Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Warry, a prisoner at HMP Stafford, on 25 September 2022

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

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Warry died in hospital on 25 September 2022, while a prisoner at HMP Stafford. His death was due to cardiogenic shock caused by severe heart failure and a heart attack. He also had underlying COVID-19. Mr Warry was 73 years old. I offer my condolences to his family and friends.

The clinical reviewer identified several significant deficiencies in the management of Mr Warry's cardiovascular risk and his clinical management when he reported chest pains on the day of his death. She concluded that these aspects of his clinical care were not equivalent to that which he could have expected to receive in the community.

Mr Warry had been assessed by the pharmacist at Stafford as at a higher risk of a heart attack or stroke, but this was not followed up by the GP or healthcare staff. The GP later withdrew Mr Warry's statin medication, but the rationale for his decision was not informed by appropriate tests, or fully documented.

I am concerned that Mr Warry's request for a medical appointment, five days before he died, was not prioritised, despite concerning symptoms. On the morning of his death, healthcare staff did not follow the expected procedures for managing and escalating recent-onset chest pain and the clinical reviewer found examples of poor clinical record keeping.

Mr Warry's family was not informed that he was seriously ill and they have yet to be reimbursed for the costs of his cremation.

I am also concerned that incorrect information about the circumstances of his death was posted on social media and that there was a comment in the post about the nature of the death, before HM Coroner had confirmed it. Given the widespread and increasing use of social media, a reminder about the need for responsible use of social media would be timely.

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 **November 2024**

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Summary

Events

1. Mr John Warry had been in prison since October 2016 and transferred to HMP Stafford on 7 February 2019. He was 69 years old. At reception health screens, it was recorded that Mr Warry had no personal or family history of cardiovascular disease. However, he had an existing prescription for simvastatin (a statin medication to treat high cholesterol and prevent heart disease) which the GP at Stafford re-prescribed.

2. In 2020, Mr Warry was assessed as at high risk of complications from COVID-19 and protective measures, such as shielding, were put in place.

3. On 29 October 2021, a QRISK assessment by the pharmacist at Stafford indicated that Mr Warry had a raised risk of having a heart attack or stroke and his blood pressure was raised.

4. Following blood tests and reviews of Mr Warry's prescription for simvastatin on 25 May and 31 August 2022, the GP stopped prescribing simvastatin.

5. On 20 September, Mr Warry requested a medical appointment, as he had felt unwell for two weeks, with symptoms of giddiness, breathlessness and weakness. He had not been seen before his death five days later.

6. At around 7.00am on 25 September, Mr Warry reported chest pains. Nurses gave him glyceryl trinitrate (GTN), but the pain continued. At 10.00am, a nurse requested an emergency ambulance, as she was concerned about the nature of his pain. Paramedics conducted an electrocardiogram (ECG) test. This indicated abnormalities, so they arranged for Mr Warry to be taken to the coronary care unit at Royal Stoke University Hospital. Mr Warry died at 8.34pm.

Findings

7. The clinical reviewer identified significant shortcomings in both the management of Mr Warry's cardiovascular risk and his care when he became acutely unwell and concluded it was not equivalent to that he could have expected to receive in the community.

8. The clinical reviewer found that the management of Mr Warry's cardiovascular risk was not in line with national guidance. Notably, the GP at Stafford did not act on the pharmacist's findings of a raised risk and high blood pressure; he did not repeat the assessment, take a blood pressure reading, or collate relevant tests to evidence that there was no longer a need for simvastatin.

9. The nurses who treated Mr Warry when he complained of chest pains on 25 September, did not comply with the national guidelines on the management of recent-onset chest pain and the administration of GTN. They did not administer another dose of GTN at the recommended interval of five minutes, or escalate his care urgently when the GTN did not relieve the pain.

10. Mr Warry's healthcare application on 20 September was not appropriately prioritised, given his symptoms.

11. Clinical record keeping did not meet the standards expected by professional medical bodies. Entries in Mr Warry's medical records did not reflect the rationale for decisions such as discontinuing simvastatin and the medical emergency on 25 September was not fully documented.

