Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eric Purkiss, a prisoner at HMP Wakefield, on 3 September 2024

A report by the Prisons and Probation Ombudsman

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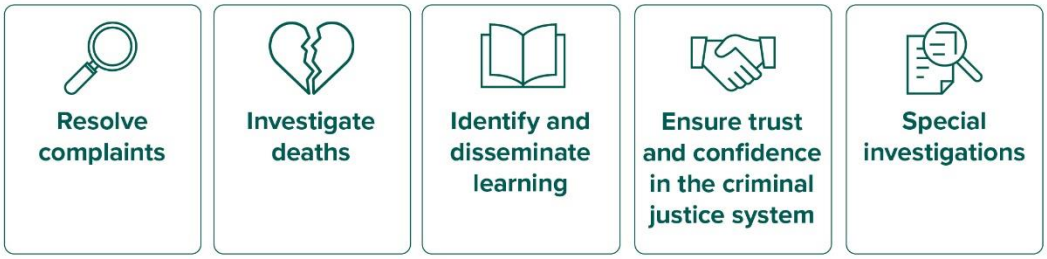
OUR VISION

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 9 May 1985, Mr Eric Purkiss was sentenced to life imprisonment for attempted murder. He died in prison of a stroke on 3 September 2024, at HMP Wakefield. He was 68 years old. We offer our condolences to Mr Purkiss's family and friends.

4. The Ombudsman's office contacted Mr Purkiss's niece to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

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

6. The clinical reviewer concluded that the clinical care Mr Purkiss 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 made one recommendation unrelated to Mr Purkiss's death which the Head of Healthcare will wish to address.

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

8. We did not find any non-clinical issues of concern. We make no recommendations.

9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They pointed out some minor factual inaccuracies in the clinical review which has been amended.

10. The inquest, held on 23 September 2024, concluded that Mr Purkiss died from natural causes.

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

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