Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin McSweeny, a prisoner at HMP Gartree, on 23 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



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Summary

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. Mr Colin McSweeny died from metastatic prostate cancer on 23 September 2024, while a prisoner at HMP Gartree. He was 68 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr McSweeny received at Gartree was of a reasonable standard and was at least equivalent to what he could have expected to receive in the community. She made five recommendations not related to Mr McSweeny's cause of death.

5. We found no evidence that the prison considered making an application for early release on compassionate grounds when Mr McSweeny's health began to deteriorate.

Recommendation

- The Governor and Head of Healthcare should introduce a robust quality assurance process to ensure that applications for early release on compassionate grounds are considered and completed at the earliest possible opportunity and are progressed without delay.

The Investigation Process

6. HMPPS notified us of Mr McSweeny's death on 24 September 2024.

7. NHS England commissioned an independent clinical reviewer, to review Mr McSweeny's clinical care at HMP Gartree.

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

9. The Ombudsman's office wrote to Mr McSweeny's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She raised concerns relating to the publication of her husband's details online. We have addressed her concerns in a separate correspondence. She also asked for a copy of our report.

Previous deaths at HMP Gartree

10. Mr McSweeny was the ninth prisoner to die at HMP Gartree since September 2021. The previous deaths were from natural causes. There are no similarities between the findings in our investigation into Mr McSweeny's death and the findings from our investigations into the previous deaths.

Key Events

11. On 9 June 2015, Mr McSweeny was sentenced to 14 years and six months in prison for murder. On 29 June 2017, he was transferred to HMP Gartree.

12. Mr McSweeny had complex medical conditions which included arthritis in the hip and spine and back pain.

13. On 25 November 2021, Mr McSweeny went to hospital due to pain and discomfort. On 9 December, he was informed that it was likely he had prostate cancer. He was discharged from the hospital and returned to Gartree on the same day.

14. On 19 December, a GP at the prison saw Mr McSweeny and confirmed that he had prostate cancer. The plan was to start chemotherapy.

15. On 25 April 2022, Mr McSweeny attended hospital to start his first of ten chemotherapy sessions. He completed his chemotherapy on 2 September.

16. On 30 December 2022, a member of prison staff introduced herself to Mr McSweeny as his family liaison officer (FLO). She explained her role and confirmed Mr McSweeny's next of kin details. She kept in contact with Mr McSweeny, and his next of kin also contacted the prison. The FLO role was later transferred to a different member of staff.

17. On 14 January 2024, a nurse saw Mr McSweeny after he complained of feeling unwell. He was taken to hospital for treatment for a urinary tract infection and returned to the prison on 16 January.

18. On 15 April, hospital staff advised Mr McSweeny that he needed four-weekly reviews with an oncologist and to discuss his prescribed medication, enzalutamide (oral hormone therapy medication used to treat prostate cancer).

19. On 31 May, the hospital consultant advised Mr McSweeny that if he had any pain or side effects he should contact the assessment centre (open 24 hours).

20. On 3 June, a nurse recorded that a multi-agency case management review meeting (a meeting attended by all professionals involved in the care of the patient) was held. Following the meeting, Mr McSweeny was referred for palliative care. Over the weeks that followed, Mr McSweeny's condition continued to deteriorate.

21. On 8 July, healthcare staff informed Mr McSweeny that his care was now palliative. Mr McSweeny said that he would prefer to spend his last days in a hospice.

22. On 26 July, Mr McSweeny declined a blood test which meant that he would not be able to receive treatment. That day, Mr McSweeny was offered the opportunity to move to a smaller wing where staff could provide better care and facilitate his medication, but he declined.

23. On 28 July, Mr McSweeny was unable to get out of bed due to pain. His observations were taken and his NEWS2 score (a tool which improves the

detection and response to clinical deterioration in adult patients) was five, which meant that he needed to be closely monitored. The nurse had a long conversation with him about relocating to another wing for his benefit and easy access for his care. Later that day, Mr McSweeny was taken to hospital as his condition started to deteriorate. He was escorted by two officers and he was not restrained.

24. At 3.00pm on 30 July, a nurse from the prison went to the hospital to complete a welfare check on Mr McSweeny. She was informed by the nurse in charge that Mr McSweeny had a bi-lateral pulmonary embolism causing pressure on his heart and pneumonia, and that he was unlikely to be discharged from hospital. Mr McSweeny had a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order in place, meaning that in the event his heart or breathing stopped, he would not be resuscitated.

25. On 31 July, prison healthcare staff spoke to nurses at the hospital and told them that there was no healthcare unit at the prison and therefore if Mr McSweeny was unable to care for himself, the prison would not be able to accommodate his needs. The hospital decided to refer Mr McSweeny to a hospice for end-of-life care.

26. On 10 August, a member of staff from the hospice asked staff at Gartree if Mr McSweeny was suitable for release on compassionate grounds. There was no evidence that the prison responded or that they considered making an application for compassionate release.

27. On 28 August, Mr McSweeny was transferred to a hospice to receive end of life care.

Events of 23 September

28. At 8.00pm on 23 September, bedwatch staff observed that Mr McSweeny was lying on his bed staring at the ceiling. His breathing was audible but shallow.

29. Approximately 40 minutes later, a nurse arrived to complete a routine check. After completing her examination, she confirmed that Mr McSweeny had died. The nurse confirmed life extinct at 8.42pm.

Contact with McSweeny's family

30. At 7.30am on 24 September, the appointed FLO attended Mr McSweeny's wife's home and informed her that Mr McSweeny had died. Prior to Mr McSweeny's death, he had regular contact with Mr McSweeny's wife, and it was previously agreed that when Mr McSweeny died, Mr McSweeny's wife would be told in person rather than over the telephone. Due to the long distance from the prison to her address, Mr McSweeny's wife was informed the day after his death. He offered his condolences and provided on-going support.

Cause of death

31. The coroner accepted the cause of death provided by the hospice doctor and no post-mortem was carried out. The hospice doctor gave Mr McSweeny's cause of death as metastatic prostate cancer (prostate cancer that has spread to other parts of the body).

Non-clinical findings

Compassionate release

32. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from prison before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS).

33. Mr McSweeny had been diagnosed with cancer on 16 December 2021. On 8 July 2024, he was informed that his care was palliative only and on 28 July, he was sent to hospital following a deterioration in his health. There is no evidence that prison staff or healthcare staff considered making an application for early release on compassionate grounds despite being prompted by the local hospice on 10 August. When his health began to deteriorate and Mr McSweeny was sent to hospital on 28 July, the prison should have considered whether making an application for ERCG was appropriate. The Temporary Head of Safer Custody said that no application for compassionate release was completed, and that Mr McSweeny and his family did not request it. She also said that there were no prescriptive timescales for an application to be considered. She said that going forward, Gartree would review the process.

34. The ERCG framework says that any member of staff within the prison, the prisoner, their family or a representative, may bring the circumstances of a case to the attention of the Governor in order that they be reviewed and where appropriate, an application made for ERCG. Although there are no prescriptive timescales for an application to be considered, the framework says applications should be considered and submitted in a timely manner. We make the following recommendation:

    The Governor and Head of Healthcare should introduce a robust quality assurance process to ensure that applications for early release on compassionate grounds are considered and completed at the earliest possible opportunity and are progressed without delay.

Inquest

35. At the inquest, held on 9 October 2024, the coroner concluded that Mr McSweeny died of natural causes.

36. The initial report was shared with HM Prison and Probation Service (HMPPS) and the healthcare provider, Practice Plus Group. No factual inaccuracies were identified.

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

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