

Independent investigation into the death of Mr Lionel Newbon, a prisoner at HMP Frankland, on 9 November 2024

A report by the Prisons and Probation Ombudsman

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



Resolve complaints



Investigate deaths



Identify and disseminate learning



Ensure trust and confidence in the criminal justice system



Special investigations

WHAT WE VALUE

Ambitious thinking

Professional curiosity Diversity & inclusion

Transparency

Teamwork



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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 1982, Mr Lionel Newbon was sentenced to life imprisonment for sexual offences. He died of acute bronchopneumonia (inflammation of the lung tubes) caused by carcinoma of the oesophagus (cancer of the tube that carries food from the mouth to the stomach) on 9 November 2024 at HMP Frankland. He was 66 years old. We offer our condolences to those who knew Mr Newbon.
- 4. The PPO investigator investigated the non-clinical issues relating to Mr Newbon's care. We did not find any non-clinical issues of concern.
- 5. NHS England commissioned an independent clinical reviewer to review Mr Newbon's clinical care at Frankland.
- 6. The clinical reviewer concluded that the clinical care Mr Newbon received at Frankland was equivalent to that which he could have expected to receive in the community. She found that Mr Newbon's medical records contained evidence of good, individualised end of life care planning.
- 7. However, the clinical reviewer found that healthcare staff were not clear about what information could be shared with custodial staff about Mr Newbon's DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) instruction form, as they perceived it to be 'medical in confidence' information. She made one recommendation, which we endorse and recast:
 - The Governor and the Head of Healthcare should review the disclosure of DNACPR instructions to custodial staff. Custodial staff should be aware of those who wish not to be resuscitated and have access to a DNACPR instruction form (which can have confidential medical information redacted).
- 8. The initial report was shared with HM Prison and Probation Service (HMPPS) and Spectrum CiC (healthcare provider). They pointed out one factual inaccuracy and this report has been amended accordingly.

Adrian Usher Prisons and Probation Ombudsman

June 2025

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Inquest

The inquest hearing was held on 18 July 2025. The Coroner concluded that Mr Newbon died of natural causes.



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