

**Prisons &
Probation**

Ombudsman
Independent Investigations

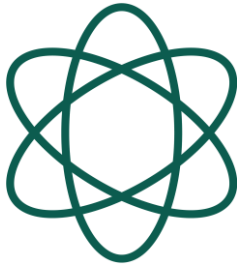
**Independent investigation into
the death of Mr John McAuley
on 11 March 2023,
following his release from
HMP Rye Hill**

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 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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
4. Mr John McAuley died in a hospice from rectal cancer on 11 March 2023, following his release from HMP Rye Hill on 9 March. He was 63 years old. We offer our condolences to those who knew him.
5. Mr McAuley's rapidly deteriorating health presented many challenges to those involved in planning for his release. We found that his community offender manager (COM) went far above and beyond what could reasonably have been expected of her to ensure he was released to a local hospice before he died.
6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr McAuley's death on 15 March 2023.
8. The PPO investigator obtained copies of relevant extracts from Mr McAuley's prison and probation records.
9. We informed HM Coroner for Coventry of the investigation. He gave us the cause of death. We have sent the Coroner a copy of this report.
10. The Ombudsman's family liaison officer contacted Mr McAuley's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
11. We shared our initial report with HMPPS. They notified us of one factual inaccuracy which has been amended in this report.

Background Information

HMP Rye Hill

12. HMP Rye Hill is a category B prison which holds up to 664 men who have been convicted of sexual offences. It is managed by G4S. The physical and mental health provider was G4S Healthcare up to November 2022 and then Practice Plus Group.

Probation Service

13. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

HM Inspectorate of Prisons

14. The most recent inspection of Rye Hill was in February 2020. Inspectors reported that prisoners with long-term conditions were monitored reasonably well. There was a GP who took the lead on older prisoners' care and appropriate end of life and palliative care arrangements were in place. The healthcare team had established links with local Macmillan nurses who could support prisoners if required.
15. Few prisoners were released from Rye Hill but those who were received good support from healthcare staff. Nurses supported prisoners to register with a GP in their area and provided them with a supply of medication if they required it. All prisoners transferring out of the prison were seen by a nurse in a discharge clinic to identify any outstanding health needs.

Key Events

16. On 14 July 2016, Mr John McAuley was convicted of sexual offences and was sentenced to 12 years imprisonment. He was moved to HMP Rye Hill on 27 April 2017.
17. On 12 April 2021, Mr McAuley was allocated a community offender manager (COM).
18. Mr McAuley had Crohn's disease (a bowel disease) and was under the care of the hospital gastroenterology team (digestive system specialists). Throughout 2022, Mr McAuley had regular appointments to review his condition. On several occasions, Mr McAuley refused to attend, discharged himself early from hospital, or refused to take his medication.
19. In November 2022, Mr McAuley told a nurse at Rye Hill that he had pain in his stomach, and that he had blood in his stools. A GP at Rye Hill saw Mr McAuley and advised him to attend his hospital appointments where he could be seen by specialists who could help diagnose his pain. The GP told Mr McAuley that if he did not attend then his condition may worsen, and it would delay any treatment he needed. Mr McAuley said that he did not want to attend any hospital appointments, and he signed a disclaimer form to confirm this.
20. Over the next month, Mr McAuley's symptoms worsened. On 23 December, Mr McAuley agreed to attend hospital for tests. A hospital doctor diagnosed Mr McAuley with a suspicious anal growth which he said needed further investigation. The doctor said he would arrange for Mr McAuley to be admitted to hospital for further tests. Mr McAuley was sent back to Rye Hill with pain medication.
21. On 16 January 2023, Mr McAuley had a parole hearing. Mr McAuley was too unwell to attend this hearing, but it went ahead in his absence.
22. The next day, the Parole Board made the decision that Mr McAuley could be released from prison. They said that his risk could be managed in the community with a set of licence conditions and a robust risk management plan. The risk management plan set out several additional licence conditions and said that Mr McAuley needed to be released to local council accommodation. As Mr McAuley's health had deteriorated over the Christmas period, the proposed risk management plan was now unsuitable. The Parole Board agreed that Mr McAuley could still be released, but his COM must get in touch with adult social care so that they could assess his healthcare needs and find him more suitable accommodation.
23. On 19 January, Mr McAuley's COM spoke with West Northamptonshire Social Care. They said that a care needs assessment review had to take place to decide on appropriate accommodation for Mr McAuley.
24. On 7 February, after a further deterioration in his health, Mr McAuley was taken to hospital by ambulance. He was admitted and was told that he needed tests to confirm if he had rectal cancer.
25. On 17 February, Mr McAuley's COM spoke with North Yorkshire Social Care. They said that before they could help with finding him suitable nursing care, they needed

to know more about his condition, diagnosis and prognosis. They said that that the healthcare team at Rye Hill and the hospital discharge team were responsible for the safe discharge planning for Mr McAuley and should take the lead.

26. On 21 February, a hospital nurse rang the healthcare team at Rye Hill and told them that Mr McAuley had rectal cancer. The nurse said they could not give a prognosis, as they were waiting for the results of further tests to identify if the cancer had spread.
27. On 22 February, the Head of Healthcare at Rye Hill agreed with Mr McAuley's COM that he was best placed to provide details of the proposed release accommodation for Mr McAuley to the Parole Board. He said that he needed to get urgent updates from the hospital about Mr McAuley's prognosis before he could say what type of accommodation would be suitable.
28. The same day, the Head of Healthcare rang the hospital to ask for an update on Mr McAuley's condition. A nurse from the hospital discharge team said that Mr McAuley would need to be discharged to a nursing home due to his complex health needs.
29. On 23 February, Mr McAuley was diagnosed with terminal rectal cancer. He was told his prognosis was poor and it was likely he would not live for more than a few weeks. The Head of Healthcare emailed Mr McAuley's COM to explain that as Mr McAuley's condition had deteriorated further, he now needed to be released to a hospice, rather than a nursing home.
30. On 25 February, a hospice near to Mr McAuley's family in Harrogate said that they could offer Mr McAuley the next bed space they had available. As Mr McAuley had pneumonia, he was too unwell to travel and had to stay in hospital to be given antibiotics.
31. Over the next week, Mr McAuley remained in hospital and waited for a bed to become available at the hospice in Harrogate.
32. On 3 March, the hospital confirmed that Mr McAuley was too weak to travel to Harrogate, so they submitted a referral to Myton Hospice in Coventry, which was in the hospital grounds. Mr McAuley remained in hospital and waited for a bed to become available.
33. On 8 March, a meeting took place between Mr McAuley's COM, the Head of Healthcare and Rye Hill's Offender Management Unit. They agreed that Mr McAuley could be released to Myton Hospice. The COM agreed that she would organise his licence to be signed off by management that day.
34. On 9 March, Mr McAuley was released on licence to Myton Hospice.
35. Mr McAuley died in the hospice two days later with his sister by his bedside.

Cause of death

36. A post-mortem examination was not carried out as the coroner accepted the cause of death provided by a doctor. The doctor gave the cause of death as metastatic rectal cancer. The doctor listed cirrhosis liver (liver damage), ischaemic heart disease and frailty as contributing factors.

Findings

37. Mr McAuley's COM told the investigator that organising Mr McAuley's release had been very challenging with the most difficult issue being the rate at which Mr McAuley was deteriorating. She said that she felt pressured to ensure that Mr McAuley was released into the community as quickly as possible, given his prognosis. This meant that she was frequently having to seek the advice of medical professionals and change her release plans to ensure Mr McAuley was released to somewhere that best suited his medical needs. She said that she did not understand some of the medical terminology used and had to seek this information for herself. She also said that she had to find out how hospice placements were funded, where she could find this funding, and look for hospices in an area that she was not familiar with.
38. The COM also spoke about the difficulties of adhering to the parole directed release. She said that she recognised that Mr McAuley was a very unwell man and the risk of harm he posed was extremely low, however she was bound by the policy and procedures of the Parole Board. She said she found that this policy was not understood by some of the professionals involved in this case who seemed to think that she was putting barriers in place. She said that she understood that the additional licence conditions seemed disproportionate but explained that given it was a parole directed release, these could not be changed or removed.

Good practice

39. We know that probation practitioners work with high caseloads of risky and complex individuals where time management and prioritising is imperative. I would like to highlight the good practice of Mr McAuley's COM, who had overall responsibility for Mr McAuley's risk management and release planning.
40. Mr McAuley's situation was unusual and presented challenges that neither his COM, nor many other probation practitioners, have dealt with before. Mr McAuley's deterioration was rapid, and his COM was under pressure to ensure that Mr McAuley was released in a decent and timely manner whilst she was bound by the legislation of a parole directed release. Despite these challenges, the COM acted with a high level of professionalism, sensitivity, and intuition.
41. Overall, it was the actions of his COM that ensured Mr McAuley was safely released to a hospice where he was able to live the last days of his life in a decent and dignified manner. We commend her handling of this case.

Adrian Usher
Prisons and Probation Ombudsman

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