

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

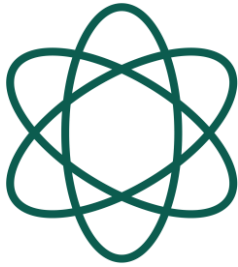
# **Independent investigation into the death of Mr John Neville, a prisoner at HMP Wymott, on 4 February 2023**

**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

**OGI**

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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. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr John Neville died in hospital of pneumonia on 4 February 2023, while a prisoner at HMP Wymott. He was 73 years old. We offer our condolences to Mr Neville's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Neville received at Wymott was partially equivalent to that which he could have expected to receive in the community. She found that Mr Neville's diagnosis of heart failure was not identified in either of his prison health assessments and she raised concerns about the management of his diabetes.
5. We found no non-clinical issues of concern.

## Recommendations

- The Head of Healthcare should ensure that nursing staff are trained in how to manage low and high blood sugar readings and when to escalate for specialist support.
- The Head of Healthcare at HMP Forest Bank and HMP Wymott should ensure that community medical records (if available) should be reviewed as part of the second health screening process and in the timescales outlined in NICE Guidance NG57.
- The Head of Healthcare should ensure that an audit of NICE Guidance NG28 Type 2 Diabetes in adults is completed within three months to ensure that all patients are being managed in line with this guidance.
- The Head of Healthcare should ensure that patients have care plans initiated and reviewed on a regular basis, which are specific to their clinical needs.

## The Investigation Process

6. HMPPS notified us of Mr Neville's death on 4 February 2023.
7. NHS England commissioned an independent clinical reviewer to review Mr Neville's clinical care at Wymott.
8. The PPO investigator investigated the non-clinical issues relating to Mr Neville's care.
9. The PPO family liaison officer wrote to Mr Neville's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. HMPPS raised some factual inaccuracies in the clinical review which has been amended and reissued with the final report.

### Previous deaths at HMP Wymott

11. Mr Neville was the sixteenth prisoner to die at Wymott since February 2020. Of the previous deaths, 14 were from natural causes and one was drug related. We have previously made recommendations about initiating care plans promptly, about identifying ongoing medical needs at health screens and diabetes management.

## Key Events

12. On 1 June 2022, Mr John Neville was sentenced to 12 years imprisonment for sexual offences. He was sent to HMP Forest Bank. On 17 June, he was moved to HMP Wymott.
13. Mr Neville had several long-term health conditions including heart failure (where the heart is unable to pump blood around the body properly), diabetes (a condition that causes too much sugar in your blood) and chronic kidney disease (where the kidneys do not work as well as they should).
14. On 17 June, during his initial health screen at Wymott, a prison nurse found Mr Neville's blood sugar level was high. She referred him to the prison diabetic clinic and the prison podiatrist (foot specialist). The nurse took no further action to monitor and manage Mr Neville's blood sugar levels.
15. The nurse completed a second health assessment the same day. Although Mr Neville's community GP records were accessible, the nurse did not record that he had heart failure. This had not been recorded by Forest Bank staff either.
16. On 23 December, Mr Neville was treated at hospital for an infection in his toe that was showing signs of necrosis (death of body tissue) and infection of the bone. He was prescribed medication to treat this and was regularly reviewed by prison nurses and a podiatrist.
17. On 20 January 2023, a GP at Wymott saw Mr Neville as he was feeling dizzy and weak. As Mr Neville's haemoglobin (a substance in red blood cells that transports oxygen around the body) levels were low, the GP sent him to hospital.
18. On 31 January, a ward nurse told the prison healthcare team that Mr Neville was not ready for discharge, had a high temperature and was receiving oxygen to support with his breathing.
19. On 4 February, a hospital consultant told the prison healthcare team that Mr Neville had rapidly deteriorated and was no longer for active treatment. At 2.14pm, Mr Neville died in hospital.

## Post-mortem report

20. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Neville's cause of death as pneumonia. Type 2 diabetes mellitus and chronic kidney disease were listed as contributory factors.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**August 2023**

## **Inquest**

21. At the inquest held on 31 July 2023, the coroner concluded that Mr Neville died from natural causes.

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