

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Shilton, a prisoner at HMP Stafford, on 15 June 2024

A report by the Prisons and Probation Ombudsman

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

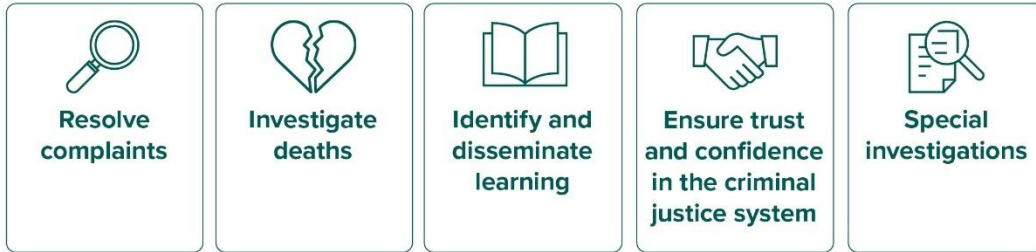
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

Summary

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 1 May 2024, Mr Michael Shilton was sentenced to six years in prison for sexual offences. He died in hospital of a stroke on 15 June 2024 while a prisoner at HMP Stafford. He was 73 years old. We offer our condolences to Mr Shilton's family and friends.
4. The Ombudsman's office contacted Mr Shilton's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
5. NHS England commissioned an independent clinical reviewer to review Mr Shilton's clinical care at Stafford.
6. The clinical reviewer concluded that the clinical care Mr Shilton received was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Shilton's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HMPPS. HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

October 2024

Inquest

At the inquest, held on 27 November 2025, the Coroner concluded that Mr Shilton died from 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 | 020 7633 4100