

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Peter Power,
a prisoner at HMP Leyhill,
on 15 July 2023**

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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. On 13 January 2021, Mr Peter Power was sentenced to 6 years and 4 months in prison for sex offences. On 12 April 2023, he was transferred to HMP Leyhill.
4. Mr Peter Power died of traumatic cerebral injuries (a brain injury), on 15 July 2023 at Stanshawes Care Home. He also had vascular dementia (a condition caused by lack of blood that carries oxygen to the brain), ischaemic heart disease (a condition caused by narrowed heart arteries) and cardiomegaly (an enlarged heart) which contributed to but did not cause his death. He was 83 years old. We offer our condolences to Mr Power's family and friends.
5. The PPO family liaison officer wrote to Mr Power's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
6. NHS England commissioned an independent clinical reviewer to review Mr Power's clinical care at HMP Leyhill.
7. The clinical reviewer concluded that the clinical care Mr Power received at Leyhill was of a reasonable standard and was equivalent to that which he would have received in the wider community. He found evidence of good communication between prison staff, healthcare staff at the prison and hospital staff which took Mr Power's individual needs into account. He made no recommendations.
8. The PPO investigator investigated the non-clinical issues relating to Mr Power's care. We did not find any non-clinical issues of concern. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman

February 2024

Inquest

9. The inquest into Mr Power's death finished on 5 May 2026. It concluded that Mr Power died of natural causes.

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