Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Cox, a prisoner at HMP Littlehey, on 17 January 2023

A report by the Prisons and Probation Ombudsman

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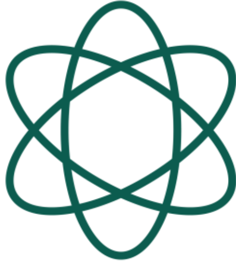
Our vision

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. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr John Cox died of cancer of the lung on 17 January 2023 while a prisoner at HMP Littlehey. He was 81 years old. We offer our condolences to Mr Cox's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Cox received at Littlehey was equivalent to that which he could have expected to receive in the community. She makes a recommendation for the Head of Healthcare to address.

5. We found that the non-clinical care provided to Mr Cox was of a good standard overall and make no recommendations.

6. We found that the Littlehey regime was commendably, proactively compassionate in their care of Mr Cox.

The Investigation Process

7. We were notified of Mr Cox's death on 17 January 2023.

8. NHS England commissioned an independent clinical reviewer to review Mr Cox's clinical care at HMP Littlehey.

9. The PPO investigator investigated the non-clinical issues relating to Mr Cox's care.

10. The PPO family liaison officer wrote to Mr Cox's next of kin (NOK), his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

11. Mr Cox's NOK received a copy of the initial report. He did not comment on the factual accuracy of the report.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out factual inaccuracies in the report, and these have been amended accordingly.

Previous deaths at HMP Littlehey

13. Mr Cox was the forty third prisoner to die at HMP Littlehey since January 2020. Of the previous deaths, forty were from natural causes, one was self-inflicted, and one was drug related. There are no similarities between our findings in the investigation into Mr Cox's death and our investigation findings for the previous deaths.

Key Events

Background

14. On 28 February 2022, Mr Cox was remanded to HMP Thameside for sex offences. On 6 June, he was transferred to HMP Pentonville.

15. During the reception process, healthcare staff recorded that Mr Cox was diagnosed with chronic obstructive pulmonary disease (COPD – a group of lung conditions that cause breathing difficulties), high blood pressure, asthma and mobility issues. Healthcare created care plans to manage these conditions.

16. On 7 June, a prison officer observed that Mr Cox was out of breath. Mr Cox said he had slept on his chair for most of the night because he was unable to climb up to the top bunk. The officer raised the issue with other officers on the landing, who later recorded that Mr Cox was sleeping on the lower bunk. He made no further complaints about the matter.

17. On 24 July, a prison officer noticed Mr Cox was looking unwell and "rather skinny". She asked Mr Cox if he was eating, and he said not much because he had no teeth and did not get enough support from healthcare. She made a note in the wing observations book before finishing her shift and asked colleagues to monitor Mr Cox during the day. No concerns were raised.

18. On 14 August, an officer noticed Mr Cox's asthma was getting worse and required monitoring. She recorded that when Mr Cox left his cell, officers should make sure that he had his asthma inhaler with him as he often forgot to take it with him. She also noted that going from his cell to the nearest staff office seemed draining for Mr Cox.

19. On 30 August, Mr Cox was given an 8-year sentence of imprisonment.

20. On 7 October, staff found Mr Cox more breathless than usual. They called a code blue emergency, triggering a request for an ambulance. Paramedics arrived quickly and transferred Mr Cox to hospital. A pulmonary embolism (when a blood vessel in the lung is blocked by a blood clot) and atrial flutter (where the top of the heart is beating too fast and is managed with medication) were diagnosed during the admission and Mr Cox remained in hospital for monitoring.

21. On 10 October, Mr Cox had a CT scan (showing detailed images of inside the body) and an x-ray of his chest which showed that he had an abnormal growth on his lung. Mr Cox was referred to the oncology team who confirmed the growth was cancer. Mr Cox was not considered fit enough to receive cancer treatment and was given a terminal diagnosis. He was transferred into palliative care.

22. On 15 November at 8.15pm, Mr Cox was discharged from hospital and admitted to the healthcare unit at Pentonville. Hospital and prison healthcare organised for Mr Cox to receive oxygen therapy 24 hours a day, to relieve symptoms of breathlessness. A registered nurse completed a set of clinical observations, and recommended Mr Cox be referred for a social care needs assessment.

23. On 4 January 2023, Littlehey approved a transfer request for Mr Cox from Pentonville. They agreed that Mr Cox could be given an end of life care cell at Littlehey, which could better meet his needs. Mr Cox was content to transfer.

