

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Donald Glenn, a prisoner at HMP Wymott, on 7 July 2025

A report by the Prisons and Probation Ombudsman

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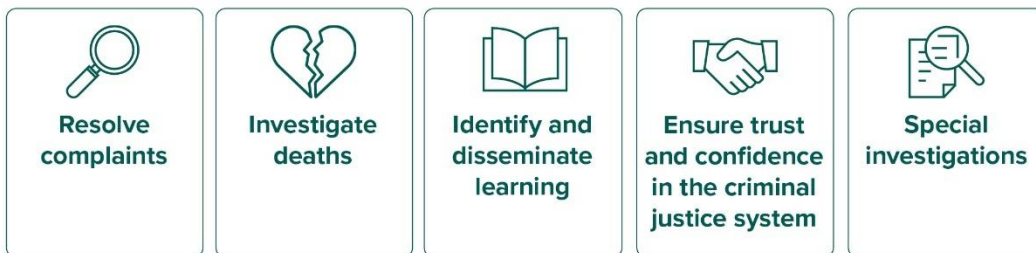
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OUR VISION

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



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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 2022, Mr Donald Glenn was sentenced to 17 years imprisonment for sexual offences. He died of heart disease on 7 July 2025 at HMP Wymott. He was 78 years old. We offer our condolences to Mr Glenn's family and friends.
4. The Ombudsman's office wrote to Mr Glenn's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They raised several queries about Mr Glenn's healthcare, which have been addressed in the clinical reviewer's report.
5. NHS England commissioned an independent clinical reviewer to review Mr Glenn's clinical care at Wymott.
6. The clinical reviewer concluded that the clinical care Mr Glenn received at Wymott was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations not related to Mr Glenn's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Glenn'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, Practice Plus Group. They pointed out two minor factual inaccuracies in the clinical reviewer's report. These have been corrected and an amended version has been attached as an annex.
10. We sent a copy of our initial report to Mr Glenn's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

February 2026

Inquest

At the inquest, held on 12 March 2026, the Coroner concluded that Mr Glenn died from natural causes.

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