

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Over, a prisoner at HMP Wakefield, on 10 June 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*



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## Summary

1. The Prisons and Probation Ombudsman (PPO) 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 David Over died of lung cancer on 10 June 2021 at HMP Wakefield. He was 64 years old. I offer my condolences to Mr Over's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Over received at Wakefield was equivalent to that which he could have expected to receive in the community. However, he found no evidence that an Advance Care Plan (ACP), which helps ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness, had ever been discussed with Mr Over. He made one recommendation.
5. The prison was unable to provide us with the escort risk assessment for Mr Over's hospital transfer on 5 June 2021. We were therefore unable to assess whether there had been appropriate use of restraints.

## Recommendations

- The Head of Healthcare should ensure that Advance Care Plans (ACP) are discussed with patients where it has been identified that they are suffering from long term chronic health conditions.
- The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

## The Investigation Process

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

## **Previous deaths at HMP Wakefield**

10. Mr Over was the 23rd prisoner to die at Wakefield since June 2019. Of the previous deaths, 19 were from natural causes and three were self-inflicted. We have previously raised the issue of Wakefield not providing all the evidence requested for our investigation.

## Key Events

11. In September 2018, Mr David Over was sentenced to 12 years imprisonment for rape. On 15 April 2021, he was moved to HMP Wakefield.
12. On 6 May, a prison GP completed a fast track referral for suspected cancer as Mr Over appeared frail and had lost a significant amount of weight.
13. On 11 May, a prison nurse requested a non-urgent ambulance for Mr Over as he was experiencing shortness of breath and felt lethargic. On 13 May, a hospital doctor diagnosed Mr Over with a primary malignancy of the lung with metastasis in the brain (lung cancer which had spread to the brain). Mr Over said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. On 18 May, he returned to Wakefield and was moved to the palliative care suite within the healthcare unit to meet his care needs.
14. On 19 May, a prison consultant gave Mr Over a prognosis of a “few weeks”. The consultant began the process of applying for release on compassionate grounds.
15. On 4 June, Mr Over had a fall and injured his knee. A prison nurse noted that he was struggling to walk independently, was in a lot of pain and required support from healthcare staff. On 5 June, he was taken to hospital. He returned from hospital in a leg brace the same day.
16. Mr Over died in the palliative care suite at Wakefield on 9 June at 4.33am.

### Cause of death

17. The Coroner held an inquest on 15 July 2021 and concluded that Mr Over died of disseminated lung cancer (lung cancer which had spread).

# Non-Clinical Findings

## Providing evidence to the PPO

18. Prison Service Instruction (PSI) 58/2010, *The Prisons and Probation Ombudsman*, says that Governors must ensure that when the PPO is carrying out investigations or enquiries, staff comply with requests for information and assistance.
19. At the start of this investigation, the PPO requested all relevant documents required for their investigation from Wakefield, including copies of escort risk assessments. When the documents were reviewed, it was found that one escort risk assessment for 5 June 2021 was missing. After several weeks of chasing by the PPO investigator, prison staff told him it could not be located.
20. We are concerned the prison was unable to provide the PPO with this document. Such documents can provide crucial evidence for investigations, and we would expect the prison to ensure that evidence is preserved following a death in custody to enable appropriate scrutiny and accountability. We are therefore unable to comment on the use of restraints and the events when Mr Over left the prison to attend hospital on 5 June. We make the following recommendation:

**The Governor should ensure that all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.**

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

**February 2022**

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