Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Walters, a prisoner at HMP Littlehey, on 27 October 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 27 July 2023, Mr Brian Walters was convicted of rape and sexual offences and sentenced to eight years in prison.

4. Mr Walters died in hospital of acute myocardial infarction (heart attack) caused by coronary artery atherosclerosis (arteries become narrowed, making it difficult for blood to flow through them) on 27 October 2024, while a prisoner at HMP Littlehey. He was 68 years old. We offer our condolences to Mr Walters' family and friends.

5. The Ombudsman's office wrote to Mr Walters' 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 Walters' clinical care at HMP Littlehey.

8. The clinical reviewer concluded that the clinical care Mr Walters received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. She identified that healthcare staff demonstrated good practice by completing a multifactorial falls risk assessment completion as a preventative, rather than a reactive, measure. The clinical reviewer made one recommendation not related to Mr Walters' death that the Head of Healthcare will wish to address.

9. The PPO investigator investigated the non-clinical issues relating to Mr Walters' care.

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

Inquest

11. The inquest into Mr Walters' death concluded on the 15 July 2025. The coroner confirmed that Mr Walters died from natural causes.

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

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