

Independent investigation into the death of Mr Peter Thompson, a prisoner at HMP Stocken, on 17 March 2023

A report by the Prisons and Probation Ombudsman

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



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. Mr Peter Thompson died of cancer of the oesophagus at Leicester Royal Infirmary, on 17 March 2023, while a prisoner at HMP Stocken. He was 51 years old. We offer our condolences to Mr Thompson's family and friends.
- 4. The PPO family liaison officer wrote to Mr Thompson'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 Thompson's clinical care at HMP Stocken.
- The clinical reviewer concluded that the clinical care Mr Thompson received at 6. Stocken was of an excellent standard and equivalent to that which he could have expected to receive in the community. She found that Mr Thompson's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made recommendations not related to Mr Thompson's death that the Head of Healthcare will wish to address.
- 7. The PPO investigator investigated the non-clinical issues relating to Mr Thompson's care. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

8. The inquest into Mr Thompson's death concluded on the 25 July 2023. The coroner confirmed that Mr Thompson died of natural causes.

Adrian Usher Prisons and Probation Ombudsman

March 2024



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