Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Preston, following his release from HMP Belmarsh, on 29 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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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 Peter Preston died from dilated cardiomyopathy (a heart muscle disease) on 29 June 2025, following his release from HMP Belmarsh on 17 June. He was 57 years old. We offer our condolences to Mr Preston's family and friends.

5. The clinical reviewer concluded that the clinical care Mr Preston received at HMP Thameside (where he was held before transferring to Belmarsh) and Belmarsh was of a good standard and more than equivalent to that which he could have expected to receive in the community. However, he found that more could have been done to support Mr Preston with his healthcare needs on release from prison. When Mr Preston was released, the Release and Transfer Service was not fully implemented at Belmarsh as the Service Lead was completing the induction process. This affected Mr Preston's continuity of care on release. There is also no evidence that Mr Preston was told how to collect his medications if he was released from court. The Head of Healthcare told us that the Release and Transfer Service has since been fully implemented.

6. We did not identify any significant learning relating to the pre-release planning or post-release supervision of Mr Preston. Accommodation referrals were not completed until Mr Preston's second probation appointment. However, we appreciate that this was due to workload/capacity issues and as Mr Preston had somewhere to stay, it was reasonable that this was not prioritised at his first appointment.

Recommendation

- The Head of Healthcare should complete an audit within six months of the date of this initial report to ensure that advice about the Electronic Prescription Service is given to those attending court and is recorded in their medical records.

The Investigation Process

7. HMPPS notified us of Mr Preston's death on 16 July 2025.

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

9. NHS England commissioned an independent clinical reviewer to review Mr Preston's clinical care at HMP Thameside and HMP Belmarsh.

10. We informed HM Coroner for Inner South London of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's office contacted Mr Preston's next of kin, his niece, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of the report and had the following questions which have been addressed in our report, the clinical review and in separate correspondence:

    - Why was she unable to contact Mr Preston while he was at Thameside and Belmarsh?
    - Why was she unable to send him money or clothing?
    - What support was in place for Mr Preston in prison?
    - What support was in place for his health conditions?
    - What plans were in place to support Mr Preston with obtaining morphine on release for his spinal injury?
    - Was Mr Preston on any other medication, and if so, what?
    - Was any contact made by the prison with the community GP to ensure Mr Preston had his medication?
    - When was Mr Preston admitted to hospital and why?
    - Why were his family not informed of his hospital admissions?
    - Why was Mr Preston in a shared cell? Was it due to concerns for his safety?
    - She said she had asked for Mr Preston's medical records, belongings and the money in his account but the prison had disregarded her request.

12. Mr Preston's family received a copy of the draft report. They pointed out a factual inaccuracy. This report has been amended accordingly.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Belmarsh

14. HMP Belmarsh holds convicted and remanded male prisoners. It is part of the long term and high secure estate and can hold prisoners requiring the highest levels of security. Healthcare services at Belmarsh are provided by Practice Plus Group.

Probation Service

15. 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.

Deaths following release from prison

16. Between September 2021 and the end of February 2026, the PPO started investigations into just over 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from Belmarsh

17. Mr Preston was the second man to die within 14 days of release from Belmarsh since June 2022 until April 2026, and the first to die from natural causes. We identified no similarities between our investigation findings about the previous death and those about Mr Preston's death.

Key Events

Background

18. On 18 December 2024, Mr Peter Preston was remanded to HMP Thameside, charged with making threats with an offensive weapon. He had a significant medical history, including chronic obstructive pulmonary disease (COPD), asthma, type 2 diabetes, hypertension and he had had two heart attacks.

HMP Thameside

19. That day, Dr A, a GP working at Thameside, completed Mr Preston's initial health screen in Reception. It was noted that Mr Preston had chronic obstructive pulmonary disease (COPD), he was prescribed pain medication for a previously broken neck and had a history of drug and alcohol misuse. Dr A referred Mr Preston to the substance misuse team. The psychosocial substance misuse team saw him regularly while at Thameside.

20. On 2 January 2025, staff radioed a medical emergency as Mr Preston had chest and abdominal pain and was unable to move. He was admitted to hospital, where he had a chest X-ray and was diagnosed with pneumonia.

