Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Malin, a prisoner at HMP Littlehey, on 20 August 2021

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
F I 020 7633 4141

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 Michael Malin, who was 83 years old, died in hospital of a stroke on 20 August 2021, while a prisoner at HMP Littlehey. We offer our condolences to Mr Malin's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Malin received at Littlehey was equivalent to that he could have expected to receive in the community. She made one recommendation.

5. We did not find any 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.

Recommendations

- The Head of Healthcare should ensure that regular medication in possession risk assessments (MIPRA) are undertaken with particular emphasis on patients where there are concerns about medication compliance and suitability for in possession medication.

The Investigation Process

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

7. The PPO investigator, has investigated the non-clinical issues in Mr Malin's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. We have sent the Coroner a copy of this report.

9. The Ombudsman's family liaison officer wrote to Mr Malin's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Littlehey

11. Mr Malin was the 28th prisoner to die at Littlehey since August 2019. Of the previous deaths, 26 were from natural causes and one was self-inflicted.

Key Events

12. In May 2016, Mr Michael Malin was sentenced to nine years in prison for sexual offences. On 18 August 2017, he was moved to HMP Littlehey.

13. Mr Malin had several long-term health conditions including ischemic heart disease, heart failure, hypertension (high blood pressure), high cholesterol and chronic kidney disease. Mr Malin was prescribed appropriate medication for these conditions. However, there were occasions when he forgot to take his medication.

14. On 31 March 2020, Mr Malin told healthcare staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order to that effect.

15. In the early hours of 16 June 2021, as he walked past Mr Malin's cell, An Operational Support Grade (OSG) heard Mr Malin moaning. When he looked through the observation panel, he saw Mr Malin lying on the floor of his cell. He called for assistance on his radio. A Custodial Manager (CM) and an officer responded and they both went into the cell and helped Mr Malin up from the floor. Mr Malin told the CM that he had got up to go to the toilet and had fallen over. The CM told the OSG to check on Mr Malin hourly for the rest of the night.

16. At around 5.00am, the OSG saw that Mr Malin had slipped down in his chair. He called for assistance on his radio. The CM responded and they both went into the cell and sat Mr Malin back up in his chair.

17. At around 6.50am, during the morning roll check, an officer saw that Mr Malin was on the floor. He called a CM. The CM and an officer went into Mr Malin's cell and helped him up. The CM noticed that the left side of Mr Malin's face had drooped and that he was unable to smile. He called for healthcare staff on his radio. A nurse responded. She was concerned that Mr Malin had had a stroke and called an ambulance. Mr Malin was taken to hospital where he was admitted.

18. On 13 July, the prison applied for Mr Malin's early release on compassionate grounds. On 15 July, the Public Protection Casework Section (within HM Prison and Probation Service) refused the application because they considered that Mr Malin's case did not meet all the criteria, namely that his risk of reoffending was not past and there was no suitable release plan in place.

19. On 10 August, hospital staff told prison staff that Mr Malin's health had deteriorated and that he was being cared for on an end of life pathway. On 20 August, Mr Malin died.

20. The post-mortem report concluded that Mr Malin died from a stroke, caused by atrial fibrillation (when the heart beats irregularly or rapidly). Hypertension and heart failure were listed as contributory factors.

Louise Richards **January 2022**
Assistant Ombudsman

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