12. Mr Warry's risk of infection from COVID-19 was managed appropriately. In spite of this, it seems that he contracted the infection within the prison.

13. Staff did not follow HMPPS national policy and Stafford's local protocol on medical emergencies involving chest pain. There are conflicting accounts as to whether a medical emergency code was called when Mr Warry first reported chest pain. There is no record of such a code or a request for an ambulance.

14. Mr Warry's next of kin was not informed that he was seriously ill in hospital, in line with Prison Rule 22 and HMPPS national policy, and they have yet to be reimbursed for the costs of Mr Warry's cremation.

15. The Governor posted incorrect information about Mr Warry's death on social media, as well as a presumption about the nature of the death. Although HMPPS provides training on the use of social media, we consider that staff should be reminded about the need to comply with the Civil Service Code.

Recommendations

- The Head of Healthcare should ensure that information from the pharmacist is shared with the healthcare team for review and action.

- The Head of Healthcare should ensure that GPs conduct a full, documented clinical assessment, in line with relevant guidance, to inform medication reviews and changes.

- The Head of Healthcare should ensure that prisoners presenting with chest pain are managed in line with NICE guidelines on the diagnosis of chest pain and, where indicated, referred for emergency treatment.

- The Head of Healthcare should ensure that prisoners who report acute symptoms receive timely medical appointments.

- The Head of Healthcare should ensure that healthcare staff fully and accurately document all clinical interactions and decisions, in line with the standards specified by the General Medical Council and Nursing and Midwifery Council.

- The Governor and Head of Healthcare should ensure that all staff are fully aware of and understand their responsibilities in a medical emergency, including the use of an emergency response code if a prisoner has chest pains and documenting incidents.

- The Governor should ensure that if a prisoner becomes seriously ill, their next of kin is notified immediately, in line with Prison Rule 22 and Prison Service Instruction 64/2011.
- The Governor should ensure that the cost of Mr Warry's cremation is reimbursed, without further delay.
- The Director General of Operations of HM Prisons and Probation Service should remind staff of the requirement to adhere to the Civil Service Code and for sensitive and responsible use of social media.
- The Governor should ensure that information published on social media about a prisoner's death is appropriate, accurate and that the nature of the death is not revealed until confirmed by HM Coroner.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Stafford, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

17. The investigator obtained copies of relevant extracts from Mr Warry's prison and medical records.

18. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Warry's clinical care at the prison. The clinical reviewer and the investigator interviewed three healthcare staff by Microsoft Teams video conferencing on 26, 27, 28 and 31 October. (Due to a general alarm in the prison on 27 October, one of the interviews was stopped and resumed on 31 October.) Additional information was obtained by email throughout the investigation.

19. We informed HM Coroner for Staffordshire South of the investigation. The coroner gave us the results of the post-mortem examination and we have shared this report with him.

20. The Ombudsman's family liaison officer contacted Mr Warry's family to explain the investigation. Mr Warry's family asked for the investigation to consider several matters relating to Mr Warry's care. The clinical review and PPO report address those which fall within our remit, summarised below:

    - Why was Mr Warry's simvastatin medication stopped and did this affect his health, or contribute to his death?

    - During the three weeks before Mr Warry's death, he had twice requested an appointment with the nurse as he felt unwell. He had also informed wing staff several times.

    - Why was Mr Warry's family not informed that he was seriously ill in hospital.

    - The Governor posted information on social media about Mr Warry's death, before some family members were informed and there were inaccuracies in his statement.

21. We sent a copy of the initial report to Mr Warry's family. They did not inform us of any factual inaccuracies.

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

Background Information

HMP Stafford

23. HMP Stafford holds approximately 750 men who have been convicted of sexual offences. Practice Plus Group provides a 24-hour healthcare service.

