

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr John Powell, a prisoner at HMP Stafford, on 27 May 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



© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

## 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. On 27 May 2021, Mr John Powell died of prostate cancer, which had spread to other parts of his body, while a prisoner at HMP Stafford. He was 65 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Powell received at Stafford was good and equivalent to that which he could have expected to receive in the community.
5. However, healthcare staff at Dartmoor should not have told Mr Powell that he was moving to the new Specialist Care Unit at Stafford when it was not open and not available to him. (It did not open until October 2021, by which time Mr Powell had died.) The clinical reviewer noted that it appeared that Dartmoor's healthcare team did not provide a true reflection of Mr Powell's health needs and the expectation that he was being transferred to a new palliative care unit at Stafford.

## Recommendations

- The Heads of Healthcare at Dartmoor and Stafford should ensure that there is effective information sharing between healthcare teams to ensure that there is no confusion about the nature of a healthcare-related prison transfer and that prisoners are given an accurate explanation about the reason for their transfer.

## The Investigation Process

6. NHS England commissioned a clinical reviewer to review Mr Powell's clinical care at HMP Stafford.
7. The PPO investigator has investigated the non-clinical issues in Mr Powell's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The Ombudsman's family liaison officer wrote to Mr Powell's sister to explain our investigation. She did not respond.
9. We shared the initial report with the Prison Service. There were three factual inaccuracies in the PPO report and two factual inaccuracies in the clinical review.

## Previous deaths at HMP Stafford

10. In the two years before Mr Powell's death, there were ten deaths from natural causes, two of which were related to COVID-19. There have been four deaths from natural causes since Mr Powell's death, two of which were from COVID-19. There are no significant similarities between our findings in this investigation and those of the other deaths.

## Key Events

11. On 14 February 2020, Mr John Powell was sentenced to eight years in prison for sex offences. On 20 March, he was transferred to HMP Dartmoor.
12. Mr Powell had prostate cancer, which was diagnosed in 2016 and for which he had had chemotherapy and radiotherapy in hospital.
13. In March 2021, hospital staff told Mr Powell that his prostate cancer had spread, that they would stop active treatment and that he had a poor prognosis. Healthcare staff at Dartmoor could not provide palliative care for Mr Powell.
14. On 1 April, a nurse spoke to healthcare staff at HMP Stafford, who told him that they could provide palliative care for Mr Powell. The nurse told Mr Powell, who agreed to move to Stafford when a space became available for him.
15. On 15 April 2021, Mr Powell was transferred by ambulance to HMP Stafford, accompanied by a nurse.
16. At his initial health screen at Stafford that day, a nurse noted that Mr Powell was unable to move or care for himself without assistance and arranged for social carers to visit him three times a day. She placed Mr Powell on the complex care register and assigned him to the local community palliative care team.
17. On 20 April, a nurse reviewed Mr Powell's cancer care plan and noted that he had a prognosis of less than six months to live. Mr Powell told the nurse that he was very upset that the palliative care unit, to which he thought that he was being transferred, was not open and that he was sent instead to a standard cell.
18. On 29 April, Mr Powell's health deteriorated, and he had increased pain. On 4 May, a palliative care nurse and a palliative care consultant discussed pain control with Mr Powell.
19. On 7 May, the Clinical Manager for the Specialist Care Unit reviewed Mr Powell. He was confused and his health had deteriorated. She and the palliative care consultant sent him to a palliative care ward in hospital.
20. On 27 May, Mr Powell died in hospital. A hospital doctor said that he died from metastatic prostate cancer (cancer which had spread to other parts of his body).

# Non-Clinical Findings

## Transfer from HMP Dartmoor to HMP Stafford

21. Mr Powell agreed to transfer to Stafford because he understood that he was being moved to the new regional Specialist Care Unit. However, the unit had not opened, and he lived instead in a standard cell.
22. A nurse said that healthcare staff looked at local options for Mr Powell, but that HMP Exeter's palliative care unit and social care wing was closed for refurbishment and none of the prisons near to Dartmoor had 24-hour healthcare which could accommodate him.
23. A Regional Service Manager, employed by Practice Plus Group, the healthcare provider at Dartmoor and at Stafford, said that after a multidisciplinary team meeting, healthcare staff said that Mr Powell's needs could not be met at Dartmoor. The Governor of Stafford was not made aware that Mr Powell was transferring to the prison. She said that she spoke to the Regional Manager for the Midlands to ask if they had space at Stafford because she knew that they had a new unit which may be suitable, although she knew that it was not yet open.
24. The Regional Service Manager said that during the multidisciplinary team meetings before Mr Powell's transfer, admission to the Specialist Care Unit for Mr Powell was never mentioned because it was not an option as there were delays with its completion.
25. The Head of Healthcare at Stafford said that when Mr Powell was transferred to Stafford, the new Specialist Care Unit had not opened. It was not due to open until 18 October. She said that when Mr Powell arrived at Stafford, she was aware that he was a palliative care prisoner, but it became clear that the clinical handover had not been correct, and that Dartmoor had not told healthcare staff at Stafford about parts of his care, particularly in relation to his mobility.
26. The Head of Healthcare said that she felt that it was an inappropriate and unsafe transfer. She said that healthcare staff at Dartmoor had told Mr Powell that he would live in the new palliative care unit. She said that Mr Powell was upset and anxious to find that this was not the case and that he would live on a standard wing. She spoke to healthcare staff at Dartmoor but was unable to find out who or when Mr Powell was told that he was moving to the new unit.
27. Although the records indicate that Mr Powell was told that he would be moving to the Specialist Care Unit at Stafford, the investigator has been unable to identify who told him this. After Mr Powell transferred to Stafford, healthcare staff at Stafford raised concerns that he had been transferred inappropriately from Dartmoor and submitted a form reflecting this.
28. The clinical reviewer said that Mr Powell received a good standard of healthcare at Stafford. She said that he was not able to be transferred to a hospice but was able to die peacefully in hospital.

29. There was a breakdown in communication between healthcare managers and healthcare staff involved in Mr Powell's transfer from Dartmoor to Stafford. It was inappropriate for healthcare staff at Dartmoor to have told Mr Powell that he was moving to the new Specialist Care Unit when it was not open and not available to him. We make the following recommendation:

**The Head of Healthcare at Dartmoor and the Head of Healthcare at Stafford should ensure that there is effective information sharing between healthcare teams to ensure that there is no confusion about the nature of a healthcare-related prison transfer and that prisoners are accurately told why the transfer is being made.**

**Caroline Mills**  
**Assistant Ombudsman**

**July 2022**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100