21. On 10 January, Mr Preston was discharged from hospital with antibiotics.

22. On 21 January, Mr Preston was taken to hospital as he felt unwell, he was short of breath and he had pins and needles. He was diagnosed with a chest infection and discharged to Thameside with antibiotics the same day.

23. On 22 January, Dr A saw Mr Preston. He recorded in the medical records that as Mr Preston had been diagnosed with a chest infection, the standard follow-up for this was for the hospital to arrange a chest X-ray in six weeks' time to check that the infection had resolved.

24. On 31 January, staff called a medical emergency as Mr Preston was vomiting and had a fever. He was admitted to hospital with breathing difficulties. While in hospital, he had a blood test, chest X-ray and was treated for sepsis.

25. On 3 February, Mr Preston was discharged from hospital.

26. On 22 February, Mr Preston was taken to hospital as he had nausea, dizziness and abdominal pain. He returned to Thameside the following day.

27. On 12 March, Dr A saw Mr Preston who reported that he was well and had no complaints. Dr A chased up Mr Preston's planned chest X-ray with the hospital as it had been more than six weeks since his chest infection started and it had still not been done. Medical records do not indicate when this X-ray took place but a chest X-ray report from the hospital was entered into the system in June.

28. On 25 April, Mr Preston had a blood test and a faecal immunochemical test (which can detect blood in the stool). Both results came back as normal, with no further action recommended.

HMP Belmarsh

29. On 14 May, Mr Preston was transferred from Thameside to HMP Belmarsh. It was recorded that Mr Preston had no outstanding hospital appointments. Nurse A completed Mr Preston's initial health screen in Reception. Mr Preston reported a number of health conditions, including hypertension, COPD, asthma and type 2 diabetes.

30. On 16 May, Mr Preston had an electrocardiogram (ECG, which measures heart activity). The results came back as normal.

31. On 21 May, Ms A, a resettlement officer, saw Mr Preston, and she completed an accommodation referral under the Commissioned Rehabilitative Service (CRS, a framework designed by the Ministry of Justice and HMPPS to provide rehabilitative support for people on probation to break the cycle of reoffending) to St Mungo's (a charity supporting people experiencing homelessness).

32. On 17 June, Nurse B reviewed Mr Preston's records as he had a court appearance the following day. The nurse recorded that Mr Preston had no outstanding hospital or GP appointments and had been prescribed medication. He was deemed medically fit for his court appearance.

Release from HMP Belmarsh

33. On 17 June, Nurse C saw Mr Preston before he left Belmarsh for court. Ms B the Head of Healthcare at Belmarsh, told us that Mr Preston was given one dose of his medications to take before attending court. She told us that an Electronic Prescription Service (EPS) has been introduced which meant that Mr Preston could collect his prescribed medication from any pharmacy if he was released. She said that he should have been aware of this from information in the Houseblocks and on prison TV and Nurse C should have reminded him before he left for court.

34. Mr Preston received a 12-month prison sentence for threatening a person with a bladed article. He was released immediately from court as he had already served time on remand. Ms C, the Head of Offender Management Services, told us that as Mr Preston was released from court, he had not been allocated a community offender manager (COM).

35. At 15.55pm, the Offender Management Unit (OMU) at Belmarsh emailed Lambeth probation office to inform them of Mr Preston's release.

36. On 18 June, Dr B, a GP operating at Belmarsh, was informed that Mr Preston had been released and he therefore prescribed his takeout medication through the EPS.

37. That day, Mr Preston attended Lambeth probation office with his licence, and he told them that he had been released from court late the previous day. Ms D, the duty officer, saw Mr Preston who told her that he was in the process of getting his medication from the GP and that he was staying at his mother's address. His next appointment was booked for 25 June.

38. On 23 June, Ms E was allocated as Mr Preston's COM. Ms F, the Head of Service at Lambeth probation office, told us that the Probation Service had a five working day timescale to allocate a COM.

39. On 25 June, Mr Preston attended his probation appointment. He said that he was in pain as his medication had not been sorted out since his release. Ms F told us that Ms E would have advised Mr Preston to contact his GP directly about this. Ms E told Mr Preston that she was concerned about him living with his mother as she was the victim of his offence. She said that the Probation Service had not approved this address and he needed to find temporary accommodation while she completed housing referrals for him. Ms E completed a CRS referral for Mr Preston for housing support and a housing referral to Lambeth Council under the legal duty to refer those at risk of homelessness.

