

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sivaguru Narendran a prisoner at HMP Swaleside on 13 February 2020

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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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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Sivaguru Narendran, who was 79 years old, died from heart disease on 13 February 2020, at HMP Swaleside. We offer our condolences to Mr Narendran's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Narendran received at Swaleside was of a good standard and at least equivalent to that which he could have expected to receive in the community. However, she made four recommendations. These were not directly related to Mr Narendran's cause of death and have not been included in our report.
5. We found no non-clinical issues of concern. We make no recommendations.

Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Narendran's clinical care at HMP Swaleside.
7. The PPO investigator has investigated the non-clinical issues in Mr Narendran's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Narendran's next of kin to explain the investigation. They did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Swaleside

10. Mr Narendran was the 12th prisoner to die at Swaleside since February 2018. Of the previous deaths, seven were from natural causes, two were self-inflicted, one was drug-related, and one is awaiting classification. There are no similarities between these deaths and Mr Narendran's.

Key Events

11. On 14 December 2018, Mr Sivaguru Narendran was sentenced to 12 years imprisonment for sexual offences. He was moved to HMP Swaleside on 27 March 2019.
12. Mr Narendran arrived at Swaleside with several serious health conditions. He had had two heart attacks before being sent to prison. He had ischaemic heart disease (insufficient blood supply to the heart), atrial fibrillation (an abnormal heart rhythm), congestive heart failure (inefficient pumping of the heart) and hypertension (high blood pressure). He also had limited vision, hearing and mobility.
13. Mr Narendran's health continued to decline while he was at Swaleside. In June, he was provided with a wheelchair. He was also found to have liver and thyroid problems and he received medication for a prostate problem.
14. Mr Narendran was a former medical professional and was fully engaged with his treatment at Swaleside. In September, he attended an appointment at the prison's Life Limited Illness clinic and continued regular appointments with the clinic up until his death. In September, he was referred to a hospice palliative care team that works in partnership with the prison. They came and discussed his options with him in November. It was Mr Narendran's wish to remain at Swaleside in the Inpatient Unit, and he completed a Do Not Attempt Resuscitation (DNAR) form on 7 November.
15. On 12 February 2020, healthcare staff visited Mr Narendran as he reported feeling unwell and he said that he had not been eating much recently. His clinical observations showed nothing of concern.
16. On 13 February, Mr Narendran was found unresponsive in his cell and a prison officer called healthcare staff. Resuscitation was not attempted as there was a DNAR in place and Mr Narendran was declared dead at 9.23am.
17. The post-mortem report shows Mr Narendran's cause of death as ischaemic and hypertensive heart disease, with haemorrhagic pancreatitis (bleeding within or around the pancreas) as a contributory factor.

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