Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr George Stephenson, a prisoner at HMP Full Sutton, on 20 April 2025

A report by the Prisons and Probation Ombudsman

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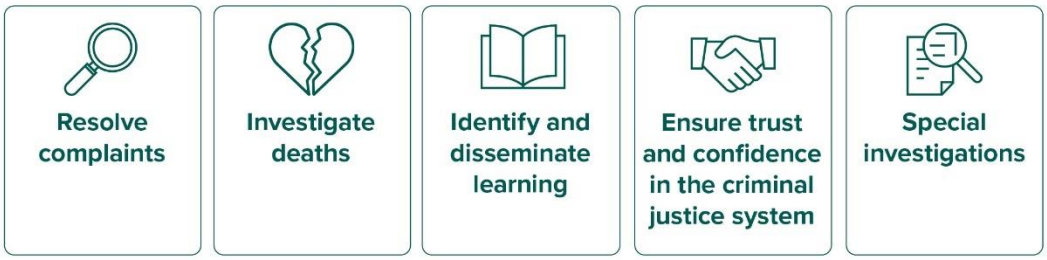
OUR VISION

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

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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 1987, Mr George Stephenson was sentenced to life imprisonment for murder, with a minimum tariff of 35 years. He died of heart failure and ischaemic heart disease on 20 April 2025, while a prisoner at HMP Full Sutton. He was 73 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer, to review Mr Stephenson's clinical care at HMP Full Sutton. The clinical reviewer's report is attached as Annex 1.

5. The clinical reviewer concluded that the clinical care Mr Stephenson received at Full Sutton was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Stephenson's care plans were detailed, appropriately initiated and updated by healthcare staff. She found several examples of kind, respectful and compassionate interactions between healthcare staff and Mr Stephenson. She made no recommendations.

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

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

8. 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 **August 2025**

Inquest

9. At the inquest held on 19 September 2025, the Coroner concluded that Mr Stephenson died of natural causes.

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