Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Cheffings, a prisoner at HMP Winchester, on 4 February 2026

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 December 2025, Mr Geoffrey Cheffings was sentenced to 64 months imprisonment for sex offences. He died in hospital of sepsis on 4 February 2026, while a prisoner at HMP Winchester. He was 78 years old. We offer our condolences to Mr Cheffings' family and friends.

4. The Ombudsman's office wrote to Mr Cheffings' 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 Cheffings' clinical care at HMP Winchester.

6. The clinical reviewer concluded that the clinical care Mr Cheffings received at Winchester was of a good standard and equivalent to that which he could have expected to receive in the community. She made one recommendation, about ensuring that the good practice identified in Mr Cheffings' clinical review report was shared with the wider healthcare team.

7. The PPO investigator investigated the non-clinical issues relating to Mr Cheffings' 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, Practice Plus Group. They found no factual inaccuracies.

10. We sent a copy of our initial report to Mr Cheffings' next of kin. They did not notify us of any factual inaccuracies.

11. At the inquest, held on 17 June 2026, the Coroner concluded that Mr Cheffings died from natural causes.

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

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