Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Milgate, a prisoner at HMP Swaleside, on 14 July 2023

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

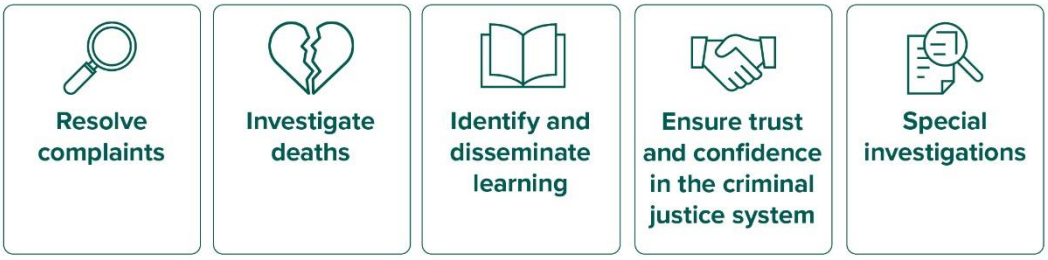
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 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. Mr Anthony Milgate was sentenced to life imprisonment in 2003 for sexual offences and false imprisonment. He died from gastric cancer, which had spread, and acute renal failure while a prisoner at HMP Swaleside. He was 64 years old. We offer our condolences to his family and friends.

4. The PPO family liaison officer wrote to Mr Milgate's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Milgate's clinical care at Swaleside. The clinical reviewer concluded that the clinical care Mr Milgate received at Swaleside was equivalent to that which he could have expected to receive in the community. The clinical review is attached as Annex 1.

6. The clinical reviewer made three recommendations which were not related to Mr Milgate's death but which the Head of Healthcare will want to address.

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

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

9. The next of kin received a copy of the draft report. They did not make any comments.

10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher **April 2023**
Prisons and Probation Ombudsman

Inquest

11. The inquest into Mr Milgate's death was held on 21 March 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Milgate's death was due to gastric cancer with metastases and acute renal failure. Mr Milgate also had skin cancer of the nose.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100