Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Cambray, a prisoner at HMP Haverigg, on 19 January 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. In October 2020, Mr Colin Cambray received an extended determinate sentence of nine years for sexual offences. He died from a hypoxic brain injury on 19 January 2024, while a prisoner at HMP Haverigg. This was caused by a cardiac arrest which was in turn caused by spontaneous pneumothorax (the presence of air or gas in the cavity between the lungs and chest wall). He was 55 years old. We offer our condolences to Mr Cambray's family and friends.

4. The Ombudsman's office wrote to Mr Cambray's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Cambray's clinical care at Haverigg.

6. The clinical reviewer concluded that the clinical care Mr Cambray received at Haverigg was of a good standard and equivalent to that which he could have expected to receive in the community. She found that appropriate reviews were held when Mr Cambray's physical health deteriorated, staff responded appropriately to the emergency code and transferred him to hospital when it was clinically indicated. The clinical reviewer made no recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Cambray's care. We did not find any significant non-clinical issues of concern related to his death and we make no recommendations.

Governor to note

8. Prison staff did not activate their body-worn cameras when the general alarm sounded on 2 January 2024, as required by Haverigg's local policy.

Good practice

9. The family liaison log for Mr Cambray was detailed, and the Governor approved a one-off payment to help his family with travel costs to visit him in hospital.

10. Haverigg provided the information needed for this case, including 15 detailed staff statements, in a timely and organised manner.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

12. At the inquest held on the 2 July 2024, the coroner concluded that Mr Cambray died of natural causes.

Adrian Usher **June 2024**
Prisons and Probation Ombudsman

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