer made a detailed entry in Mr Sedgwick's prison record about their key work session. Mr Sedgwick did not express any physical health concerns. This was the last entry in his prison record before his death.

17. On 14 January, a GP at Littlehey, saw Mr Sedgwick for a medication review. Mr Sedgwick was still taking naproxen and the GP advised against long-term use because it could cause stomach and kidney issues. Mr Sedgwick said he was content to continue as the medication was managing his pain well. The GP took Mr Sedgwick's blood pressure and recorded that it was in the acceptable range. Dr Hussain set a review for six weeks' time. There are no further entries in the medical record showing that healthcare staff saw Mr Sedgwick after this date.

18. At 4.45pm on 24 January, Mr Sedgwick telephoned his mother. They discussed a range of issues and Mr Sedgwick said that he had stopped taking his antidepressant medication but he did not say why. He did not express any concerns about his physical health.

19. At 8.00pm that day, an officer started his shift and a second officer provided a handover. There was no specific information about Mr Sedgwick. The officer carried out the evening routine check shortly after. He did not see anything unusual when he checked Mr Sedgwick.

20. At 4.30am on 25 January, the officer carried out the morning routine check. In interview, he could not recall any specific details about checking Mr Sedgwick's cell except that he did not have any concerns.

21. At 7.00am, a second officer came on duty. He asked the officer if there were any issues he needed to know about and was told there were none. He started the routine check shortly after. Mr Sedgwick's cell was dark and the second officer did not have a torch. He did not turn the night light on but said he could hear Mr Sedgwick snoring. The officer had worked on Bravo Wing for five months and knew that Mr Sedgwick often snored. He had no concerns and interpreted it as a sign of life before moving on with his checks.

22. At 8.45am, an officer started unlocking prisoners. At approximately 8.50am, he got to Mr Sedgwick's cell, opened the flap and saw Mr Sedgwick was face down on the floor. His feet were towards the observation panel, and his head was underneath a chair next to the bed. The officer called over to an officer and they both went into the cell. Mr Sedgwick did not respond to them calling and at 8.51am, an officer radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). He noted Mr Sedgwick's trousers were partially rolled up and his legs were dark purple.

23. Staff in the control room asked if an ambulance was required and at 8.52am, a SO and and an officer arrived at the cell. The officers turned Mr Sedgwick over and he was cold and rigid. The SO decided resuscitation attempts would be futile. At 8.54am, a nurse arrived and agreed. Staff in the control room were advised and called an ambulance at 8.55am which arrived at 9.15am.

24. At 9.21am, paramedics declared life extinct.

Post-mortem report

25. The post-mortem report gave Mr Sedgwick's cause of death as of cardiac arrythmia and ischaemic heart disease. There was no toxicological cause or contribution to the death.

Findings

Clinical findings

26. The clinical reviewer concluded that the care Mr Sedgwick received at Littlehey was only partially equivalent to what he could have expected to receive in the community.

27. Mr Sedgwick did not frequently attend the healthcare department. The clinical reviewer noted that, in 2022, he had a BMI of over 40 kg/m², classifying him as obese. He was advised to exercise, although it is not known whether he followed this advice. The post-mortem report recorded his weight at 128 kg, which is approximately 10kg less than when his BMI was last measured in 2022.

28. She also found that because Mr Sedgwick had turned 40 by the time of his death, he would have been eligible for an NHS Health Check. This assessment includes questions about lifestyle and a series of blood tests to measure liver function and cholesterol levels, with further tests carried out if diabetes risk is identified. The results are then used to complete a QRISK3 assessment (which calculates a person's risk of developing a heart attack or stroke in the next 10 years). There is no evidence that Mr Sedgwick undertook the health check before he died. There is nothing in his medical record to indicate that he reported any concerns related to his heart.

29. After Mr Sedgwick's death, a large amount of stockpiled medication was found under his bed, totalling over 1000 tablets of his combined medications. The toxicology report did not reveal an excess of medication in Mr Sedgwick's system, but it is concerning that the MIPRA was not updated and his adherence to his prescription was not monitored. The clinical reviewer has made recommendations about this issue which, while not directly relevant to Mr Sedgwick's death, the Head of Healthcare will wish to address.

Roll checks

30. Routine roll checks are primarily a visual security check to count prisoners to ensure that they are present in their cells, but they are also an opportunity for any concerns about a prisoner's safety to be identified and managed. HMPPS' National Security Framework expects welfare checks to take place at routine checks including that staff are able to see the prisoner's face and satisfy themselves that they are alive and well. Littlehey's local policy reflects this.

31. When Mr Sedgwick was found at 8.45am, there were clear signs that he had been dead for some time. As a result, we have considered how effective an officer's check at 7.00am was.

32. An officer told the investigator that the purpose of a roll check was to ensure the right person was in the right cell and alive. He said there was a photo of every prisoner by the cell door to aid identification. However, he also said that that it was dark when he carried out the roll checks that morning and that the prison does not provide the officers with torches. He could not see Mr Sedgwick but thought he

heard him snoring. There is no CCTV on the wing to confirm the check was carried out.

33. An officer said he did not turn on the night light because they often did not work, or prisoners frequently covered them up (although from the body worn camera footage it is not clear this had happened in this case). On this particular morning, the officer said a prisoner had asked him not to turn on any night lights as he would blow them all.

34. We asked the current the Head of Safety about these matters. She said that at the time of Mr Sedgwick's death the prison did not issue staff with torches, but they have now purchased torches for night staff. She said that any reports of night lights not working should be reported and prisoners covering their night lights should be challenged. She checked with the maintenance department and said that there were no reports that using night lights had blown the lights in other cells.

35. We consider that an officer's roll check on 25 January was ineffective. The range of issues he reported in accounting for this indicate that there may be a systemic issue among staff. We make the following recommendation:

    The Governor should introduce a robust quality assurance process to ensure officers carry out effective roll checks.

Governor to note

Emergency response

36. When a medical emergency code is broadcast over the radio, control room staff are required to call an ambulance immediately. This did not happen in Mr Sedgwick's case. Instead, staff sought clarification on whether an ambulance was needed, resulting in a four minute delay in making the call. In Mr Sedgwick's case it made no difference as he was clearly dead (and it seems from the body worn video camera footage that control room staff were made aware of this quite quickly). However, it is important that ambulances are called promptly following a medical emergency. We bring this to the Governor's attention.

37. During interview, one officer used an offensive term. We have raised this with the Governor in separate correspondence.

Inquest

38. At the inquest, held on 9 July 2025, the Coroner concluded that Mr Sedgwick's death was from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **March 2026**

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100