Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Brian Fletcher, a prisoner at HMP Hewell, on 15 December 2025

## A report by the Prisons and Probation Ombudsman

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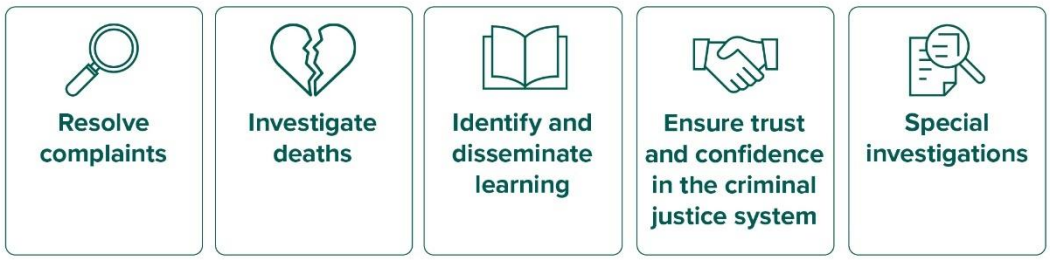
## OUR VISION

**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

# 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 Brian Fletcher died of heart failure on 15 December 2025, at HMP Hewell. He was 57 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Fletcher received at Hewell was not of a good standard and was not equivalent to that which he could have expected to receive in the community. Mr Fletcher's blood pressure, which was high when he arrived at Hewell, was never rechecked and Mr Fletcher never had care plans put in place for his long-term conditions, which included heart disease and diabetes. Also, Mr Fletcher asked for pain relief in the days leading up to his death, but the reasons for administering pain relief were not recorded.

5. There was a delay in discovering that Mr Fletcher had died as the officer who unlocked Mr Fletcher's cell on the morning of 15 March did not check on his welfare.

## Recommendations

- The Head of Healthcare should ensure that all clinicians follow the healthcare provider policy for blood pressure monitoring and that this is audited within the quality schedule.

- The Head of Healthcare should establish long term condition management as per national guidance, which includes a register, care plans, clinic monitoring and education opportunities for staff, and audit this within the quality schedule.

- The Head of Healthcare should ensure that all staff administering pain relief enter the reason why it has been requested into the clinical system and that this process is audited within the medicines management schedule.

- The Governor should ensure that:

    - The prison's local security strategy (LSS) reflects HMPPS requirements that a welfare check is completed at morning unlock and that clear guidance is provided to staff on what is expected of them.

    - A robust quality assurance process is implemented to ensure that welfare checks are carried out at morning unlock.

# The Investigation Process

6. HMPPS notified us of Mr Fletcher's death on 15 December 2025.

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

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

9. The Ombudsman's office wrote to Mr Fletcher's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but 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. They provided an action plan which is annexed to this report.

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

## Previous deaths at HMP Hewell

12. Mr Fletcher was the eleventh prisoner to die at Hewell since December 2022. Of the previous deaths, five were from natural causes, four were self-inflicted, and one is still awaiting classification. There are no similarities between the findings in our investigation into Mr Fletcher's death and the findings from our investigations into the previous deaths.

# Key Events

13. On 16 October 2025, Mr Brian Fletcher was remanded in prison, charged with sexual offences. He was taken to HMP Hewell.

14. During his reception screening, Mr Fletcher told a nurse that he had chronic obstructive pulmonary disease (COPD, a long-term lung condition), hypertension (high blood pressure) and type two diabetes. He also said he had had a heart attack 15 years earlier and had coronary bypass surgery in 2016. The nurse took his blood pressure, which was high. The nurse did not create any care plans for Mr Fletcher's long-term conditions and did not arrange for his blood pressure to be checked again.

15. On 17 October, a healthcare support worker saw Mr Fletcher for his second reception screening. They did not check his blood pressure or create any care plans.

16. On 19 November, a GP saw Mr Fletcher for a review of his COPD, after a pharmacy technician raised concerns that he was overusing his inhalers. Mr Fletcher told the GP he had both COPD and asthma and had hit his chest on his bed two weeks before so was using his inhalers more because of this. He also said he had angina (chest pain caused by reduced blood flow to the heart) and used GTN spray (medication that improves blood flow to the heart to manage symptoms). The GP examined Mr Fletcher's chest and had no concerns. Mr Fletcher said he did not need his next inhaler until 5 December. The GP did not check Mr Fletcher's blood pressure or create any care plans.

