

Independent investigation into the death of Mr Leslie Ginger, a prisoner at HMP Peterborough, on 7 January 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



Resolve complaints



Investigate deaths



Identify and disseminate learning



Ensure trust and confidence in the criminal justice system



Special investigations

WHAT WE VALUE

Ambitious thinking

Professional curiosity

Diversity & inclusion

Transparency

Teamwork



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- 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 Leslie Ginger was remanded in prison, charged with sexual offences. He died of heart disease and chronic obstructive pulmonary disease (COPD, the term for a group of serious lung diseases) on 7 January 2025, at HMP Peterborough. He was 71 years old. We offer our condolences to Mr Ginger's family and friends
- 4. The Ombudsman's office wrote to Mr Ginger'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 Ginger's clinical care at HMP Peterborough.
- The clinical reviewer concluded that the clinical care Mr Ginger received at 6. Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations not related to Mr Ginger's death, which the Heads of Healthcare at Peterborough and HMP Bedford (Mr Ginger's previous prison) will wish to address
- 7. The PPO investigator investigated the non-clinical issues relating to Mr Ginger's care.
- 8. We did not find any non-clinical issues of concern. We make no recommendations.
- 9. We shared our initial report with HMPPS and the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.
- 10. We sent a copy of our initial report to Mr Ginger's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher Prisons and Probation Ombudsman

June 2025

Inquest

At the inquest, held on 30 July 2025, the Coroner concluded that Mr Ginger died from natural causes.



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