Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ewan Homer a prisoner at HMP Stafford, on 6 November 2022

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

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 Ewan Homer died from adenocarcinoma of the postnasal space (cancer of the nose and nasal area) on 6 November 2022, at HMP Stafford. He was 66 years old. We offer our condolences to Mr Homer's family and friends.

4. The PPO family liaison officer wrote to Mr Homer's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Homer's clinical care at HMP Stafford. She concluded that the clinical care Mr Homer received at Stafford was not equivalent to that which he could have expected to receive in the community because his cancer diagnosis was delayed by eight months due to administrative errors made by the healthcare team at Stafford and the hospital.

6. The clinical reviewer made the following three recommendations related to Mr Homer's death that the Head of Healthcare and Governor will want to address:

    - **The Head of Healthcare should establish a system to check that all referral documentation is correct and includes all relevant information before being submitted;**

    - **The Head of Healthcare and the Governor must work together to ensure that security staff always liaise with healthcare staff to acknowledge healthcare priorities when there is not sufficient escort staff for all planned health appointments; and**

    - **The Head of Healthcare should liaise with the hospital to develop a system to improve communication to ensure that changes in appointments are communicated effectively.**

7. The PPO investigator investigated the non-clinical issues relating to Mr Homer's care. We did not find any non-clinical issues of concern and we make no recommendations. However, the Governor should note that when the investigator asked to see the family liaison log which records contact between the prison and the next of kin, the copy the prison provided only went up until 2 November 2022. When we asked the prison for the updated log, we were told that they were unable to locate a copy.

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

Adrian Usher **February 2024**
Prisons and Probation Ombudsman

Inquest into Mr Homer's death

The inquest into Mr Homer's death was held on 12 January 2025 and a verdict of natural causes was recorded. The coroner concluded that Mr Homer's death was due to high grade adenocarcinoma of postnasal space.

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