



Independent investigation into the death of Mr Frederick Stallwood, a prisoner at HMP Littlehey, on 10 December 2023

A report by the Prisons and Probation Ombudsman

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. In November 2017, Mr Frederick Stallwood was sentenced to 20 years imprisonment for sexual offences. He died from disseminated prostate cancer on 10 December 2023 at HMP Littlehey. He was 89 years old. We offer our condolences to Mr Stallwood's family and friends.
4. We were advised by the prison that Mr Stallwood had no identified next of kin.
5. NHS England commissioned an independent clinical reviewer to review Mr Stallwood's clinical care at HMP Littlehey.
6. The clinical reviewer concluded that the clinical care Mr Stallwood 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 the healthcare team managed Mr Stallwood's care appropriately and called on external specialist teams for support when required, including using the skills of the local Tissue Viability Team to manage his wound dressings. The clinical reviewer did not make any recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Stallwood's care. We did not find any non-clinical issues of concern and we make no recommendations.
8. We identified good practice in the detailed time to talk sessions provided to staff and prisoners following Mr Stallwood's death.
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 14 October 2024, the Coroner concluded that Mr Stallwood died of natural causes.

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