Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Trow, a prisoner at HMP Wymott, on 8 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

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 31 May 2016, Mr John Trow was sentenced to 19 years imprisonment for sexual offences. He died in hospital of aspiration pneumonia on 8 January 2025, while a prisoner at HMP Wymott. He was 71 years old. We offer our condolences to Mr Trow's family and friends.

4. The Ombudsman's office wrote to Mr Trow'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 Trow's clinical care at Wymott. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Trow received at Wymott was equivalent to what he could have expected to receive in the community. She found that healthcare staff maintained contact with the hospital during Mr Trow's hospital admissions. She found that care plans for Mr Trow were initiated appropriately, his health conditions were monitored regularly, and he was cared for compassionately by confident and competent staff. She made no recommendations.

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

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

9. Mr Trow's next of kin received a copy of the draft report. They did not make any comments.

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

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

Inquest

11. At the inquest held on 13 August 2025, the Coroner concluded that Mr Trow died of natural causes.

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