Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Waller on 10 October 2024, following his release from HMP Preston

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

Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

4. Mr Ian Waller died from metastatic small cell bladder cancer on 10 October 2024, following his release from HMP Preston on 1 October 2024. He was 59 years old. We offer our condolences to those who knew him.

5. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Waller and we make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Waller's death on 25 November 2024.

7. The PPO investigator obtained copies of relevant extracts from Mr Waller's prison and probation records.

8. We spoke to HM Coroner for Lancashire who informed us no post-mortem examination was required for Mr Waller's death. We have sent the Coroner a copy of our report.

9. The Ombudsman's office contacted Mr Waller's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

Background Information

HMP Preston

11. HMP Preston is a category B local prison, holding convicted and remand male prisoners. Spectrum Community Health CIC provides physical health and substance misuse treatment services. Tees, Esk and Wear Valleys NHS Foundation Trust provides the mental health services.

Probation Service

12. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriates. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Preston was in March 2023. Inspectors reported that the Head of Healthcare had done an outstanding job and standards had improved markedly since their last inspection, with a strong and pro-active staff team working to improve outcomes for the prisoners. The Governor had also worked to develop the partnership with the healthcare provider which led to innovations.

14. Inspectors noted that despite staffing problems, release planning was reasonably good, and the weekly resettlement services delivery and strategy meeting was attended by various partners. Overall, the work to support sentenced prisoners prepare for release was developing well and the help available was positive.

HM Inspectorate of Probation

15. The most recent inspection of National Probation Service (NPS) North West division was in July 2020. The overall rating for this division was 'good'. Inspectors found experienced, enthusiastic leaders focused on providing a high-quality service.

16. They also found stakeholder engagement was good, the division's approach to ensuring that it provided services that addressed the needs of those subject to supervision was encouraging.

17. However, inspectors noted that the North West division relied heavily on the central functions provided by HMPPS and the MOJ and when those functions did not work well that had a negative impact on the division's ability to deliver a high-quality service.

Key Events

18. On 9 August 2024, Mr Ian Waller was convicted of assault on an emergency worker and was remanded to HMP Preston.

19. That day, a nurse completed Mr Waller's initial health screen. Mr Waller said that he was 'riddled' with cancer, had reduced mobility and used a walking stick. She noted that his medical record showed that Mr Waller had cancer of the bladder. Mr Waller had brought several of his prescribed medications with him when he entered prison. He was allowed to keep some of these medications with him in his cell.

20. On 11 August, Mr Waller's cell mate informed staff that Mr Waller had fallen over in the middle of the night. That morning at the medications hatch, he appeared disorientated. A nurse sent a task to the social care team and the falls team to assess Mr Waller.

21. On 12 August, a recovery worker completed a substance misuse assessment. Mr Waller said that he had several health issues, had cancer, and that he should be moved to the healthcare unit. Mr Waller said he was on a methadone script in the community. Mr Waller tested positive for methadone. He was placed on 40ml of methadone until the substance misuse team could confirm his usual dosage. Mr Waller said he had not used heroin for several years, did not want to engage with any interventions in prison and only wanted his methadone.

22. That day, a nurse completed Mr Waller's secondary health screen. Mr Waller said he was unsure if he had any outstanding hospital appointments as he had not received any letters, but he had been prescribed medication for his cancer in the community (dihydrocodeine - prescribed for pain). Mr Waller said he had fallen over several times during the day and night, and his cell mate had to help him. The nurse noted that Mr Waller was added to the healthcare team's safety huddle meeting due to his poor mobility. A social care and a falls assessment was completed on 14 August.

23. On 14 August, a nurse spoke with Mr Waller after overhearing him refuse his Apixaban medication (used to treat and prevent blood clots). She noted Mr Waller had the capacity to make his own decisions and that he was aware of the risks associated with not taking his medication.

24. On 15 August, a nurse received a call from the hospital informing her that Mr Waller had been diagnosed with bladder cancer and the prognosis was poor. They said that Mr Waller had already been informed and a telephone appointment would be made to discuss the management of the diagnosis, and that Mr Waller was at risk of neutropoenia (abnormally low concentration of neutrophils in the blood) and all staff needed to be made aware of this in case Mr Waller became unwell.

