

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Corlett, a prisoner at HMP Forest Bank, on 12 May 2021

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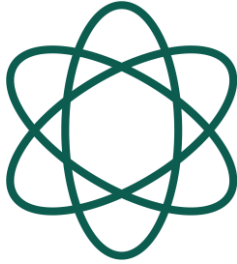
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Our vision

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

OGL

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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 Dennis Corlett died in hospital of bronchopneumonia, caused by lung cancer, on 12 May 2021 while a prisoner at HMP Forest Bank. He was 76 years old. I offer my condolences to his family and friends.
4. The clinical reviewer found that the clinical care that Mr Corlett received at Forest Bank was of a good standard and equivalent to that which he could have expected to receive in the community. He found that healthcare staff acted promptly to diagnose his condition when he was admitted to the healthcare unit. However, healthcare staff did not recognise that Mr Corlett had lost a significant amount of weight, and they did not assess his weight appropriately using appropriate tools. Although not directly linked to Mr Corlett's death, the clinical reviewer made recommendations about the need to identify weight loss in prisoners.

Recommendation

- The Head of Healthcare should ensure that staff are reminded how to identify and address significant weight loss in prisoners, including using the Malnutrition Universal Screening Tool.

The Investigation Process

5. NHS England commissioned an independent clinical reviewer to review Mr Corlett's clinical care at Forest Bank.
6. The PPO investigator has investigated non-clinical issues, including Mr Corlett's location, the security arrangements for his hospital escort, liaison with his family and whether compassionate release was considered.
7. The PPO family liaison officer wrote to Mr Corlett's wife to explain our investigation. She had no specific questions.
8. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.
9. We sent a copy of our initial report to Mr Corlett's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Forest Bank

10. Mr Corlett was the sixth prisoner to die at Forest Bank since May 2019. Of the previous deaths, two were from natural causes, one was drug-related, one was self-inflicted and another remains unclassified. Since Mr Corlett died, there has been one further death. There were no similarities between our findings in the investigation into Mr Corlett's death and our investigation findings about the previous deaths.

Key Events

11. In 2018, Mr Denis Corlett was sentenced to four years in prison for sexual offences and sent to HMP Manchester. In September 2020, he was transferred to HMP Forest Bank.
12. Mr Corlett had several significant lung conditions, including asthma, chronic obstructive pulmonary disorder, emphysema, bronchiectasis and lung cancer.
13. On 9 September, a nurse completed Mr Corlett's initial health screen at Forest Bank. His weight was recorded as 64kg.
14. Mr Corlett received his first COVID-19 vaccination on 10 February.
15. On 18 February, Mr Corlett reported pain radiating down his left side (for which he was taking paracetamol). Healthcare staff recorded that his temperature was high and that they thought this was due to his recent COVID-19 vaccination or a possible infection. They booked him to see a prison GP the next day. There was no record of his weight or body mass index (BMI).
16. On 19 February, a prison GP assessed Mr Corlett, diagnosed a back sprain and prescribed additional analgesia. There was no record of his weight or BMI.
17. At 3.30pm on 28 April, Mr Corlett reported vomiting when eating and weight loss. He was transferred to the prison's healthcare unit for further observation and assessment.
18. At 4.30am the next day, Mr Corlett was given additional analgesia. At 10.30am, a sputum sample was taken and sent for testing. At 11.09am, a prison GP recorded Mr Corlett's weight as 42.8kg, a 20kg loss since his arrival in September 2020. The GP recorded that there was a rapid deterioration in his general health and that he was at high risk of cancer. He had blood tests and was prescribed fortification drinks. There was no record that Mr Corlett was screened for malnutrition during this consultation. At 3.10pm, the GP reviewed Mr Corlett's blood test results and concluded that he should go to hospital. He was taken to hospital by ambulance. Two prison officers escorted him and he was restrained with an escort chain due to COVID-19.
19. On 3 May, Mr Corlett's risk was reviewed, and due to his medical condition, the Duty Manager instructed bed watch staff to remove the escort chain.
20. On 6 May, Mr Corlett was diagnosed with metastatic lung adenocarcinoma (lung cancer which had spread).
21. On 8 May, Macmillan nurses advised that Mr Corlett's next of kin should visit. The prison telephoned his wife and she and his daughter-in-law visited him in hospital that day. Hospital nurses advised that visitors could come at any time and they visited again on 10 and 11 May.
22. On 12 May, at 01.54am, Mr Corlett died at Salford Royal Hospital.

Post-mortem report

23. The Coroner concluded that Mr Corlett died of bronchopneumonia, caused by lung cancer, which had spread.

Caroline Mills
Assistant Ombudsman

February 2022

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