Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Helena Viljoen, a prisoner at HMP Bronzefield, on 17 May 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 February 2012, Ms Helena Viljoen was sentenced in Japan to 18 years imprisonment for a drug related offence. Ms Viljoen was repatriated to the United Kingdom in November 2021 and taken to HMP Bronzefield. She died of pneumonia (infection to the lungs) which was caused by chronic obstructive pulmonary disease (COPD – a group of lung conditions which cause breathing difficulties) on 17 May 2024 in hospital. She was 66 years old. We offer our condolences to Ms Viljoen's family and friends.

4. The Ombudsman's office contacted Ms Viljoen'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.

5. NHS England commissioned an independent clinical reviewer to review Ms Viljoen's clinical care at Bronzefield.

6. The clinical reviewer concluded that the clinical care Ms Viljoen received at Bronzefield was equivalent to that which she could have expected to receive in the community. He found that Ms Viljoen's medical records contained evidence of good, individualised end of life care planning. The clinical reviewer made recommendations not related to Ms Viljoen's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Ms Viljoen's care. We did not find any non-clinical issues of concern. We make no recommendations.

8. Ms Viljoen's family received a copy of the draft report. They did not make any comments.

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

Good practice

10. The family liaison support provided to Ms Viljoen's next of kin was excellent. Staff showed outstanding professionalism and compassion in accommodating Ms Viljoen's family in difficult circumstances. Their considerable efforts should be commended.

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

Inquest

The inquest hearing was held on 3 January 2025. The Coroner concluded that Ms Viljoen died of natural causes.

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