

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jeffrey Quirk, a prisoner at HMP The Verne, on 19 December 2024

A report by the Prisons and Probation Ombudsman

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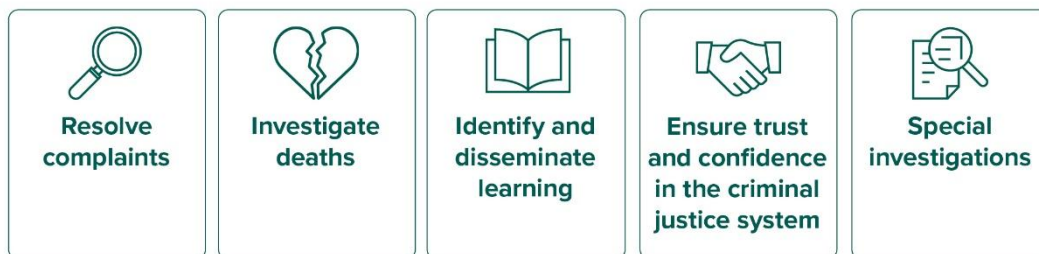
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OUR VISION

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 4 March 2022, Mr Jeffrey Quirk was convicted of rape and sentenced to 12 years in prison.
4. Mr Quirk died of carcinomatosis (cancer cells from an original tumour spread to form many tumours throughout the body) caused by carcinoma of the colon (colon cancer) on 19 December 2024, at HMP The Verne. He was 77 years old. We offer our condolences to Mr Quirk's family and friends.
5. The Ombudsman's office wrote to Mr Quirk's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She asked questions about Mr Quirk's healthcare at The Verne, which have been addressed in the clinical review. She asked for a copy of our report.
6. We also shared the initial report with Mr Quirk's family. They made comments on the clinical review which have been addressed in separate correspondence.
7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is an additional annex to this report.
8. The PPO investigator investigated the non-clinical issues relating to Mr Quirk's care. She found evidence of good practice by the family liaison officer at The Verne, which included facilitating compassionate visits for Mr Quirk's family. The family liaison officer also told Mr Quirk's family of his death soon afterwards by telephone, as they had previously requested. We did not find any non-clinical issues of concern.
9. NHS England commissioned an independent clinical reviewer, to review Mr Quirk's clinical care at The Verne. The clinical reviewer's report is attached as Annex 1.
10. The clinical reviewer concluded that the clinical care Mr Quirk received at The Verne was equivalent to that which he could have expected to receive in the community. He found evidence of good continuity of care, with a named GP seeing Mr Quirk often to provide oversight of the complex care required as he entered the final months of his life.
11. The clinical reviewer found that Mr Quirk's symptoms and test results meant that it was initially difficult to reach a diagnosis, and that healthcare staff admitted him to hospital at the right time to aid with a diagnosis. Nevertheless, the clinical reviewer found that clinicians at The Verne could have used more sophisticated tools to narrow the possible diagnoses. We make the following recommendation:

The Head of Healthcare should review the tools used to identify red flags and to diagnose cancer, including provision for use of Gateway Cancer Maps.

Inquest

12. The inquest into Mr Quirk's death concluded on the 25 June 2026. The coroner confirmed that Mr Quirk died from natural causes.

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October 2026



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