40. On 27 June, Lambeth Council responded to Ms E's referral. They said that they had staff shortages and a high volume of referrals so were unable to confirm how soon the appointment would take place. They said that they had highlighted the urgency of the case.

Circumstances of Mr Preston's death

41. On 30 June, Mr Preston's mother called Ms E and told her she had found Mr Preston unresponsive in bed over the weekend. She said she believed that he had taken drugs on Friday night. His date of death was confirmed as 29 June.

Post-mortem report

42. The post-mortem report concluded that Mr Preston died from dilated cardiomyopathy. It also found that he had bronchopneumonia which did not cause but contributed to his death.

43. The post-mortem toxicology report found that Mr Preston had morphine and pregabalin (a medication Mr Preston was prescribed) in his system. It also found evidence of previous use of cannabis.

Inquest

44. The Coroner informed us that there was no inquest held for this case. They concluded that Mr Preston died of natural causes and closed the case.

Findings

Clinical care

45. The clinical reviewer found that the care Mr Preston received in the lead up to his release was of a good standard and was more than equivalent to that which he could have expected to receive in the wider community. He noted that Mr Preston had several long-term conditions, including COPD, asthma, type 2 diabetes and hypertension and two heart attacks, which significantly affected his heart and lung function. He found that doctors at Belmarsh and Thameside frequently and appropriately reviewed Mr Preston and appropriately prescribed medications for his acute and chronic healthcare needs.

46. However, he concluded that the release planning for Mr Preston at Belmarsh was of a less than satisfactory standard as appropriate actions were not taken to ensure continuity of care and to support Mr Preston leaving prison and resettling in the community. The Head of Healthcare told us that measures had already been taken to improve the process of supporting prisoners who are unexpectedly released from court. The clinical reviewer recognised that more could be done to strengthen this process further.

Release and Transfer Service

47. Mr Preston might have benefitted from a referral to NHS Reconnect (a care after custody service that seeks to improve the continuity of care for people leaving prison with an identified health need). However, Ms G, the Lead Commissioner for the Secure and Detained Estate in London, told us that there is currently no Reconnect service in London. She told us that instead, there is a Release and Transfer Service which incorporates Reconnect principles by ensuring people have the necessary links within the community.

48. In line with Practice Plus Group's Safe Release Guidance, when somebody is released from court, the Release and Transfer Lead should contact the patient/probation officer/GP by phone on at least three occasions and send the patient summary to the community GP. This was not done for Mr Preston when healthcare staff were told of his release on 18 June.

49. The Head of Healthcare told us that when Mr Preston was released, the service was not fully in place as the Release and Transfer Lead started on 9 June 2025 and was still going through the induction. She said that the Release and Transfer Service is now fully implemented and the Release and Transfer Lead takes the appropriate steps to ensure continuity of care for all immediate releases from court.

Prescriptions in the community

50. There is no record that Mr Preston was told about the Electronic Prescription Service (EPS) in Reception before his court appearance. The Head of Healthcare told us that that she is working with the healthcare team to understand the importance of good record keeping. She also said that there is information available in the residential houseblocks and on prison TV about the EPS. She told us that she is also working with the local courts to arrange for an information booklet to be

given to prisoners released from court to explain the EPS and how to collect their prescription.

51. While we acknowledge this work, Mr Preston told the Probation Service on 25 June that his medication had not been prescribed since his release, and this indicates that he was not aware of or did not understand the EPS. A conversation with him at Reception would have ensured that he fully understood how to access his medication on release. In light of this, we make the following recommendation:

    The Head of Healthcare should complete an audit within six months of the date of this initial report to ensure that advice about the Electronic Prescription Service is given to those attending court and is recorded in their medical records.

Head of London Probation Delivery Unit to note

52. Accommodation referrals were not completed until Mr Preston's second probation appointment on 25 June. Ms F told us that Lambeth probation office is currently operating as a red site (which means there are fewer than 60% of staff working) and it was therefore not realistic to expect the duty officer to complete accommodation referrals. She said although it was not ideal for Mr Preston to live with his mother, he had somewhere to live so a housing referral was not prioritised during his induction. While we understand the resourcing pressures faced and do not make a recommendation, we bring this issue to the attention of the Head of London Probation Delivery Unit.

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

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