

**Prisons &
Probation**

Ombudsman
Independent Investigations

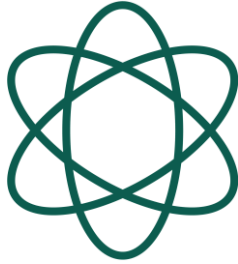
Independent investigation into the death of Mr Owen Brown, a prisoner at HMP Full Sutton, on 21 January 2022

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 Owen Brown, who was 70 years old, died in hospital from heart failure on 21 January 2022, while a prisoner at HMP Full Sutton. We offer our condolences to Mr Brown's family and friends.
4. Mr Brown was diagnosed with heart disease and kidney disease in his 50s. He was not always compliant with medication and health advice. The clinical reviewer found that he received a good standard of care for his long-term conditions but that other aspects of his care were not equivalent to that which he could have expected to receive in the community. The clinical reviewer made three recommendations but as they were not directly related to Mr Brown's cause of death, we have not included them in our report.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Brown's clinical care at HMP Full Sutton. The clinical review is attached to this report as Annex 1.
7. The PPO investigator has investigated the non-clinical issues in Mr Brown's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO's family liaison officer (FLO) wrote to Mr Brown's next of kin, his brother and cousin, to explain the investigation. They raised several issues, including asking why Mr Brown did not have a kidney transplant or why he was not released on parole. The FLO explained these matters are outside the remit of the PPO investigation.
9. We received statements from four prisoners. They also questioned why Mr Brown was not released from prison earlier on parole, which as mentioned above, is outside the remit of this investigation. They also queried the adequacy of his care which the clinical reviewer has addressed in her report.
10. The initial report was shared with two of Mr Brown's brother and a cousin. They did not make any comments.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Previous deaths at HMP Preston

12. Mr Brown was the seventh prisoner to die at Full Sutton since January 2020. Of the previous deaths, five were from natural causes and one was self-inflicted.

Key Events

13. In December 1997, Mr Owen Brown was sentenced to life imprisonment for rape. He was at HMP Full Sutton from October 2005.
14. Mr Brown was diagnosed with heart disease and kidney disease in his 50s. From 2008, he had dialysis (a procedure involving a machine that filters the blood removing harmful waste products when kidneys are unable to perform this function) three times a week. He also had hypertension (high blood pressure), hyperparathyroidism (where the body produces too much parathyroid hormone, which causes calcium imbalance in the blood that can lead to bone disease and heart and circulation problems) and atrial fibrillation (irregular heartbeat).
15. Mr Brown sometimes refused to go for dialysis even though staff made him aware of the risks of missing his dialysis sessions. He also sometimes refused to take the medication for his various conditions.
16. In August 2019, following a dialysis session, Mr Brown had a heart attack, and the following month he had an operation to insert an implantable cardioverter defibrillator (ICD - a device which constantly monitors the heart and sends electrical pulses to regulate abnormal heart rhythms).
17. In 2021, Mr Brown agreed to have an operation to treat his hyperparathyroidism. (He declined the operation in 2009 when it was first offered, then agreed to have it in 2010 but changed his mind and refused to go ahead with it.) The operation was scheduled to take place after his dialysis on 10 January 2022. However, Mr Brown's blood pressure dropped during his dialysis, as it often did. He felt unwell and asked to stop his dialysis session, which was completed that evening, and the operation was delayed until the following day.
18. Following his operation on the afternoon of 11 January, Mr Brown had a heart attack in the evening and was resuscitated. Although he initially recovered a little, he deteriorated over the next few days. Mr Brown died in hospital on 21 January.
19. There was no post-mortem examination as the coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as end stage heart failure, caused by hypertensive cardiomyopathy (the inability of the heart to effectively pump blood around the body with a background of hypertension), which in turn was caused by hypertension (high blood pressure). End stage renal (kidney) failure was given as an underlying condition that contributed to but did not cause the death.

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June 2022

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