

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr John Stafford, a prisoner at HMP Littlehey, on 22 January 2022**

**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 John Stafford died of a ruptured artery aneurysm on 22 January 2022 at HMP Littlehey. He was 56 years old. I offer my condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care Mr Stafford received at HMP Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation about the management of long-term conditions which we repeat below.
5. We found no non-clinical issues of concern.

## Recommendation

- The Head of Healthcare should ensure that there are processes in place to support with care planning, which should include the management of long-term conditions.

## **The Investigation Process**

6. NHS England commissioned an independent clinical reviewer to review Mr Stafford's clinical care at HMP Littlehey.
7. The PPO investigator has investigated non-clinical issues, including Mr Stafford's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. We wrote to Mr Stafford's next of kin, his sister, to explain the investigation. She asked about Mr Stafford's aneurysm care and asked for a copy of our report, which we have sent her.
9. Mr Stafford's sister received a copy of the initial report. She did not make any comments.
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 Stafford was the thirtieth prisoner to die at HMP Littlehey since January 2020. Of the previous 29 deaths, 28 were from natural causes and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Stafford's death and our investigation findings for the previous deaths.

## Key Events

12. On 30 October 2015, Mr John Stafford was sentenced to 15 years and 9 months imprisonment for sexual offences. He was sent to HMP Woodhill. On 21 November 2018, he transferred to HMP Littlehey.
13. Mr Stafford had several pre-existing long-term health conditions including hypertension (high blood pressure), angina (reduced blood flow to the heart), type 2 diabetes, chronic kidney disease, obesity and in 2019, he was diagnosed with sleep apnoea (where the upper airways collapse during sleep).

### 2020

14. On 3 June 2020, a prison GP saw Mr Stafford because he had a urine infection. The GP referred him for an ultrasound scan of his kidneys, ureters and bladder.
15. On 10 November, a prison GP reviewed the results of Mr Stafford's ultrasound scan. It showed that he had an abdominal aortic aneurysm (a bulge or swelling in the main blood vessel that runs from the heart down through the chest and stomach). The GP referred Mr Stafford to a hospital vascular specialist.
16. On 8 December, Mr Stafford had a telephone consultation with a consultant vascular surgeon. She advised that Mr Stafford's aneurysm needed monitoring, he would need to lose weight and be prescribed aspirin to reduce the risk of blood clots.

### 2021

17. On 30 September 2021, a hospital vascular specialist nurse saw Mr Stafford. She diagnosed two bilateral popliteal aneurysms; one in each knee. (A bilateral popliteal aneurysm is an irregular bulge that occurs in the wall of the artery located behind the knee joint. An aneurysm can burst, which may cause life-threatening, uncontrolled bleeding.) She arranged an appointment for Mr Stafford to be reviewed by the hospital's vascular surgery team.
18. On 5 October, the vascular specialist nurse sent an email to the healthcare team at Littlehey advising them that as part of Mr Stafford's ongoing assessment, he would need a CT scan. However, due to his weight, she advised that the scan might not be able to be performed at the hospital and that Mr Stafford might need to attend a specialist unit based in London.
19. On 22 November, Mr Stafford saw the hospital's consultant vascular surgeon. He assessed that the size of the abdominal aortic aneurysm was below the threshold for surgery and that due to his weight, operating on Mr Stafford carried a high risk of complications. Mr Stafford was waiting for his CT scan. The consultant said that he would be reviewed again by the vascular surgery team once this scan had been completed.
20. On 8 December, Mr Stafford attended hospital for a CT scan. There was no follow up appointment arranged by the hospital at the time. Mr Stafford died before a consultant review appointment was arranged.

## 2022

21. On 4 January 2022, a prison GP saw Mr Stafford. Mr Stafford told her that he was experiencing constipation. The prison GP requested a FIT test (a test to detect for traces of blood in faeces).
22. On 10 January, a prison GP saw Mr Stafford because the FIT test result was positive. The prison GP completed a 2 Week Wait (2WW) cancer referral. A 2WW is a referral to a specialist to review a patient where there are concerns they may have cancer.

### Events of 22 January 2022

23. At around 11.30am, staff began serving lunch on Mr Stafford's wing. Prison staff saw Mr Stafford collect his lunch. There was nothing in his presentation that caused staff any concern.
24. At around 2.20pm, a prisoner saw Mr Stafford returning to his cell from the showers. This was the last time Mr Stafford was seen alive.
25. At around 3.30pm, a prisoner went into the staff office on the wing and told an officer that a prisoner had collapsed in his cell and was non-responsive. The officer immediately went to the cell and, as he did so, asked another officer to call a 'code blue' (an emergency code used when a prisoner is experiencing breathing difficulties or is unconscious/non-responsive).
26. The officer went into Mr Stafford's cell and found him lying on the floor with his back against the rear wall of his cell. He was pale and cold to the touch. The officer called out to Mr Stafford and pinched his ear but got no response.
27. An officer called a code blue. Two nurses attended immediately. Prison control room staff called an ambulance at 3.36pm.
28. Both officers and the prisoner moved Mr Stafford away from the back wall of the cell so that they could begin CPR. A Senior Officer (SO) arrived at Mr Stafford's cell. He took over CPR while an officer cut away Mr Stafford's clothing to attach the defibrillator. Healthcare staff arrived and a nurse applied the defibrillator. It advised 'no shock' and the nurses gave Mr Stafford oxygen. Nursing staff carried out CPR until the paramedics arrived.
29. At 3.49pm, the ambulance arrived at HMP Littlehey. Paramedics reached Mr Stafford at 3.58pm and took over CPR from nursing staff. Paramedics gave Mr Stafford adrenaline, but he did not respond to emergency treatment. At 4.19pm, paramedics pronounced Mr Stafford dead in his cell.
30. At around 4.15pm, the prison appointed a family liaison officer (FLO). The FLO was not at work that day but drove to the prison and arrived there about 5.00pm.
31. At 5.35pm, the FLO rang Mr Stafford's next of kin, his sister, and told her that her brother had died and offered their condolences. In line with policy, the prison contributed to the cost of Mr Stafford's funeral.

## **Post-mortem report**

32. The pathologist concluded in the post-mortem that Mr Stafford died of a ruptured right common iliac artery aneurysm (the bursting of a bulge and weakness in the wall of one of the iliac arteries, which branch off the abdominal aorta in the pelvis). He also had hypertension (high blood pressure) and type 2 diabetes mellitus which did not cause but contributed to his death.

## Clinical Findings

33. The clinical reviewer concluded that the clinical care Mr Stafford received at HMP Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. She did, however, raise one area of concern.

### Long Term Condition care planning

34. The clinical reviewer found that although Mr Stafford was reviewed in line with National Institute for Health Care Excellence (NICE) guidance for the management of his chronic kidney disease, hypertension and type 2 diabetes, there were no up to date care plans in place for these conditions. General evidence suggests that a lack of care planning can affect the continuity and coordination of care and may miss the views of the patient. We make the following recommendation:

**The Head of Healthcare should ensure that there are processes in place to support with care planning, which should include the management of long-term conditions.**

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**July 2022**

**Prisons &  
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