Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Sleigh, a prisoner at HMP Littlehey, on 16 September 2023

A report by the Prisons and Probation Ombudsman

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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. Mr Philip Sleigh died of dementia on 16 September 2023 at HMP Littlehey. He was 88 years old. We offer our condolences to Mr Sleigh's family and friends.

4. The PPO family liaison officer wrote to Mr Sleigh's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

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

6. The clinical reviewer concluded that the clinical care Mr Sleigh received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. The healthcare team consistently supported Mr Sleigh as his general health declined. He was supported in the long-term conditions clinic and then by the palliative care support services at Littlehey. The Dying Well in Custody Charter was embedded in Mr Sleigh's care and support. He also had a comprehensive social care support package in place.

7. The clinical reviewer highlighted the good practice in the palliative and end-of-life care provided to Mr Sleigh at Littlehey which was performed over and above the expected practice and was of a very high standard.

8. The clinical reviewer made no recommendations about Mr Sleigh's clinical care.

9. The PPO investigator investigated the non-clinical issues relating to Mr Sleigh's care. We did not find any non-clinical issues of concern. We make no recommendations.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

Record of inquest

11. The inquest into Mr Sleigh's death was held on 16 January 2024 and a verdict of natural causes was recorded. The Coroner concluded that Mr Sleigh's death was due to dementia.

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