



Independent investigation into the death of Mr Raymond Cheshire, a prisoner at HMP Peterborough, on 21 April 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



OGL

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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. 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. On 24 February 2024, Mr Raymond Cheshire was remanded in prison charged with rape. He died in hospital of heart failure on 21 April, while a prisoner at HMP Peterborough. He was 56 years old. We offer our condolences to Mr Cheshire's family and friends.
4. The Ombudsman's office contacted Mr Cheshire's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Cheshire's clinical care at Peterborough.
6. The clinical reviewer concluded that the clinical care Mr Cheshire received at Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community. He made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Cheshire's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared our initial report with HMPPS and with the prison's healthcare provider, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.
10. We sent a copy of our initial report to Mr Cheshire's son. He did not notify us of any factual inaccuracies.

**Adrian Usher
Prisons and Probation Ombudsman**

October 2024

Inquest

The inquest, held on 13 November 2024, concluded that Mr Cheshire died from natural causes.



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