Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Henry Bangs, a prisoner at HMP Frankland, on 2 February 2024

A report by the Prisons and Probation Ombudsman

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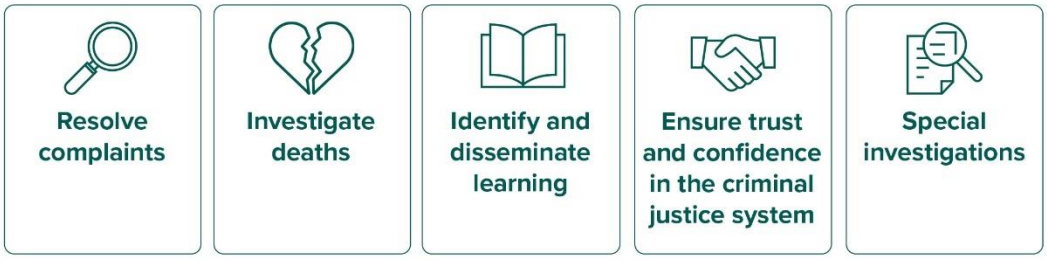
OUR VISION

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 15 October 2001, Mr Henry Bangs was sentenced to life imprisonment for murder. He died from lung cancer which had spread to other organs on 2 February 2024, while a prisoner at HMP Frankland. He was 71 years old. We offer our condolences to anyone who knew Mr Bangs.

4. The PPO investigator investigated the non-clinical issues relating to Mr Bangs' care. We did not find any non-clinical issues of concern.

5. NHS England commissioned an independent clinical reviewer to review Mr Bangs' clinical care at HMP Frankland.

6. The clinical reviewer concluded that the clinical care Mr Bangs received at HMP Frankland was partially equivalent to that which he could have expected to receive in the community. She found that Mr Bangs had good care for his long-term conditions. However, Mr Bangs was not urgently referred for a chest X-ray in January 2024 as he should have been. Staff should also have discussed him at the multi professional complex case conference (MPCCC) to ensure his healthcare needs were being met.

7. We make the following recommendations related to the clinical care Mr Bangs received:

   The Head of Healthcare should ensure that when patients are presenting with red flag symptoms an urgent chest X-ray is ordered under the 2-week guidelines and in accordance with NICE Guidelines NG12 suspected cancer: recognition and referral.

   The Head of Healthcare should ensure that the appropriate persons are being discussed in the multi professional complex case conference (MPCCC) so that the wider healthcare team have full oversight of their needs.

8. The clinical reviewer also made recommendations not related to Mr Bangs' death that the Head of Healthcare will want to address.

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

10. At the inquest held on 19 November 2024, the Coroner concluded that Mr Bangs died of natural causes.

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

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