Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damian Round, on 7 April 2024, following his release from HMP Nottingham

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

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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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.

3. If my office is to best assist HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failures.

4. Mr Damian Round died of metastatic non-small cell lung cancer on 7 April 2024, following his release from HMP Nottingham on 2 April. He was 44 years old. We offer our condolences to his friends and family.

5. The clinical reviewer found that healthcare staff appropriately referred Mr Round to hospital when he presented with concerning symptoms. Mr Round chose to discharge himself against medical advice on several occasions, which the clinical reviewer found might have led to a delay in identifying his diagnosis. She found that there was appropriate liaison with community services prior to Mr Round's release and that the clinical care he received in prison was equivalent to that which he might expect to receive in the community.

The Investigation Process

6. We were informed of Mr Round's death on 11 September 2024.

7. The PPO investigator obtained copies of relevant extracts from Mr Round's prison and probation records.

8. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Round received at Nottingham.

9. The Ombudsman's office contacted Mr Round's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

10. The initial report was shared with HMP Prison and Probation Services (HMPPS), and they identified a factual inaccuracy which has been amended.

Background Information

HMP Nottingham

11. HMP Nottingham is a men's local prison, serving the courts of Nottinghamshire and Derbyshire. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services.

Probation Service

12. The Probation Service work with all individuals over 18 years of age subject to custodial and community sentences. (Children under 18 are managed by the local Youth Offending Team.) During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

13. On 19 December 2023, Mr Damian Round was sentenced to 30 weeks in prison (of which ten weeks would be custodial) for theft. Mr Round had been to prison several times before. On arrival at HMP Nottingham, he did not identify any significant physical health issues.

14. On 28 December, during a hospital in-patient admission, Mr Round was diagnosed with pneumococcal pneumonia and COVID-19. However, against the advice of medical staff at the hospital, Mr Round self-discharged and returned to Nottingham on 1 January 2024.

15. On 13 January, Mr Round was transferred to HMP Sudbury. On 29 January, a GP at Sudbury noted that he needed a chest X-ray, in follow-up to his recent admission.

16. On 1 February, Mr Round was admitted to hospital for chest pain, but self-discharged shortly afterwards, before being assessed. Mr Round continued to report chest pain over the following week.

17. On 13 February, Mr Round was transferred to HMP Fosse Way.

18. On 20 February, Mr Round reported increasing pain and swelling to his neck. A nurse booked a GP appointment for the following day.

19. On 21 February, a GP at Fosse Way assessed Mr Round and recorded his increasingly swollen neck, which she linked to recent neck and chest pain. The GP requested an urgent A&E admission. Mr Round went to hospital but chose to self-discharge after waiting around eight hours to be seen.

20. On 23 February, Mr Round continued to report symptoms and was sent to A&E at Leicester Royal Infirmary. He was discharged on 28 February, with a diagnosis of lung cancer with brain metastasis.

21. On 5 March, Mr Round was released from prison. A nurse contacted a hospital in his local area to transfer care and ensured that Mr Round knew how to contact their cancer specialist team.

22. On 6 March, Mr Round did not attend a post-release meeting with his community offender manager (COM). Police were asked to visit his release address and found that he was not there. His COM recorded that Mr Round was very abusive and said that he did not intend to live at that address or engage with probation staff. She initiated a 14-day recall to prison.

23. On 15 March, Mr Round was an inpatient at the Royal Derby Hospital when his recall was activated. (We do not know when Mr Round became an inpatient. When his COM spoke to him on 6 March, he was not in hospital.) Although Mr Round was recalled to Nottingham, he spent the entire recall period in hospital receiving treatment.

24. On 2 April, Mr Round was released from prison custody but remained in hospital due to his poor prognosis.

Post Release

25. On 2 April, Mr Round agreed to phone appointments with his COM, in order to accommodate his health needs.

26. On 6 April, Mr Round left the hospital and was reported to police by nursing staff. He maintained contact with probation services and expressed that he was afraid of his diagnosis. He said that he intended to obtain drugs as the medication given to him in hospital was not strong enough. Probation staff advised Mr Round to return to hospital. Mr Round subsequently returned to hospital in the early hours of 7 April.

Circumstances of Mr Round's death

27. On 7 April, Mr Round died at Royal Derby Hospital.

Post-mortem report

28. There was no post-mortem examination. A hospital consultant recorded the cause of death as metastatic non-small cell lung cancer.

Findings

29. The clinical reviewer found that the clinical care that Mr Round received in prison was equivalent to that which he might expect to receive in the community. Mr Round was referred to hospital in a timely manner on all occasions when he presented with concerning symptoms. On most of these occasions, Mr Round chose to self-discharge against medical advice, however his records confirm that the healthcare staff attempted to persuade him to accept the hospital care offered. The clinical reviewer found that Mr Round's cancer diagnosis might have come earlier had he not chosen to discharge himself against medical advice.

30. The clinical reviewer also found that the healthcare team appropriately liaised with Mr Round's treating clinical team at the hospital throughout his periods of in-patient admission. She found that the healthcare team at Fosse Way appropriately liaised with community services both prior to and on his release from custody on 5 March 2024.

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

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