

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Edward Dalton a prisoner at HMP Littlehey on 27 April 2019

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Edward Dalton died in hospital on 27 April 2019 of organ failure, while a prisoner at HMP Littlehey. He was 71 years old. I offer my condolences to Mr Dalton's family and friends.

Mr Dalton had several long-term conditions which were appropriately managed by the prison. I am satisfied that he received a standard of care at Littlehey 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.

**Elizabeth Moody**  
**Deputy Prisons and Probation Ombudsman**  
**December 2019**

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# Summary

## Events

1. On 12 October 2012, Mr Dalton was sentenced to 12 years in prison for sexual offences and sent to HMP Elmley. On 15 August 2018, he was moved to HMP Littlehey. He had several long-term conditions including chronic obstructive pulmonary disease (COPD – a collection of serious lung diseases), asbestosis, angina and high blood pressure.
2. On 30 January 2019, Mr Dalton reported increased breathlessness. A nurse arranged blood tests and the results showed low haemoglobin levels. A doctor examined Mr Dalton and felt a mass in his abdomen. She was unsure if it was an enlarged spleen or bowel cancer and referred him for an urgent hospital appointment under the suspected cancer pathway.
3. In February, while undergoing an endoscopy (an examination of the inside of the body using a long, flexible tube with a camera at one end), Mr Dalton suffered severe internal bleeding. He was put into an induced coma but never recovered. He died in hospital on 27 April.

## Findings

4. We are satisfied that the care Mr Dalton received at HMP Littlehey was equivalent to that he could have expected to receive in the community. Staff managed his long-term conditions well and made appropriate referrals when there were concerns.
5. We make no recommendations.

## The Investigation Process

6. 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.
7. The investigator obtained copies of relevant extracts from Mr Dalton's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Dalton's clinical care at the prison.
9. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation. The coroner provided a copy of the post-mortem report. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Dalton's nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. They also pointed out some factual inaccuracies within the clinical review and, where the clinical reviewer agrees, she has made amendments.

# Background Information

## HMP Littlehey

12. HMP Littlehey is a medium security prison housing approximately 1,200 men. A high proportion of the prison's population are men who have been convicted of sexual offences.
13. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

## HM Inspectorate of Prisons

14. The most recent inspection of HMP Littlehey was in March 2015. Inspectors reported that a small group of GPs who regularly attended the prison had significantly improved patient care. Lifelong conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments for prisoners were rarely cancelled. Risk assessments for keeping medications in-possession were not always reviewed and recorded correctly.

## Independent Monitoring Board

15. 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 31 January 2018, the IMB reported that the prison's working relationship with the local hospice was positive, enabling men to opt for end of life care where they could be surrounded by family and friends. The IMB had concerns about whether the number of trained family liaison officers was sufficient to deal with the large numbers of deaths in custody. It stated that the End of Life Suite, completed in 2013, continued to be unused due (reportedly) to a lack of funding.

## Previous deaths at HMP Littlehey

16. Mr Dalton was the 19th prisoner to die at Littlehey since April 2017. Seventeen deaths were from natural causes and one was self-inflicted. There were no similarities with Mr Dalton's case.

## Key events

17. On 12 October 2012, Mr Dalton was sentenced to 12 years in prison for sexual offences and sent to HMP Elmley. On 15 August 2018, Mr Dalton was moved to HMP Littlehey. He had chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema), asbestosis (a serious long-term lung condition caused by exposure to asbestos), high blood pressure and angina (chest pain caused by reduced blood flow to the heart).
18. On 15 August 2018, a nurse carried out Mr Dalton’s reception screen and noted his long-term conditions. A prison GP prescribed appropriate medication.
19. On 30 January 2019, a nurse conducted Mr Dalton’s six-monthly cardiovascular heart disease check. He was more relaxed and said his angina was less frequent. Mr Dalton said his COPD was not good and he was getting more breathless, so the nurse arranged blood tests.
20. On 1 February, a prison GP saw Mr Dalton about the blood test results. His platelet count was low but stable, and his haemoglobin levels were low. She did not identify any internal bleeding but noted his history of gastric varices (abnormal large veins in the stomach which can be a life-threatening cause of bleeding in the gastrointestinal tract). She felt a large mass in his abdomen and was unsure whether it was an unusually large spleen or bowel cancer. She made a referral for an urgent hospital appointment under the suspected cancer pathway (for an appointment within two weeks) and prescribed iron tablets.
21. On 6 February, a prison GP discussed the referral with the multidisciplinary team. On 9 February, a nurse created a Psychological and Emotional Care Plan to support Mr Dalton with any potential cancer diagnosis.
22. On 13 February, Mr Dalton was seen by a consultant gastroenterologist. He thought Mr Dalton’s symptoms required further investigation but his long-term conditions meant he was not fit for a full set of investigations. Instead, the consultant arranged an endoscopy (where a long, flexible tube with a camera at one end (endoscope) is passed down the throat to see into the stomach) and a CT colonoscopy (a scan of the bowel).
23. On 22 February, Mr Dalton refused to go to his scan appointment. A nurse saw him and explained the importance of it and he agreed to go if it was rebooked.
24. On 28 February, Mr Dalton was taken to a hospital for the endoscopy. He was restrained using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
25. The endoscopy showed that Mr Dalton had oesophageal and gastric varices. There were complications of bleeding during the procedure and Mr Dalton was admitted as an inpatient. Staff removed the escort chain and it was never reapplied.
26. On 1 March, Mr Dalton was moved to a hospital in London in an induced coma. Healthcare staff at Littlehey stayed in touch with the hospital and by 9 March, A

nurse recorded that Mr Dalton was awake. However, on 14 April, a minute by She referred to Mr Dalton still being in an induced coma.

27. On 18 April, Mr Dalton was moved back to a hospital's critical care unit where he continued to deteriorate. On 27 April, at 11.06am, a hospital doctor recorded that Mr Dalton had died.

### **Liaison with Mr Dalton's family**

28. On 28 February, the prison appointed a prison manager as the family liaison officer (FLO). The FLO contacted the next of kin that day and explained that Mr Dalton was in hospital. He stayed in touch to give him information and offer support. On 27 April, when Mr Dalton died, the FLO travelled to the next of kin's home to give him the news in person.
29. Mr Dalton's funeral was on 23 May and the FLO and the deputy family liaison officer attended. The prison paid for the funeral, in line with national policy.

### **Support for prisoners and staff**

30. After Mr Dalton's death, a prison manager debriefed the staff on the hospital bedwatch to ensure they had the opportunity to discuss any issues arising, and to offer support.
31. The prison posted notices informing other prisoners of Mr Dalton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Dalton's death.

### **Post-mortem report**

32. The post-mortem report listed the cause of death as multiple organ failure, caused by bilateral pneumonia (infection of both lungs). Liver cirrhosis with oesophageal varices (abnormal veins), splenomegaly (enlarged spleen), ascites (protein-containing fluid in the abdomen), cor pulmonale (complications arising from high blood pressure in the pulmonary arteries, also known as right sided heart failure) and COPD were listed as contributory factors.

# Findings

## Clinical care

33. The clinical reviewer was satisfied that the care Mr Dalton received at HMP Littlehey was equivalent to that he could have expected to receive in the community. Staff put in place care plans to manage his long-term conditions and made appropriate referrals when there were concerns.
34. We make no recommendations.

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