

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Terence Matthews a prisoner at HMP Dartmoor on 28 December 2019

A report by the Prisons and Probation Ombudsman

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Terence Matthews, who was 86 years old, died at HMP Dartmoor from pancreatic cancer on 28 December 2019. We offer our condolences to Mr Matthews' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Matthews received at Dartmoor was of a good standard and at least equivalent to that which he could have expected to receive in the community.
5. We make no recommendations.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at HMP Dartmoor.
7. The PPO investigator has investigated the non-clinical issues in Mr Matthews' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Matthews' nominated next of kin to explain the investigation. He did not respond.
9. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Previous deaths at Dartmoor

10. Mr Matthews was the seventh prisoner to die at Dartmoor since December 2017. Of the previous deaths, four were from natural causes and two were self-inflicted. There are no similarities between our findings in the investigation of Mr Matthews' death and the other deaths.

Key Events

11. On 25 July 2017, Mr Terence Matthews was sentenced to six and half years' imprisonment for sexual offences. He was moved to HMP Dartmoor on 15 December 2017.
12. Mr Matthews arrived at Dartmoor with several serious health conditions, including respiratory problems (chronic obstructive pulmonary disease (COPD) and suspected pulmonary fibrosis (scarring to the lung) attributed to asbestos exposure), for which he was receiving long term oxygen therapy. He also had type 2 diabetes. He self-reported at his initial health assessment at Dartmoor, that following a previous prognosis, he thought his life expectancy was two years.
13. Mr Matthews' health continued to decline throughout his time at Dartmoor. Following a fall on 28 August 2019, staff assessed that his care needs could be better met by a transfer to a prison with more facilities.
14. On 29 August, staff at Dartmoor contacted HMP Exeter to see if Mr Matthews could be admitted to their social care unit. However, there was no space for him.
15. Mr Matthews was admitted to hospital briefly in September and October. In September, a treatment escalation plan (TEP) was put in place, and regularly updated. At the end of October, an advanced care plan was discussed with him.
16. There was a marked deterioration in Mr Matthews' health in December, and his care moved into a palliative phase. Staff discussed end of life plans with him, and he expressed a clear wish not to be resuscitated or hospitalised. He said his preferred place of death would be Dartmoor. During the latter part of the year, staff liaised with a hospice and, from 12 December, Marie Curie nurses attended Mr Matthews through the night for most of the rest of the month, and were present when he died on 28 December.
17. The post-mortem report shows Mr Matthews' cause of death as pancreatic cancer. This had not been previously diagnosed. However, the clinical reviewer said that pancreatic cancer is not easy to diagnose early, as by the time that indicative jaundice sets in (as it did with Mr Matthews in the last month of his life), the cancer is usually already advanced. Given the very poor prognosis for pancreatic cancer, and Mr Matthews' pre-existing ill health and frailty, which the GP at Dartmoor considered in October 2019 to rule out surgical procedures, the clinical reviewer did not think that surgery for cancer treatment would have been feasible. He said he thought that the palliative treatment that Mr Matthews received at Dartmoor was appropriate.

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Assistant Ombudsman

April 2020

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