Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bernard Crathorne, a prisoner at HMP Norwich, on 6 October 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. On 19 August 2020, Mr Bernard Crathorne was remanded to prison, charged with sexual offences. On 14 October 2022, he was sentenced to four years and six months imprisonment. Mr Crathorne died of frailty of old age and ischaemic heart disease, at HMP Norwich, on 6 October 2024. He was 92 years old. We were unable to identify a next of kin, or any family members, but we offer our condolences to those who knew him.

4. NHS England commissioned an independent clinical reviewer to review Mr Crathorne's clinical care at HMP Norwich. The clinical reviewer's report was attached as Annex 1.

5. The clinical reviewer concluded that the clinical care Mr Crathorne received at Norwich was equivalent to that which he could have expected to receive in the community. She found evidence in his medical records that he was managed effectively, with appropriate care plans and his specialist palliative care was in line with the Ambitions Framework for palliative and end of life care.

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

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

8. We shared a copy of the initial report with HMPPS. They identified a factual inaccuracy in the clinical review report, which has been amended.

Inquest

9. At an inquest held on 29 April 2025, the coroner concluded that Mr Crathorne died from natural causes.

Adrian Usher **January 2026**
Prisons and Probation Ombudsman

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