

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Reginald Warry, a prisoner at HMP Ashfield, on 27 March 2023**

**A report by the Prisons and Probation Ombudsman**

## 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



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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 Reginald Warry died in hospital of pneumonia (lung infection) and urosepsis (sepsis caused by a bladder infection) on 27 March 2023, while a prisoner at HMP Ashfield. He was 88 years old. We offer our condolences to Mr Warry's family and friends.
4. The PPO family liaison officer wrote to Mr Warry's next of kin, his grandson, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Warry's clinical care at Ashfield. The clinical reviewer concluded that the clinical care Mr Warry received was of a reasonable standard and was largely equivalent to that which he could have expected to receive in the community.
6. The clinical reviewer made two recommendations not directly related to Mr Warry's death which the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Warry's care. We did not find any non-clinical issues of concern. We make no recommendations.
8. We shared our initial report with HMPPS. They found no factual inaccuracies in this report. They pointed out a minor error in the clinical review which has been amended.

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

**January 2024**

## **Inquest**

The inquest, held on 4 April 2024, concluded that Mr Warry died from natural causes.

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