Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Amos Matthews, a prisoner at HMP Berwyn, on 23 March 2022

A report by the Prisons and Probation Ombudsman

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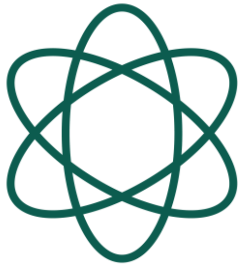
Our vision

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 Amos Matthews, who was 82 years old, died in hospital of cancer on 23 March, while a prisoner at HMP Berwyn. We offer our condolences to Mr Matthews' family and friends.

4. The clinical reviewer concluded that the clinical care Mr Matthews received at Berwyn was equivalent to that which he could have expected to receive in the community.

5. We are concerned that although the prison considered that Mr Matthews was eligible to apply for compassionate release, they did not start a formal application for Mr Matthews to be released before he died.

Recommendations

- The Governor should ensure that staff understand the process for compassionate release and that applications are progressed in a timely manner and submitted as promptly as possible.

The Investigation Process

6. Health Inspectorate Wales commissioned an independent clinical reviewer to review Mr Matthews' clinical care at HMP Berwyn.

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. The PPO's family liaison officer wrote to Mr Matthews' next of kin, his son, to explain the investigation. He did not respond.

9. We informed HM Coroner for North Wales of the investigation. We have sent the Coroner a copy of this report.

10. We shared our initial report with HM Prison and Probation Service (HMPPS). They pointed out some minor factual inaccuracies in the clinical review report, which has been amended. They provided an action plan which is annexed to this report.

Previous deaths at HMP Berwyn

11. Mr Matthews was the sixth prisoner to die at Berwyn since March 2020. Of the previous deaths, four were from natural causes and one was self-inflicted. There are no similarities between our findings from the investigation into Mr Matthews' death and our investigation findings from the previous deaths.

Key Events

12. On 4 May 2021, Mr Amos Matthews was remanded in prison custody, charged with sexual offences, and sent to HMP Berwyn. He was later sentenced to 19 years in prison.

13. The nurse who completed Mr Matthews' initial health screen noted that Mr Matthews had previously had a deep vein thrombosis (DVT) and was prescribed warfarin (to prevent blood clots). Mr Matthews told the nurse that he had a pain in his groin that was causing him difficulty when walking. He also said that his urine was black. The nurse recorded that Mr Matthews' urine sample contained blood.

14. The following day, the prison GP saw Mr Matthews and referred him to the hospital for urgent blood tests, an X-ray and a computerised tomography (CT) scan (uses X-rays and a computer to create detailed images of the inside of the body).

15. On 10 June, Mr Matthews was taken to hospital for a CT scan. On 8 July, the prison GP saw Mr Matthews and told him that the CT scan showed he had a tumour in his bladder which had likely spread to his pelvis.

16. On 20 July, the prison received an email that said that Mr Matthews would need an operation to remove the tumour and then a definite diagnosis would be given and further information about treatment would be decided.

17. On 26 August, Mr Matthews had an operation to remove the tumour in his bladder. He returned to prison the same day.

18. In September, Mr Matthews was formally diagnosed with bladder cancer. He was deemed unsuitable for surgery and it was decided that he would be referred to the oncology team for palliative radiotherapy.

19. On 28 October, Mr Matthews received a letter from the hospital telling him that his cancer had spread to the bones of his pelvis. He was told that the cancer could not be cured, and he would only be suitable for palliative care.

20. Over the next few weeks Mr Matthews regularly went to hospital for radiotherapy treatment.

21. On 3 December, a nurse documented that Mr Matthews had fresh blood in his urine. The prison GP said that he needed to be taken to hospital.

22. The following day, Mr Matthews was admitted to hospital where he was treated for acute kidney injury (the term used for when the kidneys stop working properly) and a possible urine infection. He was given intravenous antibiotics and fluids.

23. While in hospital, Mr Matthews tested positive for COVID-19. We cannot say whether he caught COVID-19 in hospital or in prison.

24. In January 2022, Mr Matthews was moved to the rehabilitation ward in hospital. He could not return to Berwyn because the prison was unable to provide the level of care that he needed.

25. Over the next couple of months, Mr Matthews’ health gradually deteriorated, and he died in hospital on 23 March.

Cause of death

26. The Coroner accepted the cause of death provided by the hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Matthews’ cause of death as Metastatic Bladder Carcinoma with Bone Metastases (bladder cancer that has spread to the bones).

Non-Clinical Findings

Compassionate release

27. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can permanently be released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for indeterminate sentenced prisoners are set out in Chapter 12 of Prison Service Order (PSO) 4700. The criteria include that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS).

28. On 9 December 2021, the Head of Healthcare asked the Governor to start an application for Mr Matthews to be released from prison on compassionate grounds.

29. The Head of Healthcare contacted the hospital consultant to ask for a prognosis on how long Mr Matthews was expected to live.

30. On 10 January, the hospital consultant responded to the Head of Healthcare and said that Mr Matthews had a prognosis of only a few months.

31. We are concerned that the prison did not start an application for compassionate release as soon as they received the consultant's prognosis. When the investigator asked why an application was not started, the prison said that they had contacted the Parole Board and they were not satisfied that the email from the consultant contained enough information.

32. PSO 4700 says that where it is considered that compassionate release may be appropriate, the Governor must refer any cases to PPCS and PPCS will liaise with the Parole Board.

33. We are concerned that prison staff did not follow the correct process and that an application for compassionate release was not submitted before Mr Matthews died. We recommend:

    The Governor should ensure that staff understand the process for compassionate release and that applications are progressed in a timely manner and submitted as promptly as possible.

Louise Richards **September 2022**
Assistant Ombudsman

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