Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Coleman, a prisoner at HMP Wymott, on 25 October 2023

A report by the Prisons and Probation Ombudsman

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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

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 HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 21 September 2018 Mr Kevin Coleman was sentenced to 13 years in prison for sex offences. He was transferred to HMP Wymott on 15 February 2023.

4. Mr Coleman died of infective exacerbation of interstitial lung disease (this is a condition where an infection triggers a sudden deterioration of respiratory function) on 25 October 2023. He also had heart failure (progressive heart disease that affects the pumping action of the heart), chronic obstructive pulmonary disease (a lung condition that makes breathing difficult), and acute kidney injury (sudden and rapid loss of kidney function) which contributed to but did not cause the death. He was 87 years old. We offer our condolences to Mr Coleman's family and friends.

5. The PPO family liaison officer wrote to Mr Coleman's next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

6. The PPO investigator investigated the non-clinical issues relating to Mr Coleman's care. We did not find any non-clinical issues of concern. We make no recommendations.

7. NHS England commissioned an independent clinical reviewer to review Mr Coleman's clinical care at HMP Wymott.

8. The clinical reviewer concluded that the clinical care Mr Coleman received at Wymott was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She found that Mr Coleman's medical records contained evidence of individualised end of life care planning with kind, respectful and compassionate interactions between Mr Coleman the healthcare team.

9. The clinical reviewer made one recommendation, not related to Mr Coleman's death, that the Head of Healthcare will wish to address.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

11. Mr Coleman's friend received a copy of the initial report. She noted one inaccuracy in the clinical review that was amended.

12. The inquest into Mr Coleman's death was held on 2 May 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Coleman's death was due to infective exacerbation of interstitial lung disease (a condition where an infection triggers a sudden deterioration of respiratory function). He also had heart failure (progressive heart disease that affects the pumping action of the heart), chronic obstructive pulmonary disease (a lung condition that makes breathing

difficult), and acute kidney injury (sudden and rapid loss of kidney function) which contributed to but did not cause the death.

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

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