

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Shaun Leggett, a prisoner at HMP Exeter, on 9 August 2024**

**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



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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 19 May 2023, Mr Shaun Leggett was sentenced to 20 years in prison for sex offences. He died from multiple myeloma (a blood cancer that affects the plasma cells) on 9 August 2024, while a prisoner at HMP Exeter. He was 59 years old. We offer our condolences to Mr Leggett's family and friends.
4. The PPO family liaison officer wrote to Mr Leggett's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about the delay in Mr Leggett receiving cancer treatment. We have addressed this in paragraph 7 below.
5. NHS England commissioned an independent clinical reviewer to review Mr Leggett's clinical care at HMP Exeter. The clinical review is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Leggett received at Exeter was of a good standard and was at least equivalent to that which he could have expected to receive in the community. She found that there was good communication between healthcare staff at Exeter and the hospital. Although it did not affect Mr Leggett's clinical care before his death, she found that some aspects of the end-of-life care planning were not discussed with Mr Leggett until three months before he died. The clinical reviewer made a recommendation about this which was not related to Mr Leggett's death but which the Head of Healthcare will want to address.
7. In response to the family's question, the clinical reviewer found that Mr Leggett initially declined cancer treatment but there was no delay in him receiving it once he agreed to it.
8. The PPO investigator investigated the non-clinical issues relating to Mr Leggett's care.
9. We did not identify any non-clinical learning and 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 Leggett's next of kin received a copy of the draft report. They did not make any comments.
12. At an inquest held on 7 May 2026, the Coroner concluded that Mr Leggett died of natural causes.

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

**October 2025**

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