Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Michael Murphy, a prisoner at HMP Littlehey, on 9 July 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

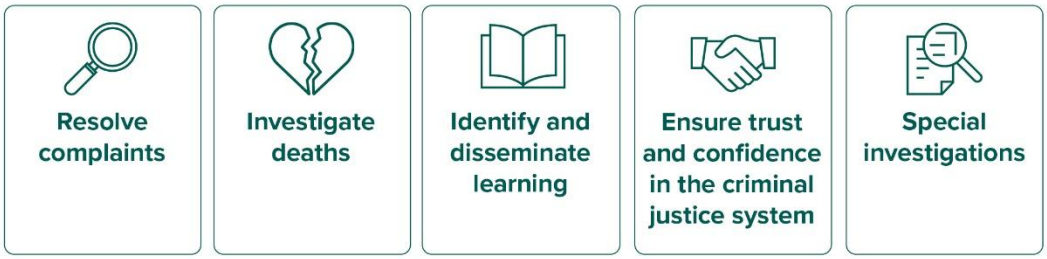
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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. In March 2023, Mr Michael Murphy was sentenced to seven years in prison for sex offences. He died of lung cancer on 9 July 2025, at HMP Littlehey. He was 69 years old. We offer our condolences to Mr Murphy's family and friends.

4. The Ombudsman's office wrote to Mr Murphy's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Murphy's clinical care at HMP Littlehey. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Murphy received at Littlehey was of the required standard and equivalent to that which he could have expected to receive in the community. He found that care plans relevant to Mr Murphy's needs were in place and he had access to palliative care services following his diagnosis of cancer. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Murphy's care.

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

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. At an inquest held on 13 March 2026, the Coroner concluded that Mr Murphy died of natural causes.

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

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100