Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Sean Willingale, a prisoner at HMP Oakwood, on 14 November 2024

## A report by the Prisons and Probation Ombudsman

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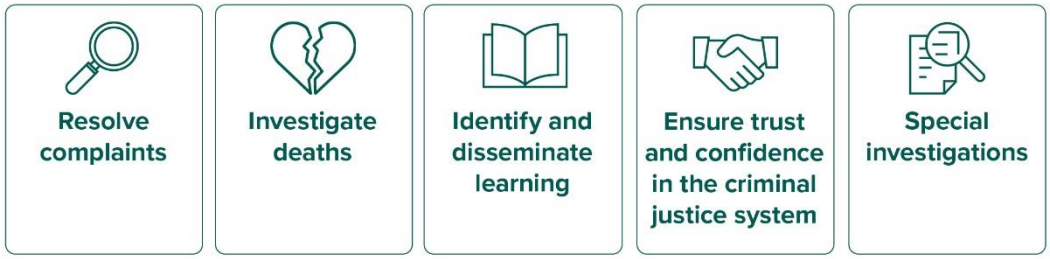
## OUR VISION

**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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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 14 September 2022, Mr Sean Willingale was convicted of breach of a restraining order and remanded to HMP Birmingham. On 12 October, Mr Willingale was sentenced to 28 months in prison. Over the following year and a half, Mr Willingale was twice released from prison and subsequently recalled for breach of licence conditions. His final recall was on 15 April 2024, and he was transferred to HMP Oakwood on 3 May.

4. On 14 November 2024, Mr Willingale died in hospital while a prisoner at Oakwood. We have not been provided with a cause of death, but Mr Willingale had been diagnosed with squamous cell carcinoma of the tongue (tongue cancer). He was 58 years old. We offer our condolences to Mr Willingale's family and friends.

5. The Ombudsman's office wrote to Mr Willingale's nominated next of kin, his probation officer, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond. We were contacted afterwards by family members who asked for a copy of the initial report. One raised concerns about Mr Willingale's healthcare at HMP Oakwood which have been addressed in separate correspondence.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. NHS England commissioned an independent clinical reviewer, to review Mr Willingale's clinical care at Oakwood.

8. The clinical reviewer highlighted that Mr Willingale was unwell for a considerable length of time. She noted that he was a complex man who posed significant challenges for the professionals who cared for him, but that there was evidence of compassionate, holistic and dynamic care from the healthcare team at Oakwood. The clinical reviewer concluded that the clinical care Mr Willingale received at Oakwood was of a good standard and equivalent to that which he could have expected to receive in the community.

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

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

11. The inquest into Mr Willingale's death concluded on the 30 October 2025. The coroner confirmed that Mr Willingale died of natural causes.

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

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