

**Prisons &
Probation**

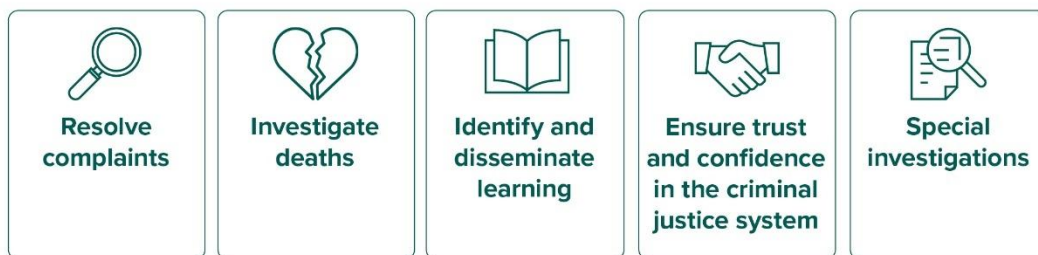
Ombudsman
Independent Investigations

**Independent investigation into
the death of Ms Fay Newman,
a prisoner at HMP Downview,
on 20 July 2025**

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. On 2 December 2024, Ms Fay Newman was sentenced to 20 months in prison for causing death by careless driving. She died in a hospice of metastatic spindle cell sarcoma (connective tissue cancer) on 20 July 2025, while a prisoner at HMP Downview. She was 53 years old. We offer our condolences to Ms Newman's family and friends.
4. The Ombudsman's office wrote to Ms Newman's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had concerns about Ms Newman's medical care relating to timeliness of treatment and Ms Newman not being granted early release on compassionate grounds. They asked for a copy of our report. The family's questions about timeliness of treatment have been addressed in the clinical review.
5. NHS England commissioned an independent clinical reviewer, to review Ms Newman's clinical care at Downview. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Ms Newman received at Downview was of a good standard and was equivalent to that which she could expect to receive in the wider community. She noted that the care Ms Newman received involved a collaboration from the healthcare team, prison staff, local hospitals and the wider specialist oncology teams and acknowledged the professionals involved with caring for Ms Newman.
7. However, the clinical reviewer found there was a gap between initial assessment of symptoms and the final diagnosis, which did not correspond to equivalent care. She noted that this was in part due to the complex nature of symptoms that were presented. However, there were opportunities missed that might have led to an earlier diagnosis, including no acknowledgement of 'red flag' symptoms, no urgent re-referral when a timely two-week wait appointment was not received, and an underestimation of symptoms in relation to pain management.
8. The clinical reviewer noted that Ms Newman presented with metastatic advanced cancer so this short delay would not have impacted on the rapid decline and subsequent death.
9. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff are properly trained to recognise and escalate red flag symptoms in relation to back pain, and that they understand when to make urgent GP or emergency referrals and how to record the urgency of the referral.

The Head of Healthcare should ensure that two-week wait cancer referrals are properly monitored and escalated if appointments are not actioned in the timeframe.

10. The PPO investigator investigated the non-clinical issues relating to Ms Newman's care. We did not find any non-clinical issues that warranted a recommendation but bring the Governor and Head of Healthcare's attention to the below.
11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
12. We also shared the initial report with Ms Newman's next of kin. They did not make any comments.

Governor and Head of Healthcare to note

Early Release on Compassionate Grounds (ERCG)

13. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and their family. The policy framework says that the application must include a report from the medical specialist (usually a consultant) involved in the care of the prisoner, to include factors such as diagnosis, prognosis, treatment plan and a clear indication of life expectancy. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).
14. On 20 June 2025, Downview submitted an initial ERCG application form to PPCS due to Ms Newman's declining health. This application did not include a specialist medical report in support of release, which is a requirement of the policy framework. Later the same day, PPCS contacted the Offender Management Unit (OMU) at Downview and informed them the application form was incomplete and that a specialist medical report was required.
15. On 2 July, OMU provided medical information in the form of hospital reports to PPCS, but this did not include the necessary information required to support an ERCG application. On 3 July, PPCS requested further medical information in the form of a consultant cancer specialist report. On 17 July, OMU supplied a copy of the relevant report from a consultant in palliative medicine to PPCS.

16. While the absence of the relevant medical report was noted in this case, the ERCG application was ultimately refused due to a change in Ms Newman's care needs and circumstances, as she had at that stage moved to a hospice near to her home in which she was unaccompanied by prison staff (and therefore early release would provide no change to her circumstances). We bring this to the attention of the Governor and the Head of Healthcare to consider the need for a process that allows prison and healthcare staff to obtain consultant letters more expediently.

Good practice

17. Ms Newman was released on unaccompanied Special Purpose Licence (ROTL) from 24 June, which allowed her to transfer to a hospice closer to her family and removed the need for escort staff.
18. The family liaison officer and other prison staff demonstrated efforts that went above and beyond in their compassion and support offered to both Ms Newman and her family, which was commendable.
19. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman

February 2026

Inquest

At the inquest held on 9 April 2026, the Coroner concluded that Ms Newman died from natural causes.

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