Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glen Candler, a prisoner at HMP Wakefield, on 6 March 2025

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. In 2023, Mr Glen Candler was sentenced to 18 years imprisonment for sexual offences. He died of pneumonia and COVID-19 on 6 March 2025 at HMP Wakefield. He was 67 years old. We offer our condolences to Mr Candler's family and friends.

4. The Ombudsman's office wrote to Mr Candler's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. The PPO investigator investigated the non-clinical issues relating to Mr Candler's care. We did not find any non-clinical issues of concern.

6. NHS England commissioned an independent clinical reviewer to review Mr Candler's clinical care at HMP Wakefield.

7. The clinical reviewer concluded that apart from two specific aspects, the clinical care Mr Candler received at Wakefield was equivalent to that which he could have expected to receive in the community. She found that Mr Candler was not offered the flu and COVID-19 vaccinations in autumn 2024 as he should have been. He was in hospital around that time but should have been offered the vaccinations once he returned to the prison. We recommend:

   The Head of Healthcare should review the current vaccinations process to ensure that if a patient is unavailable, a further appointment is offered.

8. The clinical reviewer also found that Mr Candler did not have a long-term condition review for his chronic obstructive pulmonary disease (COPD, the term for a group of serious lung diseases), though she was satisfied this did not affect the clinical management of his COPD. She made a recommendation about the management of long-term conditions which the Head of Healthcare will wish to address.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. Practice Plus Group provided an action plan which is annexed to this report.

10. We sent a copy of our initial report to Mr Candler's next of kin. They did not notify us of any factual inaccuracies.

11. The inquest, held on 21 March 2025, concluded that Mr Candler died from natural causes.

Adrian Usher **June 2025**
Prisons and Probation Ombudsman

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