Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Clowes, a prisoner at HMP Winchester, on 13 September 2020

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 Ian Clowes, who was 68 years old, died in a hospice of cancer on 13 September 2020, while a prisoner at HMP Winchester. We offer our condolences to Mr Clowes' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Clowes received at Winchester was of a good standard and equivalent to that which he could have expected to receive in the community. She made three recommendations but as two were not directly related to Mr Clowes' death, we have not included those recommendations in our report.

5. We did not find any non-clinical issues of concern.

Recommendations

- The Head of Healthcare should review the nurse triage system so that where a nurse has tried to visit a prisoner but has been unable to gain access to them, there is a system in place to ensure that this is followed up the next day.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer, to review Mr Clowes' clinical care at HMP Winchester. The clinical review is attached to this report as Annex 1.

7. A PPO investigator has investigated the non-clinical issues in Mr Clowes' 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 Clowes' next of kin, his sister, to explain the investigation. She did not respond.

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

Previous deaths at HMP Winchester

10. Mr Clowes was the 11th prisoner to die at Winchester since September 2018. Of the previous deaths, six were from natural causes and four were self-inflicted

Key Events

11. On 16 January 2019, Mr Ian Clowes was sent to prison for five years and four months for arson. He was sent to HMP Winchester.

12. On 28 September 2019, Mr Clowes made an application to see the doctor because he had a growth on the inside of his cheek. The triage nurse tried to see Mr Clowes the next morning and a second nurse tried to see him in the afternoon, but neither could get access to him. The second nurse recorded that she had "rebooked for tomorrow" but there was no record Mr Clowes was seen.

13. Mr Clowes was not seen by the prison GP until 11 October. The GP was concerned that the growth might be cancer so referred Mr Clowes to the prison dentist. The dentist saw Mr Clowes that same day and made an urgent referral to the hospital.

14. On 29 October, Mr Clowes was seen at the hospital where he had a biopsy and a CT scan (uses X-rays and a computer to create detailed images of the inside of the body).

15. On 18 November, the prison GP received a letter from the hospital to say that Mr Clowes had mouth cancer.

16. On 2 December, Mr Clowes was due to go to hospital for treatment, but he refused to go and signed a disclaimer to say that he was refusing treatment.

17. On 12 December, Mr Clowes went to the head and neck clinic, and said that he wanted radiotherapy treatment. On 18 December, a care plan was created and Mr Clowes was referred for palliative care only because he had declined surgery.

18. On 27 December, healthcare staff discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) with Mr Clowes, who agreed that if he stopped breathing he did not want to be resuscitated.

19. On 6 March 2020, Mr Clowes was moved to the healthcare unit so that he could be closely monitored and cared for.

20. In May, Mr Clowes started a week of radiotherapy treatment; he knew that this was palliative only and would not cure the cancer.

21. On 1 June, prison staff started an application for compassionate release for Mr Clowes. The prison GP documented that Mr Clowes had a terminal diagnosis and was in the last few months of his life. On 3 June, the prison Governor completed his part of the compassionate release application and agreed that Mr Clowes should be released on compassionate grounds.

22. On 4 September, after a deterioration in Mr Clowes' health, he was moved to a hospice for end of life care. As the compassionate release application had not yet been processed, Mr Clowes was released from prison on a temporary licence. He remained in the hospice until 13 September when he died.

Cause of death

23. The coroner accepted the cause of death provided by the hospice and no post-mortem examination was conducted. The hospice recorded Mr Clowes' cause of death as squamous cell carcinoma. Ischemic heart disease and diabetes were listed as contributing factors.

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Assistant Ombudsman

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