

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

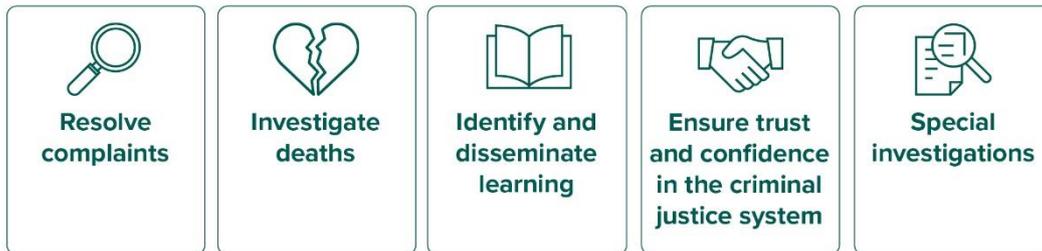
# **Independent investigation into the death of Mr John Thirling, a prisoner at HMP Moorland, on 3 February 2024**

**A report by the Prisons and Probation Ombudsman**

## 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 April 2022, Mr John Thirling was sentenced to 11 years and six months imprisonment for sexual offences. He died of lung cancer on 3 February 2024, at HMP Moorland. He was 78 years old. We offer our condolences to Mr Thirling's family and friends.
4. The Ombudsman's office did not write to Mr Thirling's next of kin because they did not want to be contacted.
5. NHS England commissioned an independent clinical reviewer to review Mr Thirling's clinical care at HMP Moorland.
6. The clinical reviewer concluded that the clinical care Mr Thirling received at Moorland was mostly equivalent to that which he could have expected to receive in the community. She found that after Mr Thirling was diagnosed with lung cancer and his condition deteriorated, staff cared for him with compassion. She made two recommendations about the management of Mr Thirling's long-term conditions, which are not directly related to his death but which the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Thirling's care. 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.
9. At the inquest held on 5 September 2024 the coroner concluded that Mr Thirling died of natural causes.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**September 2024**

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