HM Inspectorate of Prisons

24. The most recent full inspection of HMP Stafford was in January 2020. (There was also a short scrutiny visit in June 2020.) Inspectors reported that healthcare had improved since the previous inspection in 2016. There was strong clinical leadership, staff received regular clinical supervision and the training provision was impressive. Nurses triaged potentially urgent issues and clinical records were professional and subject to audit. Responses to medical emergencies were sound and staff knew how to obtain support from the ambulance service, if needed.

25. Inspectors found that there was an effective incident management system to review serious concerns and the learning from untoward incidents was shared across the healthcare team. PPO recommendations after investigations were implemented.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 April 2022, the IMB reported that the treatment of patients had been severely and negatively impacted by failings in medicines management over an extended period. There had been systemic failings and a focus on process rather than outcome.

27. The Board also noted that the COVID-19 pandemic had significantly impacted on the prison. However, aside from medicines management, the quality of all other aspects of healthcare was generally good.

Previous deaths at HMP Stafford

28. Mr Warry was the 17th prisoner at Stafford to die since September 2020. Of the previous deaths, 16 were from natural causes and one was self-inflicted. There have been five further deaths, of which one was self-inflicted and four from natural causes. Disappointingly, in previous investigations, we have raised problems with the prescribing and management of medication, information sharing between healthcare staff, notifying prisoners' next of kin that they are seriously ill and the payment of funeral expenses.

Key Events

29. Mr John Warry was remanded to prison on 19 October 2016. In November, he was convicted of sexual offences and sentenced to nine years imprisonment, with an extended licence period of one year.

30. Mr Warry transferred from HMP Parc to HMP Stafford on 7 February 2019. At an initial health screen, his ongoing medical conditions were listed as asthma and glaucoma. A secondary health assessment, completed on 18 February, noted that he had no personal or family history of cardiovascular disease at that time.

31. The GP at Stafford re-prescribed an existing prescription for simvastatin. Mr Warry had regular blood tests to monitor his lipid levels (fatty compounds) and the results were reported as within normal range.

2020 to 2021

32. On 8 June 2020, a GP assessed Mr Warry's risk of complications from COVID-19 as high, due to his asthma. Mr Warry was later allocated to a unit for men who were shielding.

33. During the pandemic, Mr Warry had regular welfare checks and meetings with his prison key worker. In 2021, he received three COVID-19 vaccinations. He was tested for COVID-19 before hospital appointments and he was twice placed in isolation after exposure to COVID-19. On 9 April 2021, following new NHS shielding guidance, Mr Warry decided to stop shielding.

34. On 29 October 2021, the pharmacist at Stafford conducted a QRISK assessment to calculate Mr Warry's risk of cardiovascular disease and the score was 26.19%. (A score of over 10% represents a raised risk of having a stroke or heart attack within 10 years.) He also noted that Mr Warry's blood pressure was high and recommended that the GP consider a calcium channel blocker medication (to help lower blood pressure). There is no evidence that this was actioned.

2022

35. Mr Warry tested positive for COVID-19 in April 2022. He was placed in protective isolation and monitored daily by healthcare staff.

36. On 25 May, a GP at Stafford reviewed Mr Warry's simvastatin prescription. He noted that a recent blood test had shown raised triglycerides (fat) levels and recorded options to address this. (High levels can raise the risk of heart disease and stroke.)

37. On 15 June, a prison GP discussed with Mr Warry whether he still needed to take simvastatin and arranged a blood test. He noted that Mr Warry could not remember why it had been prescribed, as he had no history of heart disease or stroke. A blood test taken on 28 June, showed Mr Warry's triglycerides level was within normal limits.

38. On 23 August, Mr Warry placed a request for a repeat prescription of simvastatin, an asthma pump and eye drops.

39. At a review on 31 August, a prison GP found that Mr Warry's triglycerides level was lower and his lipid levels were within normal range. He therefore stopped the simvastatin and planned to request another blood test in six months. He noted that Mr Warry had agreed to this.

40. Mr Warry sent a reminder about his medication request on 7 September, but noted that he no longer needed simvastatin as the GP had stopped it. At a meeting on the same day, Mr Warry's prison key worker noted that he appeared to be physically well.

