

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Garrard, a prisoner at HMP Leyhill, on 23 March 2020

**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*



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## 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 Stephen Garrard, who was 65 years old, died of colon cancer on 23 March 2020, at HMP Leyhill. I offer my condolences to Mr Garrard's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Garrard received at Leyhill was equivalent to that which he could have expected to receive in the community. However, he made one recommendation about the care Mr Garrard received at his previous prison, HMP Usk.
5. We found no non-clinical issues of concern.

## Recommendations

- The Head of Healthcare at HMP Usk should ensure that abnormal blood test results are considered fully in relation to any previous abnormal blood tests.

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Garrard's clinical care at Leyhill.
7. The PPO investigator has investigated non-clinical issues, including Mr Garrard's location, the security arrangements for his hospital escorts, and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Garrard's next of kin to explain the investigation. She did not respond.
9. The initial report was shared with the Prison Service. The Prison Service found a factual inaccuracy in the clinical review which has now been amended.

## Previous deaths at HMP Leyhill

10. Mr Garrard was the fifth prisoner to die at Leyhill since March 2018. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Garrard's death and our investigation findings for the previous deaths.

## Key Events

11. On 12 February 2015, Mr Stephen Garrard was sentenced to 16 years in prison. He was sent to HMP Usk.
12. In November 2018, blood test results showed that Mr Garrard had an iron deficiency, and he was told that this could indicate possible cancer. Mr Garrard said that he was feeling perfectly well, and did not want any further investigations.
13. In February 2019, Mr Garrard had another blood test which again showed an iron deficiency. However, the results of the blood test were marked as satisfactory, and there was no discussion with Mr Garrard about a referral for further investigation.
14. On 8 July, a prison GP saw Mr Garrard because he said that he felt unwell. She found that his heartbeat was irregular and she sent him to hospital. Mr Garrard had a computerised tomography (CT) scan (uses X-rays and a computer to create detailed images of the inside of the body), which showed that he had a tumour.
15. On 10 July, Mr Garrard had an operation to try to remove the tumour, but it was unsuccessful. Mr Garrard was told that he had bowel cancer, and he was returned to prison on 26 July.
16. On 23 September, Mr Garrard had another operation to try to remove the tumour. This was also unsuccessful and the doctor told Mr Garrard that the cancer had spread to his liver and kidney.
17. Over the next two months, Mr Garrard developed wound and other post-operative infections, and he had to be admitted to hospital for treatment on several occasions.
18. Mr Garrard's health continued to deteriorate. In November, healthcare staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Garrard, who agreed that if he stopped breathing he did not wish to be resuscitated.
19. On 6 January 2020, Mr Garrard was moved to HMP Leyhill because he needed 24-hour nursing care. He was appropriately located on the healthcare wing.
20. In February, Mr Garrard said that he would like to apply for compassionate release. Leyhill started the process but were unable to find anywhere suitable for Mr Garrard to be released to as he had no home, or family address to go to.
21. On 20 March, Mr Garrard was moved to the palliative care suite, and on 23 March, he died. At 9.35pm, a prison GP confirmed Mr Garrard's death.

## **Cause of death**

22. The Coroner accepted the cause of death provided by the prison GP and no post-mortem examination was carried out. The GP gave Mr Garrard's cause of death as colon cancer.

**Louise Richards**  
**Assistant Ombudsman**

**September 2020**

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