

**Prisons &
Probation**

Ombudsman
Independent Investigations

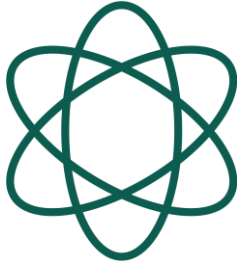
Independent investigation into the death of Mr Samuel Cree, a prisoner at HMP Wymott, on 14 January 2021

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

© Crown copyright, 2023

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

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. Mr Samuel Cree, who was 59 years old, died in hospital of cancer on 14 January 2021, while a prisoner at HMP Wymott. We offer our condolences to Mr Cree's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Cree received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
5. We did not find any non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Cree's clinical care at HMP Wymott.
7. The PPO investigator has investigated the non-clinical issues in Mr Cree's 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 Cree's next of kin, a friend, to explain the investigation. He asked for a copy of our report but raised no issues for investigation.
9. Mr Cree's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Previous deaths at HMP Wymott

11. Mr Cree was the 12th prisoner to die at Wymott since January 2019. Of the previous deaths, ten were from natural causes and one was drug related.

Key Events

12. In February 2008, Mr Samuel Cree was given an indeterminate prison sentence for sexual offences. In August 2014, he was moved to HMP Wymott.
13. On 3 April 2020, Mr Cree tested positive for COVID-19. He was appropriately isolated in line with NHS England guidelines.
14. On 26 June, a prison GP saw Mr Cree because he felt unwell, had lost weight and was still feeling short of breath following his COVID-19 infection. He arranged for Mr Cree to have blood tests.
15. On 30 June, a prison GP told Mr Cree that his blood test results showed signs of infection and anaemia. He prescribed Mr Cree with antibiotics for a throat infection, and iron tablets for anaemia. He told Mr Cree that he would need to have his blood tests repeated in two weeks' time.
16. On 17 July, Mr Cree's blood tests were repeated. The results showed that Mr Cree's haemoglobin (a substance found in red blood cells that carries oxygen around the body) levels were very low and the hospital's blood laboratory advised that Mr Cree should go to hospital. When a prison nurse told Mr Cree that he needed to go to hospital for further tests, he said that he did not trust English hospitals and refused to go. He signed a disclaimer.
17. On 21 July, a prison GP saw Mr Cree and said that as he had had cancer before (Mr Cree had been diagnosed with skin cancer in 1999 and with testicular cancer in 2002), there was a high risk that he had cancer again and he needed to go to hospital. Mr Cree refused to go. He said that he still had a sore throat, so the GP prescribed some more antibiotics and Mr Cree said that if he was not better in a week's time he would go to hospital.
18. On 29 July, a prison GP saw Mr Cree again, who said that his appetite had returned, and his throat was a bit better. The GP again explained the possibility that Mr Cree may have cancer and told him that he needed to go to hospital. Mr Cree still refused. The GP told him to tell staff if he changed his mind.
19. On 2 December, a prison GP saw Mr Cree, who said that he was struggling to swallow food and still had a sore throat. The GP noted that Mr Cree had lost 10kg in weight since July. He told Mr Cree that his symptoms were indicative of cancer and again advised him to go to hospital. Mr Cree continued to refuse.
20. On 24 December, a healthcare assistant noted that Mr Cree was pale and when she took his clinical observations, she noted that his blood pressure and blood oxygen saturation levels were low. A nurse saw him and referred him to a prison GP. Mr Cree said he had shortness of breath and heart palpitations. He refused to go to hospital but did agree to a referral. The GP made the referral using the suspected cancer pathway (for an appointment in two weeks). Mr Cree's observations were taken twice a day by healthcare staff and each time they asked if he had changed his mind about going to hospital.
21. On 1 January 2021, Mr Cree pressed his alarm button and told a nurse that he felt very unwell and would go to hospital. Mr Cree was escorted by two officers and

was restrained using the single cuffing method (when the prisoner's wrist is attached to a prison officer's wrist by a set of handcuffs). Mr Cree was admitted to hospital for a blood transfusion and further tests. The following morning all restraints were removed.

22. On 6 January, the prison appointed a family liaison officer and started an application for Mr Cree to be released on compassionate grounds.
23. On 11 January, Mr Cree was diagnosed with squamous cell carcinoma (skin cancer). His health rapidly deteriorated and on 14 January he died in hospital.

Cause of death

24. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was conducted. The hospital recorded Mr Cree's cause of death as cancer of unknown aetiology (unknown origin).

Louise Richards
Assistant Ombudsman

May 2021

Inquest

25. The inquest, heard on 23 August 2023, concluded that Mr Cree died from natural causes.

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100