Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Stuart Walker a prisoner at HMP Rye Hill on 26 August 2019

**A report by the Prisons and Probation Ombudsman**

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## Our Vision

**To carry out independent investigations to make custody and community supervision safer and fairer.**

## Our Values

**We are:**

**Impartial:** *we do not take sides*
**Respectful:** *we are considerate and courteous*
**Inclusive:** *we value diversity*
**Dedicated:** *we are determined and focused*
**Fair:** *we are honest and act with integrity*

# 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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Stuart Walker, who was 76 years old, died of bowel cancer on 26 August 2019 at HMP Rye Hill. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care Mr Walker received was equivalent to that which he could have expected to receive in the community. She made three recommendations, but as they do not relate directly to Mr Walker's death we have not repeated them here.

5. There is no record that staff discussed the option of early release on compassionate grounds with Mr Walker after he received his terminal diagnosis.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff discuss the option of early release on compassionate grounds with terminally ill prisoners, record the outcome of those discussions and progress as appropriate.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Walker's clinical care at HMP Rye Hill. The clinical review is attached to this report as Annex 1.

7. The PPO has investigated the non-clinical issues in Mr Walker's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. One of our family liaison officers wrote to Mr Walker's named next of kin, his friend, to explain the investigation. She did not raise any specific issues.

9. Mr Walker's named next of kin also received a copy of the initial report. She did not raise any further issues or comment on the factual accuracy of the report.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

## Previous deaths at Rye Hill

11. Mr Walker was the ninth prisoner to die at Rye Hill since August 2017. All the previous deaths were from natural causes. In a previous investigation, we made a recommendation that applications for early release on compassionate grounds should be progressed without delay.

## Key Events

12. On 4 December 2015, Mr Stuart Walker was sentenced to 17 years and 11 months in prison for sexual offences. He was moved to HMP Rye Hill on 12 September 2016.

13. In October 2017, a prison GP made an urgent referral for a hospital appointment after Mr Walker reported loose stools. On 6 November, hospital doctors diagnosed Mr Walker with bowel cancer. Surgery was planned, but then Mr Walker's heart condition deteriorated, and it was decided that he would probably not recover from surgery.

14. On 8 March 2018, Mr Walker signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order (stating that he did not want to be resuscitated if his heart or breathing stopped). Apart from several admissions to hospital for treatment for pneumonia, Mr Walker remained at Rye Hill, where he received palliative care.

15. On the morning of 26 August 2019, Mr Walker was found dead in his cell. Paramedics pronounced his death at 8.48am.

16. There was no post-mortem examination as the coroner accepted the cause of death provided by a prison GP. The GP recorded the cause of death as cancer of the caecum (part of the colon). Ischaemic heart disease and chronic obstructive pulmonary disease were listed as contributory factors.

## Findings

17. 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 for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 [or PSO 4700 for prisoners serving indeterminate sentences]. 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 his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS).

18. There is no record that staff discussed the option of early release on compassionate grounds with Mr Walker. The Head of Healthcare told the investigator that as no one had made a record, she could not be sure that the conversation had taken place. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff discuss the option of early release on compassionate grounds with terminally ill prisoners, record the outcome of those discussions and progress as appropriate.**

**Louise Richards**
**Assistant Ombudsman** **February 2020**