Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Anderson, a prisoner at HMP Ranby, on 10 March 2025

A report by the Prisons and Probation Ombudsman

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

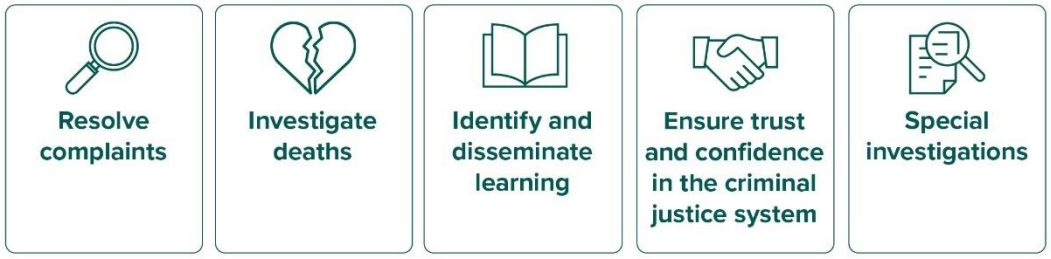
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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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. 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 Roy Anderson died in hospital of oesophageal cancer on 10 March 2025, while a prisoner at HMP Ranby. He was 77 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Anderson received at Ranby was of a good standard and was equivalent to that which he could have expected to receive in the community.

5. The use of restraints on Mr Anderson when he was taken to hospital on 3 February was inappropriate. We were told that restraints were used because the transfer took place out of hours when staffing levels were much lower, but this is not a relevant consideration. No one considered whether it was proportionate to use restraints on a very unwell 77-year-old man.

6. Despite Mr Anderson being told on 7 February that he had only a few weeks left to live, prison staff did not start an application for Early Release on Compassionate Grounds (ERCG) for him.

Recommendation

- The Governor should:
    - Review local policy on applying restraints to prisoners taken to hospital out of hours to ensure it is compliant with the Graham Judgment.
    - Ensure there is a robust quality assurance process in place to check that escort risk assessments properly consider the appropriateness of restraints based on the prisoner's age, health and mobility.

The Investigation Process

7. HMPPS notified us of Mr Anderson's death on 10 March 2025.

8. NHS England commissioned an independent clinical reviewer to review Mr Anderson's clinical care at HMP Ranby.

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

10. The prison was unable to trace a next of kin for Mr Anderson, so the Ombudsman's office did not contact anyone regarding Mr Anderson's death.

11. We shared our initial report with HMPPS and the prison's healthcare provider, Nottinghamshire Healthcare NHS Foundation Trust. HMPPS did not find any actual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Ranby

12. Mr Anderson was the eighth prisoner to die at HMP Ranby since March 2022. Of the previous deaths, two were from natural causes, three were self-inflicted, and two were drug related. There are no similarities between the findings in our investigation into Mr Anderson's death and the findings from our investigations into the previous deaths.

Key Events

13. On 1 November 1967, Mr Roy Anderson was sentenced to life in prison for murder. On 25 October 2022, he was moved to HMP Ranby.

14. On 10 January 2025, Mr Anderson told a wing officer that he felt unwell and asked to see healthcare staff. The officer phoned the healthcare unit and asked if they could see him as he was short of breath, had a reduced appetite, and had a lump on his stomach.

15. Later that day, a nurse saw Mr Anderson in the healthcare unit. He said he had been feeling short of breath during exercise for the past week. The nurse took his clinical observations, which were normal, and recorded that she saw no signs of breathing problems at the time. She noted that a GP would review his case on Tuesday (14 January) and told him to let officers know if he felt worse over the weekend. (Mr Anderson was not seen by a GP on 14 January.)

16. On 23 January, wing officers again contacted healthcare staff because Mr Anderson looked unwell, was pale, and was not eating. A nurse visited his cell, took his clinical observations, and calculated a NEWS2 score of 1. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk. A score of 1 is low risk.) Mr Anderson showed the nurse a lump on his chest, which she thought was likely a small hernia (a bulge caused by tissue pushing through a weak spot in the stomach area). She told him he had an appointment booked with the GP and to contact healthcare again if he was feeling unwell in the meantime.

17. On 30 January, a wing officer phoned healthcare staff again because Mr Anderson still felt unwell, had shortness of breath and was “looking yellowish in colour”. A nurse took Mr Anderson’s clinical observations, which were normal. She told him that he had a GP appointment booked on 3 February and to contact healthcare staff if his symptoms worsened.

18. On 31 January, a wing officer phoned the healthcare unit to ask if they had a wheelchair so they could bring Mr Anderson there as he was not well. The nurse told the officer that he had a GP appointment booked for the following Monday but if they brought him to the healthcare unit, they would see him in the clinic.

