Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Long, a prisoner at HMP Oakwood, on 10 March 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 October 2024, Mr Peter Long was sentenced to 25 years imprisonment for sexual offences. He died in hospital of heart failure on 10 March 2025, while a prisoner at HMP Oakwood. He was 66 years old. We offer our condolences to Mr Long's family and friends.

4. The Ombudsman's office wrote to Mr Long's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. NHS England commissioned an independent clinical reviewer to review Mr Long's clinical care at HMP Oakwood.

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

7. The clinical reviewer concluded that the clinical care Mr Long received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community. However, she found no evidence of a care plan for managing Mr Long's hypotension (low blood pressure). We recommend:

   The Head of Healthcare ensures that all patients with a recognised long-term condition always have an up-to-date care plan for management of the condition.

8. The clinical reviewer also made a recommendation that was not related to Mr Long's death, which the Head of Healthcare will wish to address.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. Practice Plus Group pointed out some factual inaccuracies in the clinical review. This has been amended. Practice Plus Group provided an action plan.

10. At the inquest, held on 25 September 2025, the Coroner concluded that Mr Long died from natural causes.

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

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