

**Prisons &
Probation**

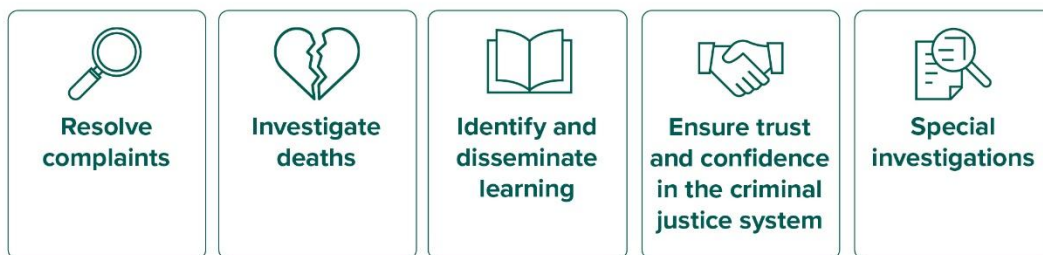
Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Raymond Noble,
a prisoner at HMP Leyhill, on 19
May 2025**

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 June 2022, Mr Raymond Noble was sentenced to six years imprisonment for sexual offences. He died of congestive cardiac failure (when the heart cannot pump enough blood to the rest of the body) caused by mitral and tricuspid valve regurgitation (when the heart valves do not close properly and there is a back flow of blood in the heart). Pneumonia (infection of the lungs) and atrial flutter (when the heart's rhythm is too fast) also contributed to but did not cause Mr Noble's death. He was 91 years old when died on 19 May 2025 in hospital. We offer our condolences to Mr Noble's family and friends.
4. The Ombudsman's office wrote to Mr Noble'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 Noble's clinical care at HMP Leyhill.
6. The clinical reviewer concluded that the clinical care Mr Noble received at Leyhill was of good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Noble's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

Inquest

The inquest hearing was held on 14 April 2026. The Coroner concluded that Mr Noble died of natural causes.

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