

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Caddle, a prisoner at HMP Wakefield, on 17 February 2021

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*

OGL

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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 John Caddle died from disseminated adenocarcinoma of the pylorus (stomach cancer which had spread) on 17 February 2021 at HMP Wakefield. He was 80 years old. We offer our condolences to his family and friends.
4. The clinical reviewer found that the clinical care that Mr Caddle received at Wakefield was both responsive and equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer found that Mr Caddle's care met the requirements of the Death in Custody Charter (for palliative and end-of-life care) and that anticipatory (end-of-life) medicines were appropriately prescribed. She noted that entries in Mr Caddle's medical records indicate respectful and compassionate communication between healthcare and prison staff.
6. We did not identify any non-clinical issues of concern and we make no recommendations.
7. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

The Investigation Process

8. NHS England commissioned a clinical reviewer to review Mr Caddle's clinical care at HMP Wakefield. The clinical review is attached to this report at Annex 1.
9. The PPO investigator has investigated the non-clinical issues in Mr Caddle's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
10. The Ombudsman's family liaison officer wrote to Mr Caddle's next of kin to explain our investigation. They did not respond.
11. We shared the initial report with the Prison Service, there were no factual inaccuracies.

Previous deaths at Wakefield

12. There were 18 deaths from natural causes (three of which were related to COVID-19) and two self-inflicted deaths at HMP Wakefield in the two years before Mr Caddle's death. Six prisoners have died at Wakefield since Mr Caddle's death, five from natural causes (three of which were related to COVID-19) and one was self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

13. On 11 February 2016, Mr John Caddle was sentenced to 20 years in prison for sex offences. On 29 September 2017, he was transferred to HMP Wakefield.
14. Mr Caddle had Type 2 diabetes, hypertension and an enlarged prostate.
15. On 13 April 2019, Mr Caddle saw a nurse because he felt unwell and was dizzy. Mr Caddle told the nurse that he had rectal bleeding. Blood tests identified that Mr Caddle had low haemoglobin levels which made him anaemic (a low number of red blood cells). Healthcare staff sent him to hospital, where he had a blood transfusion and was given iron tablets.
16. On 20 April, Mr Caddle had a gastroscopy (a procedure to examine the interior of the stomach).
17. On 11 July, a consultant general surgeon told Mr Caddle that he had stomach cancer. On 26 July, hospital staff fitted a stent (a procedure to widen a blockage in the stomach) and between August and October, Mr Caddle had six treatment cycles of palliative chemotherapy.
18. On 20 January 2020, a consultant medical oncologist told Mr Caddle that the cancer was growing and had caused another obstruction in his stomach.
19. On 10 February 2021, Mr Caddle's health deteriorated and he was transferred to the end-of-life suite at Wakefield, where he died on 17 February. Healthcare staff were with him when he died.
20. A respiratory consultant established that Mr Caddle died from disseminated adenocarcinoma of the pylorus (stomach cancer which had spread). There was no post-mortem examination.

Caroline Mills
Assistant Ombudsman

August 2021

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