

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Trevor Ward a prisoner at HMP Rye Hill on 3 April 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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Trevor Ward, who was 59 years old, died from heart failure on 3 April 2020, at HMP Rye Hill. We offer our condolences to Mr Ward's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Ward received at Rye Hill was equivalent to that which he could have expected to receive in the community.
5. We found no non-clinical issues of concern. We make no recommendations.

## Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Ward's clinical care at HMP Rye Hill.
7. The PPO investigator has investigated the non-clinical issues in Mr Ward's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO's family liaison officer wrote to Mr Ward's next of kin, to explain the investigation. He did not respond.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at Rye Hill

10. Mr Ward was the 12th prisoner to die at Rye Hill since April 2018. All the previous deaths were from natural causes. There are no significant similarities between these deaths and Mr Ward's.

## Key Events

11. On 17 August 2010, Mr Trevor Ward was sentenced to 18 years imprisonment for sexual offences. He was moved to HMP Rye Hill on 25 September 2014.
12. Mr Ward arrived at Rye Hill with several serious health conditions, including previous heart attacks, angina (chest pain caused by reduced blood flow to the heart muscles), hypertension (high blood pressure), sleep apnoea (breathing stopping and starting while asleep) for which he used a CPAP machine (a machine to keep the airways open), and type 2 diabetes (the inability of the body to regulate sugar in the blood). In addition, while at Rye Hill, Mr Ward was diagnosed with chronic kidney disease (a long-term condition where the kidneys do not work properly).
13. Mr Ward was prescribed medication to control his conditions, but for many years he had frequently refused to take them or attend clinical appointments. He also had a long history of self-harm by cutting. Both the self-harm and refusals of medication/ treatment were usually a form of protest against a perceived wrong.
14. Mr Ward's health continued to decline while he was at Rye Hill. He was morbidly obese and attempts by healthcare staff to get him to adopt a healthier diet were unsuccessful. He had regular input from the Mental Health Team to help him address his problems. His refusals of medical interventions were also regularly reviewed and assessments indicated that Mr Ward had the mental capacity to make these decisions.
15. In November and December 2019, and during the first few months of 2020, Mr Ward visited hospital several times, both as a diabetes and cardiology outpatient, and as an inpatient. It was noted in his medical records that his health was deteriorating. After an appointment at the beginning of January 2020, Mr Ward said that he thought he would not live for long. He once again refused to take his medications in February as he said that he wanted to hasten his death.
16. On 26 March, Mr Ward was having trouble with breathing and staff called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance). He was taken to hospital, but later discharged. He was put in isolation on return from the prison while Covid-19 tests were processed. These later showed that Mr Ward did not have Covid-19.
17. On 30 March, after another code blue, Mr Ward was taken to hospital again. He discharged himself against the advice of medical staff in the early hours of 31 March. When he arrived back at the prison, healthcare staff were unable to persuade him to return to hospital. From this point, palliative care (care with the focus on optimising the quality of life and reducing suffering) was the primary focus for Mr Ward.
18. On 2 April, staff began the process of considering early release on compassionate grounds. However, Mr Ward had said on several occasions that he did not want to be released from prison and he would reoffend to get back in, so it was very unlikely that an application would have been approved.

19. On 3 April, discussions with a hospice resulted in an agreement that Mr Ward should be transferred there. However, these plans were abandoned because it was considered that the journey was not in his best interests as he was so ill.
20. Mr Ward was on half hourly checks in his cell. At 9.15pm on 3 April, he was found to be unresponsive. Resuscitation was not attempted as there was a Do Not Attempt Resuscitation (DNAR) order in place, following discussions between Mr Ward and prison doctors earlier in the year.
21. There was no post-mortem examination as the coroner accepted the cause of death provided by a prison doctor, who gave the cause of death as heart failure due to ischaemic heart disease (restriction of the blood supply to the heart). The doctor noted that Mr Ward also had chronic kidney disease and type 2 diabetes.

**Louise Richards**  
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