Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Varley, a prisoner at HMP Wakefield, on 8 June 2024

A report by the Prisons and Probation Ombudsman

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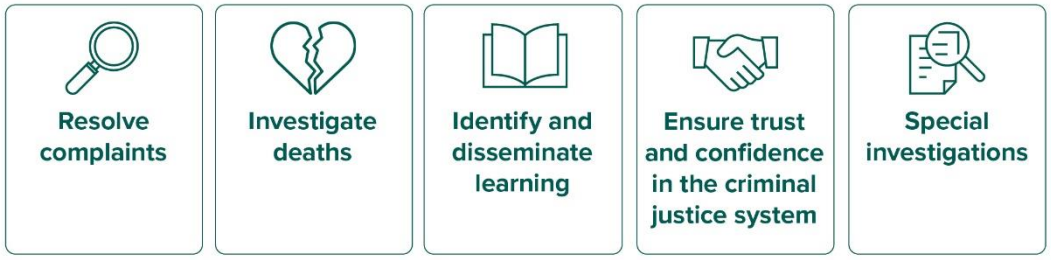
OUR VISION

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. On 11 June 2018, Mr Roy Varley was convicted of rape and fraud offences and was sentenced to 22 years in prison.

4. Mr Varley died of malignant adenocarcinoma (cancer) of the rectum on 8 June 2024, while a prisoner at HMP Wakefield. He was 63 years old. We offer our condolences to Mr Varley's family and friends.

5. The Ombudsman's office contacted Mr Varley's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and we have amended this report accordingly.

7. NHS England commissioned two independent clinical reviewers to review Mr Varley's clinical care at Wakefield.

8. The clinical reviewers concluded that the clinical care Mr Varley received at Wakefield was of a reasonable standard and equivalent to that which he could have expected to receive in the community. They made four recommendations not directly related to Mr Varley's death that the Head of Healthcare will wish to address. The clinical reviewers identified areas of good practice, including the inclusion of Mr Varley's palliative care consultant in monthly healthcare multidisciplinary team meetings.

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

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

Inquest

11. The inquest into Mr Varley's death concluded on the 8 July 2024. The coroner confirmed that Mr Varley died of natural causes.

Adrian Usher **January 2025**
Prisons and Probation Ombudsman

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