

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Hatton, a prisoner at HMP Littlehey, on 20 May 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Arthur Hatton died of vascular dementia on 20 May 2020 at HMP Littlehey. Old age and frailty contributed to but did not cause his death. He was 92 years old. We offer our condolences to those who knew him.
4. The clinical reviewer concluded that the clinical care that Mr Hatton received at Littlehey was of a high standard and at least equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer said that there were several areas of good practice, including the instruction of an Independent Mental Capacity Advocate (whose role is to support those who lack the capacity to make decisions, where they do not have family or friends to help them) and the compassionate decision by a nurse and an officer to sit with Mr Hatton in the hour before he died.
6. We did not identify any non-clinical issues of concern and we make no recommendations.
7. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Investigation Process

8. NHS England commissioned an independent clinical reviewer to review Mr Hatton's clinical care at HMP Littlehey. The clinical review is attached to this report at Annex 1.
9. The PPO investigator has investigated the non-clinical issues in Mr Hatton's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. We shared the initial report with the prison service. There were no factual inaccuracies.

Previous deaths at Littlehey

11. There were 14 deaths from natural causes (three of which were related to COVID-19) and one self-inflicted death at HMP Littlehey in the two years before Mr Hatton's death. Two prisoners have died at Littlehey since Mr Hatton's death, one was self-inflicted and the other from natural causes. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

12. On 14 July 2016, Mr Arthur Hatton was convicted of sex offences and was sentenced to seventeen years in prison. On 27 January 2017, he was transferred to HMP Littlehey.
13. Mr Hatton had urinary incontinence, and received daily social care, including help with washing and dressing. He used a Zimmer frame on the wing and a wheelchair for longer distances.
14. On 6 March 2020, Mr Hatton fell over in his cell and banged his head. He went to hospital, where he had a CT scan which identified possible dementia. He also had a urinary tract infection for which he received intravenous antibiotics.
15. On 1 May, prison staff found Mr Hatton on the floor of his cell. He was sent to hospital, where he had an x-ray which showed a historic leg fracture.
16. During the last weeks of his life, Mr Hatton's mobility worsened until he became bed-bound and needed full-time nursing. He had pressure sores which healthcare staff graded and dressed.
17. An application for compassionate early release was being processed but Mr Hatton died on 20 May before it was completed. Mr Hatton died of vascular dementia. Old age and frailty contributed to but did not cause his death.

Caroline Mills
Assistant Ombudsman

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