Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Amos, a prisoner at HMP Oakwood, on 22 April 2024

A report by the Prisons and Probation Ombudsman

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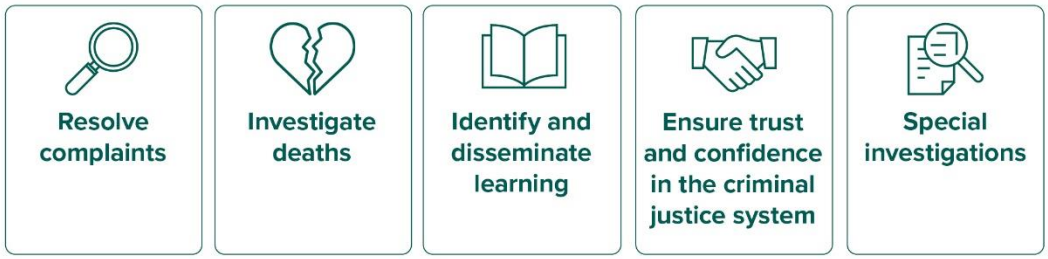
OUR VISION

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. On 7 April 2009, Mr Lee Amos was sentenced to life in prison with a minimum term of 35 years (later varied on appeal to 32 years) for murder and attempted murder.

4. Mr Amos died in hospital of cardiac arrest caused by ventricular fibrillation (rapid, erratic heartbeats that cause the heart to abruptly stop pumping blood to the body) due to cardiomegaly (enlarged heart) on 28 April 2024, while a prisoner at HMP Oakwood. He was 48 years old. We offer our condolences to Mr Amos' family and friends.

5. The Ombudsman's office wrote to Mr Amos' brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. NHS England commissioned an independent clinical reviewer to review Mr Amos' clinical care at HMP Oakwood.

8. Mr Amos' death was sudden and unexpected. Although he had Crohn's disease, he managed this well in prison and it was not related to his death. There was no indication of any other healthcare issues for Mr Amos and he had no recorded history of heart disease. Prison and healthcare staff did not report any concerns for him in the time before his death.

9. The clinical reviewer found that Mr Amos received a good standard of health care that was equivalent to that which he might expect to receive in the community. She made one recommendation around care planning for long-term conditions that the Head of Healthcare will wish to address.

10. The PPO investigator investigated the non-clinical issues relating to Mr Amos' care. We did not find any non-clinical issues of concern.

11. We make no recommendations.

Inquest

12. The inquest into Mr Amos' death concluded on the 20 August 2025. The coroner confirmed that Mr Amos died of natural causes.

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

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