Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reginald Northrop, a prisoner at HMP The Verne, on 28 June 2024

A report by the Prisons and Probation Ombudsman

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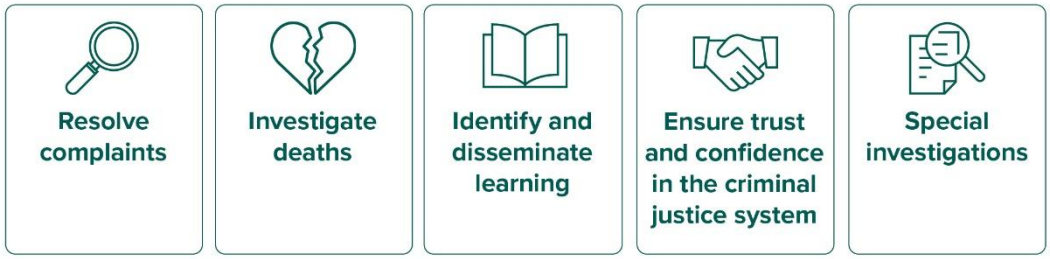
OUR VISION

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 1 August 2017, Mr Reginald Northrop was sentenced to 12 years in prison for sex offences. He died from progressive multiple sclerosis on 28 June 2024, while a prisoner at HMP The Verne. He was 80 years old. We offer our condolences to Mr Northrop's family and friends.

4. The Ombudsman's office wrote to Mr Northrop's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

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

6. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. The PPO investigator investigated the non-clinical issues relating to Mr Northrop's care. We did not find any non-clinical issues of concern.

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

9. The clinical reviewer concluded that the clinical care Mr Northrop received at The Verne was of a varying standard and was partially equivalent to that which he could have expected to receive in the community. She found that healthcare engaged well with Mr Northrop's wife about his end-of-life care, but improvements were needed in starting timely end-of-life care. The clinical reviewer made a number of recommendations which the Head of Healthcare will want to address. We repeat two of them in this report as they were related to Mr Northrop's death:

   The Head of Healthcare should ensure that all patients on the palliative care pathway have an advanced care plan in place in accordance with the NICE guideline [NG142] for 'end of life care for adults: service delivery' (2019) and the NHSE 'universal principles for advanced care planning' (2022). This care plan should include ceiling of care decisions and treatment escalation plans and be shared with social care staff who may care for patients out of hours.

   The Head of Healthcare should ensure that there is a clear process in place for patients discharged from hospital to HMP The Verne on an end-of-life care pathway. This process will ensure that any recommendations from the hospital are initiated quickly, and that treatment escalation plans and ceiling of care decisions are translated into care plans in accordance with the NHSE framework for 'dying well in custody charter' (2024).

10. At an inquest held on 15 September 2025, the Coroner concluded that Mr Northrop died of natural causes.

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

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