

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Arthur Moss, a prisoner at HMP Littlehey, on 6 November 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*



© Crown copyright 2017

This publication is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3) or email the Copyright Team at [psi@nationalarchives.gov.uk](mailto:psi@nationalarchives.gov.uk)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

When you use this information under the Open Government Licence, you should include the following attribution: Independent investigation into the death of Mr Arthur Moss at HMP Littlehey on 6 November 2020, Prisons and Probation Ombudsman, 3 November 2021, licensed under the Open Government Licence.

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.

The Ombudsman's 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 Arthur Moss died on 6 November 2020 of bronchopneumonia at HMP Littlehey. He was 83 years old. I offer my condolences to Mr Moss' family and friends.

The clinical reviewer concluded that the health care Mr Moss received was of a reasonable standard and equivalent to that which he could have expected to receive in the community. We found no non-clinical issues of concern.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**September 2021**

## **Contents**

Summary.....	1
The Investigation Process .....	2
Background Information .....	3
Key Events .....	4
Findings.....	11

# Summary

## Events

1. In September 2017, Mr Arthur Moss was remanded into prison custody charged with historic sexual offences. In November, he was sentenced to 16 years in prison.
2. When he entered prison, Mr Moss had a number of pre-existing medical conditions, including raised blood pressure, type 2 diabetes and arthritis.
3. Mr Moss transferred to HMP Littlehey on 11 January 2019.
4. A prison GP saw Mr Moss in January and March after he complained of dizziness and ordered tests. He subsequently referred him to the cardiology department at Hinchinbrook Hospital where he had further tests.
5. On 17 October 2020, Mr Moss had a triple heart bypass. He remained in hospital until 29 October when he was discharged to Littlehey. Prison healthcare staff cared for him in his cell.
6. On 6 November, during an early morning roll check, Mr Moss was found unresponsive in his cell. Staff radioed a medical emergency code blue (indicating a prisoner is unconscious or is having difficulty breathing). A nurse arrived promptly but decided not to begin CPR as there were signs that Mr Moss had been dead for some time.
7. At 7.53am, paramedics arrived at the cell and confirmed that Mr Moss had died.
8. The post-mortem examination found that Mr Moss died of bronchopneumonia. He also had type 2 diabetes which contributed to but did not cause his death.

## Findings

9. The clinical reviewer concluded that the clinical care Mr Moss received at Littlehey was of a reasonable standard and equivalent to that which he could have expected to receive in the community.
10. The clinical reviewer did, however, identify one area of concern, in that there is no evidence to indicate that healthcare staff wore appropriate personal protective equipment (PPE) while carrying out medical interventions after Mr Moss returned to Littlehey in October. This is not in line with national guidance.

## Recommendations

- The Head of Healthcare should ensure that it is noted in a prisoner's medical records that appropriate PPE is worn by healthcare staff when undertaking medical interventions during the COVID-19 pandemic.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact him. No-one responded.
12. The investigator obtained copies of relevant extracts from Mr Moss' prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Moss' clinical care at the prison.
14. We informed HM Coroner for Cambridgeshire and Peterborough 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. One of the PPO's family liaison officers wrote to Mr Moss' next of kin, his daughter, to explain the investigation. She did not respond to our letter.
16. 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.

# Background Information

## HMP Littlehey

17. 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.
18. 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

19. The most recent inspection of HMP Littlehey was in July to August 2019. Inspectors reported that healthcare provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. They noted that innovative means of increasing secondary care consultation slots, such as Skype, were being introduced where demand outstripped escort availability.

## Independent Monitoring Board

20. 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 2020, the IMB reported that the Governor and senior management team had spent time and effort to deal with a range of structural and facilities issues which continued to undermine the morale of prisoners and staff. They noted that healthcare provisions were of generally good quality but were restricted on a fortnightly basis because of staff training and limited by the number of hospital appointments that could be scheduled each day.

## Previous deaths at HMP Littlehey

21. Mr Moss was the 15th prisoner to die at HMP Littlehey since November 2018. Of the previous deaths, 13 were from natural causes and one was a self-inflicted death. There have been 12 further deaths since Mr Moss' death, all from natural causes.