17. Between 4 December and 15 December, Mr Fletcher asked for pain relief medication three times. A pharmacist technician recorded in Mr Fletcher's medical record that he gave him the pain relief medication on each occasion but did not record the reason why Mr Fletcher had asked for it.

18. CCTV shows that at around 8.30am on 16 December, Officer A unlocked Mr Fletcher's cell. He pushed the door open but did not look in or enter the cell. He then continued walking around the landing.

19. At around 9.24am, Mr Fletcher's cellmate realised that Mr Fletcher, who was lying in his bed, was unresponsive. He left the cell to ask for help from Officer A. Officer A walked back to the cell with him and they both entered. Officer A was unable to get a response from Mr Fletcher. He then left the cell to find help and locked the door, with Mr Fletcher's cellmate inside.

20. Officer A asked a senior officer outside the main office for help. He told her that he thought Mr Fletcher had died. They returned to the cell, unlocked and entered it, and the senior officer immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff to attend and the control room to call an ambulance). She saw that Mr Fletcher had waxy, mottled skin and was very cold to the touch.

21. Healthcare staff arrived at the cell but did not start CPR because there were clear signs Mr Fletcher had died some time ago. At 9.33am, a paramedic at Hewell assessed Mr Fletcher for Recognition of Life Extinct (ROLE) features and observed

rigor mortis (stiffening of the body that occurs two to six hours after death) and hypostasis (blood settling in the body after death).

22. The ambulance crew arrived at 9.37am and agreed that CPR was not appropriate as Mr Fletcher had been dead for several hours. The ambulance crew pronounced life extinct at 9.52am.

## Post-mortem report

23. The post-mortem report concluded that Mr Fletcher died of cardiac failure caused by ischaemic heart disease (lack of blood flow to the heart), which was caused by severe coronary artery atherosclerosis (narrowing of arteries). COPD was listed as a contributory factor.

# Findings

## Clinical findings

24. The clinical reviewer concluded that the care Mr Fletcher received at Hewell was not of the required standard and therefore was not equivalent to that which he could have expected to receive in the community.

25. When Mr Fletcher had his first reception screening, the nurse recorded that he had high blood pressure. This was not rechecked during his second health screen or during his GP appointment on 19 November, as per national guidance. We recommend:

    **The Head of Healthcare should ensure that all clinicians follow the healthcare provider policy for blood pressure monitoring and that this is audited within the quality schedule.**

26. When Mr Fletcher arrived at Hewell he had several long-term health conditions including COPD, diabetes, and high blood pressure. Mr Fletcher did not have any care plans in place for managing these conditions while at Hewell and was not referred to a long-term condition clinic for monitoring as per national guidance.

27. The Head of Healthcare told the clinical reviewer that they were unable to run any long-term condition clinics due to staffing issues. A complex care nurse had recently been employed, and an advanced care practitioner was being employed to lead and manage complex conditions going forward. We recommend:

    **The Head of Healthcare should establish long term condition management as per national guidance, which includes a register, care plans, clinic monitoring and education opportunities for staff, and audit this within the quality schedule.**

28. Mr Fletcher asked for pain relief medication three times between 4 December and 15 December, in the lead up to his death. The pharmacy technician gave Mr Fletcher the medication but did not record the reason Mr Fletcher had asked for it. We recommend:

    **The Head of Healthcare should ensure that all staff administering pain relief enter the reason why it has been requested into the clinical system and that this process is audited within the medicines management schedule.**

29. The clinical reviewer also found that Mr Fletcher's second reception screening was completed by a healthcare support worker instead of a nurse, which is not in line with national guidance. The Head of Healthcare told her that from 1 February 2026, only qualified nurses would complete first and second reception screenings.

