Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Ankers, a prisoner at HMP Wymott, on 18 August 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 Darren Ankers died in hospital of pneumonia on 18 August 2023 while a prisoner at HMP Wymott. He was 41 years old. I offer my condolences to Mr Ankers' family and friends.

4. The PPO family liaison officer wrote to Mr Ankers' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Ankers' next of kin asked about Mr Ankers' clinical care, why there had been a delay of a week and a half before Mr Ankers was sent to hospital after he had had a fall and why he was not given sufficient pain relief. These concerns have been addressed in the clinical review report which is annexed. They also had other concerns which have been addressed in a separate letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Ankers' clinical care at HMP Wymott. She concluded that the clinical care Mr Ankers received at Wymott was of a good standard and equivalent to what he could have expected to receive in the community. She found that the healthcare team made appropriate assessments when required and transferred Mr Ankers to hospital for further assessment and care when needed. She made no recommendations.

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

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

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

At the inquest held on 22 October to 24 October 2024, the coroner concluded Mr Ankers died of a combination of natural causes and an accident.

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