Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tony King, a prisoner at HMP Swaleside, on 18 June 2024

A report by the Prisons and Probation Ombudsman

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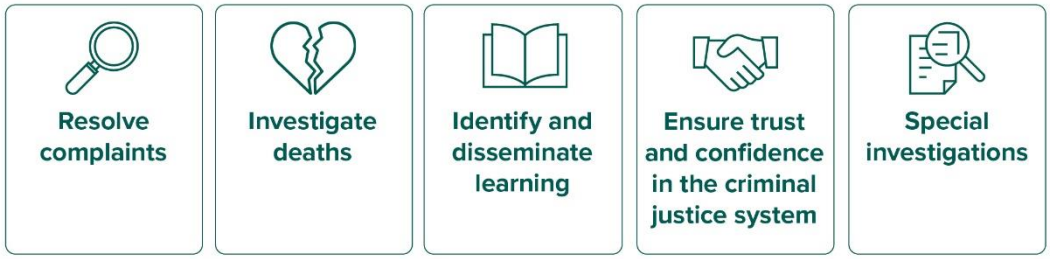
OUR VISION

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. On 23 June 2023, Mr Tony King was sentence to life for murder. He was initially remanded at HMP Lewes and then, on 3 August 2023, transferred to HMP Swaleside.

4. Mr King died of sudden cardiac death due to chronic myocardial scarring (a condition where the heart muscle is scarred due to injury or disease) on 18 June 2024, at Swaleside. He was 61 years old. We offer our condolences to Mr King's family and friends.

5. The Ombudsman's office contacted to Mr King's friend, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions.

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

7. NHS England commissioned an independent clinical reviewer to review the clinical care Mr King received at Swaleside.

8. The clinical reviewer concluded that the majority of the clinical care that Mr King received at Swaleside was of a good standard and was equivalent to that which he would have received in the community. However, on 17 June 2024, the day before he died, Mr King presented with chest pains. The clinical reviewer found that he should have been reviewed by a doctor and referred to hospital. We make the following recommendations:

   The Head of Healthcare should ensure that all staff are trained in the local operating procedure 'Management of Acute Chest Pain' and understand how to refer to the GP and local hospital.

   The Head of Healthcare should review the Local Operating Procedure to include the management of patients that have chest pain that decline clinical observations.

9. The inquest into Mr King's death concluded on 4 June 2025, returning a verdict of natural causes.

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

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