Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Sowter, a prisoner at HMP Wymott, on 20 June 2025

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

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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. On 26 April 2024, Mr Raymond Sowter was convicted of sexual offences and was sentenced to nine years in prison.

4. Mr Sowter died in hospital of advanced gastric carcinoma (cancer that began in the stomach which has spread to another part of the body) on 20 June 2025, while a prisoner at HMP Wymott. He was 77 years old. We offer our condolences to Mr Sowter's family and friends.

5. The Ombudsman's office wrote to Mr Sowter's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. NHS England commissioned an independent clinical reviewer, to review Mr Sowter's clinical care at HMP Wymott. The clinical reviewer's report is attached as Annex 1.

8. The clinical reviewer concluded that the clinical care Mr Sowter received at Wymott was of a good standard and equivalent to that which he could have expected to receive in the community. She identified good practice in relation to timely referral to the palliative care team and collaborative working to manage Mr Sowter's symptoms.

9. The PPO investigator investigated the non-clinical issues relating to Mr Sowter's care.

10. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

11. The inquest into Mr Sowter's death concluded on 2 April 2026. The coroner confirmed that Mr Sowter died of natural causes.

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

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