Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Corbett, a prisoner at HMP Wymott, on 11 November 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 James Corbett died of cardio-renal syndrome (a disorder of the heart and kidneys) as a result of heart failure, which in turn was caused by heart disease on 11 November 2020 at HMP Wymott. He was 82 years old. We offer our condolences to his family and friends.
4. The clinical reviewer concluded that the clinical care that Mr Corbett received at Wymott was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.
5. The clinical reviewer has made two recommendations which are not directly related to Mr Corbett's death but which the Head of Healthcare will need to address.
6. We did not identify any non-clinical issues of concern and we make no recommendations.

Investigation Process

7. NHS England commissioned a clinical reviewer to review Mr Corbett's clinical care at HMP Wymott.
8. The PPO investigator has investigated the non-clinical issues in Mr Corbett's care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Corbett's sister to explain the investigation. She had no specific questions.
10. We shared the initial report with Mr Corbett's sister. She did not respond.
11. We shared the initial report with the prison service. There was one factual inaccuracy and the report has been amended accordingly.

Previous deaths at Wymott

12. There were ten deaths from natural causes at HMP Wymott in the two years before Mr Corbett's death and one death from natural causes after his death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

13. On 15 March 2013, Mr James Corbett was sentenced to fourteen years in prison for sex offences. On 2 July 2018, he was transferred to HMP Wymott.

14. Mr Corbett had many pre-existing health conditions: he had had a heart attack in 1995 and 2012, a coronary stent fitted (a procedure to widen blocked or narrow coronary arteries) in 2009, chronic anaemia and high cholesterol diagnosed, ischaemic heart disease, heart failure, chronic obstructive pulmonary disease (COPD, a lung disease) and diabetes.

15. Mr Corbett had reduced mobility and walked with a stick.

16. On 27 April 2020, a prison GP sent Mr Corbett to hospital because he had felt dizzy, he had had several falls, his kidney function was deteriorating, and he was weak. Hospital staff treated him for postural hypertension (a fall in blood pressure that occurs when changing position). While in hospital, Mr Corbett tested positive for COVID-19. On 5 May, Mr Corbett returned to Wymott.

17. On 23 October, a prison GP reviewed Mr Corbett. His leg swelling and mobility had worsened. The GP sent him to hospital.

18. On 11 November, Mr Corbett died in hospital of cardio-renal syndrome as a result of heart failure which in turn was caused by heart disease.

Caroline Mills
Assistant Ombudsman **June 2021**