

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Howard-Tricker, a prisoner at HMP Littlehey, on 18 March 2025

A report by the Prisons and Probation Ombudsman

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

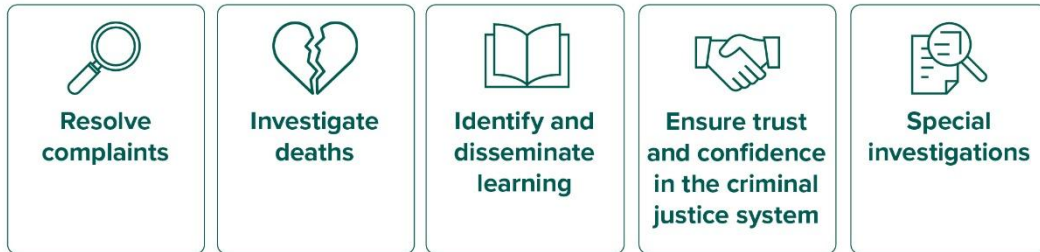
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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



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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 August 2019, Mr Russell Howard-Tricker was convicted of sexual offences and sentenced to 14 years in prison.
4. Mr Howard-Tricker died on 18 March 2025, at HMP Littlehey. A consultant in palliative medicine identified three joint causes of death. Firstly, pancytopenia secondary to carbimazole (abnormally low amounts of all three types of blood cells caused by a drug used to treat hyperthyroidism.) Secondly, heart failure with reduced ejection fraction due to ischaemic heart disease. Thirdly, pulmonary fibrosis (lung disease). Hyperthyroidism (an overactive thyroid) was a secondary factor contributing to but not causing the death. Mr Howard-Tricker was 83 years old. We offer our condolences to his family and friends.
5. Mr Howard-Tricker had no recorded next of kin, and none was identified following his death.
6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS raised one concern about the Governor and Head of Healthcare to Note and we have amended this report accordingly. Spectrum community healthcare provider also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended recommendations one and two in their report.
7. NHS England commissioned an independent clinical reviewer, to review Mr Howard-Tricker's clinical care at Littlehey.
8. The clinical reviewer concluded that the clinical care Mr Howard-Tricker received at Littlehey was of a reasonable standard and equivalent to that which he could have expected to receive in the community. He made two recommendations not related to Mr Howard-Tricker's death that the Head of Healthcare will wish to address.
9. The PPO investigator investigated the non-clinical issues relating to Mr Howard-Tricker's care.

Governor and Head of Healthcare to Note

10. On the night that Mr Howard-Tricker died, the night patrol officer found him lying on the floor of his cell semi-naked covered in urine and faeces. She identified that he was breathing and moving his arms and legs and concluded that there was no immediate danger to life. In line with local and national policy, she did not therefore immediately enter the cell to help Mr Howard-Tricker. Instead, she requested and waited for additional staff to arrive.

11. Local and national policy on unlocking cells at night in an emergency instructs staff to make a dynamic risk assessment of whether it is safe to do so. If they conclude that it is not safe to enter the cell alone, they must ask for additional staff to attend. Mr Howard-Tricker was 83 years old, in poor health and with very poor mobility and the night team had already been into his cell twice to support him. On the final occasion, the lone member of staff requested support from colleagues before entering the cell.
12. We are concerned that the policy is not flexible enough to support staff faced with situations like this. However, the Governor set out the complex decision making process faced by staff at night, and that he fully supported their actions on the night Mr Howard-Tricker died and we are satisfied that he has given significant thought to whether there is any wider learning from Mr Howard-Tricker's death.

Inquest

13. The inquest into Mr Howard-Tricker's death concluded on the 8 July 2025. The coroner confirmed that Mr Howard-Tricker died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

January 2026

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