

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Houghton, a prisoner at HMP Whatton, on 14 February 2025

A report by the Prisons and Probation Ombudsman

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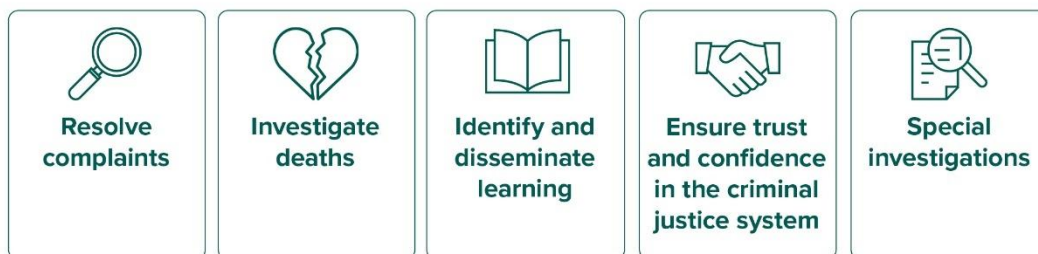
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OUR VISION

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. On 23 November 2023, Mr Edward Houghton was sentenced to three years in prison for sexual offences. He began his sentence in HMP Lincoln before being transferred to HMP Whatton on 5 August 2024.
4. Mr Houghton died of inoperable oesophageal cancer (a non-removable malignant tumour in the oesophagus) on 14 February 2025, at Hayward House Hospice. He was 82 years old. We offer our condolences to Mr Houghton's family and friends.
5. The Ombudsman's office contacted Mr Houghton's nephew, his nominated next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Houghton's nephew did not have any specific questions.
6. NHS England commissioned an independent clinical reviewer, to review the clinical care Mr Houghton received at Whatton. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Houghton received at Whatton was of a good standard and equivalent to that which he could expect to receive in the community. The clinical reviewer identified that Mr Houghton had complex physical health needs and commended the quality of care he received throughout his time in prison, including through multi agency review meetings as his health declined.
7. The PPO investigator investigated the non-clinical issues relating to Mr Houghton's care. We did not find any non-clinical issues of concern. We make no recommendations.
8. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.
9. We also shared the initial report with Mr Houghton's nephew. He did not make any comments.
10. The inquest into Mr Houghton's death concluded on 4 March 2025, recording a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

October 2025

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