

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Guy Oprey a prisoner at HMP Long Lartin on 31 August 2019

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2020

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Guy Oprey, who was 58 years old, died of hepatocellular carcinoma (the most common type of liver cancer), hepatitis B and C and chronic obstructive pulmonary disease (COPD the name for a range of lung conditions) on 31 August 2019, at Long Lartin. We offer our condolences to Mr Oprey's family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Oprey received at Long Lartin was equivalent to that which he could have expected to receive in the community. She has made four recommendations about clinical issues.
5. We did not find any non-clinical issues of concern.

Recommendations

- **The Head of Healthcare and Head of Security should develop a protocol for an open-door policy to allow healthcare staff urgent access to prisoners during night state.**
- **The Head of Healthcare should explore the availability for battery operated nebulisers for prisoners with chronic lung problems who require regular external appointments.**
- **The Head of Healthcare and the Head of Safer Custody should ensure that the ACCT process is not used for long term health monitoring.**
- **The Head of Healthcare should ensure the waiting times for access to Psychology specialists are monitored against NHS standards.**

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Oprey's clinical care at HMP Long Lartin. The clinical review is attached to this report as Annex 1.
7. The PPO has investigated the non-clinical issues in Mr Oprey's care, including his location, the security arrangements for his hospital escorts and whether compassionate release was considered.
8. Mr Oprey's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at Long Lartin

10. Mr Oprey was the tenth prisoner to die at HMP Long Lartin in the last two years. Two of those deaths have been from natural causes.
11. There are no similarities between our findings in the investigation of Mr Oprey's death and the other deaths.

Key Events

12. In 1996, Mr Oprey was sentenced to life imprisonment for murder, with a minimum tariff to serve of fourteen years. He was sent to HMP Frankland. He transferred to HMP Long Lartin in January 2014.
13. Mr Oprey arrived into custody with a number of pre-existing medical conditions, the most serious being chronic obstructive pulmonary disease (COPD). He had a long history of substance misuse and was a smoker, who, despite repeated attempts refused smoking cessation advice until 2017.
14. While at Long Lartin, Mr Oprey was regularly reviewed by healthcare staff. His medications were appropriately reviewed and adjusted in line with NICE (National Institute for Health and Care Excellence) guidelines.
15. In March 2019, healthcare staff discovered a mass in Mr Oprey's abdomen. They made a two week wait referral (an urgent referral made for those patients suspected to be suffering from cancer) and after carrying out a series of tests, hospital staff confirmed he had developed liver cancer.
16. Following his diagnosis, healthcare staff opened an ACCT document to assist them to monitor Mr Oprey's health (Assessment Care in Custody and Teamwork, a document used for those prisoners who have expressed thoughts of self-harm). He had not expressed any thoughts of self-harm.
17. In July, hospital staff confirmed that Mr Oprey's cancer was inoperable. They also considered that he would not be suitable for chemotherapy treatment. The only treatment option left open to him was palliative care.
18. An application for release on compassionate grounds (ECRG) was made on his behalf. However, as he had not been given a prognosis of less than three months, he did not meet the criteria for early release. As his condition deteriorated, Mr Oprey stated he wished to remain at Long Lartin where he felt supported by his peers and staff.
19. On 12 August, Mr Oprey told healthcare staff he was experiencing severe abdominal pain. He was taken to Royal Worcester Hospital by emergency ambulance. Following a review by hospital staff, he was admitted as an inpatient. He was unrestrained during his final admission to hospital.
20. Mr Oprey's condition continued to deteriorate and at 10.30pm on 30 August, he died. A hospital doctor confirmed his death at 12.25am.
21. There was no post-mortem examination, the Coroner accepted the cause of death given by a hospital doctor as hepatocellular carcinoma, hepatitis B and C and COPD.

Lisa Burrell
Assistant Ombudsman

March 2020