

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Sneddon, a prisoner at HMP North Sea Camp, on 18 April 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

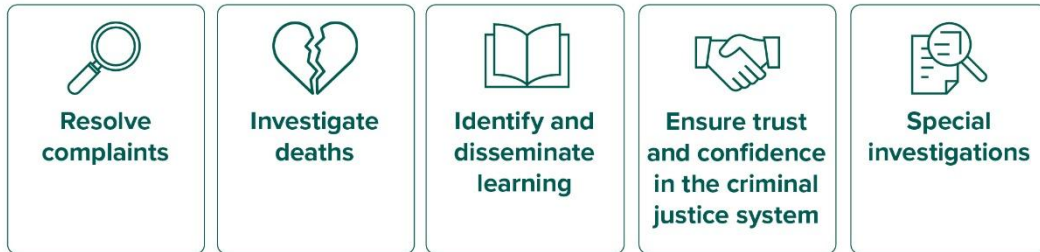
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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. In 2015, Mr Robert Sneddon was sentenced to life imprisonment for a sexual offence. He died of ischaemic and valvular heart disease (where the heart muscle has insufficient oxygen caused by narrowed coronary arteries, which causes reduced blood flow to and from the heart) on 18 April 2025, at HMP North Sea Camp. He was 72 years old. We offer our condolences to Mr Sneddon's family and friends.
4. The Ombudsman's office wrote to Mr Sneddon's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had a question relating to Mr Sneddon's employment, which has been addressed in separate correspondence.
5. NHS England commissioned an independent clinical reviewer, to review Mr Sneddon's clinical care at HMP North Sea Camp. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Sneddon received at North Sea Camp was of good standard and equivalent to that which he could have expected to receive in the community. She found that healthcare staff provided diligent care, promptly identifying, treating and referring Mr Sneddon for his health conditions. The clinical reviewer also noted that appropriate care plans were in place, with healthcare staff demonstrating good practice by reviewing Mr Sneddon after hospital admissions, maintaining regular weight management checks and ensuring continuity of care.
7. The clinical reviewer made one recommendation not related to Mr Sneddon's death that the Head of Healthcare will wish to address.
8. The PPO investigator investigated the non-clinical issues relating to Mr Sneddon's care.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
11. Mr Sneddon's family received a copy of the draft report. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

Inquest

12. The inquest into Mr Sneddon's death concluded on 22 April 2026 and returned a verdict of natural causes.

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