Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Thompson, on 15 July 2024, following his release from HMP Norwich

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

Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.

3. 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.

4. Mr Paul Thompson died from multiple traumatic injuries after he was hit by a train on 15 July 2024 following his release from HMP Norwich four days earlier. He was 53 years old. We offer our condolences to his family and friends.

5. Mr Thompson was released from court on 11 July 2024, and the healthcare team at Norwich did not see him before his release due to an oversight by prison staff. Healthcare staff at Norwich subsequently made efforts to put in place community mental health support for Mr Thompson.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Thompson's death on 26 July 2024.

8. The PPO investigator obtained copies of relevant extracts from Mr Thompson's prison and probation records.

9. NHS England commissioned an independent clinical reviewer to review Mr Thompson's clinical care at HMP Norwich. The clinical review is attached as Annex 1.

10. As part of the investigation, the PPO investigator and the clinical reviewer interviewed three members of prison staff and six members of healthcare staff.

11. We informed HM Coroner for Greater Suffolk of the investigation. They gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. The Ombudsman's office contacted Mr Thompson's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

14. The initial report was shared with NHS England, who pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

Background Information

HMP Norwich

15. HMP Norwich is a category B and C prison which holds convicted and remanded young and adult male prisoners. Health Care Resourcing Group provides physical healthcare and clinical substance misuse services. Norfolk and Suffolk NHS Foundation Trust provides mental health services. Phoenix Futures provides psychosocial substance misuse services.

Probation Service

16. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Key Events

Background

17. On 28 May 2024, Mr Paul Thompson was remanded to HMP Norwich, charged with harassment. Suicide and self-harm prevention procedures (known as ACCT) were started when he arrived in prison as he had thoughts of suicide and while in police custody, he had said and written that he had no choice but to take his life.

18. During his initial health screen, Mr Thompson said that he misused alcohol in the community. He was prescribed chlordiazepoxide for alcohol withdrawal and detoxification. A nurse reviewed Mr Thompson's medical history and referred him urgently to prison mental health services.

19. Mr Thompson had a significant medical history, including anxiety and depression, psychosis, post-traumatic stress disorder (PTSD) and functional neurological disorder (an incurable condition with neurological symptoms such as seizures, movement issues or weakness) which caused constant pain and limited mobility.

20. On 29 May, an ACCT review was completed. Mr Thompson shared that he had thoughts of suicide and that he had attempted suicide four times in the past. He said that he aimed to get killed in prison. Staff referred him to the substance misuse team for his alcohol misuse.

21. That day, Nurse A completed an initial psychiatric assessment for Mr Thompson. He presented as depressed and hopeless but was open to receiving help. Nurse A booked a GP appointment for 31 May. The GP prescribed him sertraline (an antidepressant).

22. On 3 June, during an ACCT review, Mr Thompson told staff that he had put himself in prison on purpose, and he wanted to walk in front of a moving train but could not because of his son. On 6 June, Mr Thompson was found with a small cut on his arm. He told staff that he did this out of frustration at not having vape capsules. He told staff during welfare checks that he was 'giving up'.

23. On 15 June, Mr Thompson was seen hitting his head against the wall and crying that he 'wanted to die'. During an ACCT review, Mr Thompson did not engage with staff and continued to hit his head against a wall.

24. During a further review on 19 June, Mr Thompson told staff that he had daily thoughts of killing himself but did not act on them as he hoped that a prisoner would attack or kill him. He told staff that he was in a lot of physical pain due to his neurological disorder.

25. At 11.05am on 21 June, staff found Mr Thompson on his cell floor, with a cut to his head from headbutting the wall. They completed an immediate ACCT review.

26. On 26 June, Mr Thompson completed a therapy session with Ms A, psychological therapist. He told Ms A that he was not suicidal but wished he was dead because of the pain he experienced from the neurological disorder.

27. On 27 June, Mr Thompson's ACCT was closed as Mr Thompson was engaging in therapy sessions and staff believed his risk could be managed through this.

28. Mr Thompson had two more psychological therapy sessions on 3 July and 9 July. Mr Thompson continued to have pain and feelings of hopelessness. Ms A told Mr Thompson that she would write up a summary of their sessions, and if he was released from court, he could take it to his community GP to decide on a course of action.

29. On 11 July, Mr Thompson attended a court hearing by video link from the prison. He was convicted of the offence and sentenced to 12 weeks in prison. As he had already served this time while on remand, he was released from Norwich. Mr Thompson stated he was concerned about his release and told a prison officer he had suicidal thoughts. The officer contacted Custodial Manager (CM) A and CM B about this. CM B told the investigator that he went to reception and spoke to Mr Thompson about his concerns about returning to his house and his bank cards which the prison held for him. CM B said they spoke at length about his suicidal thoughts and that Mr Thompson had said he needed to be there for his son.

30. CM B told the investigator that he was concerned about Mr Thompson's body language and suicidal thoughts so told Mr A, the duty governor. Mr A and CM A went to reception to speak to Mr Thompson about his concerns. After they retrieved his bank cards, CM B said that Mr Thompson's demeanour improved from his initial presentation. Mr Thompson was then escorted to the gate and released from Norwich at approximately 7.20pm. Mr Thompson was planning to return to Durham.

