

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jefferey Earp, a prisoner at HMP Wealstun, on 2 January 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



© Crown copyright, 2025

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Jefferey Earp died on 2 January 2025 from metastatic pancreaticobiliary carcinoma (pancreatic cancer that had spread to other organs) while a prisoner at HMP Wealstun. He was 57 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care Mr Earp received was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.
5. We concluded that the prison did not adequately review Mr Earp's cuffing arrangements while he was in hospital despite a number of occasions which should have triggered a review.

Recommendations

- The Governor should ensure that the prison's review of their local processes addresses the issues about the use of restraints identified in this report.

The Investigation Process

6. HMPPS notified us of Mr Earp's death on 2 January 2025.
7. NHS England commissioned an independent clinical reviewer to review Mr Earp's clinical care at HMP Wealstun.
8. The PPO investigator investigated the non-clinical issues relating to Mr Earp's care. She interviewed five members of staff from Wealstun on 10 and 17 March.
9. The Ombudsman's office wrote to Mr Earp's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Wealstun

11. Mr Earp was the sixth prisoner to die at HMP Wealstun since 2 January 2022. Of the previous deaths, two were from natural causes, two were self-inflicted and one is currently being investigated as a homicide. There are no similarities between the findings in our investigation into Mr Earp's death and the findings from our previous investigations.

Key Events

12. On 13 June 2018, Mr Jefferey Earp was sentenced to 14 years and four months in prison for robbery. Having served his sentence in a number of prisons, he was transferred to Wealstun on 22 March 2022.
13. On 10 December 2024, wing staff contacted healthcare staff to raise concerns about Mr Earp. They described him as looking 'yellow'. A nurse examined Mr Earp and discussed his symptoms with a prison GP, who advised that Mr Earp should be sent to hospital for further investigations.
14. Before Mr Earp left the prison, the nurse completed a medical risk assessment. He stated that there was no objection to the use of restraints and he did not think that Mr Earp's medical condition restricted his ability to escape.
15. A security risk assessment was completed and Mr Earp was identified as posing a normal risk. Information from his intelligence file was recorded which included incidents when Mr Earp had broken prison rules, including an assault on another prisoner within the previous twelve months. Mr Earp was restrained using a single cuff (where one cuff is on the wrist of the prisoner and the other is on the wrist of an officer) and escorted to and at hospital by two officers.
16. At 9.00pm, a nurse informed one of the escorting prison officers that Mr Earp was to remain in hospital. It was recorded that the restraint was changed to an escort chain. (The entry does not state what type of cuff or escort chain was used, but it is usually a length of metal chain or cable with a cuff at each end, which attaches the prisoner to an officer.)
17. At approximately 2.30am on 11 December, it was recorded on the prisoner escort record that Mr Earp had made comments about removing the restraint. He was informed that this was not going to happen.
18. On 12 December, a new risk assessment was completed as Mr Earp remained in hospital. The security and medical assessment remained unchanged and it was decided that a D-cuff and escort chain should be used. (The D-cuff escort chain is a cable coated in plastic which has a heavy-weight handcuff at each end.)
19. At 2.00pm on 15 December, one of the escort officers recorded in the bed watch log that he contacted the prison and spoke to a Custodial Manager (CM) in his capacity as the duty officer in charge. He told the CM that Mr Earp was complaining that the cuff was hurting him and it was causing bruising.
20. The CM told the investigator that he passed this information to the security team, who told him that a risk assessment would be done the next day. He was unable to confirm to whom he spoke and he said that there was no written record kept of issues that were reported to the duty officer.
21. At 8.37am on 16 December, an officer recorded in Mr Earp's bed watch log that bloods were being taken and that there was bruising on Mr Earp's wrist. At 9.55am, he recorded that he called the duty officer and asked about changing the type of escort chain that was being used.

22. During his interview, the officer told the investigator that he could not fully recall the conversation but thought he had asked if a different cuff and escort chain could be used (a standard handcuff and a metal link chain, which are lighter). There was no record of the duty officer providing a response. However, he said he thought that the duty officer called him back and told him that the metal link escort chain had been decommissioned. This information was incorrect as a standard cuff and metal escort chain were an approved form of restraint.
23. At 3.15am on 18 December, it was recorded that Mr Earp tried to remove his cuffs. The bed watch officer recorded that he informed the duty officer.
24. On 19 December, a nurse visited Mr Earp in hospital. He recorded that Mr Earp was being treated for spinal cord compression and there were lesions on his spine, liver and bone and he had received radiotherapy. He said that Mr Earp's mobility had reduced and that he now shuffled and held onto furniture as he walked, he had reduced sensation and was intermittently incontinent.
25. On 20 December, Mr Earp was told that he had terminal cancer and he was referred to the hospital's palliative care team. It was recorded in the bed watch log that the duty officer was informed of the diagnosis. A new risk assessment was not completed.
26. At 3.40am on 22 December, it was recorded that Mr Earp was getting agitated ,had problems with the cuffs and was in discomfort. A mercury intelligence report was submitted which set out that Mr Earp had been rude and aggressive towards an officer. They described Mr Earp pulling the officer around (by the escort chain), pushing the officer's hand away and that he had grabbed his crutch and raised it towards an escort officer.
27. At approximately 8.50am, Mr Earp became angry because he was not allowed outside to vape. It was reported that he was shouting in an officer's face, he was making threats and he had picked up his crutch. In response, the officer restrained Mr Earp by pinning him down on the bed while the other officer went to get a double cuff (a restraint where both hands are cuffed in front). The officer recorded that Mr Earp then calmed down and they decided not to apply a double cuff. The incident was reported to the duty officer. There is no evidence that a new risk assessment was completed.
28. On 23 December, a prison GP completed the medical report to accompany Mr Earp's application for early release on compassionate grounds (ERCG) in light of the terminal diagnosis.
29. That day, the hospital palliative care nurse recorded in the medical record that there was a sore on Mr Earp's left wrist where the handcuff was rubbing.
30. At 7.00am on 24 December, the Head of Security at that time carried out a bed watch management check. He recorded that there had not been any change in Mr Earp's medical condition and that Mr Earp still had a good level of mobility and self-management. He concluded that the security arrangements (two officers and a D-cuff escort chain) were appropriate when balancing medical care, decency and managing risk.

