

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Cox, a prisoner at HMP Norwich, on 7 January 2025

A report by the Prisons and Probation Ombudsman

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

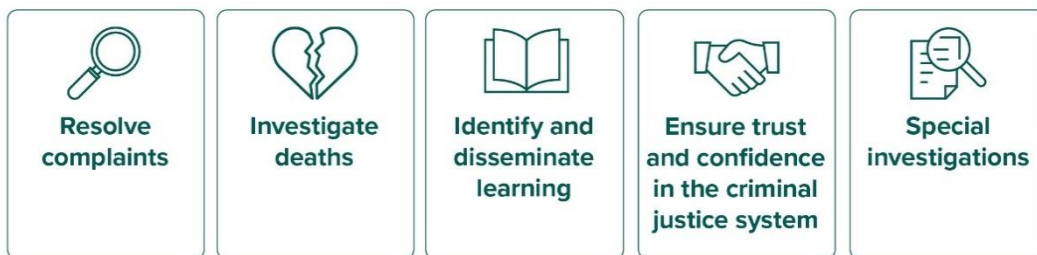
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 March 2024, Mr Kenneth Cox was sentenced to six months in prison for a sexual offence. In September, he was sentenced to a further 27 months in prison for another sexual offence. He died of hemopericardium (a condition that causes a build-up of blood around the heart, which compresses the heart) caused by an aortic dissection (a tear in the wall of the main artery), on 7 January 2025, while a prisoner at HMP Norwich. Hypertension (high blood pressure) also contributed to his death. He was 66 years old. We offer our condolences to Mr Cox's family and friends.
4. The Ombudsman's office wrote to Mr Cox's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer, to review Mr Cox's clinical care at Norwich. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Cox received at Norwich was variable and partially equivalent to that which he could have expected to receive in the community. The clinical reviewer found evidence of good practice in how healthcare staff communicated with Mr Cox, prompting him to manage his health needs and repeatedly encouraging him to take medication for his high blood pressure. The clinical reviewer was satisfied that appropriate care plans were in place to manage his hypertension. However, she also identified areas for improvement. She found no evidence of a care plan or any action taken following Mr Cox's abnormal electrocardiogram (ECG – used to measure the electrical activity of the heart) in December 2024. We make the following recommendations:
 - **The Head of Healthcare should ensure that a clear management plan is documented when abnormal test results are received.**
 - **The Head of Healthcare should ensure that prisoners with complex health needs are discussed at multi-disciplinary meetings.**
7. The clinical reviewer also made two other recommendations not related to Mr Cox's death that the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Cox's care.
9. We did not find any non-clinical issues of concern.

10. We shared the initial report with HM Prison and Probation Service (HMPPS) and the prison's healthcare provider, HCRG Care Group. They did not find any factual inaccuracies and their action plan is an additional annex to this report.

Adrian Usher
Prisons and Probation Ombudsman

May 2026

Inquest

11. At the inquest, held on 29 January 2026, the Coroner concluded that Mr Cox died from natural causes.



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

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

T | 020 7633 4100