



# **Independent investigation into the death of Ms Susan Truscott, a prisoner at HMP Peterborough, on 21 October 2023**

**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



© Crown copyright, 2024

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 November 2018, Ms Susan Truscott was sentenced to ten years imprisonment for sexual offences. She died in hospital of COVID-19 pneumonia on 21 October 2023, while a prisoner at HMP Peterborough. She was 71 years old. We offer our condolences to Ms Truscott's family and friends.
4. The PPO family liaison officer wrote to Ms Truscott'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. However, he subsequently asked for a copy of our initial report via the Coroner.
5. NHS England commissioned an independent clinical reviewer to review Ms Truscott's clinical care at Peterborough. He concluded that the clinical care Ms Truscott received was of a satisfactory standard and equivalent to that which she could have expected to receive in the community. He made no recommendations.
6. The PPO investigator investigated the non-clinical issues relating to Ms Truscott's care. We did not find any non-clinical issues of concern. We make no recommendations.
7. We shared our initial report with HMPPS. They found no factual inaccuracies.
8. We sent a copy of our initial report to Ms Truscott's son. He did not notify us of any factual inaccuracies.

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

**May 2024**

## **Inquest**

The inquest, held on 4 October 2024, concluded that Ms Truscott died of natural causes.



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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T 020 7633 4100