

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Brumpton, a prisoner at HMP Holme House, on 9 October 2023

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



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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. On 1 July 2015, Mr John Brumpton was sentenced to 18 years in prison for sex offences. He died from locally advanced urethral cancer on 9 October 2023, while a prisoner at HMP Holme House. He was 74 years old. We offer our condolences to Mr Brumpton's family and friends.
4. The Ombudsman's office wrote to Mr Brumpton's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Brumpton's clinical care at HMP Holme House.
6. The clinical reviewer concluded that the clinical care Mr Brumpton received at HMP Holme House was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found that healthcare staff adhered to the Dying Well in Custody Charter to prepare for Mr Brumpton's death and to ensure his wishes were taken into account. The clinical reviewer made recommendations not related to Mr Brumpton's death that the Head of Healthcare will want to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Brumpton's care.
8. We did not find any non-clinical issues of concern and we make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. At an inquest held on 26 April 2024, the Coroner concluded that Mr Brumpton died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

May 2024

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