## Key Events

22. On 13 September 2017, Mr Arthur Moss was remanded into prison custody charged with historic sexual offences. He was taken to HMP Wandsworth.
23. During his initial health screen at Wandsworth, a prison nurse noted Mr Moss had a number of pre-existing medical conditions including raised blood pressure, insulin dependent diabetes and arthritis which made it difficult for him to move around. He also told the nurse he had been diagnosed with leukaemia in 2007, and while he had not received any active treatment, he had been subject to six monthly blood tests. Referrals were made to secondary care providers to ensure continuity of his care.
24. On 21 November, Mr Moss was sentenced to 16 years in prison. He returned to HMP Wandsworth.
25. On 21 September 2018, Mr Moss transferred to HMP Swaleside. At an initial health screen, his pre-existing medical conditions were noted, and his prescribed medications and care plans were reviewed and updated.
26. On 11 January 2019, Mr Moss transferred to HMP Littlehey.
27. A nurse carried out an initial health screen and noted Mr Moss' pre-existing medical conditions. She also noted he was awaiting cardiac investigations to try to find the cause of his high blood pressure. During the health screen, Mr Moss also told the nurse he had experienced bouts of dizziness. She referred him for a review by a prison GP. Mr Moss' care plans were reviewed and updated, and he was referred to secondary care providers to ensure continuity of his care. Specialist clinics managed his care at the prison.
28. On 19 January, Mr Moss was reviewed by a prison GP. Mr Moss told him that he had been experiencing occasional dizziness for the previous ten months. As there were no other symptoms, the GP considered the dizziness was caused by vertigo.
29. On 28 March, the prison GP reviewed Mr Moss after he again complained of dizziness. He considered Mr Moss would benefit from an ECG.
30. The ECG was carried out on 2 April. The results indicated he had developed a first-degree atrioventricular block (where the heart beats more slowly or with an abnormal rhythm). The prison GP referred Mr Moss for a cardiac review at Hinchinbrook Hospital.
31. The review took place on 14 October 2019. Hospital staff considered Mr Moss needed an angiogram (an X-ray which uses contrast dye to highlight damage to the coronary arteries) and a myocardial perfusion (which measures the efficiency of the blood flow to the heart). The results of the tests were reviewed by hospital staff on 14 January 2020, and they referred him for further investigations.
32. In August 2020, a cardiac consultant diagnosed Mr Moss with a blocked artery and cardiovascular disease. He considered that only treatment option open to Mr Moss was a triple heart bypass. The procedure was carried out on 16 October, and Mr Moss remained in hospital as an inpatient.

33. Mr Moss was discharged back to Littlehey on 29 October. Due to COVID-19 restrictions, he was required to isolate on his return to prison and healthcare staff nursed him in his cell.
34. On 1 November, a nurse saw Mr Moss because he complained of shortness of breath. She checked his observations, and they were normal. She advised him to sit up and take deep breaths and to walk around his cell. She also arranged for him to get help with his medications.
35. On 2 November, Mr Moss was reviewed by a prison GP, who noted that although Mr Moss was extremely tired and spending most of the day in bed, he was improving daily.
36. On 5 November, a nurse reviewed Mr Moss. She was concerned that he was sitting on his bed with a sweater and a coat on, but without any trousers, and appeared to be confused. She checked his blood sugar levels, which were low, so she encouraged him to eat something. She reviewed him again later that evening and noted his condition had improved.

### **Events of 6 November**

37. The following morning at 7.30am on 6 November, while carrying out an early morning roll check, a prison officer looked through the observation panel of Mr Moss' cell door to check on his well-being. He saw Mr Moss sitting upright on the end of his bed with his feet on the floor, leaning slightly to one side. He knocked on the door and called to him, but he did not respond. He was aware that Mr Moss had undergone coronary surgery, so went to the wing office to telephone the Custodial Manager (CM) for permission to enter the cell to check on him.
38. At 7.35am, the CM, who was also aware of Mr Moss' recent surgery, took the decision to radio a medical emergency code blue (indicating a prisoner is unconscious or having difficulty breathing).
39. A prison officer who was near Mr Moss' cell, responded and entered the cell. He noted Mr Moss was cold to the touch. He checked for signs of life, but there were none. He also noted there was evidence of cyanosis (a blue tinge to the body caused by lack of oxygen.) The CM and a senior manager arrived at the cell almost immediately afterwards.
40. At 7.40am, a nurse practitioner also arrived at the cell. She checked Mr Moss for signs of life, but there were none. She also noted the signs of cyanosis in his head and fingers. She decided not to begin cardiopulmonary resuscitation as it was clear that Mr Moss had been dead for some time.
41. At 7.53am, paramedics arrived at the cell and confirmed that Mr Moss had died.

### **Post-mortem report**

42. The post-mortem examination found that Mr Moss died of bronchopneumonia. He also had type 2 diabetes which did not cause but contributed to his death.

### **Contact with Mr Moss' Family**

22. The prison appointed the Head of Offender Management at Littlehey as family liaison officer (FLO).
23. At 8.45am, he telephoned Mr Moss' daughter to inform her of her father's death. He remained in contact with Mr Moss' daughter, offering her support.
24. Mr Moss' funeral was held on 8 December 2020. The prison paid for the full cost of the funeral in line with national guidance.

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

25. After Mr Moss' death, a senior manager debriefed the staff who were involved, giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
26. The prison posted notices informing other prisoners of Mr Moss' 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 his death.

# Findings

## Clinical care

27. The clinical reviewer concluded that the care Mr Moss received at Littlehey was of a reasonable standard and at least equivalent to that which he could have expected to receive in the community.
28. The clinical reviewer did, however, identify one area of concern.
29. During, the COVID-19 pandemic, HM Prison and Probation Service and Public Health England issued joint guidance, *Preventing and controlling outbreaks of COVID-19 in prisons and places of detention*. It provides operational recommendations for custodial and healthcare staff on preventing and managing outbreaks of COVID-19, including specific advice on population management, social distancing, actions to take if a prisoner, or staff member develops symptoms, and the use of personal protective equipment (PPE).
30. The clinical reviewer was concerned that when Mr Moss returned to prison on 29 October and had to isolate due to COVID-19 restrictions, there is no evidence in his medical records to indicate that appropriate PPE was worn by healthcare staff when carrying out medical interventions, which is not in line with the guidance. We make the following recommendation:

**The Head of Healthcare should ensure that it is noted in a prisoner's medical records that appropriate PPE is worn by healthcare staff when undertaking medical interventions during the COVID-19 pandemic.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations