

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Merritt, a prisoner at HMP Wymott, on 26 February 2023

A report by the Prisons and Probation Ombudsman

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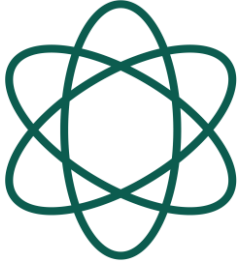
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Our vision

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

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 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.
3. Mr John Merritt died in a hospice on 26 February 2023 of pancreatic cancer, while a prisoner at HMP Wymott. He was 61 years old. We offer our condolences to Mr Merritt's family and friends.
4. The clinical reviewer concluded that the care Mr Merritt received at Wymott was equivalent to that which he could have expected to receive in the community.
5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Merritt's clinical care at HMP Wymott.
7. The PPO investigator investigated the non-clinical issues relating to Mr Merritt's care.
8. The PPO family liaison officer wrote to Mr Merritt's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She had questions about the clinical care Mr Merritt received at Wymott. These have been addressed in the clinical review.
9. Mr Merritt's daughter received a copy of the draft report. She did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Wymott

11. Mr Merritt was the twenty-third prisoner to die at Wymott since February 2020. Of the previous deaths, 20 were from natural causes, one was drug related and one was self-inflicted.

Key Events

12. On 28 April 2021, Mr John Merritt was sentenced to eight years imprisonment for sexual offences. On 19 August, he was moved to HMP Wymott.
13. On 24 July 2022, Mr Merritt told a prison nurse that he had right-sided back pain. The nurse gave him pain medication and made a GP appointment. The next day, a GP at Wymott saw Mr Merritt and gave him stronger pain medication.
14. On 30 July, Mr Merritt was taken to A&E after he said that the pain in his back was getting worse. Hospital tests found nothing of significance and Mr Merritt was sent back to the prison with pain relief in the early hours of 31 July.
15. Over the next two months, prison nurses saw Mr Merritt regularly and took his observations, which were within normal ranges and did not suggest any deterioration in his health.
16. On 11 October, Mr Merritt told a nurse at Wymott that he was still having pain in his back, and also pain in his stomach. He told the nurse that he had lost his appetite and that he had not eaten much for the past few weeks. The nurse took his observations which were within normal ranges.
17. On 20 October, a GP reviewed Mr Merritt and was concerned about his weight loss. The GP made a suspected cancer referral to the local hospital.
18. Over the next month, Mr Merritt continued to have pain in his lower back and stomach. He was given regular pain relief while he waited for his hospital appointment.
19. On 15 November, Mr Merritt was taken to hospital for a gastroscopy (a test to check inside the throat, food pipe and stomach).
20. On 1 December, Mr Merritt had a telephone appointment with a nurse from the hospital. She told Mr Merritt that he had pancreatic cancer which was suspected to have spread to his liver and his lungs. The nurse told Mr Merritt that he would need to have a biopsy of the lung to confirm this (a procedure where a sample of lung tissue is removed to check for the presence of cancer).
21. On 18 December, Mr Merritt had a lung biopsy at the local hospital. Two days later, an oncologist (a cancer specialist) told Mr Merritt that the lung biopsy confirmed that the cancer had spread to his lungs.
22. On 5 January 2023, an oncologist told Mr Merritt that his cancer was terminal and could not be cured.
23. On 13 January, Mr Merritt attended an oncology appointment at a local cancer centre. The oncologist told Mr Merritt that as his cancer had spread, he had a prognosis of approximately six months. The oncologist said that although the cancer could not be cured, Mr Merritt could have chemotherapy to control the symptoms and potentially prolong his life. Mr Merritt said that he did not want to have chemotherapy.

24. Mr Merritt remained at Wymott for the next few weeks, where he was given pain relief and monitored by the healthcare team.
25. On 11 February, after a deterioration in his health, Mr Merritt was taken by ambulance to a local hospital for palliative care.
26. On 16 February, Mr Merritt was moved to a local hospice to receive end-of-life care. He died there on 26 February.

Post-mortem report

27. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Merritt's cause of death as metastatic pancreatic adenocarcinoma (pancreatic cancer that had spread to other areas in the body).
28. At the inquest held on the 14 September 2023, the Coroner concluded that Mr Merritt died of natural causes.

Adrian Usher
Prison and Probation Ombudsman

September 2023

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