Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John North, a prisoner at HMP Northumberland, on 7 August 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 March 2021, Mr John North was convicted of sexual offences and sentenced to an 11-year extended sentence (ten years custody with a one-year extended licence period).

4. Mr North died in hospital of metastatic lung cancer (spread of cancer from where it started in the lung) on 7 August 2024, while a prisoner at HMP Northumberland. He was 71 years old. We offer our condolences to Mr North's family and friends.

5. The Ombudsman's office wrote to Mr North's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. NHS England commissioned an independent clinical reviewer, to review Mr North's clinical care at HMP Northumberland. The clinical reviewer's report is attached as Annex 1.

8. The clinical reviewer concluded that the clinical care Mr North received at Northumberland was of a good standard and equivalent to that which he could have expected to receive in the community.

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

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

Inquest

11. The inquest into Mr North's death concluded on the 21 January 2025. The coroner confirmed that Mr North died from natural causes.

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

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