Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Porter, a prisoner at HMP Wandsworth, on 6 February 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

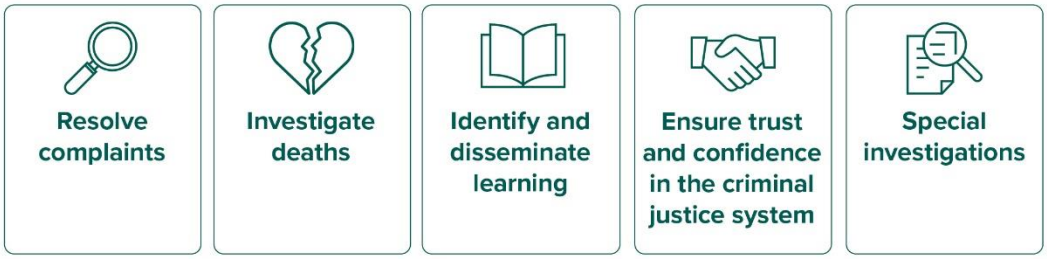
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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 2023, Mr Kevin Porter was sentenced to 40 months imprisonment for sexual offences.

4. Mr Porter died of aspiration pneumonia as a result of Parkinson's Disease on 6 February 2024, at HMP Wandsworth. He was 63 years old. We offer our condolences to Mr Porter's family and friends.

5. The Ombudsman's office contacted Mr Porter's family to explain the investigation and to ask if they had any matters they wanted us to consider. They had concerns about Mr Porter's medical care relating to his Parkinson's Disease and asked for a copy of our report. The family's concerns have been addressed in the clinical review.

6. NHS England commissioned an independent clinical reviewer to review Mr Porter's clinical care at HMP Wandsworth.

7. The clinical reviewer concluded that the clinical care Mr Porter received at Wandsworth was of a good standard and was equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.

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

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

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

11. Mr Porter's family received a copy of the draft report. They did not make any comments.

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

Inquest

12. At the inquest held on 16 January 2025, the Coroner concluded that Mr Porter died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100