Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Brown a prisoner at HMP Wymott on 13 March 2020

A report by the Prisons and Probation Ombudsman

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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Thomas Brown died in the hospital on 13 March 2020 of aspiration pneumonia and lung cancer, while a prisoner at HMP Wymott. He also had chronic obstructive pulmonary disease (COPD - lung disease) which did not cause but contributed to his death. Mr Brown was 71 years old. I offer my condolences to Mr Brown's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Brown received at Wymott was equivalent to that he could have expected to receive in the community. She made one recommendation.

5. We found no non-clinical issues of concern.

Recommendation

- The Head of Healthcare should ensure that clinical staff are aware that those patients who are at risk of malnutrition (particularly those undergoing chemotherapy) are appropriately screened and assessed and that a nutritional plan of care is implemented accordingly.

The Investigation Process

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

7. The PPO investigator has investigated non-clinical issues, including Mr Brown's location, the security arrangements for his hospital escort/s, liaison with his family and whether compassionate release was considered.

8. The PPO family liaison officer wrote to Mr Brown's next of kin, to explain the investigation. She did not respond to our letter.

9. 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.

Previous deaths at HMP Wymott

10. Mr Brown was the 12th prisoner to die at HMP Wymott since March 2018. Of these deaths, eight were from natural causes and three were drug related. There are no similarities between our findings in the investigation into Mr Brown's death and our investigation findings for the previous deaths.

Key Events

11. Mr Thomas Brown was sent to prison in May 2016 for sexual offences. He transferred to HMP Wymott on 24 February 2017. He had a history of heart disease, kidney disease, lung disease and high blood pressure. In 1997, he had major surgery to remove cancer from his mouth.

12. In August 2018, Mr Brown was taken to hospital and diagnosed with pneumonia and stage 2 kidney injury (kidney disease). In October 2018, he returned to hospital for further tests. A chest X-ray showed signs of infection in both lungs and shadowing on the left side. He was referred to a specialist chest clinic and on 5 November, a hospital consultant diagnosed probable lung cancer. Mr Brown was not suitable for surgery due to his poor lung function and started chemotherapy in March 2019.

13. Mr Brown completed chemotherapy and radiotherapy in July 2019. On 12 August, Mr Brown said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

14. On 14 December, Mr Brown said that he was having trouble swallowing his medication and was unable to eat. He was taken to hospital the same day and did not return to prison. In January 2020, Mr Brown was diagnosed with a tracheo-oesophageal fistula (an opening between the air-pipe/trachea and the gullet/food pipe/oesophagus).

15. On 11 March, the hospital began end of life care and withdrew all treatment except for pain relief. The same day the Parole Board granted Mr Brown release at a scheduled hearing. They did not have the authority to grant immediate release, so their decision was rescinded.

16. On 12 March, an application for Mr Brown's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS).

17. Mr Brown's condition deteriorated rapidly and he died in hospital on 13 March with the application for compassionate release still pending.

Cause of death

18. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Brown's cause of death as aspiration pneumonia (the leakage of the stomach contents into the airways) caused by trachea-oesophageal fistula (opening between the air pipe and oesophagus) and squamous cell lung cancer. He also had chronic obstructive pulmonary disease (COPD lung disease) which did not cause but contributed to his death.

Sue McAllister CB
Prisons and Probation Ombudsman **October 2020**

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