41. On 20 September, Mr Warry sent an application to healthcare, stating that the GP had stopped prescribing simvastatin at the end of August and that he had felt unwell for two weeks. He described his symptoms as giddiness, racing heart, breathlessness and no strength. One of the healthcare team annotated the form to indicate that he had been added to the senior nurse list. (Mr Warry died before receiving an appointment.)

Events of 25 September

42. At around 7.05am on 25 September, night patrol staff contacted healthcare staff, as Mr Warry had chest pains. An officer recorded the incident in the wing observation book, but it is unclear whether it had been reported as an emergency.

43. Two nurses assessed Mr Warry in his cell (time unknown). Mr Warry said that he had pain on his left side that had started two weeks before, but had been worse during the night. He thought it might have been caused by coughing. The nurses took Mr Warry's clinical observations and a COVID-19 test, which was positive. They gave him two sprays of glyceryl trinitrate (GTN - used to treat angina) at the same time, but it did not help the pain. They planned to review him in an hour.

44. A nurse asked a Nursing Associate to check Mr Warry before starting the medication round (time unknown). When she did so, she was told that he was no longer in pain. Just after 8.45am, a prison officer told the nurse that Mr Warry's pain had returned. The nurse told a colleague.

45. A nurse repeated a full assessment at around 10.00am. She was concerned about Mr Warry's description of his pain and thought that he needed an electrocardiogram (ECG – recording of the heart's electrical activity) as well as other checks. She asked an officer to call a code blue, so that an emergency ambulance would be requested.

46. The paramedics arrived at Mr Warry's cell at 10.15am. An ECG showed that he had had a serious heart attack, so they contacted Royal Stoke University Hospital and arranged for Mr Warry to be admitted to the coronary care unit. They left the prison just before 11.00am. Two prison officers escorted Mr Warry and no restraints were used.

47. The escort officers updated the prison throughout the day. This included notification that stents were inserted into Mr Warry's blocked arteries at around 6.00pm; at

6.40pm he had another cardiac arrest and was described as in a critical condition; and at 7.50pm, there was a third cardiac arrest.

48. At 8.11pm, the escort officers briefed the family liaison officer. They informed him that doctors were considering a 'do not resuscitate' order in the event of another cardiac arrest. At 8.26pm, they said that Mr Warry had had a further cardiac arrest and hospital staff were "working on" him.

49. Mr Warry died at 8.34pm.

Contact with Mr Warry's family

50. Due to Mr Warry's condition, the prison assigned him a family liaison officer (FLO), at around 7.00pm, and he went to the prison.

51. At 9.55pm, the FLO and a prison officer left the prison to inform Mr Warry's wife of his death. They arrived at 1.20am, but no one answered the door. They then went to the address listed for Mr Warry's son and informed him that his father had died. Mr Warry's son told the officers the correct location for Mr Warry's wife, as there were two houses with the same door number.

52. The officers broke the news of Mr Warry's death to his wife and daughter at around 2.30am. They offered support and the FLO kept in touch with Mr Warry's wife and daughter over the following weeks. In line with national policy, the prison offered Mr Warry's family a contribution to the costs of his cremation, which took place in October 2022. This has yet to be processed.

Support for prisoners and staff

53. After Mr Warry's death, the duty governor debriefed the escort staff, offering immediate support and signposting them to other avenues of support. Debriefs and offers of support were later extended to the family liaison officers, as well as operational and clinical staff.

54. The prison posted notices informing other staff and prisoners of Mr Warry's death and offering support.

Post-mortem report

55. No post-mortem examination was held, as the coroner accepted the hospital's clinical certification that the cause of Mr Warry's death was cardiogenic shock as a result of severe left ventricular failure and late presenting myocardial infarction. Mr Warry also had underlying COVID-19, which did not cause but contributed to his death.

Findings

Clinical Findings

56. The clinical reviewer considered that Mr Warry's asthma and the risks relating to COVID-19 were managed to a reasonable standard, at least equivalent to that which he could have expected to receive in the community. However, she found significant deficiencies in the management of his cardiovascular risk in 2022 and his care when he became acutely unwell. She concluded that these aspects of his clinical management did not meet the required standard.

