Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Tucker, a prisoner at HMP Littlehey, on 28 July 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

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 6 November 2017, Mr Christopher Tucker was sentenced to 15 years in prison for sex offences. He died on 28 July 2025, while a prisoner at HMP Littlehey, from decompensated heart failure and sepsis, caused by aortic stenosis (narrowing of the aortic valve). This was contributed to but not caused by: Alzheimer's disease, atrial fibrillation (an irregular heart rhythm) and non-alcoholic fatty liver disease. He was 79 years old. We offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer, to review Mr Tucker's clinical care at HMP Littlehey.

5. The clinical reviewer concluded that the clinical care Mr Tucker received at Littlehey was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found that healthcare managed Mr Tucker's dementia well and found clear evidence of multidisciplinary management of Mr Tucker's healthcare needs. She made no recommendations.

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

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

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

9. In an inquest held on 29 September 2025, the Coroner concluded that Mr Tucker died of natural causes.

Adrian Usher **February 2026**
Prisons and Probation Ombudsman

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