Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Garth Walker, a prisoner at HMP Altcourse, on 17 March 2024

A report by the Prisons and Probation Ombudsman

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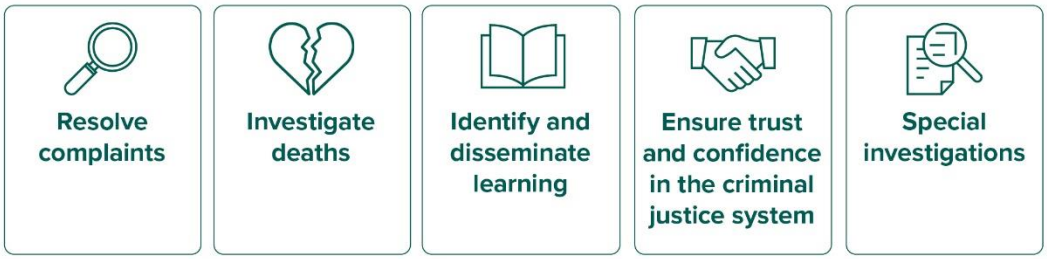
OUR VISION

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 January 2016, Mr Garth Walker received two sentences of imprisonment for seven years and 18-months to be served consecutively for sexual offences. He died of congestive heart failure (when the heart does not pump blood sufficiently well) and ischaemic heart disease (caused by narrowed heart arteries) on 17 March 2024, in hospital, while a prisoner at HMP Altcourse. He was 77 years old. We offer our condolences to Mr Walker's family and friends.

4. The Ombudsman's office wrote to Mr Walker's 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 Walker's clinical care at Altcourse.

6. The clinical reviewer concluded that the clinical care Mr Walker received at Altcourse was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer recognised areas of good practice. She also made recommendations, which did not impact on her assessment of equivalence, that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Walker's 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 Walker's next of kin received a copy of the draft report. They did not make any comments.

10. At the inquest held on 15 April 2024, the Coroner concluded that Mr Walker died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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