57. Full details of the clinical reviewer's findings are in the clinical review report. We summarise them below and reflect the recommendations linked to Mr Warry's cause of death. The clinical reviewer made additional recommendations, which the Head of Healthcare will need to consider.

Management of Mr Warry's cardiovascular risk

58. National Institute for Health and Care Excellence (NICE) clinical guideline CG181, on cardiovascular disease, covers the assessment and care of those at risk of conditions such as heart disease and stroke. It states that patients should be prioritised for a full, formal risk assessment if their QRISK score is 10% or more. It includes advice on the need for discussions with patients about how lifestyle changes and statins can be used to reduce their risk, as well as the risk/benefits of changing to a high intensity statin. The clinical reviewer had several concerns about the clinical management of Mr Warry's cardiovascular risk.

59. There is no evidence that the pharmacist's findings of a high QRISK score of 26.19% and raised blood pressure, in October 2021, were referred to the GP and Mr Warry's next blood pressure check was in March 2022.

60. The clinical reviewer also noted specific concerns about the prison GP's assessment of Mr Warry's risk, including:

- He was not aware of the pharmacist's QRISK findings, although this was recorded on Mr Warry's SystmOne medical records;
- there was no formal QRISK assessment or up to date blood pressure reading when he reviewed Mr Warry's prescription for simvastatin;
- there was no care plan in place, or specific advice to support Mr Warry to make lifestyle changes to reduce his risk;
- blood test results in July 2022, suggested that the use of statin medication was working, yet it was stopped; and
- relevant tests were not collated to evidence the decision to stop prescribing simvastatin.

61. A further concern was that the GP's record keeping was not in line with the standards specified by the Royal College of Physicians and the General Medical Council. (We make further comment on record keeping below.)

62. We share the clinical reviewer's concerns that Mr Warry's cardiovascular risk was not managed in line with NICE guidelines and recommend:

    The Head of Healthcare should ensure that information from the pharmacist is shared with the healthcare team for review and action.

    The Head of Healthcare should ensure that GPs conduct a full, documented clinical assessment, in line with relevant guidance, to inform medication reviews and changes.

63. The GP no longer works at Stafford, but is still employed by Practice Plus Group, and the clinical reviewer has recommended that her findings are shared with him.

Recognition of Mr Warry's deteriorating health

64. NICE clinical guideline CG95 about recent-onset chest pain states that chest pain that lasts longer than 15 minutes might be a sign of an acute coronary syndrome, such as a heart attack. It lists several actions that should be taken to monitor chest pain, including taking ECG tests.

65. A nurse said that as Mr Warry was COVID-19 positive, she considered it inappropriate to take him through the prison to use the ECG machine in the healthcare centre and there was no portable machine.

66. British National Formulary (BNF) guidelines states that a second dose of GTN should be given five minutes after the first, if needed. However, urgent medical attention should be sought if the pain does not subside five minutes after the second dose, or sooner if the pain is worsening or the patient is unwell.

67. Another nurse said he did not follow the BNF guidance to give another dose of GTN, as he thought that Mr Warry's blood pressure might drop and the pain was more likely to muscular due to coughing.

68. The clinical reviewer found that the assessment, treatment and escalation of Mr Warry's report of chest pain on 25 September and the administration of GTN was not in line with NICE and BNF guidance, respectively and healthcare staff should have requested an ambulance sooner. We recommend:

    The Head of Healthcare should ensure that prisoners presenting with chest pain are managed in line with NICE guidelines on the diagnosis of chest pain and, where indicated, referred for emergency treatment.

Healthcare appointments

69. Mr Warry applied for a healthcare appointment on 20 September, listing his symptoms as a racing heart, giddiness and breathlessness. He was placed on the waiting list for review by the senior nurse. There is no record of Mr Warry informing operational staff that he had felt unwell around that time.

