

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Preece, a prisoner at HMP Frankland, on 10 July 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 May 2016, Mr Gordon Preece was sentenced to 25 years in prison for sexual offences. He died in hospital on 10 July 2025, while a prisoner at HMP Frankland. He was 80 years old. The Coroner has given the provisional cause of death as cardiomegaly (an enlarged heart). We offer our condolences to Mr Preece's family and friends.
4. The Ombudsman's office wrote to Mr Preece'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.
5. NHS England commissioned an independent clinical reviewer to review Mr Preece's clinical care at Frankland.
6. The clinical reviewer concluded that the clinical care Mr Preece received at Frankland was of a reasonable standard and was at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made two recommendations not related to Mr Preece's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Preece's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

February 2026

Inquest

At the inquest, held on 20 May 2026, the Coroner concluded that Mr Preece died from natural causes.

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