

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Reay, a prisoner at HMP Northumberland, on 28 October 2025

A report by the Prisons and Probation Ombudsman

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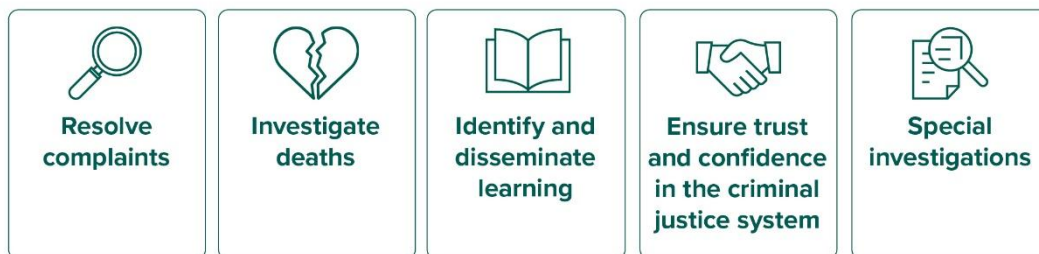
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OUR VISION

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. On 26 February 2024, Mr John Reay was sentenced to eleven years in prison for sex offences. He died from transitional cell bladder cancer with squamous cell differentiation (the most common form of bladder cancer) on 28 October 2025, while a prisoner at HMP Northumberland. He was 57 years old. We offer our condolences to Mr Reay's family and friends.
4. The Ombudsman's office wrote to Mr Reay's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about support Mr Reay received from the healthcare team and they were concerned about the management of his pain. This has been addressed in the clinical review.
5. NHS England commissioned an independent clinical reviewer to review Mr Reay's clinical care at HMP Northumberland. The clinical review is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Reay received at HMP Northumberland was of a good standard and was at least equivalent to that which he could have expected to receive in the community. She found that healthcare staff had put in place appropriate care plans to manage Mr Reay's blood pressure and complex needs. While she found that Mr Reay's weight loss was not managed appropriately at times, this did not directly relate to his death and she made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Reay's care. We did not find any non-clinical issues of concern and we make no recommendations.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
9. Mr Reay's family received a copy of the draft report. They did not make any comments.
10. At an inquest held on 19 March 2026, the Coroner concluded that Mr Reay died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

May 2026



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