

**Prisons &  
Probation**

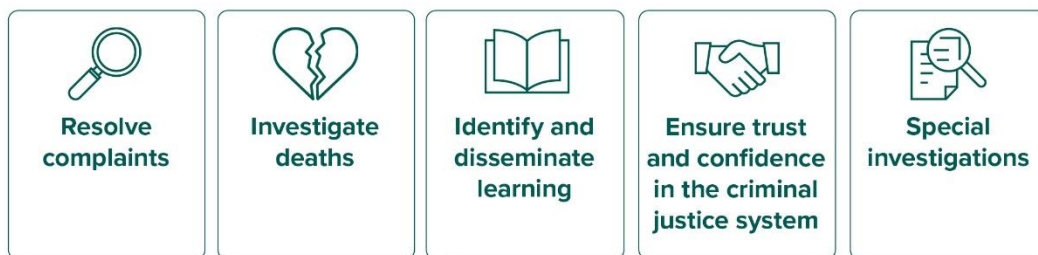
**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Terrence Rox,  
a prisoner at HMP Peterborough,  
on 20 October 2025**

## 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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concern

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 July 2017, Mr Terrence Rox was sentenced to 20 years imprisonment for attempting to cause grievous bodily harm with intent. He died in hospital of pneumonia on 20 October 2025, while a prisoner at HMP Peterborough. He was 60 years old. We offer our condolences to Mr Rox's family and friends.
4. The Ombudsman's office wrote to Mr Rox'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.
5. NHS England commissioned an independent clinical reviewer to review Mr Rox's clinical care at HMP Peterborough.
6. The clinical reviewer concluded that the clinical care Mr Rox received at Peterborough was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation not related to Mr Rox's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Rox'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, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**April 2026**

### **Inquest**

At the inquest, held on 15 May 2026, the Coroner concluded that Mr Rox died from natural causes.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100