

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Graham Stridgeon, a prisoner at HMP Wymott, on 16 February 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 2018, Mr Graham Stridgeon was sentenced to five years imprisonment for sexual offences. In 2019, after appeal, the sentenced was changed to an extended sentence of five years and ten months imprisonment and three years on licence. Mr Stridgeon was briefly released in August 2024, but was recalled to prison the following month.
4. Mr Stridgeon died of pneumonia (infection to the lungs) on 16 February 2025, in hospital while a prisoner at HMP Wymott. Diabetes (disease that causes high blood sugar levels) contributed to but did not cause his death. He was 70 years old. We offer our condolences to those who knew Mr Stridgeon.
5. NHS England commissioned an independent clinical reviewer to review Mr Stridgeon's clinical care at HMP Wymott.
6. The clinical reviewer concluded that the clinical care Mr Stridgeon received at Wymott was partially equivalent to that which he could have expected to receive in the community. She noted that Mr Stridgeon had appropriate reviews and care for his long-term conditions. However, she found that healthcare staff missed signs of sepsis and that they should have transferred Mr Stridgeon to hospital in the evening of 11 February, rather than waiting until the next morning. We make the following related recommendations:

The Head of Healthcare should ensure that all healthcare staff undertake the deteriorating patient learning module and ensure annual updates are completed.

The Head of Healthcare should ensure that healthcare staff record prisoners' physical observations and NEWS2 scores in their clinical record.
7. The PPO investigator investigated the non-clinical issues relating to Mr Stridgeon's care. We make no recommendations although we note the apparent lack of interaction with Mr Stridgeon in the last months of his life as detailed below.

Governor to Note

8. There are no records of any meaningful interaction between Mr Stridgeon and prison staff, including keyworkers, in the last four months of his life. When asked by the investigator, the prison was unable to identify a member of staff who could tell us how Mr Stridgeon had seemed during this time.
9. The prison explained that, due to staff shortages, they had agreed with the Prison Group Director to deliver a restricted regime which prioritised unlocking prisoners

and delivering education and workshops. They also said they aim to deliver 89 keyworker sessions per week (out of 387 when fully staffed), which they have consistently surpassed during the last four months. Keywork is prioritised for prisoners who are transgender, young adults, new to the prison or are on an imprisonment for public protection sentence. Therefore, Mr Stridgeon did not qualify for these sessions. We bring the apparent lack of interaction with Mr Stridgeon to the Governor's attention as they work towards reinstating a full keyworker regime.

10. The initial report was shared with HM Prison and Probation Service (HMPPS) and Practice Plus Group. They pointed out one factual inaccuracy in the clinical reviewer's report, which has now been amended.

Adrian Usher
Prisons and Probation Ombudsman

July 2025

Inquest

The inquest into Mr Stridgeon's death was held on 25 March 2026. The Coroner concluded that Mr Stridgeon died of natural causes.

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