Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Thompson, a prisoner at HMP Stafford, on 26 August 2024

A report by the Prisons and Probation Ombudsman

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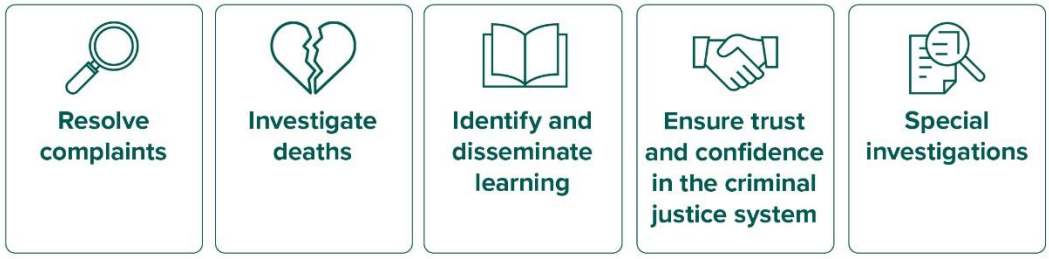
OUR VISION

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

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. Mr Derek Thompson died of colon cancer on 26 August 2024 at HMP Stafford. He was 67 years old. We offer our condolences to Mr Thompson's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Thompson received at Stafford was equivalent to that which he could have expected to receive in the community.

5. Mr Thompson was restrained by single handcuffs (when one cuff is applied to the prisoner's wrist and the other to an officer's) when taken to his hospital appointments, some of which were for chemotherapy treatment. The use of restraints on Mr Thompson was not justified. Staff failed to consider his health and his category D status (which meant he was trusted to be held in open conditions).

Recommendations

- The Governor should ensure that:
    - all staff undertaking risk assessments for prisoners attending hospital appointments consider the prisoner's security category and their current health, and if the prisoner is attending for chemotherapy treatment, restraints are authorised only where they can be justified in line with prison policy, and
    - there is a robust quality assurance process in place to check that these measures are in place and effective.

The Investigation Process

6. HMPPS notified us of Mr Thompson's death on 26 August 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Thompson's clinical care at HMP Stafford.

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

9. The Ombudsman's office contacted Mr Thompson's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of our report.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. HMPPS provided an action plan which is annexed to this report.

11. We sent a copy of our initial report to Mr Thompson's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Stafford

12. Mr Thompson was the 29th prisoner to die at Stafford since August 2021. Of the previous deaths, 25 were from natural causes and three were self-inflicted.

13. We have previously made recommendations in two cases on the inappropriate use of restraints on prisoners attending hospital while at Stafford. However, the circumstances of this case were considerably different.

Key Events

14. In September 2018, Mr Derek Thompson was sentenced to 14 years in prison for sexual offences. On 22 May 2019, he was moved to HMP Stafford.

15. In 2021, Mr Thompson was diagnosed with advanced colon cancer and received treatment.

16. In March 2024, Mr Thompson was told that the cancer had returned and was terminal.

17. On 26 March, healthcare and prison staff started an application for early release on compassionate grounds for Mr Thompson.

18. Between April and August, Mr Thompson attended numerous hospital appointments. For each of these appointments the authorising manager decided that single cuffs (where a set of handcuffs is used to attach a prisoner's wrist to an officer's wrist) should be used. Some of these appointments (one in April, May, June and July) were for palliative chemotherapy.

19. On 21 May, Mr Thompson was recategorised from category C to category D (staff had assessed that he no longer needed to be kept in closed conditions and could be trusted in an open prison).

20. On 29 July, the Public Protection Casework Section (PPCS) of HMPPS rejected Mr Thompson's application for early release on compassionate grounds. PPCS concluded that Mr Thompson's risk could not be safely managed in the community and there was no evidence that he was in the last few months of his life.

21. Mr Thompson died on 26 August in Stafford's palliative care wing.

Cause of death

22. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Thompson's cause of death as metastatic caecum adenocarcinoma (colon cancer that has spread to other parts of the body).

Findings

Clinical care

23. The clinical reviewer concluded that Mr Thompson's clinical care was equivalent to that which he could have expected to receive in the community. He found that Mr Thompson was referred appropriately and received timely treatment in the form of chemotherapy and surgery to help manage his advanced colon cancer. When his condition advanced in 2024 to the extent that he required palliative care, he received holistic and comprehensive care from the medical team in HMP Stafford and was able to see specialists in his cell to enable him to have a planned and dignified death.

Restraints, security and escorts

24. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

25. The Prevention of Escape: External Escorts policy framework states that an escort risk assessment must take into consideration a prisoner's security category. There was no evidence the authorising manager considered Mr Thompson's category D status when completing the escort risk assessment. The policy framework also states the use of restraints on a prisoner receiving chemotherapy (or other lifesaving treatment) is degrading and inhumane unless justified by other relevant considerations.

26. We asked the Head of Security about the level of restraint used in this case and he said that as Mr Thompson was held at a category C prison, he would have been subject to the standard cuffing arrangements for category C prisoners, which was single cuffs. When asked if there were any circumstances in which no cuffs would be used, he gave examples of elderly men with mobility issues.

27. The use of restraints on Mr Thompson was wholly inappropriate in our view. Not only was he a category D prisoner from 21 July onwards (so assessed as very low risk of escape), he was terminally ill with cancer and was receiving palliative chemotherapy. We recommend:

The Governor should ensure that:

- **all staff undertaking risk assessments for prisoners attending hospital appointments consider the prisoner's security category and their current health, and if the prisoner is attending for chemotherapy treatment, restraints are authorised only where they can be justified in line with prison policy, and**
- **there is a robust quality assurance process in place to check that these measures are in place and effective.**

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

Inquest

The inquest, held on 22 May 2025, concluded that Mr Thompson died from natural causes.

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