Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Warrener, a prisoner at HMP Holme House, on 26 June 2023

A report by the Prisons and Probation Ombudsman

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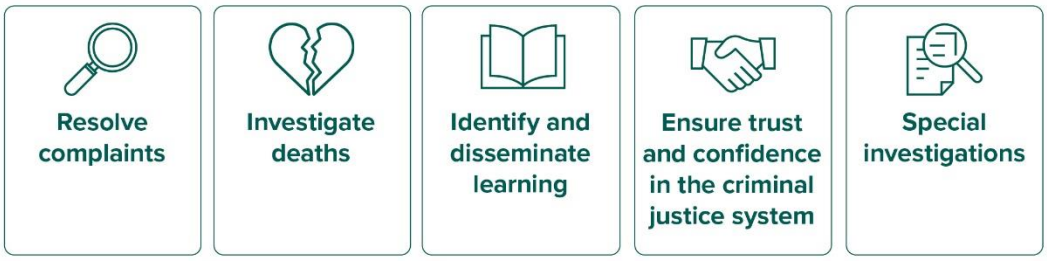
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Michael Warrener died of recurrent squamous cell carcinoma of the larynx (throat cancer) on 26 June 2023, at HMP Holme House. He was 70 years old. We offer our condolences to those who knew him.

4. The clinical reviewer concluded that the clinical care Mr Warrener received at HMP Holme House was equivalent to what he could have expected to receive in the community. She made no recommendations.

5. We did not find any non-clinical issues of concern.

The Investigation Process

6. HMPPS notified us of Mr Warrener's death on 27 June 2023.

7. NHS England commissioned an independent clinical reviewer, to review Mr Warrener's clinical care at Holme House.

8. The PPO investigator investigated the non-clinical issues relating to Mr Warrener's care.

9. The PPO family liaison officer wrote to Mr Warrener's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Holme House

11. Mr Warrener was the nineteenth prisoner to die at Holme House since 1 June 2020. Of the previous deaths, 14 were from natural causes, three were self-inflicted and one was drug related. There are no similarities between the findings in our investigation into Mr Warrener's death and the findings from our investigations into the previous deaths.

Key Events

12. On 16 May 2012, Mr Michael Warrener was remanded to HMP Durham for a sexual offence. On 24 May, he was sentenced to 19 years in prison. He was 59 years old.

13. In 1997, Mr Warrener was diagnosed with cancer in his tonsils (a type of head and neck cancer) and this was treated with surgery. In October 2016, he was diagnosed with cancer of the larynx (throat) and this was treated by surgery and radiotherapy and he had a permanent tracheostomy (an opening in the front of the neck so a tube can be inserted into the windpipe to help breathe). Mr Warrener was also diagnosed with heart failure, hypothyroidism (an underactive thyroid) and epilepsy.

14. On 22 July 2019, Mr Warrener was sent to HMP Holme House.

15. A nurse completed Mr Warrener's first reception health screen and noted his pre-existing medical conditions. Mr Warrener was unable to speak and communicated through writing. The nurse referred Mr Warrener for speech and language therapy, for a swallowing and communication assessment, the long-term conditions pathway and for a palliative care nurse to offer on-going support for his various health conditions. Mr Warrener was offered appropriate annual reviews to ensure his long-term conditions were under control and his quality of life was maximised.

16. In October 2021, Mr Warrener was diagnosed with Barrett's oesophagus (a condition where some cells in the food pipe grow abnormally). He was also diagnosed with a hiatus hernia (a problem effecting the stomach, which can cause acid to travel into the throat) and oesophagitis (inflammation of the food pipe in September 2022). Healthcare staff monitored Mr Warrener regularly over the months that followed.

2023

17. On 21 March 2023, a GP at the prison saw Mr Warrener. Mr Warrener told the GP that he had not been able to swallow for the last few days. That day, Mr Warrener was sent to hospital and admitted as an inpatient. He had a CT scan of his neck and the results showed that the cancer had returned and was pressing on the major blood vessels in his neck. A biopsy conducted on 27 March, confirmed the diagnosis.

18. That day, Mr Warrener had a swallow assessment. Mr Warrener was no longer able to swallow any food or drink. As a result, he would be fed through a tube inserted into his stomach.

19. On 13 April, the hospital put in place a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order on Mr Warrener's behalf due to his cancer diagnosis and frailty. This meant that in the event his heart or breathing stopped, he would not be resuscitated.

20. On 17 April, Mr Warrener was discharged from hospital and returned to Holme House.

21. The next day, a Head and Neck consultant at the hospital sent a letter to the prison and confirmed that Mr Warrener's life expectancy was unpredictable and he possibly had up to six to 12 months to live. However, he was also at risk of sudden death due to the involvement of the arteries, veins and nerves in his neck.

22. On 19 April, a multi-disciplinary meeting took place and Mr Warrener attended. Mr Warrener was informed that there were no further treatment options available to him. Mr Warrener agreed to move to the palliative care suite at Holme House.

23. On 21 April, healthcare staff discussed and put in place an Emergency Health Care Plan (EHCP) for Mr Warrener. This included information that needed to be communicated during an emergency to ensure timely access to the right treatments and specialists. Mr Warrener was happy to be sent to hospital for treatable conditions only.

24. On 18 May, Mr Warrener attended hospital to see the Head and Neck consultant and the Consultant Oncologist. He was escorted by two officers using an escort chain, due to his reduced mobility. The consultants told Mr Warrener that his cancer might respond to a treatment called palliative immunotherapy. Mr Warrener gave his written consent to proceed with the immunotherapy treatment plan.

25. On 13 June, Mr Warrener attended the hospital chemotherapy unit for his first dose of immunotherapy. Mr Warrener was escorted by two officers and he was not restrained. He returned to the prison that day.

Events leading up to 26 June.

26. On 23 June, a nurse saw Mr Warrener and he appeared unsettled. The nurse gave him morphine and paracetamol for his pain and discomfort.

27. At 3.00pm on 26 June, a GP at Holme House was asked to see Mr Warrener because his health was deteriorating. The GP noted that Mr Warrener was agitated and breathing quickly. The GP gave him morphine for pain relief. At 4.00pm, the GP saw Mr Warrener again. Mr Warrener was more settled, but was still breathing quickly. At 5.09pm, Mr Warrener had settled and his breathing was normal. A team support worker sat with him.

28. At 6:35pm it was confirmed that Mr Warrener had died.

Cause of death

29. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Warrener's cause of death as recurrent squamous cell carcinoma of the larynx (throat cancer). Heart failure (when the heart is unable to pump blood around the body properly), epilepsy (a common condition that effects the brain and causes frequent seizures), and hypothyroidism (an underactive thyroid that does not produce enough hormones) were listed as contributory factors.

30. At the inquest held on the 24 January 2024, the Coroner concluded that Mr Warrener died of cancer of the larynx.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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