Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sam Jones, a prisoner at HMP Isle of Wight, on 1 January 2025

A report by the Prisons and Probation Ombudsman

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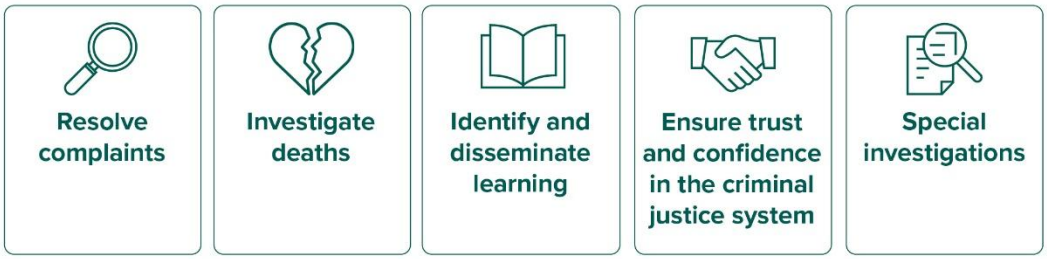
OUR VISION

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 February 2021, Mr Sam Jones (previously known as Mr Clive Andrews) was sentenced to 13 years imprisonment for sexual offences. He died of severe pneumonia (infection of the lungs) caused by longstanding chronic obstructive pulmonary disease (COPD – a group of lung conditions which cause breathing difficulties) on 1 January 2025 at HMP Isle of Wight. He was 63 years old. We offer our condolences to Mr Jones' family and friends.

4. The Ombudsman's office wrote to Mr Jones' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Jones' clinical care at Isle of Wight. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Jones received at Isle of Wight was equivalent to that which he could have expected to receive in the community. She found that Mr Jones' medical records contained evidence of good individualised end of life care planning. She made no recommendations.

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

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

9. Mr Jones' next of kin received a copy of the draft report. They did not make any comments.

10. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

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

Inquest

The inquest hearing was held on 18 February 2026. The Coroner concluded that Mr Jones died of natural causes.

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