19. Later that day, two nurses saw Mr Anderson in the clinic. He said he felt generally unwell and had been feeling dizzy, had trouble swallowing, and was short of breath. They took his clinical observations and calculated a NEWS2 score of 2 (low risk). Mr Anderson had low blood pressure, so the nurses took a blood sample to run urgent tests.

20. On 3 February, Mr Anderson’s blood tests results came back as abnormal (they indicated poor liver function) and the laboratory advised he go to hospital immediately. At around 8.00pm, prison staff took Mr Anderson to A&E. Mr Anderson was double cuffed for the journey (the prisoner’s hands are handcuffed together and a second pair of handcuffs is used to attach the prisoner’s wrist to a prison officer’s wrist).

21. On 4 February, at around 2.35am, Mr Anderson was moved to a hospital ward. The escorting officer switched him to an escort chain (a long cable with a cuff at one end attached to the prisoner and at the other to a prison officer).

22. On 5 February, Mr Anderson had an endoscopy (a test using a camera to look inside the body), which showed he had cancer in his oesophagus (the tube that carries food from the mouth to the stomach).

23. On 7 February, a hospital doctor told Mr Anderson that he had cancer, and it had spread to his liver and probably to other parts of his body. He was told he likely had only a few weeks to live.

24. On 8 February, at 10.00am, Mr Anderson's escort chain was removed by bed watch officers, after approval from the authorising manager.

25. On 14 February, a nurse at Ranby phoned the hospital to ask how Mr Anderson was doing. She wrote in his medical notes that he was now a 'fast-track patient' because of his diagnosis but was not eligible for Early Release on Compassionate Grounds (ERCG). (This was based on incorrect information from Mr Anderson's community offender manager.)

26. On 9 March, Mr Anderson deteriorated. The doctors agreed that if he did not improve, they would remove all active treatment.

27. On 10 March, at around 8.40am, Mr Anderson died in hospital.

Cause of death

28. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as metastatic oesophageal cancer (cancer which has spread to other parts of the body).

29. At the inquest, held on 25 September 2025, the Coroner concluded that Mr Anderson died from natural causes.

Findings

Clinical findings

30. The clinical reviewer concluded that the care Mr Anderson received at Ranby was of a good standard and was equivalent to that which he could have expected to receive in the community.

31. The clinical reviewer made four recommendations not directly related to Mr Anderson's death which the Head of Healthcare will wish to address.

Use of restraints

32. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also 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. 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 suffering from 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.

33. The investigator asked the Head of Security at Ranby about the decision to double cuff Mr Anderson when he was taken to hospital on 3 February. He said it was typical for prisoners going to hospital out of hours to be double cuffed due to reduced staffing levels. He said as Mr Anderson left the prison at around 8.00pm, was mobile and was not going to hospital as an emergency, he considered the cuffing level was reasonable.

34. We disagree. Mr Anderson was 77 years old, was unwell and had required a wheelchair to get to the healthcare unit on 31 January. It is difficult to imagine how he could possibly have escaped from two escorting prison officers. We are concerned at the apparent blanket approach to double cuffing prisoners who are taken to hospital out of hours. This is not in line with policy which says that a prisoner's age, health, and mobility must be taken into account when assessing the appropriateness of restraints. We recommend:

The Governor should:

- **Review local policy on applying restraints to prisoners taken to hospital out of hours to ensure it is compliant with the Graham Judgment.**

- **Ensure there is a robust quality assurance process in place to check that escort risk assessments properly consider the appropriateness of restraints based on the prisoner's age, health and mobility.**

Early release on compassionate grounds

35. 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 (ERCG) Policy Framework. An application for ERCG must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.

36. The ERCG Policy Framework says applications may be considered for prisoners suffering from a terminal illness who are in the last few months of life.

37. We found that an application for ERCG was not started for Mr Anderson, despite him having a terminal diagnosis and a short prognosis in February.

38. The investigator spoke with the current interim Head of Offender Management Unit (OMU) at Ranby. While she was in a different role at the time of Mr Anderson's death, she told the investigator that an application for ERCG was not formally started for Mr Anderson as at a multidisciplinary team (MDT) meeting, Mr Anderson's community offender manager said that he was not eligible. This was not further looked into by staff at the time.

39. The interim Head of OMU said she would set up an internal process to ensure that anyone who is given a terminal diagnosis will automatically be assessed for ERCG, which will be managed by OMU hub managers. She will also create and share guidance across all relevant departments to prevent any future delays. In light of this, we make no recommendation.

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

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Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
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