Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Masterson, a prisoner at HMP Wakefield, on 3 February 2025

A report by the Prisons and Probation Ombudsman

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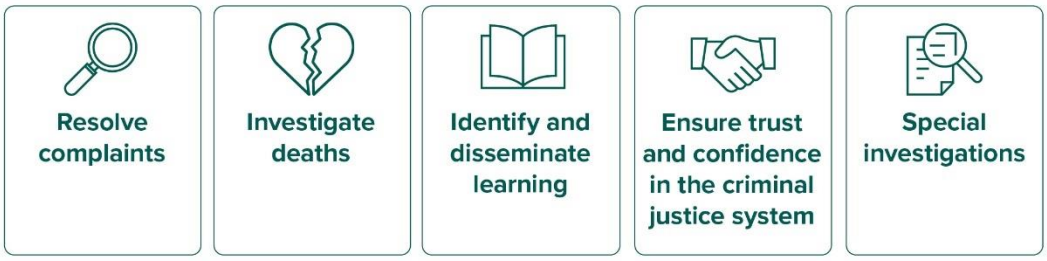
OUR VISION

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 July 2018, Mr Peter Masterson was remanded HMP Wormwood Scrubs charged with sexual offences. In September 2018, he was sentenced to 22 years in prison for rape. In March 2019, Mr Masterson was transferred to HMP Wakefield.

4. On 3 February 2025, Mr Masterson died of lung cancer at Wakefield. He was 64 years old. We offer our condolences to those who knew him.

5. The Ombudsman's office wrote to Mr Masterson'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.

6. NHS England commissioned an independent clinical reviewer to review Mr Masterson's clinical care at Wakefield.

7. The clinical reviewer concluded that the clinical care Mr Masterson received at Wakefield was of a reasonable standard and equivalent to what he could have expected to receive in the community. He found that Mr Masterson had care plans in place for his long-term health conditions and had regular reviews. The clinical reviewer made recommendations not related to Mr Masterson's death that the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Masterson's care.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. At the inquest held on 21 February 2025, the Coroner concluded that Mr Masterson died of natural causes.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prison and Probation Ombudsman **June 2025**

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