Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Elliot Matthews, a prisoner at HMP Preston, on 26 September 2023

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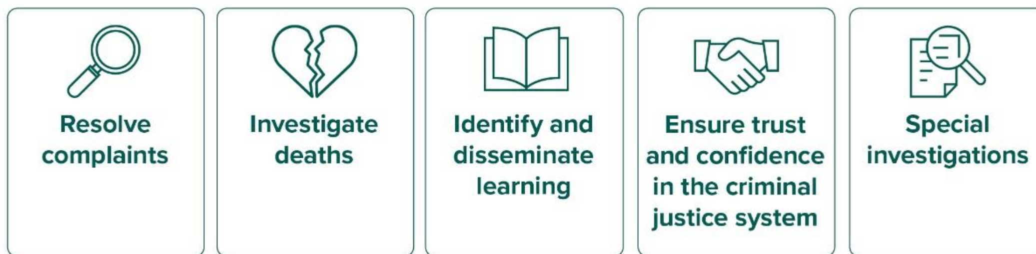
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 15 November 2022, Mr Elliot Matthews was sentenced to 12 years in prison for sexual offences. Mr Matthews died in hospital from bronchopneumonia, caused by advanced squamous cell carcinoma (cancer) of the oesophagus (throat) on 26 September 2023, while a prisoner at HMP Preston. He was 52 years old. We offer our condolences to Mr Matthews' family and friends.

4. The PPO family liaison officer wrote to Mr Matthews' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Matthews' next of kin asked for information about Mr Mathews' diagnosis and treatment, and why he was not granted compassionate release. These issues have been addressed in the clinical review and in this report.

5. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at HMP Preston.

6. The clinical reviewer concluded that the clinical care Mr Matthews received at HMP Preston was of a good standard and equivalent to what he could have expected to receive in the community. The clinical reviewer made recommendations not related to Mr Matthews' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Matthews' care.

8. In September 2023, prison staff at Preston started an application for compassionate release. The application was not completed before Mr Matthews died.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. We shared the initial report with Mr Matthew's family. Mr Mathews' mother made a number of observations related to the clinical review, which the clinical reviewer has amended.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. HMPPS made comments about the clinical review. The clinical reviewer amended the report in the light of the comments.

Adrian Usher
Prisons and Probation Ombudsman **March 2024**

Inquest

The inquest, held on 2 May 2024, concluded that Mr Matthews died from natural causes.

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