Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Corran, a prisoner at Isle of Man Prison, on 12 November 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 April 2021, Mr John Corran was sentenced to 11 years in prison for sex offences. He died in hospital of a gastrointestinal haemorrhage, caused by gastroesophageal erosions, on 12 November 2024, while a prisoner at Isle of Man Prison. He was 77 years old. We offer our condolences to Mr Corran's family and friends.

4. The Ombudsman's office wrote to Mr Corran's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. The letter was returned by the Post Office as undelivered.

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

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

7. However, when Mr Corran attended hospital on 8 October 2024, he was inappropriately restrained with a single cuff. We were told this was an administrative oversight resulting from a prison officer ticking an incorrect box on the restraints risk assessment. We do not make a recommendation about this as it appears to have been a one-off administrative error. Staff removed the restraints promptly on the way to the hospital and Mr Corran was not restrained for subsequent hospital appointments.

8. We commissioned an independent clinical reviewer to review Mr Corran's clinical care at Isle of Man Prison.

9. The clinical reviewer concluded that the clinical care Mr Corran received at Isle of Man Prison was partially equivalent to that which he could have expected to receive in the community. She found that when Mr Corran was acutely unwell, specialist assessments and reviews were completed appropriately and in a timely manner. However, she was concerned that there was no clinical governance framework in place to help ensure practice, policies and procedures were evidence-based. We make the following clinical recommendation:

   Clinical Leads within Manx Care should ensure that healthcare staff have the appropriate competencies to the level of care they are providing for acutely ill/deteriorating patients, in line with the Royal College of Physicians, NEWS2 score for assessing patients at risk of deterioration.

10. The clinical reviewer made five other recommendations which were not related to Mr Corran's death but which that the Head of Healthcare will want to address.

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

12. At an inquest held on 24 April 2025, the Coroner concluded that Mr Corran died of natural causes.

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

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