Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Whittemore, a prisoner at HMP Isle of Wight, on 23 July 2023.

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

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 22 July 2019, Mr Michael Whittemore was convicted of rape and sentenced to 13 years in prison. He was sent to HMP Nottingham.

4. Mr Whittemore died of carcinomatosis caused by carcinoma of the head of the pancreas (pancreatic cancer), on 23 July 2023, at HMP Isle of Wight. He was 52 years old. We offer our condolences to Mr Whittemore's family and friends.

5. The PPO family liaison officer wrote to Mr Whittemore's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Whittemore's next of kin was concerned about the clinical care Mr Whittemore received prior to his death. These concerns have been addressed in the clinical review report.

6. NHS England commissioned an independent clinical reviewer to review Mr Whittemore's clinical care at HMP Isle of Wight.

7. The clinical reviewer concluded that the clinical care Mr Whittemore received at Isle of Wight was of a good standard and equivalent to what he could have expected to receive in the community. She found that healthcare staff at Isle of Wight provided good person-centred care, planning and treatment for Mr Whittemore. The clinical reviewer made recommendations not related to Mr Whittemore's death that the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Whittemore's care. 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. HMPPS also pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer, who removed the paragraph relating to the events of 31 May 2023.

Adrian Usher **April 2024**
Prisons and Probation Ombudsman

Inquest

At the inquest held on the 28 November 2025 the coroner concluded that Mr Whittemore died of natural causes.

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