Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Alan Burnell, a prisoner at HMP The Verne, on 17 February 2024

## A report by the Prisons and Probation Ombudsman

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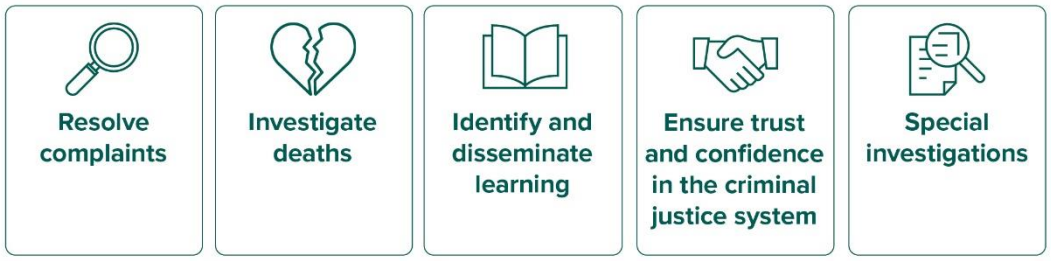
## OUR VISION

**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 14 December 2021, Mr Alan Burnell was sentenced to 18 years in prison for sex offences. He died of sepsis, caused by liver abscesses due to acute cholecystitis (inflammation of the gall bladder) on 17 February 2024, at HMP The Verne. He was 70 years old. We offer our condolences to Mr Burnell's family and friends.

4. The Ombudsman's office contacted to Mr Burnell's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He had no questions.

5. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Burnell received at The Verne.

6. The clinical reviewer concluded that the clinical care Mr Burnell received at The Verne was of a good standard and was equivalent to that which he would have received in the community. He found that staff at The Verne were diligent and compassionate in their care for Mr Burnell.

7. The PPO investigator investigated the non-clinical issues relating to Mr Burnell care.

8. We did not find any non-clinical issues of concern. We make no recommendations.

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

10. The inquest into Mr Burnell's death concluded on 24 October 2024 and returned a verdict of natural causes.

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

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