Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Rose, a prisoner at HMP Parc, on 27 February 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

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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 30 September 2016, Mr John Rose was convicted of sexual offences and sentenced to 11 years in prison.

4. Mr Rose died in hospital on 27 February 2024, while a prisoner at HMP Parc. His cause of death was heart failure and chronic kidney disease, with diabetes mellitus and peripheral vascular disease (reduced circulation of blood to the body) as contributory factors. We offer our condolences to Mr Rose's family and friends.

5. The Ombudsman's office contacted Mr Rose's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Rose's family did not respond.

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

7. Healthcare Inspectorate Wales commissioned an independent clinical reviewer, to review Mr Rose's clinical care at Parc. The clinical reviewer's report is attached as Annex 1.

8. The clinical reviewer concluded that the clinical care Mr Rose received at Parc was equivalent to that which he could have expected to receive in the community. The clinical reviewer made five recommendations not related to Mr Rose's death that the Head of Healthcare has addressed.

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

Inquest

10. The inquest into Mr Rose's death concluded on the 8 November 2024. The coroner confirmed that Mr Rose died of natural causes.

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

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