

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Fuge, a prisoner at HMP Wymott, on 12 September 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



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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 June 2017, Mr David Fuge was sentenced to 16 years imprisonment for sexual offences. He died of heart disease on 12 September 2024, at HMP Wymott. He was 76 years old. We offer our condolences to Mr Fuge's family and friends.
4. The Ombudsman's office contacted Mr Fuge's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked some questions about the healthcare Mr Fuge received at Wymott, which are addressed in the clinical review.
5. The PPO investigator investigated the non-clinical issues relating to Mr Fuge's care.
6. We did not find any non-clinical issues of concern.
7. NHS England commissioned an independent clinical reviewer to review Mr Fuge's clinical care at HMP Wymott.
8. The clinical reviewer concluded that the clinical care Mr Fuge received at Wymott was partially equivalent to that which he could have expected to receive in the community. She found that healthcare staff did not carry out a full assessment of Mr Fuge or escalate his care when he complained of chest pain on 11 September. We recommend:

The Head of Healthcare should ensure that there is a robust management plan for escalation of patients who have chest pain and that all healthcare staff are aware and trained in this process.
9. We shared our initial report with HMPPS and the prison's healthcare provider, Greater Manchester West Mental Health NHS Foundation Trust. They found no factual inaccuracies.
10. We sent a copy of our initial report to Mr Fuge's daughter. She did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

March 2025

Inquest

At the inquest, held from 17 to 19 August 2026, the Coroner reached a narrative conclusion:

Mr David Fuge died on 12 September 2024. The medical cause of death is hypertensive and ischaemic heart disease. Mr Fuge had pre-existing medical conditions of high blood pressure and high cholesterol. These are known risk factors for cardiac events. Mr Fuge had reported feeling unwell from the 7 September and on the 10 September a code blue was called. The attending nurse completed physical observations and an ECG was performed. These were reported within normal range and the ambulance was stood down. There was a missed opportunity for assessment by an ambulance crew on 10 September. Given the circumstances, medical records could have also been checked to identify relevant past medical history and potential risk factors for a cardiac event. On 11 September, Mr Fuge was seen by a HCA due to feeling unwell and he reported a burning sensation in his chest. Physical observations were completed. There was a missed opportunity for escalation to the healthcare team or to a code blue. There was also a failure in effective handover of Mr Fuge's recent physical health presentation.



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