25. On 22 August, a nurse received a call from a specialist palliative care nurse from the local hospice. The specialist palliative care nurse informed her that they had received a community referral for symptom management prior to Mr Waller entering prison. The nurse said that Mr Waller was waiting for an appointment with the oncology team at the hospital to discuss treatment plans. The specialist palliative care nurse said that she would review Mr Waller after his appointment.

26. On 23 August, Mr Waller signed a disclaimer to say that he did not want to attend his oncology appointment because he had a court appearance in the afternoon. (Mr Waller did not have a court appearance that day.) Mr Waller had a telephone appointment in September and agreed to start chemotherapy.

27. On 29 August, a nurse and the specialist palliative care nurse saw Mr Waller in his cell, and they discussed his cancer diagnosis. Mr Waller said that he did not want to attend any hospital appointments or receive treatment while in prison as his symptoms were being managed. Mr Waller understood he was at risk of infection, but said that if he became unwell, he did not want treatment at the hospital. He also refused to have any bloods taken. They discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (meaning that in the event his heart or breathing stopped he would not be resuscitated) and Mr Waller agreed. A DNACPR order was put into place later that day.

28. On 16 September, a clinical practitioner at Preston reviewed Mr Waller because he was struggling with symptom management. He offered Mr Waller amitriptyline (used to treat a variety of pain syndromes as well major depressive order) but Mr Waller declined, so he was prescribed nortriptyline (used for neuropathic pain and an antidepressant) to use at night. On 27 September, a nurse created a palliative care plan for Mr Waller.

29. On 1 October, Mr Waller was sentenced to eight weeks in prison, however he was released from court that evening due to time he had already served on remand.

30. On 2 October, Mr Waller attended the probation office for his initial appointment. Probation staff were unaware of his release and his probation appointment so a Community Offender Manager (COM) had not been allocated to him. Managers noted that he needed to be inducted and the duty probation officer saw him. Mr Waller told her that he was suffering with terminal bladder cancer and felt he was not able to attend the probation office every week. She agreed for Mr Waller to attend the office the following week to discuss this with his allocated COM.

31. On 9 October, the duty probation officer was allocated as Mr Waller's COM. That day, Mr Waller did not attend his probation appointment. She phoned Mr Waller, but he did not answer, so she left a voicemail and sent him a text message.

32. The COM sent Mr Waller a licence compliance letter following his missed appointment and gave him another appointment for 18 October.

33. On 10 October, Mr Waller's GP was concerned he had not collected his methadone and contacted his daughter who was listed as his next of kin. Mr Waller's daughter said she had not seen her father since August, and arranged for a welfare check to be completed.

34. An ambulance was dispatched to Mr Waller's address. Mr Waller did not answer his door, but the front door was unlocked so the paramedics entered his flat. Mr Waller was slumped in his wheelchair; he was not breathing and unresponsive. The paramedics noted clear signs that Mr Waller had died and pronounced life extinct at 7.26pm.

35. On 18 October, the COM was still unaware that Mr Waller had died, so she completed a home visit to his address but there was no answer. She asked the emergency services to conduct a welfare check and was then informed that Mr Waller had died eight days earlier.

Cause of death

36. Mr Waller's death was not referred to the Coroner and no post-mortem examination was carried out. A hospital registrar recorded Mr Waller's cause of death as metastatic small cell bladder cancer. Bronchiectasis, emphysema and pulmonary embolism were listed as contributing factors.

Findings

37. We are satisfied that prison and healthcare staff supported Mr Waller with the deterioration of his health. The healthcare team at Preston regularly monitored Mr Waller, made the appropriate referrals for his needs and there were well evidenced notes of good communication between the prison healthcare team and community agencies, ensuring Mr Waller was well supported with his cancer diagnosis.

38. Mr Waller was not allocated a COM due to his immediate release from court as probation staff were unaware of his imminent release. However, his COM tried to re-engage Mr Waller after he failed to attend his probation appointments and visited him at his home address to check on his welfare.

39. We make no recommendations.

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

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