

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Howard Davies, a prisoner at HMP Parc, on 10 June 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



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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 HM 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 Howard Davies died in hospital of sepsis (a life-threatening reaction to an infection) and renal (kidney) failure, caused by bilateral lower lobe bronchopneumonia (a chest infection) and chronic obstructive pulmonary disease (COPD - a lung disease). He died on 10 June 2023, while a prisoner at HMP Parc. Mr Davies was 84 years old. He also had chronic nephrosclerosis (changes of the kidney caused by high blood pressure and ageing) which contributed to but did not cause his death. We offer our condolences to his family and friends.
4. The PPO family liaison officer wrote to Mr Davies' family to explain the investigation and to ask if she had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. Healthcare Inspectorate Wales (HIW) commissioned an independent clinical reviewer to review Mr Davies' clinical care at HMP Parc.
6. The clinical reviewer concluded that the clinical care Mr Davies received at Parc was equivalent to that which he could have expected to receive in the community.
7. The clinical reviewer made four recommendations not directly related to Mr Davies' death which the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Davies care. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared the initial report with the Prison Service. There were four factual inaccuracies in the clinical review which has been amended accordingly.
10. We shared the initial report with Mr Davies' family. They did not respond.
11. The inquest hearing into the death of Mr Davies was held on 14 June 2024. It confirmed that Mr Davies died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

January 2024

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