Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Turner, a prisoner at HMP Swaleside, on 6 February 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. In February 2020, Mr Peter Turner was sentenced to 21 years imprisonment for sexual offences. He died of a ruptured abdominal aortic aneurysm (AAA) on 6 February 2025 at HMP Swaleside. He was 85 years old. We offer our condolences to Mr Turner's family and friends.

4. The Ombudsman's office wrote to Mr Turner's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He was aware that Mr Turner had been diagnosed with an AAA and asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Turner's clinical care at HMP Swaleside.

6. The clinical reviewer concluded that the clinical care Mr Turner received at Swaleside was of a good standard and equivalent to that which he could have expected to receive in the community. She made two recommendations not related to Mr Turner's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Turner'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 the prison's healthcare provider, Oxleas NHS Foundation Trust. They found no factual inaccuracies.

10. We sent a copy of our initial report to Mr Turner's brother. He pointed out a factual inaccuracy in the clinical review. This has been corrected and reattached as an annex.

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

Inquest

At the inquest, held on 24 October 2025, the Coroner concluded that Mr Turner died from natural causes.

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