

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr John Yates, a prisoner at HMP Lincoln, on 11 October 2025**

**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. In August 2025, Mr John Yates was sentenced to five years and four months imprisonment for sexual offences. He died in hospital of duodenal cancer on 11 October, while a prisoner at HMP Lincoln. He was 70 years old. We offer our condolences to Mr Yates' family and friends.
4. The Ombudsman's office wrote to Mr Yates' 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 Yates' clinical care at HMP Lincoln.
6. The clinical reviewer concluded that the clinical care Mr Yates received at Lincoln was of a good standard and was equivalent to that which he could have expected to receive in the community. She found clear evidence of multidisciplinary working and regular, timely and responsive review by members of the multidisciplinary team. She also found that interactions between healthcare and custodial teams and Mr Yates were kind, respectful and compassionate.
7. The PPO investigator investigated the non-clinical issues relating to Mr Yates' care.
8. The investigator found that staff, and in particular, the prison's family liaison officer, reacted quickly and proactively to the rapid deterioration in Mr Yates' health. The family liaison officer provided excellent support to Mr Yates and his family through his final days.
9. We did not find any non-clinical issues of concern. We make no recommendations.
10. We shared the initial report with HMPPS and the prison's healthcare provider, Nottinghamshire Healthcare NHS Foundation Trust. They pointed out a factual inaccuracy in the clinical review. This has been corrected and the updated clinical review is annexed to this report.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**March 2026**

## **Inquest**

At the inquest, held on 17 September 2026, the Coroner concluded that Mr Yates died from natural causes.



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