Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Brady, a prisoner at HMP The Verne, on 7 August 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 John Brady died in hospital on 7 August 2020 of bilateral bronchopneumonia while a prisoner at HMP The Verne. He was 67 years old. I offer my condolences to Mr Brady's family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Brady received at HMP The Verne was equivalent to that which he could have expected to receive in the community. He made one recommendation.

5. We did not find any non-clinical issues of concern. We make no recommendations.

6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigations.

Recommendation

- **The Head of Healthcare should ensure that chronic diseases are managed within a structured management approach involving care planning.**

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Brady's clinical care at HMP The Verne.

8. A PPO investigator has investigated non-clinical issues, including Mr Brady's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Brady's next of kin, his sister and son, to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They did not respond to our letter.

10. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at HMP The Verne

11. Mr Brady was the first prisoner to die at HMP The Verne since June 2014. There have been seven further deaths from natural causes since Mr Brady's death.

Key Events

12. On 15 January 2016, Mr John Brady was sentenced to an extended determinate sentence of 13 years imprisonment for sexual offences. He was sent to HMP Thameside. On 19 February 2019, Mr Brady transferred to HMP The Verne from HMP Isle of Wight.

13. On his arrival at The Verne, a nurse completed an initial reception screen. Mr Brady's chronic medical conditions were noted which included hepatitis C, high blood pressure, asthma, and an underactive thyroid. He was referred to a prison GP for review and saw a GP the next day, on 20 February, and had a secondary health screen. A care plan was created for his asthma, but one was not created for his high blood pressure.

14. On 20 April 2020, Mr Brady complained of abdominal pains and saw a prison GP. On 23 April, Mr Brady was taken to hospital for a colonoscopy (an internal examination of the bowel and rectum using a tiny camera). It showed nothing of concern.

15. On 28 April, Mr Brady saw a prison GP for an abdominal examination. She was concerned that he might have pancreatic cancer and referred him under NHS fast track procedures for a scan. A CT scan was arranged for 13 May, but Mr Brady refused to attend.

16. The CT scan was rearranged for 19 May, which Mr Brady attended. The results showed a shadow on his lung, which suggested he had cancer. As a result, further tests were arranged.

17. On 4 June, Mr Brady was taken to hospital for another CT scan and on 9 June, he had a bronchoscopy (an internal examination of the airways using a tiny camera). Following analysis of these tests, Mr Brady was diagnosed with lung cancer on 12 June. He was referred for chemotherapy and radiotherapy and on 21 July, he started treatment at Poole Hospital.

18. On 3 August, Mr Brady attended hospital for a routine chemotherapy and radiotherapy appointment accompanied by two officers. Mr Brady told hospital staff that he felt more unwell and they assessed him. Blood tests suggested he had sepsis and he was given antibiotics and intravenous fluid.

19. Later that evening, Mr Brady had a CT scan. It showed he had a collapsed lung. The hospital medical team inserted a chest drain to remove air from the membrane around his lung. However, despite the treatment he was receiving, Mr Brady's health worsened. On 6 August, treatment was withdrawn, and Mr Brady was transferred to a specialist cancer ward at Poole Hospital for end of life care.

20. At 08.00am on 7 August, Mr Brady died at Poole Hospital.

Post-mortem report

21. The Coroner concluded in the post-mortem that Mr Brady died of bilateral bronchopneumonia (an inflammation of the airways and lung) caused by right

sided lung cancer. He also had macronodular liver cirrhosis which did not cause but contributed to his death.

Lisa Burrell
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