## Welfare checks at unlock

30. Prison Service Instruction (PSI) 75/2011, Residential Services, sets an expectation that staff will check on the welfare of prisoners at morning unlock by, for example, obtaining a verbal response from them. Prisons are required to have clearly

understood systems in place for staff to assure themselves of the well-being of prisoners during “or shortly after” morning unlock. The PSI also deems it unacceptable for staff completing morning unlock not to notice that a prisoner has died overnight.

31. More recent guidance to staff on the HMPPS intranet sets an expectation that a welfare check is undertaken at unlock to check that the prisoner is present and in good health. The welfare check should include a physical check that the prisoner is present and a gesture of acknowledgement from the prisoner that they are alive and well. Should they fail to get a response staff should open the door to check. All prisons are required to ensure their staff are aware of the requirements and that every prison’s local security strategy (LSS) reflects this.

32. Officer A unlocked Mr Fletcher’s cell at around 8.30am. When Mr Fletcher was found at 9.24am, he had rigor mortis (stiffening of the body that occurs two to six hours after death). The ambulance crew recorded in their log that they thought Mr Fletcher had died around six hours before he was found. The evidence indicates that Mr Fletcher was dead at 8.30am and therefore Officer A did not carry out a welfare check on Mr Fletcher when he unlocked his cell.

33. The Head of Residential Services told the investigator that on Mr Fletcher’s house block, officers were not expected to obtain a positive response from each prisoner at morning unlock. He said that if prisoners were awake, officers were generally expected to tell them why the door had been unlocked and to say good morning, which should elicit a response.

34. A safety hub manager told the investigator that in their experience on Mr Fletcher’s house block, the expectation at unlock was to check that prisoners were present and to wake those required to go to work during weekdays. They said it was not common practice to wake prisoners if they were still in bed. (Both Mr Fletcher and his cellmate were non-workers.)

35. However, the custodial manager (CM) for House Block One, gave a different account. He told the investigator that during morning unlock, officers were required to visually confirm the presence and apparent wellbeing of each prisoner. That meant looking for signs of movement, breathing, or a verbal response. If a prisoner was not responsive or visible, officers were expected to take further steps, which might include entering the cell, if necessary, to make sure the prisoner was safe.

36. The CM said the quality assurance processes for unlock checks included daily morning briefings where supervising officers outlined duties, shared relevant intelligence, and reiterated expectations for the day, including the importance of welfare checks during unlock. Supervising officers also conducted regular spot checks and observations to monitor compliance with unlock procedures. He said that any deviations from expected practice were addressed promptly through line management and additional training if needed.

37. The investigator asked for a copy of the written policy on unlock procedures. The Head of Safety and Diversity and Inclusion said that, if such a policy existed, it would be contained in the local security strategy (LSS). The investigator found no written policy on unlock procedures within the LSS and was not provided with any separate policy during the investigation.

38. Managers gave differing accounts of the expectations of staff carrying out morning unlock and there was no written local policy covering the checks required. Some staff said they were not required to wake prisoners if they were not going to work, which is not in line with prison policy on the checks required at morning unlock. We recommend:

**The Governor should ensure that:**

- **The prison's local security strategy (LSS) reflects HMPPS requirements that a welfare check is completed at morning unlock and that clear guidance is provided to staff on what is expected of them.**
- **A robust quality assurance process is implemented to ensure that welfare checks are carried out at morning unlock.**

## Governor to note

39. Officer A did not radio a code blue when he found that Mr Fletcher was not breathing. In his statement, he said he was unsure what to do because he had not experienced that situation before. He decided to seek help and locked the cell, leaving Mr Fletcher's cellmate inside. This resulted in a short delay in the code blue being called.

40. The delay in radioing the code blue did not change the outcome for Mr Fletcher, who was dead when found. However, we are concerned that Officer A did not know he should radio a code blue when he found Mr Fletcher was unresponsive and not breathing. We also consider it inappropriate that Mr Fletcher's cellmate was locked in the cell alone with Mr Fletcher while Officer A went to get help. We bring this to the Governor's attention.

## Inquest

41. At the inquest, held on 18 June 2026, the Coroner concluded that Mr Fletcher died from natural causes.

**Adrian Usher**
**Prisons and Probation Ombudsman** **July 2026**

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