

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Victor Farrant, a prisoner at HMP Wakefield, on 3 May 2024

A report by the Prisons and Probation Ombudsman

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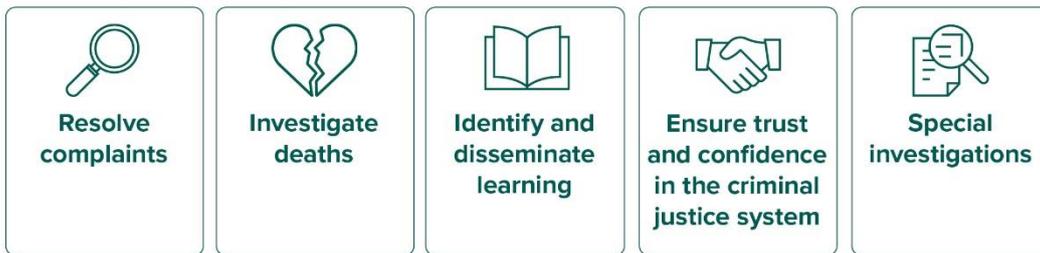
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OUR VISION

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



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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 January 1998, Mr Victor Farrant was sentenced to life imprisonment with a whole life order for murder (meaning he was not expected to be released). He died of cancer of the tongue on 3 May 2024, at HMP Wakefield. He was 74 years old. We offer our condolences to Mr Farrant's family and friends.
4. The Ombudsman's office contacted Mr Farrant's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about some missed hospital appointments and asked why Mr Farrant had not been released on compassionate grounds.
5. NHS England commissioned an independent clinical reviewer to review Mr Farrant's clinical care at HMP Wakefield.
6. The clinical reviewer concluded that the clinical care Mr Farrant received at Wakefield was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer has addressed the missed hospital appointments in her report.
7. The PPO investigator investigated the non-clinical issues relating to Mr Farrant's care. We did not find any non-clinical issues of concern. We are satisfied that the correct process was followed in respect of an application for early release on compassionate grounds and that Mr Farrant did not qualify for early release.
8. We make no recommendations.
9. We shared our initial report with HMPPS. They found no factual inaccuracies.
10. We sent a copy of our initial report to Mr Farrant's next of kin. They did not notify us of any factual inaccuracies.
11. The inquest, held on 20 May 2024, concluded that Mr Farrant died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

September 2024

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