Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Cheeseman, a prisoner at HMP Littlehey, on 11 July 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

Summary

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 April 2022, Mr Dennis Cheeseman was sentenced to 12 years in prison for sexual offences. He died of pancreatic cancer on 11 July 2024 while a prisoner at HMP Littlehey. He was 88 years old. We offer our condolences to Mr Cheeseman's family and friends.

4. The Ombudsman office was unable to contact Mr Cheeseman's next of kin due to her personal circumstances.

5. NHS England commissioned an independent clinical reviewer to review Mr Cheeseman's clinical care at HMP Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Cheeseman received at HMP Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community. He found that Mr Cheeseman's condition was managed as well as possible within a secure setting and additional care was provided as his condition deteriorated. The clinical reviewer did not make any recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Cheeseman's care.

8. We did not identify any non-clinical learning. 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 29 January 2025, the Coroner concluded that Mr Cheeseman died of natural causes.

Adrian Usher **November 2024**
Prisons and Probation Ombudsman

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