Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Warwick, a prisoner at HMP Frankland, on 25 December 2025

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. In December 2016, Mr Arthur Warwick was sentenced to 12 years imprisonment for sexual offences. He died from heart disease on 25 December 2025, at HMP Frankland. He was 67 years old. We offer our condolences to Mr Warwick's family and friends.

4. The Ombudsman's office wrote to Mr Warwick'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 Warwick's clinical care at HMP Frankland.

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

7. The PPO investigator and clinical reviewer interviewed three members of staff during February 2026.

8. The clinical reviewer concluded that the clinical care Mr Warwick received at Frankland was, in part, equivalent to that which he could have expected to receive in the community. She found that some aspects of Mr Warwick's care, unrelated to his death, were not of the required standard. She made five recommendations which the Head of Healthcare will wish to address.

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

10. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies.

11. We sent a copy of our initial report to Mr Warwick's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher **July 2026**
Prisons and Probation Ombudsman

Inquest

At the inquest, held on 5 November 2026, the Coroner concluded that Mr Warwick died from natural causes.

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