Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Farrell, a prisoner at HMP Wormwood Scrubs, on 5 May 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. In December 2021, Mr John Farrell was sentenced to 13 years in prison for sex offences. He died in hospital from bronchopneumonia and an acute cerebrovascular event on 5 May 2025, while a prisoner at HMP Wormwood Scrubs. He was 76 years old. We offer our condolences to Mr Farrell's family and friends.

4. The Ombudsman's office wrote to Mr Farrell'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 and did not want a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Farrell's clinical care at Wormwood Scrubs.

6. The clinical reviewer concluded that the clinical care Mr Farrell received at Wormwood Scrubs was of a good quality and was equivalent to that which he could have expected to receive in the community. He found that there was good evidence of advanced care planning and that Mr Farrell's wishes were evident in this. However, he found that there was no single place where all this information was readily available. The clinical reviewer made recommendations which were not related to Mr Farrell's death but which the Head of Healthcare will want to address.

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

8. We did not identify any non-clinical learning and we make no recommendations.

Good practice

9. Mr Farrell's family liaison officer attended the Coroner's office on their non-working day to register Mr Farrell's death as his next of kin was unable to make the journey.

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

11. North London Coroner's Service told us that an inquest was not required for this case.

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

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