70. The clinical reviewer considered that the delay in assessing Mr Warry was possibly a missed opportunity for investigation of his symptoms before he became acutely unwell. We consider that the symptoms Mr Warry noted in his application merited higher priority and a more urgent response. We recommend:

The Head of Healthcare should ensure that prisoners who report acute symptoms receive timely medical appointments.

Clinical record keeping

71. The clinical reviewer identified several weaknesses in clinical record keeping, including:

- The GP's medical records were brief. They did not fully reflect his discussion with Mr Warry, or any information given to him about lifestyle management and the use of statins and lacked detail about his rationale for withdrawing simvastatin;
- the member of the healthcare team who processed Mr Warry's healthcare application on 20 September did not record their name;
- the medical emergency on 25 September was not fully documented. There was insufficient detail about the times and sequence of events, and there were no entries by a nurse and a Nursing Associate, who had assessed Mr Warry that morning.

We recommend:

The Head of Healthcare should ensure that healthcare staff fully and accurately document all clinical interactions and decisions, in line with the standards specified by the General Medical Council and Nursing and Midwifery Council.

Management of Mr Warry's risk of infection from COVID-19

72. Mr Warry was identified as at high risk of complications if he contracted COVID-19 and was managed appropriately. He was given the opportunity to shield, was tested at appropriate points and received all the vaccinations due at the time of his death. When he was either exposed to, or caught the virus, he was placed in isolation.

73. From late August to mid-October 2022, Stafford was a COVID-19 outbreak site. In line with HMPPS policy, Stafford put in place several protective measures across the prison to manage the risks, such as wing closures, testing prisoners and suspension of routine medical appointments. Healthcare staff completed daily welfare checks and clinical observations for COVID-19 positive patients.

74. We are satisfied that Mr Warry's risk of infection from COVID-19 was managed appropriately. However, in spite of the protective measures, it seems that he contracted the virus at the Stafford, as he had not left the prison for some time.

Emergency response

75. Prison Service Instruction (PSI) 3/2013, *Medical Emergency Response Codes* and Stafford's local policy SIN 208/18, *Response to Medical Emergencies* set out the actions staff should take in a medical emergency. This includes a mandatory requirement that a code blue emergency should be called if a prisoner has chest pain or breathing difficulties and the communications room should request an ambulance immediately.

76. There are conflicting accounts as to whether Mr Warry's first report of chest pain was communicated by telephone, or radioed as a code blue medical emergency. The nurses who examined him believed there had been a code blue call (although the Head of Healthcare said there was no evidence of this) and it was listed as such in the report by the prison's duty manager. The entry in the wing observations book did not record the incident as a code blue and, significantly, there is no reference to it in the communications room log. The Ambulance Service has no record of a request for an ambulance for an incident at that time.

77. The guidance is very clear that chest pains must be treated as a medical emergency with an urgent response and healthcare staff have the discretion to stand down an ambulance if it is not required. In view of the conflicting information, we are not satisfied that staff complied with the expected emergency response procedures. We recommend:

    The Governor and Head of Healthcare should ensure that all staff are fully aware of and understand their responsibilities in a medical emergency, including the use of an emergency response code if a prisoner has chest pains and documenting incidents.

Informing Mr Warry's family of his illness and death

78. Prison Rule 22 and Prison Service Instruction (PSI) 64/2011, *Safer Custody*, requires prisons to inform a prisoner's next of kin immediately if they become seriously ill, or if there is unpredicted or rapid deterioration in their physical health. It also sets out the actions to be taken after a death in custody.

79. We are concerned that the prison did not inform Mr Warry's wife that he was seriously unwell and in hospital. A prison manager told the investigator that the prison's protocol is for a prisoner's next of kin to be notified if he has been admitted to hospital for more than 72 hours, unless it is an emergency. She added that they did not consider Mr Warry to be critically ill as the hospital had not asked for his family to be informed.

