Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Cordingley, a prisoner at HMP Littlehey, on 1 August 2025

A report by the Prisons and Probation Ombudsman

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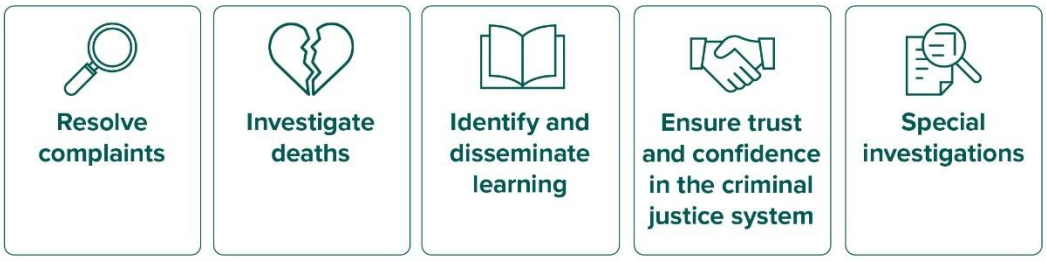
OUR VISION

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

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 23 January 2015, Mr Peter Cordingley was sentenced to 12 years imprisonment for sexual offences.

4. Mr Cordingley died of lung cancer on 1 August 2025, while a prisoner at HMP Littlehey. He was 79 years old. We offer our condolences to Mr Cordingley's family and friends.

5. The Ombudsman's office wrote to Mr Cordingley's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

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

7. The clinical reviewer concluded that the clinical care Mr Cordingley received at Littlehey was of a reasonable standard and equivalent to what he could have expected to receive in the community. She found that Mr Cordingley's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made one recommendation not related to Mr Cordingley's death that the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Cordingley's care. We did not find any non-clinical issues of sufficient concern to require a recommendation.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Northamptonshire Healthcare NHS Foundation Trust pointed out some factual inaccuracies and this report has been amended accordingly.

10. At the inquest held on 20 October 2025, the coroner concluded that Mr Cordingley died of natural causes.

Adrian Usher **December 2025**
Prisons and Probation Ombudsman

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