Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Vickery, a prisoner at HMP Dartmoor, on 27 October 2023

A report by the Prisons and Probation Ombudsman

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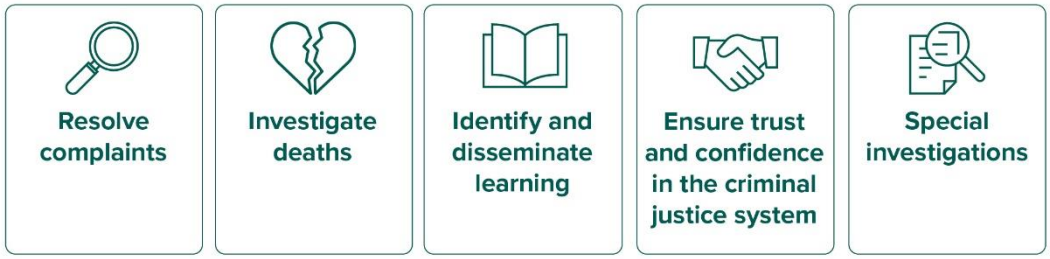
OUR VISION

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

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 18 March 2021, Mr Frederick Vickery was sentenced to eight years in prison for indecent assault and attempted rape. He died from a right-sided malignant middle cerebral artery infarction (a stroke) on 27 October 2023, while a prisoner at HMP Dartmoor. He was 64 years old. We offer our condolences to Mr Vickery's family and friends.

4. The PPO family liaison officer wrote to Mr Vickery'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 Vickery's clinical care at HMP Dartmoor.

6. The clinical reviewer concluded that the clinical care Mr Vickery received at HMP Dartmoor was of a good standard and at least equivalent to that which he could have expected to receive in the wider community.

7. The clinical reviewer made one recommendation which is not related to Mr Vickery's death but which the Head of Healthcare will want to address.

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

9. We did not find any non-clinical issues of concern. We make no recommendations.

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

11. Mr Vickery's family received a copy of the draft report. They did not make any comments.

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

12. At an inquest held on 22 July 2025, the Coroner concluded that Mr Vickery died of natural causes.

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