Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Surendra Patel, a prisoner at HMP Hewell, on 31 October 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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. Mr Surendra Patel was remanded into custody on 15 October 2024, charged with murder. He died in hospital of a lower respiratory tract infection, caused by malnutrition, on 31 October 2024, while a prisoner at HMP Hewell. He was 78 years old. We offer our condolences to Mr Patel's family and friends.

4. The Ombudsman's office wrote to Mr Patel's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She had a number of questions about Mr Patel's treatment at Hewell which have been addressed in the clinical review and in separate correspondence.

5. The PPO investigator investigated the non-clinical issues relating to Mr Patel's care. We did not identify any non-clinical learning.

6. NHS England commissioned an independent clinical reviewer, to review Mr Patel's clinical care at Hewell.

7. The clinical reviewer concluded that the clinical care Mr Patel received at Hewell was of a reasonable standard but was not equivalent to that which he could have expected to receive in the community. When Mr Patel began refusing food, guidelines in the food refusal policy were not fully followed and a multi-disciplinary care plan was not completed in a timely manner. However, healthcare staff ensured that Mr Patel received regular monitoring, observations and blood tests. The clinical reviewer made the following recommendations:

   - **The Head of Healthcare should ensure that relevant care planning is completed as soon as possible, within the guidelines outlined in the food refusal policy.**

   - **The Head of Healthcare and the Mental Health Team Manager should ensure that a formal capacity assessment is completed for vulnerable individuals in the quickest timescale possible.**

   - **The Mental Health Team Manager should review the timescales for assessment and referral to the Multi-Disciplinary Team or psychiatrist for vulnerable individuals at risk of harm.**

   - **The Head of Healthcare should ensure that the equipment used by healthcare staff, such as weighing scales, work effectively to ensure the accurate recording of critical physical observations.**

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

9. Mr Patel's family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

10. At an inquest held on 10 March 2026, the Coroner concluded at inquest that Mr Patel died from a lower respiratory tract infection. He found that Mr Patel had malnutrition and type 2 diabetes which did not cause but contributed to his death. The Coroner added that self-neglect through malnutrition contributed to his lower respiratory tract infection.

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

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