Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerard Browne, a prisoner at HMP Wymott, on 19 January 2024

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 June 2017, Mr Gerard Browne was sentenced to 14 years imprisonment for sexual offences. He died in hospital of pneumonia and colovesical fistula (an abnormal connection between the colon and bladder which can cause recurrent urinary tract infections) on 19 January 2024, while a prisoner at HMP Wymott. He was 85 years old. We offer our condolences to Mr Browne's family and friends.

4. The Ombudsman's office contacted Mr Browne's niece to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

6. NHS England commissioned an independent clinical reviewer to review Mr Browne's clinical care at Wymott.

7. The clinical reviewer concluded that the clinical care Mr Browne received at Wymott was equivalent to that which he could have expected to receive in the community. However, she identified some areas for learning. She found that healthcare staff missed an opportunity to discuss Mr Browne at a complex care needs multidisciplinary meeting following his discharge from hospital in December 2023. She also found that more could have been done to assess Mr Browne's risk of malnutrition and dehydration.

8. We make the following recommendations:

   - **The Head of Healthcare should ensure that patients with multiple healthcare needs are discussed at the multi professional complex case conference meeting so that the MDT has full oversight of their complex care and multiple care needs.**

   - **The Head of Healthcare should ensure that all healthcare staff undertake a MUST assessment when a person is weighed and ensure any concerns are escalated with immediate effect.**

   - **The Head of Healthcare should ensure that all healthcare staff undertake a risk assessment when an adult presents with risk factors that make them at increased risk of dehydration and ensure that a plan of care is in place.**

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman **July 2024**

Inquest

The inquest, held on 15 November 2024, concluded that Mr Browne died from natural causes.

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