

**Prisons &
Probation**

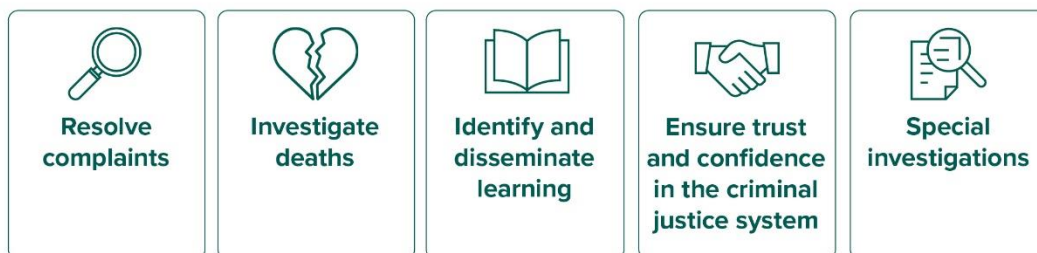
Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr John Whitehead,
a prisoner at HMP Littlehey,
on 31 October 2024**

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 March 2021, Mr John Whitehead was sentenced to 17 years in prison for sexual offences. He died in hospital of lung disease on 31 October 2024, while a prisoner at HMP Littlehey. He was 83 years old. We offer our condolences to Mr Whitehead's family and friends.
4. The prison was unable to contact Mr Whitehead's next of kin as they could not trace their current contact details. Therefore, the Ombudsman's office did not contact anyone about the investigation into his death.
5. NHS England commissioned an independent clinical reviewer to review Mr Whitehead's clinical care at Littlehey.
6. The clinical reviewer concluded that the clinical care Mr Whitehead received at Littlehey was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations not related to Mr Whitehead's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Whitehead'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, Northamptonshire Healthcare NHS Foundation Trust. They found no factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

March 2025

Inquest

At the inquest, held on 22 August 2025, the Coroner concluded that Mr Whitehead died from natural causes.

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