

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Alan Jones,
a prisoner at HMP Garth,
on 28 January 2021**

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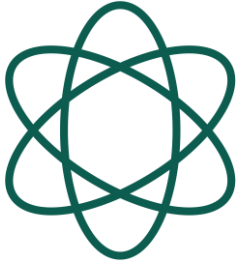
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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Alan Jones, who was 77 years old, died of a heart attack on 28 January 2021 while a prisoner at HMP Garth. We offer our condolences to Mr Jones' family and friends. We apologise for the delay in this investigation caused by operational issues related to COVID-19.
4. The clinical reviewer concluded that the clinical care Mr Jones received was equivalent to that which he could have expected to receive in the community.
5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Jones' clinical care at HMP Garth.
7. The PPO has investigated the non-clinical issues in Mr Jones' care, including his location, the security arrangements for his hospital escorts and liaison with his family.
8. Our family liaison officer wrote to Mr Jones' next of kin, his son, to explain the investigation. He did not have any specific questions for us to consider but asked for a copy of the report.
9. Mr Jones' next of kin received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Garth

11. Mr Jones was the 13th prisoner to die at HMP Garth since January 2019. Five of the previous deaths were from natural causes, five were drug-related and two were self-inflicted. There were no significant similarities between the circumstances of Mr Jones' death and the previous deaths. Two more prisoners have died at Garth since Mr Jones' death, one from natural causes and one self-inflicted.

Key Events

12. On 14 November 2019, Mr Alan Jones was sentenced to 14 years in prison for sexual offences. He transferred from HMP Altcourse to HMP Garth on 10 November 2020.
13. When he first got to Garth, Mr Jones refused initial health assessments. Healthcare staff managed to take his observations, which were normal, apart from his blood pressure which was raised (154/87), and his Body Mass Index, which was 26.8, meaning he was overweight. A nurse noted that Mr Jones had been diagnosed with atrial fibrillation (irregular heartbeat) in 2014, but he said he did not have it and did not want any treatment for it. The nurse noted that he took no medication and had no outstanding hospital treatment but referred Mr Jones for a GP review because of his age and apparent anger issues.
14. On 20 November, a GP assessed Mr Jones in his cell and recorded that he had no concerns about his physical or mental health. A GP review was planned for six to eight weeks' time.
15. On 27 November, the mental health team and the primary care team completed Mr Jones' secondary health screen and assessed his mental health. There were no concerns, although they referred him to the GP again to discuss his anger and conditions related to his age.

January 2021

16. A prison GP spoke to Mr Jones on 8 January following the GP's referral in November. The GP recorded that Mr Jones said he felt fine and was keen to be vaccinated against COVID-19. The GP noted that he should continue to be managed by the GP team.
17. On 27 January 2021, officers asked a nurse to review Mr Jones as they were concerned about his presentation. He walked to the treatment room for the review, but the nurse noted that his oxygen was low, he was breathing quickly, he reported severe stomach pain and had lost his appetite. She assessed him using the NEWS2 tool (a tool to detect acute illness and health deterioration) and determined that he needed urgent GP review.
18. The GP reviewed Mr Jones using the NEWS2 tool and assessed that he needed to go to hospital for further assessment and treatment. The prison called an urgent ambulance at 11.30am. The nurse stayed with Mr Jones and monitored his condition, repeating his observations until an ambulance eventually arrived at 2.20pm. Mr Jones was restrained on his way to hospital, and we consider that the prison adequately reflected Mr Jones' medical condition in their risk assessment.
19. On 28 January, healthcare staff were notified that Mr Jones had died in hospital. There was no post-mortem examination. A doctor confirmed that Mr Jones had died of a myocardial infarction (heart attack). In her statement, the doctor reported that Mr Jones was likely to have had a heart attack in the days before coming to hospital and had had two more heart attacks while he was in hospital. After the

second heart attack, hospital doctors agreed that further treatment was inappropriate, and he died shortly afterwards.

20. The prison's family liaison officer (FLO) contacted Mr Jones' next of kin, his son, who was with him when he died. The FLO remained in contact with Mr Jones' son and offered a contribution to funeral expenses in line with Prison Service policy.

Sarah Stolworthy
Acting Assistant Ombudsman

March 2022

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