Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Albert Walkom, a prisoner at HMP Littlehey, on 5 April 2025

A report by the Prisons and Probation Ombudsman

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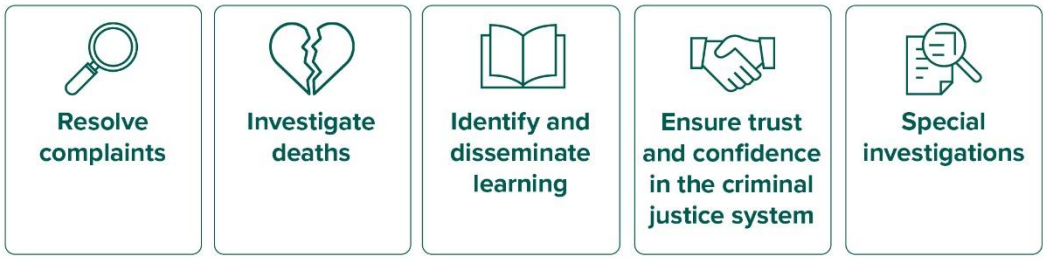
OUR VISION

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

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 August 2023, Mr Albert Walkom was sentenced to 10 years imprisonment for sexual offences. He was 86 years old when he died of frailty of old age on 5 April 2025 at HMP Littlehey. Type 2 diabetes, chronic urinary retention and recurrent urinary tract infections contributed to but did not cause Mr Walkom's death. We offer our condolences to Mr Walkom's family and friends.

4. The Ombudsman's office wrote to Mr Walkom'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.

5. NHS England commissioned an independent clinical reviewer to review Mr Walkom's clinical care at Littlehey.

6. The clinical reviewer concluded that the clinical care Mr Walkom received at Littlehey was equivalent to that which he could have expected to receive in the community. She found that Mr Walkom's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Walkom's care. We did not find any non-clinical issues of concern. We make no recommendations.

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

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

Inquest

The inquest hearing was held on 25 November 2025. The Coroner concluded that Mr Walkom died of natural causes.

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