Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Russell Tillson, a prisoner at HMP Littlehey, on 25 November 2024

A report by the Prisons and Probation Ombudsman

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

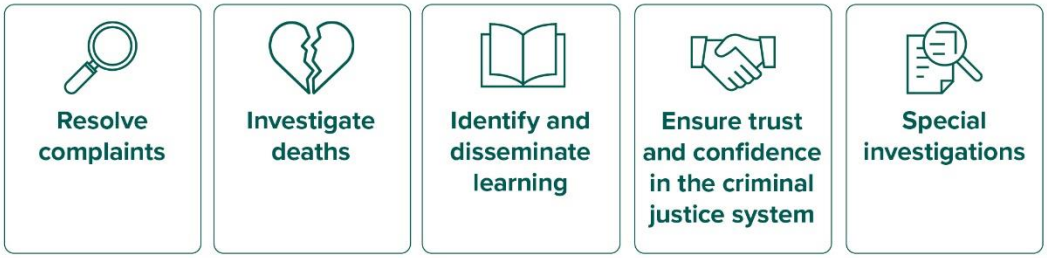
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 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

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 September 2023, Mr Russell Tillson was sentenced to 68 months for indecent assault. He died of acute left ventricular failure on 25 November 2024 at HMP Littlehey. He was 74 years old. We offer our condolences to Mr Tillson's family and friends.

4. The Ombudsman's office wrote to Mr Tillson'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 Tillson's clinical care at Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Tillson received at Littlehey was of a reasonable standard and at least equivalent to what he could have expected to receive in the community. He found that Mr Tillson's medical records showed that he consistently refused to go to hospital for further assessment and management of his high potassium levels, but he was regularly reviewed by nurses, GPs and a palliative medicine consultant who provided appropriate care. The clinical reviewer also found that Mr Tillson had care plans in place for cardiovascular diseases, CKD, and diabetes, but he did not have a plan in place for palliative care.

7. The clinical reviewer made no recommendations but has raised other issues not related to Mr Tillson's death that the Head of Healthcare will wish to consider.

8. The PPO investigator investigated the non-clinical issues relating to Mr Tillson's care. We did not find any non-clinical issues of concern.

9. We make no recommendations.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher **April 2025**
Prisons and Probation Ombudsman

At the inquest held on 23 May 2025, the coroner concluded Mr Tillson died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T l 020 7633 4100