Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Mattocks, a prisoner at HMP High Down, on 4 September 2024

A report by the Prisons and Probation Ombudsman

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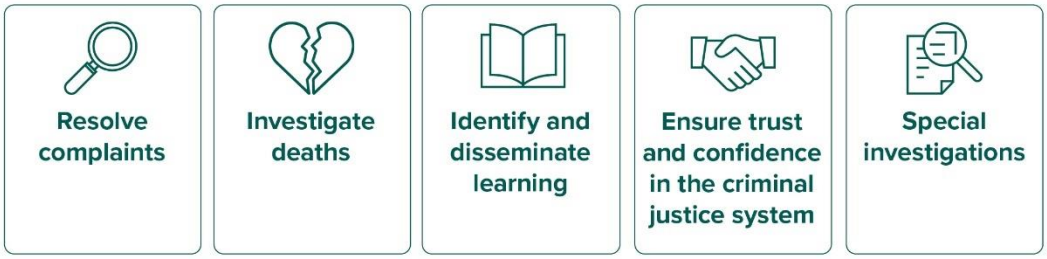
OUR VISION

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. In May 2024, Mr Ian Mattocks was sentenced to ten years imprisonment for sexual offences. He died in hospital of advanced alcoholic liver disease on 4 September, while a prisoner at HMP High Down. He was 76 years old. We offer our condolences to Mr Mattocks' family and friends.

4. The Ombudsman's office contacted Mr Mattocks' wife to explain the investigation and to ask if she had any matters she wanted us to consider. She had some questions about Mr Mattocks' health care which have been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Mattocks' clinical care at High Down.

6. The clinical reviewer concluded that the clinical care Mr Mattocks received at High Down was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made several recommendations not related to Mr Mattocks' death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Mattocks' care.

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

9. We shared our initial report with HMPPS and the prison's healthcare provider, Central and North West London NHS Foundation Trust. They found no factual inaccuracies. The healthcare provider made representations about one of the recommendations in the clinical review report, which has been removed. The revised clinical review report is annexed to this report.

10. We sent a copy of our initial report to Mr Mattocks' wife. She did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

Inquest

The inquest, held on 14 May 2025, concluded that Mr Mattocks died from natural causes.

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