

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Colin Milner, a prisoner at HMP Wandsworth, on 5 July 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



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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. On 15 August 2022, Mr Colin Milner was sentenced to one year and four months in prison for public order offences. He was granted conditional release on 23 January 2023, but was recalled on 28 January 2023 for breaching his licence conditions.
4. Mr Milner died from metastatic oesophageal cancer on 5 July 2023 while a prisoner at HMP Wandsworth. He was 56 years old. We offer our condolences to Mr Milner's family and friends.
5. The PPO family liaison officer wrote to Mr Milner'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.
6. The PPO investigator investigated the non-clinical issues relating to Mr Milner's care. We did not find any non-clinical issues of concern.
7. NHS England commissioned an independent clinical reviewer to review Mr Milner's clinical care at HMP Wandsworth. He concluded that the clinical care Mr Milner received at Wandsworth was equivalent to what he could have expected to receive in the community. However, he found that there was a delay in Mr Milner's initial suspected cancer assessment at HMP Rochester and this aspect of his care was not equivalent. The clinical reviewer made two recommendations not directly related to Mr Milner's death that the Head of Healthcare will wish to consider.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). Oxyleas Trust pointed out some factual inaccuracies in the clinical reviewer's report, and this has been amended accordingly.
9. Mr Milner's family received a copy of the initial report. They did not make any comments.
10. At the inquest held on 25 June 2024, the coroner concluded that Mr Colin Milner died of natural causes.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**June 2024**

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