Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glen Haigh, a prisoner at HMP Stafford, on 3 November 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

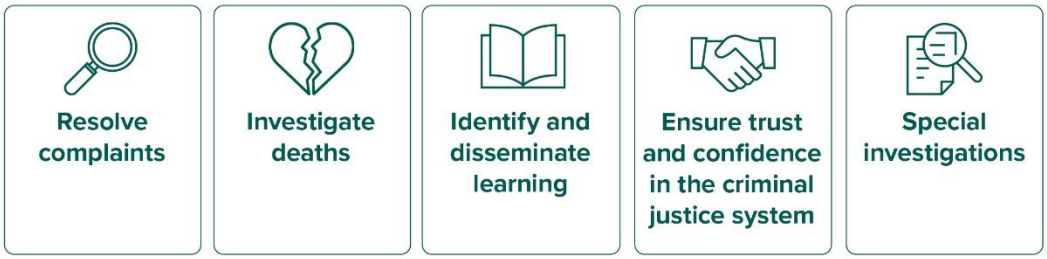
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. In 2017, Mr Glen Haigh was sentenced to ten and a half years imprisonment for sexual offences. On 3 November 2023, while a prisoner at HMP Stafford, Mr Haigh died in hospital of septic shock, which was caused by pyelonephritis (a kidney infection). Heart disease, circulation problems and chronic kidney disease contributed to, but did not cause his death. Mr Haigh was 66 years old. We offer our condolences to Mr Haigh's family and friends.

4. The PPO family liaison officer wrote to Mr Haigh's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Haigh's clinical care at Stafford.

6. The clinical reviewer concluded that the clinical care Mr Haigh received at Stafford was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.

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

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. The inquest into Mr Haigh's death concluded that he died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100