Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Cannan, a prisoner at HMP Full Sutton, on 6 November 2024

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. In 1989, Mr John Cannan was sentenced to life imprisonment for murder. He died of a ruptured abdominal aortic aneurysm on 6 November 2024, while a prisoner at HMP Full Sutton. He was 70 years old. We offer our condolences to Mr Cannan's family and friends.

4. The Ombudsman's office wrote to Mr Cannan's next of kin 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 Cannan's clinical care at Full Sutton.

6. The clinical reviewer concluded that the clinical care Mr Cannan received at Full Sutton was of a good standard and equivalent to that which he could have expected to receive in the community. She found that although Mr Cannan made unwise decisions to refuse healthcare treatments despite being warned of the risks, she was satisfied that he had the mental capacity to make such decisions. She concluded that Mr Cannan was managed with respect and cared for by confident, competent staff. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Cannan's care. We found no significant non-clinical issues and make no recommendations.

Governor to note

8. There was a delay in the nurse attending the emergency response because the healthcare gate was incorrectly double locked. Full Sutton told us that this was a one-off mistake. Mr Cannan had a DNACPR in place. As the delay did not affect the outcome for Mr Cannan, we draw it to the Governor's attention to prevent a recurrence.

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

10. Mr Cannan's family received a copy of the draft report. They did not make any comments.

11. At an inquest held on 27 March 2025, the Coroner concluded that Mr Cannan died of natural causes.

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

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