

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Brook, a prisoner at HMP Isle of Wight, on 7 July 2024

A report by the Prisons and Probation Ombudsman

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

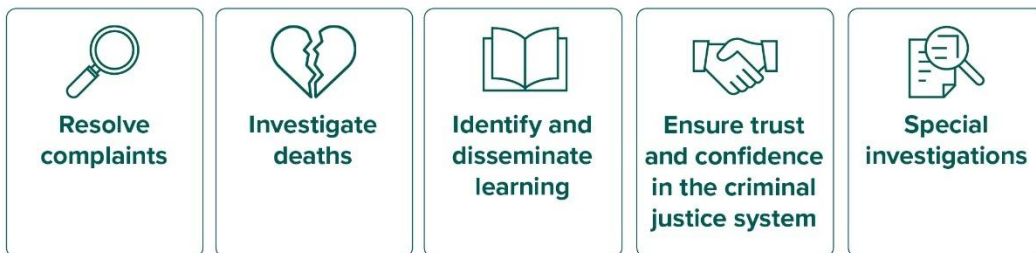
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 10 September 2021, Mr John Brook was sentenced to 14 years in prison for sexual offences. He died of a cardiac arrest caused by ischaemic heart disease and left ventricular hypertrophy (thickening of the wall of the heart's pumping chamber) on 7 July 2024, at HMP Isle of Wight. He was 71 years old. We offer our condolences to Mr Brook's family and friends.
4. NHS England commissioned an independent clinical reviewer to review Mr Brook's clinical care at HMP Isle of Wight.
5. The clinical reviewer concluded that the clinical care Mr Brook received at Isle of Wight was of a good standard and equivalent to what he could have expected to receive in the community. She found evidence of excellent individualised end of life care planning, care delivery and decision making. The clinical reviewer made a recommendation not related to Mr Brook's death that the Head of Healthcare will wish to address.
6. The PPO investigator investigated the non-clinical issues relating to Mr Brook's care. We did not find any non-clinical issues of concern.
7. We make no recommendations.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Practice Plus Group did not find any factual inaccuracies.
9. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.
10. At the inquest held on 30 December 2025, the coroner concluded that Mr John Brook died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

July 2025

**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 | 020 7633 4100