31. Fifteen minutes after his release, Nurse B told CM B that Mr Thompson had been released without healthcare discharging him. CM B thought that a nurse had already seen him. The nurse subsequently completed a report on datix (a healthcare incident reporting system used for safeguarding purposes).

32. On 12 July, healthcare staff tried to call Mr Thompson four times but could not reach him. They also contacted a community mental health team that he had previously seen. As he was no longer a service user, they could only update their records to note that they had attempted to make contact with him.

33. Nurse C then called Durham Crisis team who told her that they had tried to contact Mr Thompson but he had not answered. They told Nurse C that they would take this forward. Nurse C then contacted Mr Thompson's last registered GP practice to notify them that Mr Thompson had expressed thoughts of suicide.

Release from HMP Norwich

34. On 12 July, Mr Thompson attended an initial probation appointment with Ms B who was the duty community offender manager (COM) at North Durham probation office. Ms B told the investigator that they were not expecting him but she saw him as she was the duty COM. She told the investigator that Mr Thompson changed from emotional and crying to emotionless. She logged in his probation records that Mr Thompson appeared anxious. He told Ms B that on his journey to the probation office, he thought about jumping in front of a train. He told Ms B that he hoped to go to prison so others would kill him as he wanted to die but could not kill himself. Ms B contacted the Crisis team while Mr Thompson was in the office. However, after she

was put on hold for 35 minutes, Mr Thompson left the building, stating that he did not want the Crisis team to be called and was aware how to contact them if needed. He was given his next appointment date.

35. Ms B told the investigator that it was agreed Mr Thompson would be allocated to her caseload. On 19 July, Mr Thompson did not attend his second probation appointment. Ms B told the investigator that she contacted the police and the Ambulance Service to conduct a welfare check but did not hear anything from them after that. She then contacted Mr Thompson's aunt (whose details were in his probation records) who told her that he had died.

Circumstances of Mr Thompson's death

36. At approximately 6.00pm on 15 July, the British Transport Police were called to the train tracks at Elmswood rail station in Suffolk following a report that a man had jumped from the platform and had been hit by a train. In his police statement, the train driver stated that he saw Mr Thompson jump down from the platform and lie down on the tracks, with his head on the rails.

Post-mortem report

37. The post-mortem report concluded that Mr Thompson died of multiple injuries. Post-mortem toxicology results found no drugs in his system.

Inquest

38. At an inquest held on 4 December 2025, the Coroner concluded that Mr Thompson died of suicide.

Findings

Clinical findings

39. The clinical reviewer concluded that the clinical care Mr Thompson received before his release from HMP Norwich was of a good standard. However, she found that the care he received on the day of his release was not equivalent to that which he could have expected to receive in the community.

40. While she found that Nurse C's actions after she was notified of Mr Thompson's release were an example of excellent practice, she identified issues with information-sharing on the day of Mr Thompson's release which led to him being released from Norwich without the healthcare team seeing and discharging him appropriately.

Discharge from HMP Norwich

41. When prison leavers are released from prison by the court, staff should ensure they are appropriately released, including returning their property, providing a travel warrant and providing continuity of care by ensuring they are seen by the healthcare team. Norwich uses a checklist which prison staff and healthcare staff must sign as completed. Prison staff manage this checklist to ensure the discharge process is completed properly.

42. Prison staff did not check the discharge list before escorting Mr Thompson to the prison gate on release. This meant that they did not see that the healthcare team had not yet reviewed him. This only came to light after Mr Thompson had been released. This meant that healthcare staff did not assess Mr Thompson's risk of suicide and self-harm or put in place measures to address his risk or ensure continuity of mental healthcare in the community.

43. Prison staff told the investigator that it was busier than usual on the day Mr Thompson was released and it was an oversight on their part. While we agree with the clinical reviewer that the healthcare team must see prison leavers before release to ensure continuity of care and manage their risk, we also recognise that staff must release prison leavers as soon as possible as they have no legal authority to keep them detained. During our investigation, we found that the Governor had issued an email in June 2023, reminding prison reception staff of the discharge process. The investigator also reviewed several recent discharge checklists from April and May 2025 which had all been completed appropriately and in full, indicating that this does not appear to be a systemic issue at Norwich at present. We therefore do not make a recommendation.

Pre-release management of Mr Thompson's mental health

44. Mr Thompson was released from Norwich without any mental health support in place. As Mr Thompson's release was not expected, the mental health team was not able to prepare for his release. Ms C, the then Head of Safer Prisons, told the investigator that the prison is sometimes informed of court appearances on the day, and there is no reasonable way to foresee a prisoner being released by the court. As a result, it is difficult for staff to make appropriate community referrals. After

Nurse B completed the datix report, healthcare staff made significant and appropriate attempts to inform mental health teams in the community that Mr Thompson was at risk. They also tried repeatedly to contact Mr Thompson but were unsuccessful.

45. As Ms B was assigned as Mr Thompson's COM after his release, and the Probation Service was not aware of his release until he attended their office unannounced, they could not complete any pre-release planning for him. Mr Thompson died before any post-release support could be provided.

Adrian Usher
Prisons and Probation Ombudsman **February 2026**

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