Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Ward, a prisoner at HMP Fosse Way, on 22 March 2025

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. In January 2019, Mr Paul Ward was remanded to HMP Hewell after being charged with burglary. In March 2019, he was sentenced to 13 years in prison.

4. In January 2024, Mr Ward was transferred to HMP Fosse Way.

5. On 22 March 2025, Mr Ward died of hemopericardium (a build-up of blood in the pericardial sac of the heart), at Fosse Way. He was 70 years old. We offer our condolences to Mr Ward's family and friends.

6. The Ombudsman's office wrote to Mr Ward's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about Mr Ward's funeral arrangements and his valuables. These questions have been addressed in separate correspondence.

7. NHS England commissioned an independent clinical reviewer to review Mr Ward's clinical care at Fosse Way. The clinical reviewer's report is attached as Annex 1.

8. The clinical reviewer concluded that the clinical care Mr Ward received at Fosse Way was of a reasonable standard and at least equivalent to what he could have expected to receive in the community. He found that the healthcare team implemented steps to monitor and manage Mr Ward's chronic physical health conditions. They recognised the deterioration in his clinical condition and managed this appropriately. The clinical reviewer made no recommendations.

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

10. We did not find any non-clinical issues of concern.

Governor to note

11. PSI 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It requires all prisons to have a medical emergency response code protocol in place to ensure a timely, appropriate and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff are alerted, the correct equipment is brought, and an ambulance is called immediately. Most prisons, including Fosse Way, use codes blue (for breathing problems) and red (for bleeding).

12. Officer A was the first on scene officer. In his written statement, he said that at approximately 4.20pm, he found Mr Ward lying on his back, he was grey in colour

and unresponsive. He said he immediately radioed the healthcare team to attend the wing but he did not radio a code blue. Officer B attended Mr Ward's cell immediately and radioed a code blue.

13. The Investigations Manager at Fosse Way told the investigator that the prison is conducting an internal investigation into Officer A's actions on 22 March 2025. This has not yet been concluded.

14. Although Officer A did not adhere to the medical emergency response code policy, this did not affect the emergency care given to Mr Ward because a code blue was called within one minute of discovery. However, it is important prison staff are aware of their responsibilities when they find a prisoner unresponsive, so it does not lead to a delay in staff arriving promptly to medical emergencies and calling an ambulance.

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

16. Mr Ward's family received a copy of the initial report. They did not make any comments.

Inquests

17. At the inquest held on 17 November 2025, the coroner concluded Mr Ward died of natural causes.

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

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