HMP Littlehey

24. On 9 January, Mr Cox was transferred to Littlehey. Reception healthcare screenings identified Mr Cox's medical history and ensured continuity of his medications. Healthcare staff created the appropriate care plans, completed a fire evacuation risk assessment and plan and submitted a social care referral. They also scheduled hourly welfare checks for Mr Cox and a wing 'buddy' to assist with his day-to-day needs. Mr Cox was located in a disability cell which provided space for his hospital bed and oxygen equipment.

25. Later the same day, Mr Cox discussed his end of life plans with staff and signed a Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR) to be used if his heart or breathing stopped.

26. On 10 January, Mr Cox discussed the process of applying for an early release on compassionate grounds (ERCG) with a palliative care clinical nurse specialist. Mr Cox said he did not have a home address to go to and was finding his transfer to Littlehey a positive change. Mr Cox said his preferred place of death was at Littlehey. Mr Cox agreed that if his symptoms could not be managed in prison, his second choice of care and location for death would be in hospital. He therefore declined to progress the ERCG process.

27. On 11 January, the palliative care clinical nurse specialist, with Social Care, met with Mr Cox to discuss his social care needs. They issued a fall alarm and showed Mr Cox how to use it.

28. On 14 January at approximately 11.10am, Mr Cox's fall alarm went off. Staff found Mr Cox in bed and very out of breath. He needed assistance to reach some medication and his breathing pump. Mr Cox said he was breathless from going to the toilet but did not require healthcare support as this was very normal for him. Staff continued to monitor Mr Cox and reminded him to use his fall alarm if he needed assistance.

29. On 15 January at 3.07pm, healthcare checked on Mr Cox. He had been removing his oxygen mask deliberately, so healthcare asked prison officers to increase Mr Cox's welfare checks to half hourly. Mr Cox was also given a nebuliser to help with discomfort in his throat and lungs.

30. On 15 January at 3.33pm, Mr Cox removed his oxygen mask again and a senior officer and a prison officer convinced him to put it back on. Officers shared their concerns with healthcare who said there was nothing further officers could do.

31. On 15 January at 4.15pm, a custodial manager visited Mr Cox to discuss concerns raised by other officers about his removal of his oxygen tube. He asked why Mr Cox was removing his tube and he said the tube was hurting the area behind his ears. He suggested that healthcare look into the matter. He recorded concerns that he could not see Mr Cox's head area when looking through the pane in his cell door. He wondered how staff could have a clear view when checking on him. Officers

asked social care staff if Mr Cox could be turned around so he could be seen more clearly through the observation panel, which they actioned.

32. Later that day, a registered nurse recorded that Mr Cox's condition was deteriorating but that he was comfortable and 'just wanted to sleep'.

Events leading up to Mr Cox's death

33. On 16 January, a palliative care consultant reviewed Mr Cox and confirmed that he was likely in the last days of his life. Mr Cox said that he did not want any active treatment.

34. At 11.10am, the palliative care consultant contacted the family liaison officer (FLO), to make him aware of Mr Cox's deteriorating condition. The FLO contacted Mr Cox's son and organised for him to bring his scheduled visit forward from 19 to 17 January.

35. At 11.10pm, Mr Cox was discovered unresponsive in his cell. A custodial manager and a prison officer attended and completed the necessary observations.

36. At 11.15pm, the custodial manager asked the communications team to call for an ambulance because he believed Mr Cox had died. The ambulance control room declined to send an ambulance and advised the prison to call 111, who confirmed an out of hours doctor would attend between 3.00am and 6.00am.

37. On 17 January at 2.00am, the FLO made a decision to call Mr Cox's son to update him on the situation, given the time it would take for the doctor to confirm death. This was in line with an earlier agreement with Mr Cox's son, that contact should be made over the phone.

38. At 2.54am an out of hours doctor confirmed Mr Cox had died.

Post-mortem report

39. The post-mortem report concluded that Mr Cox died of purulent bronchitis (infection of the bronchial tree resulting in fluid and mucus formation) and disseminated carcinoma of the lung (cancer cells which travel through the blood or lymph system to other organs or tissues in the body), which was caused by chronic obstructive pulmonary disease (a group of lung conditions that cause breathing difficulties) and cor pulmonale (a condition that causes the right side of the heart to fail).

Inquest

40. The inquest into Mr Cox's death concluded on the 4 September 2023. The coroner confirmed that Mr Cox died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **September 2023**

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