

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Winters, a prisoner at HMP Whatton, on 25 November 2025

A report by the Prisons and Probation Ombudsman

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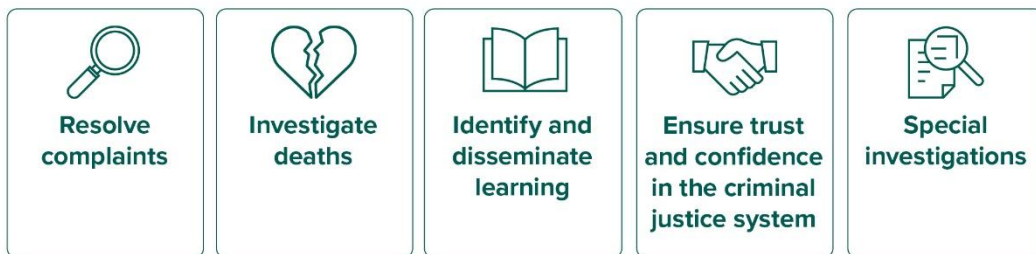
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OUR VISION

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. In July 2021, Mr Gary Winters was sentenced to ten years imprisonment for sexual offences. He died in hospital of lung cancer on 25 November 2025, while a prisoner at HMP Whatton. He was 65 years old. We offer our condolences to those who knew him.
4. The prison was unable to trace a next of kin for Mr Winters. Therefore, the Ombudsman's office did not contact anyone about this investigation.
5. NHS England commissioned an independent clinical reviewer to review Mr Winters' clinical care at HMP Whatton. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Winters received at Whatton was of a reasonable standard and equivalent to that which he could have expected to receive in the community. Despite Mr Winters receiving a diagnosis of advanced cancer only a month before he died, she found that the care provided by the GPs at Whatton was thorough and of a good standard. They had long suspected Mr Winters had cancer but extensive investigations had shown no sign of this. The clinical reviewer made four recommendations not related to Mr Winters' death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Winters' 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, Practice Plus Group. They did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

April 2026

Inquest

10. At the inquest held on 10 June 2026, the Coroner concluded that Mr Winters died from natural causes.

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