Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Walker, a prisoner at HMP Full Sutton, on 22 December 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 Scott Walker died of acute bronchopneumonia caused by metastatic bladder cancer on 22 December 2023, at HMP Full Sutton. He was 53 years old. We offer our condolences to Mr Walker's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Walker received at Full Sutton was equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found that despite starting an Early Release on Compassionate Grounds (ERCG) application promptly, prison staff did not request a report from Probation staff and the GP at Full Sutton did not complete their report before Mr Walker died as they should have done.

Recommendations

- **The Governor and the Head of Healthcare should ensure that Early Release on Compassionate Grounds applications are completed in line with Policy Framework by:**
    - **ensuring that prison staff request a report from Probation staff for the application; and**
    - **completing all reports for the application, including GP reports, in a timely manner.**

The Investigation Process

6. HMPPS notified us of Mr Walker's death on 22 December 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Walker's clinical care at Full Sutton.

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

9. The Ombudsman's office contacted Mr Walker's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Full Sutton

11. Mr Walker was the third prisoner to die at Full Sutton since December 2021. Of the previous deaths, one was from natural causes, and one was self-inflicted. Up to the end of March 2024, there have been three natural causes deaths at Full Sutton since Mr Walker's death. There are no similarities between the findings in our investigation into Mr Walker's death and the findings from our investigations into the previous deaths.

Key Events

12. In September 2021, Mr Walker was sentenced to life imprisonment for murder. He was 51 years old. At that time, he was being held on remand at HMP Peterborough.

13. On 11 October, Mr Walker was transferred to HMP Full Sutton.

14. At his reception health screen, healthcare staff noted that Mr Walker suffered from back pain.

15. On 12 August 2022, Mr Walker attended a healthcare appointment and reported that he had been passing blood in his urine. Healthcare staff referred him to the Urology Service.

16. On 31 August, the Urology Specialist Nurse diagnosed Mr Walker with possible bladder cancer. Mr Walker was placed on a waiting list to have a procedure to remove the bladder cancer, biopsies and CT scans. However, he declined further investigations and treatment because he felt overwhelmed and wanted to discuss this with his family. On 22 September, Mr Walker agreed to further investigations and treatment for his condition.

17. Over the months that followed, Mr Walker continued to receive treatment and support from the prison's healthcare team and the Urology Specialist Nurse.

18. On 18 May 2023, the Urology Specialist advised Mr Walker that the cancer had now spread to his bones.

19. On 1 September, Mr Walker commenced chemotherapy. However, he declined to have any further treatment in October, as it was making him unwell.

20. On 18 September, Mr Walker said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

21. On 5 October, Mr Walker's prison offender manager started an Early Release on Compassionate Grounds (ERCG) application. She completed her report and sent the application to the GP at the prison to complete. She did not send it to the community offender manager (COM) for completion as she should have done. There is no evidence that the GP completed the report prior to Mr Walker's death.

22. On 8 December, Mr Walker was transferred to the Healthcare Unit at Full Sutton for palliative care. Mr Walker had previously refused to transfer to the unit.

23. On the morning of 22 December, prison officers found Mr Walker unresponsive in his cell, and called a code blue (indicating a prisoner is unconscious or is having breathing difficulties). Nurses arrived and remained with Mr Walker until a doctor arrived. At 8:56am, the GP at the prison arrived and confirmed that Mr Walker had died.

Post-mortem report

24. The post-mortem report concluded that Mr Walker died of acute bronchopneumonia caused by metastatic bladder cancer. Coronary artery atheroma and pulmonary emphysema also contributed to Mr Walker's death.

Non-clinical findings

Compassionate release

25. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

26. Mr Walker's prison offender manager (POM) started his ERCG application promptly in October 2023, and requested a report from the GP at the prison. She completed her report that day, however there is no evidence that she received a report from the GP.

27. The HMPPS policy holder told us that where a community offender manager (COM) is yet to be assigned to a case, a duty COM must complete the report.

28. As Mr Walker did not have an allocated COM, we would have expected the POM to send the application to the relevant Probation Delivery Unit for allocation to a duty COM for completion.

29. The POM was responsible for sending the application to Probation, but she did not do so, and incorrectly noted within the application that, as Mr Walker did not have an allocated COM, she would complete the report. The POM told us that she was not aware that even when a prisoner does not have an allocated COM, the ERCG application must be completed by a duty COM.

30. Although this was not the sole reason the application was delayed, we consider that it contributed to the overall delay in the processing of the application once it had been submitted. We make the following recommendation:

    The Governor and the Head of Healthcare should ensure that Early Release on Compassionate Grounds applications are completed in line with Policy Framework by:

    - **ensuring that prison staff request a report from Probation staff for the application; and**
    - **completing all reports for the application, including GP reports, in a timely manner.**

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

Inquest

31. At the inquest held on 7 August 2024, the Coroner concluded that Mr Walker died of natural causes.

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