Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kunwar Patton, a prisoner at HMP Liverpool, on 11 September 2024

A report by the Prisons and Probation Ombudsman

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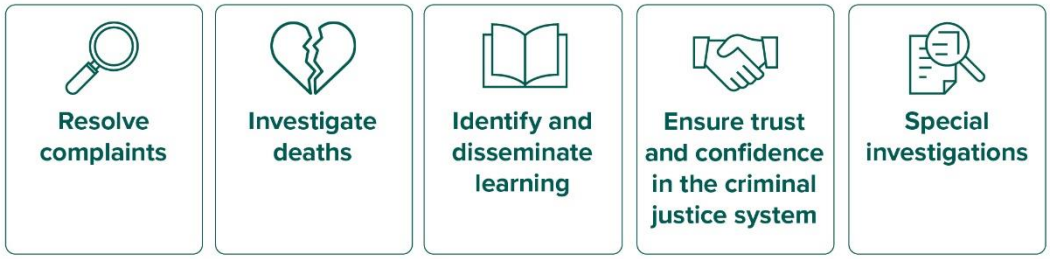
OUR VISION

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 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 24 September 2018, Mr Kunwar Patton was convicted of sexual offences and sentenced to eight years in prison.

4. Mr Patton died on 11 September 2024, while a prisoner at HMP Liverpool. His cause of death was myocardial infarction (heart attack) and coronary artery atheroma (build-up of fatty material causing a narrowing of the coronary arteries), with hyperlipidaemia (high level of cholesterol or triglycerides in the blood), chronic kidney disease stage 4, hypertension (high blood pressure) and type 2 diabetes contributing factors. Mr Patton was 57 years old. We offer our condolences to his family and friends.

5. The Ombudsman's office wrote to Mr Patton's wife to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Patton's daughter asked a question about the healthcare Mr Patton received in prison, which has been addressed in the clinical review.

6. We also shared the initial report with Mr Patton's family. They did not make any comments.

7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

8. NHS England commissioned an independent clinical reviewer to review Mr Patton's clinical care at HMP Liverpool.

9. The clinical reviewer concluded that the clinical care Mr Patton received at Liverpool was equivalent to that which he could have expected to receive in the community. She identified kind, respectful, and compassionate interactions between healthcare and custodial teams and Mr Patton. She made no recommendations.

10. The PPO investigator investigated the non-clinical issues relating to Mr Patton's care.

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

Inquest

12. The inquest into Mr Patton's death concluded on the 25 September 2024. The coroner confirmed that Mr Patton died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

October 2025

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