

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Hyde, a prisoner at HMP Stocken, on 5 January 2025

A report by the Prisons and Probation Ombudsman

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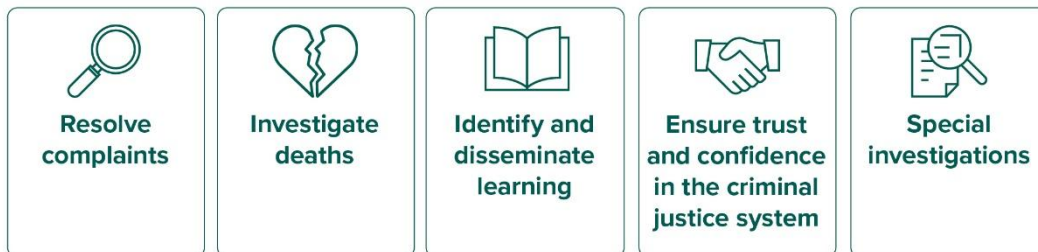
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OUR VISION

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. On 13 December 1988, Mr Carl Hyde was sentenced to life for murder. He was released from prison on 8 October 2021 and recalled to prison on 8 August 2024. He died from multiple organ failure on 5 January 2025, while a prisoner at HMP Stocken. This was caused by acute gastroenteritis, influenza A and sepsis. He was 68 years old. We offer our condolences to Mr Hyde's family and friends.
4. The Ombudsman's office wrote to Mr Hyde's 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 Hyde's clinical care at HMP Stocken. The clinical review was attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Hyde received at Stocken was partially equivalent to that which he could have expected to receive in the community. She found that while an ambulance was called for Mr Hyde, healthcare staff did not call a code blue. She also found evidence that healthcare staff did not document if they stayed with Mr Hyde while waiting for the ambulance. The clinical reviewer made recommendations which were not related to Mr Hyde's death but which the Head of Healthcare will want to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Hyde's care.
8. We did not identify any non-clinical learning and we make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. At an inquest held on 2 October 2026, the Coroner concluded that Mr Hyde died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

December 2025



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