

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Alan Jones,
a prisoner at HMP Whitemoor,
on 26 September 2021**

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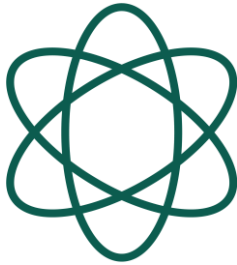
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Our vision

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 died in a hospice of cancer on 26 September 2021, while a prisoner at HMP Whitemoor. He was 72 years old. We offer our condolences to Mr Jones's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Jones received at Whitemoor was of a good standard and was equivalent to that he could have expected to receive in the community. However, she found that a hospital referral made in December 2019 after Mr Jones was diagnosed with iron deficiency anaemia, was not made using the suspected cancer pathway as it should have been. This made no difference to the outcome as Mr Jones refused to attend hospital for further investigations, but staff should be reminded of the guidance for suspected cancer referrals.
5. We found no non-clinical issues of concern.

Recommendations

- The Head of Healthcare should ensure all healthcare staff are aware of NICE guidance for suspected cancer and how to refer to appropriate services.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Jones's clinical care at Whitemoor.
7. The PPO investigator has investigated non-clinical issues, including Mr Jones' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. Mr Jones had no appointed next of kin so there was no family involvement in this investigation.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whitemoor

10. Mr Jones was the sixth prisoner to die at Whitemoor since September 2019. Of the previous deaths, three were from natural causes, one was self-inflicted, and one was drug related. There are no similarities between our findings in the investigation into Mr Jones's death and our investigation findings for the previous deaths.

Key Events

11. In February 1998, Mr Alan Jones was sentenced to life imprisonment with an eight-year tariff for arson. In June 2008, he was sentenced to a further seven years' imprisonment for sexual offences. He was moved to HMP Whitemoor on 15 February 2018.
12. On 12 December 2019, blood tests showed that Mr Jones had iron deficiency anaemia (caused by lack of iron, often because of blood loss). Mr Jones consented to a referral to the hospital's gastroenterology department (branch of medicine focused on the digestive system). However, there is no evidence that the referral was made using the suspected cancer pathway as it should have been. Mr Jones also had an electrocardiogram (ECG – to check the heart's rhythm) on 12 December and was diagnosed with atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate).
13. Mr Jones subsequently withdrew his consent for further investigations into his anaemia and heart condition. Staff assessed that he had the mental capacity to make this decision.
14. On 1 April 2021, Mr Jones had a telephone consultation with a hospital consultant about his heart condition, after reporting weakness in his face and limbs. The hospital consultant told him that he needed further investigations in hospital. Mr Jones said he was unwilling to attend hospital until he had received his second COVID-19 vaccination, which was booked for 7 May.
15. Between April and May, staff encouraged Mr Jones to attend hospital for investigations into his deteriorating health. However, he continued to refuse until he received his second COVID-19 vaccination.
16. On 28 May, Mr Jones attended hospital for an examination and blood tests. Following abnormal blood test results, Mr Jones had an ultrasound scan on 1 June. The scan found a blockage in his kidney/bladder area and there were signs that his liver was cancerous, although further scans were required to confirm this. The hospital doctor recommended that Mr Jones was admitted for further investigation, but Mr Jones declined and said he would like a few days to consider his options.
17. Mr Jones refused to attend a GP appointment on 10 June and said he would not go to hospital and wanted to die in prison. Staff assessed that Mr Jones had the mental capacity to make these decisions.
18. On 11 June, a hospital consultant advised the prison GP that Mr Jones was likely to have a terminal illness and his life expectancy was three to six months. Mr Jones refused to move to the prison's healthcare unit.
19. Mr Jones subsequently consented to a move and was moved to the prison's healthcare unit on 13 July. On 11 August, Mr Jones said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
20. On 27 August, Mr Jones refused a move to the palliative care suite within the prison's healthcare unit. He subsequently agreed on 4 September. On 17

September, the prison palliative care consultant assessed that Mr Jones now had a life expectancy of several days to a few weeks.

21. On 21 September, staff submitted an application for Mr Jones's early release on compassionate grounds to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). On the same day, Mr Jones was moved to a hospice for end-of-life care.
22. Mr Jones died at the hospice on 26 September at 9.41pm.

Post-mortem report

23. The post-mortem report concluded that Mr Jones died of metastatic colonic adenocarcinoma (bowel cancer which had spread to other parts of the body).

Louise Richards
Assistant Ombudsman

February 2022

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