

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Thompson, a prisoner at HMP/YOI Doncaster, on 9 January 2025

A report by the Prisons and Probation Ombudsman

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

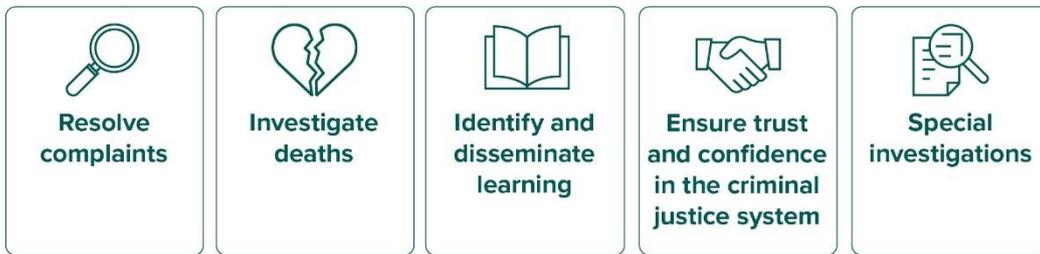
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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. In December 2024, Mr Andrew Thompson was remanded to prison for assaulting a police officer. He was not sentenced prior to his death. Mr Thompson died of a hemopericardium (the presence of blood in the pericardial sac around the heart) on 9 January 2025, at HMP Doncaster. He was 41 years old. We offer our condolences to Mr Thompson's family and friends.
4. The Ombudsman's office wrote to Mr Thompson's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer to review Mr Thompson's clinical care at HMP Doncaster. The clinical reviewer's report is attached as Annex 1.
6. The PPO investigator and the clinical reviewer jointly interviewed six members of staff by video conference on 12 March, 15 and 16 May 2025. The transcripts of the interviews are attached as Annex 2.
7. The clinical reviewer concluded that the clinical care Mr Thompson received at Doncaster was equivalent to what he could have expected to receive in the community. She found that the mental health team reviewed Mr Thompson regularly. He was discussed at the Multi-Professional Complex Case Conference meeting and a care plan was agreed. The clinical reviewer also noted that the records showed evidence of good working relationships between healthcare, mental health and custodial teams. The clinical reviewer did not make any recommendations related to Mr Thompson's death.
8. Ms Wallis investigated the non-clinical issues relating to Mr Thompson's care.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. Mr Thompson's family received a copy of the initial report. They did not make any comments.

Adrian Usher
Prison and Probation Ombudsman

September 2025

Inquest

At the inquest held on 9 December 2025, the coroner concluded Mr Thompson died of natural causes.

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