Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Acott, a prisoner at HMP/YOI Lewes, on 17 September 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. On 19 June 1995, Mr Brian Acott was sentenced to life imprisonment for murder. On 8 June 2005 he was released from prison on a life licence. On 2 November 2015, Mr Acott was recalled to prison on his life licence for committing grievous bodily harm, for which he was sentenced to 99 months imprisonment. On 14 September 2021, Mr Acott was released from prison. On 25 May 2022 he was recalled to prison again for breaching his licence on 25 May 2022. On 23 February 2024, the Parole Board directed Mr Acott's release from prison. Unfortunately, as no suitable accommodation could be secured, he remained in prison until his death.

4. Mr Acott died of metastatic cancer of an unknown primary on 17 September 2024, at hospital, while a resident at HMP Lewes. He was 79 years old. We offer our condolences to Mr Acott's family and friends.

5. The Ombudsman's office wrote to Mr Acott'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. NHS England commissioned an independent clinical reviewer to review Mr Acott's clinical care at Lewes.

7. The clinical reviewer concluded that the clinical care Mr Acott received at Lewes was of a reasonable standard and was equivalent to what he could have expected to receive in the community.

8. She found that there was little to no information sharing between the prison healthcare department and the hospital regarding Mr Acott's healthcare and treatment needs, which resulted in a delay to him receiving appropriate medication. She found that there was no appropriate transport process in place to assess Mr Acott's suitability for transport to hospital. She also found that there were significant delays in conducting assessments, such as mental health assessments, and no clear recorded care and treatment plans in place for Mr Acott's dementia, frailty, and falls.

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

10. We did not find any non-clinical issues of concern. We make the following recommendations related to the clinical care Mr Acott received:

    The Head of Healthcare should meet with the appropriate person or department at the Princess Royal Hospital and the Royal Sussex County Hospital to ensure there is an understanding of the limits of nursing care that a prison can provide, and to highlight the importance of information sharing

namely discharge summaries on the discharge of a patient to ensure there is no delay to ongoing treatment.

The Head of Healthcare alongside the Governor should complete a review of appropriate transport provided to ensure that the transport requested meets the needs of prisoners.

Governor to note: On 16 August, having returned from hospital earlier that day, healthcare assessed that Mr Acott needed to be transferred back to hospital. A taxi was ordered to transport him. Mr Acott had several mobility issues and he was unable to travel in the taxi so patient transport was then arranged. We consider that this delay in being transported to hospital would have caused further emotional distress to Mr Acott at an already difficult and distressing time. The Governor may wish to consider this.

11. At the inquest held on 13 November 2024, the Coroner concluded that Mr Acott died of natural causes.

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

13. Mr Acott's family received a copy of the draft report. They did not make any comments.

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

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