

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Sharp, a prisoner at HMP Littlehey, on 25 December 2025

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



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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 December 2009, Mr David Sharp was sentenced to ten years in prison for sexual offences. He died in hospital of pneumonia and lung cancer on 25 December 2025, while a prisoner at HMP Littlehey. He was 65 years old. We offer our condolences to Mr Sharp's family and friends.
4. The Ombudsman's office wrote to Mr Sharp's next of kin, his brother and daughter, to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer to review Mr Sharp's clinical care at HMP Littlehey.
6. The clinical reviewer concluded that the clinical care Mr Sharp received at Littlehey was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Sharp'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 pointed out a factual inaccuracy within the clinical reviewer's report (at paragraph 5.1.6). A corrected version of the clinical reviewer's report has been attached as an annex.
10. We sent a copy of our initial report to Mr Sharp's next of kin. They did not notify us of any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

June 2026

Inquest

At the inquest, held on 2 September 2026, the Coroner concluded that Mr Sharp died from natural causes.



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