Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Norman Heaton, a prisoner at HMP Full Sutton, on 2 November 2025

A report by the Prisons and Probation Ombudsman

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 May 2002, Mr Norman Heaton was sentenced to life imprisonment for murder. He received a minimum tariff of 10 years 11 months. He died of Bronchopneumonia on 2 November 2025, at HMP full Sutton. He was 66 years old. We offer our condolences to Mr Heaton's family and friends.

4. The Ombudsman's office wrote to Mr Heaton'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 Heaton's clinical care at HMP Full Sutton. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Heaton received at Full Sutton was of a good standard and equivalent to what he could have expected to receive in the community. She found that the care Mr Heaton received whilst on the palliative care suite at Full Sutton was kind, compassionate, timely and appropriate. There was excellent multidisciplinary collaboration between the prison and external health services, and evidence documented within Mr Heaton's medical records of timely referrals, DNACPR discussions and advance care planning. The clinical reviewer made one recommendation not related to Mr Heaton's death that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Heaton'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 **March 2026**
Prisons and Probation Ombudsman

Inquest

10. At the inquest held on 29 June 2026, the coroner concluded that Mr Heaton died of natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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

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

T I 020 7633 4100