31. On 24 December, a prison offender manager and the community offender manager completed their reports for the ERCG application.
32. On 25 December, Mr Earp complained to officers about his cuffs. He said that managers should have approved for the cuffs to be made looser.
33. On 28 December, the escort officers recorded that Mr Earp was feeling angry about being restrained. They noted that it was “understandable” that he was struggling.
34. At 8.15am on 29 December, an officer recorded in the log that the hospital doctor was not happy with the restraints arrangements. In his interview, he said he called through to the duty officer and asked for permission to remove the cuffs, but that this was denied due to public protection concerns.
35. At 11.38am, the medical record was updated to note a discussion with the duty governor about the hospital doctor’s request for Mr Earp’s restraints to be removed for a procedure. It was noted that the duty governor was concerned due to a “historic” attack on staff and a recent incident four days earlier. The nurse told the duty governor that she was not able to provide advice as they were unable to assess Mr Earp as he was in hospital.
36. The investigator spoke to the Head of Healthcare about the healthcare team’s involvement in decisions about the use of restraints. She said that she and her team were familiar with the Graham judgment (a high court judgment which required prison staff to distinguish a prisoner’s risk of escape and risk to the public when fit and when suffering from a serious medical condition). She said that every day, except on Thursdays, the Head or Deputy Head of Healthcare attended the prison’s morning meeting to discuss prisoners who were in hospital. She said this included a discussion about the appropriateness of any restraints. She said that the nurse who spoke to the duty governor was an agency nurse and she was not sure if they would be familiar with the Graham judgment.
37. At 8.56pm, the Head of Reducing Reoffending emailed colleagues about Mr Earp. She said an officer had spoken to her after the surgeon’s request for restraints to be removed as Mr Earp needed treatment on both arms all day. She wrote that she had not been able to get hold of the surgeon who had asked for the restraints to be removed and she had checked the policy which set out how decisions to remove restraints are made in end-of-life circumstances. She had also reviewed the current risk assessment and intelligence reports. She said that she had told the officer that Mr Earp’s restraint should remain in place, and that he had said that the hospital team were trying to find an alternative option.
38. On 9.10am, it was recorded in the bed watch log that Mr Earp was agitated with the restraints and an escort officer had called the duty officer to ask for an update on restraints arrangements. At 11.00am, the officer was informed that the Head of Residence (now the Head of Security) would complete a security risk assessment the following day.
39. At approximately 10.00am on 31 December, the Head of Residence spoke to the Deputy Head of Healthcare about Mr Earp’s condition. They discussed his restraints arrangements.

40. At 3.40pm, the Head of Residence carried out a management check and attended a hospital multidisciplinary meeting which included Mr Earp and his hospital doctor. The doctor said that Mr Earp had inoperable cancer and he was at high risk of liver failure. She said that while he was still mobile, he needed support and was slow and unsteady. She said that his condition reduced his ability to leave the ward.
41. At 5.00pm, following a review of the up-to-date security information, the Head of Residence decided that Mr Earp's restraints should be removed. This was actioned.
42. On 2 January 2025, the Deputy Governor completed Mr Earp's ERCG form and sent it to HMPPS' Public Protection Casework Section.
43. At 6.25pm, Mr Earp died.
44. In line with her wishes, Mr Earp's sister was notified of his death by telephone. Staff involved in Mr Earp's care were invited to attend a meeting later that day.

Post-mortem report

45. A hospital doctor concluded that Mr Earp died from metastatic pancreaticobiliary carcinoma (pancreatic cancer that had spread to other organs). The Coroner accepted this cause of death and no post-mortem examination was carried out.

Inquest into Mr Earp's death

46. The inquest into Mr Earp's death was held on 30 January 2025 and a verdict of natural causes was recorded. The Coroner concluded that Mr Earp's death was due to metastatic pancreaticobiliary carcinoma.

Findings

Restraints and the risk assessment process

47. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.
48. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
49. Following Mr Earp's admission to hospital, there were a number of occasions when bed watch staff contacted the prison about restraints issues. This included that Mr Earp had complained of pain and officers and nursing staff saw bruising and later a sore which had developed because of the rubbing caused by the cuff. Furthermore, there were significant changes in Mr Earp's demeanour, one of which required the use of force and there were also changes in his medical condition, including a terminal diagnosis. While these concerns were noted in the escort paperwork, there was no record that the duty officer had received this information or any information about follow-up action taken and there was no record to explain why no further action was needed.
50. The investigator asked the prison for information about the risk assessment review process and how the prison recorded information from bed watch officers. The Head of Residence told the investigator that a custodial manager or duty governor carried out a bed watch check and unless there was a change in the risk, the existing risk assessment was not reviewed. She also confirmed that there was no log to record bed watch checks completed by the duty officer and there was no record of the in-depth discussions about prisoners on escort which take place at the morning meetings. She told the investigator that she had asked for a full review of their local processes.
51. The prison should have reviewed the type and level of restraint used on Mr Earp given the changes documented. We therefore make the following recommendation:

The Governor should ensure that the prison's review of their local processes addresses the issues about the use of restraints identified in this report.

Adrian Usher
Prisons and Probation Ombudsman

June 2025

**Prisons &
Probation**

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100