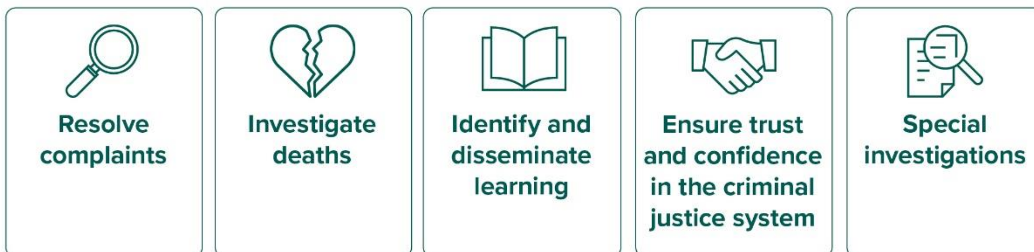
Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Spillane, a prisoner at HMP Whatton, on 3 June 2025

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 June 2007, Mr Trevor Spillane received a sentence of imprisonment for public protection for sex offences. The minimum term he had to serve in prison before consideration for release was four years and two months. He died of a sudden cardiac death caused by idiopathic left ventricular hypertrophy (thickening of the walls of the lower left heart chamber) on 3 February 2025, at HMP Whatton. He was 44 years old. We offer our condolences to Mr Spillane's family and friends.

4. The Ombudsman's office wrote to Mr Spillane's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer, to review Mr Spillane's clinical care at Whatton.

6. The clinical reviewer concluded that the clinical care Mr Spillane received at Whatton was not of a good standard and was not equivalent to that which he could have expected to receive in the community. She found that the initial health screenings were not comprehensive, with important information not noted, and there were incorrect entries in Mr Spillane's medical record. She noted that nurses inappropriately started and continued emergency resuscitation despite clear signs that rigor mortis had set in. She also found that the emergency response bag did not contain an oxygen mask, although this did not affect the outcome for Mr Spillane. The clinical reviewer made four recommendations not related to Mr Spillane's cause of death, but which the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Spillane's care. She and the clinical reviewer, interviewed two members of healthcare staff on 26 June 2025.

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

Governor to note

9. Mr Spillane was found face down on his bed at 8.12am and rigor mortis was present, indicating he had been dead for some time. The officer who completed the 7.00am roll check said in his statement that he thought he saw a small movement and Mr Spillane appeared to be asleep in bed, which is a sufficient response in line with the Management of Internal Security Procedure Policy Framework. Since Mr Spillane's death, the Governor has issued a notice to staff which provides further clarity regarding roll check expectations.

10. According to national policy, the officers who unlocked Mr Spillane's cell at 8.03am should have also checked his wellbeing. We do not make a recommendation as the notice to staff covers this issue. However, experience tells us that notices to staff are not always sufficient to drive behavioural change and the Governor will want to monitor staff actions at roll check and unlock. In Mr Spillane's case, the delay was minimal as a prisoner entered the cell and called for staff quickly after it was unlocked.

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

12. At an inquest held on 14 October 2025, the Coroner concluded that Mr Spillane died of natural causes.

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

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