Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harold Nicholson, a prisoner at HMP Northumberland, on 27 November 2024

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 l 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. On 23 April 2024, Mr Harold Nicholson was sentenced to 18 years in prison for sexual offences. He died of sepsis caused by bronchopneumonia on 27 November 2024, at HMP Northumberland. He was 75 years old. We offer our condolences to Mr Nicholson's family and friends.

4. The Ombudsman's office wrote to Mr Nicholson's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Nicholson's family asked about the clinical care Mr Nicholson received in prison and asked for a copy of our report. The family's questions have been addressed in the clinical review and in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Nicholson's clinical care at HMP Northumberland.

6. The clinical reviewer concluded that the clinical care Mr Nicholson received at Northumberland was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Nicholson's medical records contained evidence of excellent individualised end of life care engagement. The clinical reviewer made recommendations not related to Mr Nicholson's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Nicholson'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 and Healthcare (Spectrum Community Health CIC) did not find any factual inaccuracies.

10. At the inquest held on 20 May 2025, the coroner concluded that Mr Harold Nicholson died of natural causes.

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

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