80. A critical care unit provides high dependency care for serious heart conditions which require continuous monitoring and treatment. We consider that Mr Warry's immediate admission to the unit when he arrived at the hospital at around 11.00am, clearly indicated serious illness and should have prompted the prison to notify his wife immediately. We do not know whether she would have been permitted to visit or speak to him, but she would have at least had the opportunity to get updates on his condition directly from hospital staff.

81. Clinical deterioration can be rapid and prison staff could not have predicted Mr Warry would die. However, the escort staff had kept the prison closely informed of events throughout the day and reported that his condition had become life threatening around two hours before he died.

82. We consider that the prison had ample opportunity to inform Mr Warry's wife that he was seriously ill and that the lack of a request from the hospital was not a reason to disregard national HMPPS policy. We recommend:

The Governor should ensure that if a prisoner becomes seriously ill, their next of kin is notified immediately, in line with Prison Rule 22 and Prison Service Instruction 64/2011.

83. Another concern was the delay in notifying Mr Warry's wife of his death. PSI 64/2011 states that, if possible, the family liaison officer must break the news of a death in person and timing is important to try to ensure that the deceased's family do not find out from another source. It also says that if a prisoner was located a long distance from their family, prisons must consider asking a family liaison officer from the nearest prison, or the police, to break the news. Stafford's decision log guides family liaison officers to consider resource limitations and available specialist assistance.

84. Mr Warry's wife lived around 150 miles from the prison, and the family liaison officer made a considerable effort to inform her face to face. There was no evidence in the family liaison decision log that a quicker way of contacting her was considered, but a prison manager explained that most other prisons would have had reduced staff in the evening.

85. On balance, we are satisfied that the prison's rationale was sound, given the limited capacity at other prisons at that time of night, as well as little risk of the news being leaked. However, decisions in these circumstances should be better documented.

Reimbursement of cremation expenses

86. PSI 64/2011 sets out the processes after a death in custody, including financial help. Prisons must offer a contribution of up to £3,000 towards funeral expenses.

87. The discussions with Mr Warry's family about expenses were not documented, but a prison manager told the investigator what had happened. The prison had offered a contribution towards Mr Warry's cremation and told his family that the funeral director would be paid directly, on receipt of an invoice. However, Mr Warry's family had settled the invoice before sending it to the prison for reimbursement and it was unclear how to resolve this.

88. We are concerned that, over six months after Mr Warry's cremation, the payment to his family has yet to be processed. We recommend:

The Governor should ensure that the cost of Mr Warry's cremation is reimbursed, without further delay.

Use of social media

89. Social media guidance for civil servants: October 2014, sets out the principles for using social media appropriately and the requirement to do so in accordance with the Civil Service Code. Notably, users are expected to apply the same standards online as offline, whether acting in an official or personal capacity; and should check accuracy and sensitivity before posting online.

90. Mr Warry's family was concerned that the Governor had posted information on social media about Mr Warry's death before all the family members had been told. This included a statement implying that prison staff and the emergency services had given life support and that the death was due to natural causes.

91. The Governor did not name the deceased in his message. In a reply, also on social media, Mr Warry's daughter had asked if he was referring to her father and gave his name, which the Governor then confirmed.

92. By the time Mr Warry's family raised concerns with us about the content of the post, it had been removed, but the wording of it suggests the Governor posted it a few days after Mr Warry died. Mr Warry's family was understandably upset that some of the information in the message was inaccurate and we agree that it was inappropriate to categorise it as a natural death before the coroner had confirmed this.

93. We understand that the HMPPS Communications team provides guidance and training on the use of social media. The team is actively considering how to increase awareness of senior leaders and prisons about the risks and sensitivities around this. We recommend:

    The Director General of Operations of HM Prisons and Probation Service should remind staff of the requirement to adhere to the Civil Service Code and for sensitive and responsible use of social media.

    The Governor should ensure that information published on social media about a prisoner's death is appropriate, accurate and that the nature of the death is not revealed until confirmed by HM Coroner.

Inquest

94. At an inquest held on 4 February 2025, the Coroner concluded that Mr Warry died of natural causes.

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Independent Investigations

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