Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John McGovern, a prisoner at HMP The Verne, on 13 June 2024

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

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 6 May 2016, Mr John McGovern was sentenced to 19 years imprisonment for sexual offences.

4. Mr McGovern died from pancreatic cancer on 13 May 2024 while a prisoner at HMP The Verne. He was 58 years old. We offer our condolences to Mr McGovern's family and friends.

5. The Ombudsman's office contacted Mr McGovern's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr McGovern's family asked questions about Mr McGovern's clinical care, which have been addressed in the clinical review, and asked for a copy of our report.

6. The PPO investigator investigated the non-clinical issues relating to Mr McGovern's care.

7. We did not find any non-clinical issues of concern.

8. NHS England commissioned an independent clinical reviewer, to review Mr McGovern's clinical care at HMP The Verne.

9. The clinical reviewer concluded that the clinical care Mr McGovern received at The Verne was of the required standard and was equivalent to what he could have expected to receive in the community. He found that Mr McGovern's reported chest pain in February 2024 could have been a possible missed diagnosis, and he had concerns regarding the distance of travel for Mr McGovern when he transferred from Ashfield to The Verne. We make the following recommendations:

   The Head of Healthcare at HMP Ashfield should ensure clinical staff are up to date with guidelines on assessment of chest pain in the primary care setting.

   The Head of Healthcare at HMP Ashfield should ensure clinical staff are aware of local and national guidelines relating to the management of ascites in a non-hospital setting.

   The Governor and the Head of Healthcare at HMP The Verne should ensure that a clear protocol is in place for the transfer of prisoners with a limited life expectancy.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

11. Mr McGovern's family received a copy of the draft report. They did not make any comments.

Adrian Usher
Prisons and Probation Ombudsman **October 2025**

Inquest

12. At the inquest held on 26 November 2025, the Coroner concluded that Mr McGovern died of natural causes.

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