Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Matthews, a prisoner at HMP Hollesley Bay, on 13 June 2024

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 l 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. In February 2023, Mr Anthony Matthews was sentenced to five years and 10 months in prison for firearms offences. He died of cardiomegaly (an abnormal enlargement of the heart) on 13 June 2024, while a prisoner at HMP Hollesley Bay. He was 59 years old. We offer our condolences to Mr Matthews' family and friends.

4. The Ombudsman office wrote to Mr Matthews' next of kin, his father, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Matthews' clinical care at HMP Hollesley Bay.

6. The clinical reviewer concluded that the clinical care Mr Matthews received at Hollesley Bay was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community. She found that Mr Matthews received individualised support for his needs and the medical records described compassionate interactions with him. However, she was not satisfied that Mr Matthews' care was equivalent in relation to his raised blood pressure and cardiovascular risk score. We make the following recommendations:

   The Head of Healthcare should ensure all staff comply with national guidance regarding the diagnosis and management of hypertension.

   The Head of Healthcare should ensure all staff comply with national guidance around the risk management and reduction of cardiovascular disease.

7. The PPO investigator investigated the non-clinical issues relating to Mr Matthews' care. We did not find any non-clinical issues of concern.

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

9. At an inquest held on 28 March 2025, the Coroner concluded that Mr Matthews died of natural causes.

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

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 l 020 7633 4100