Prisons & Probation Ombudsman
Independent Investigations

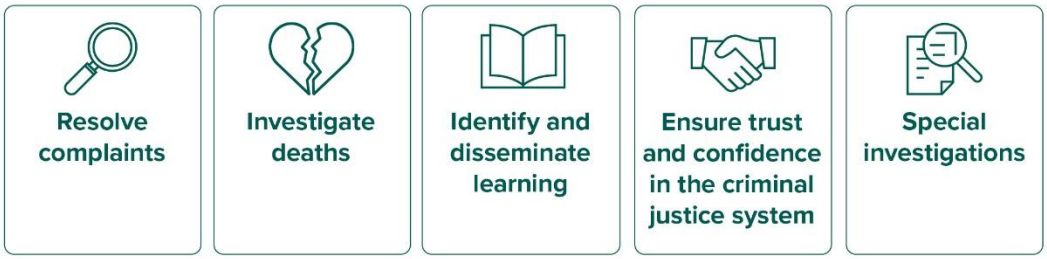
Independent investigation into the death of Mr Eric Harrison, a prisoner at HMP Whatton, on 14 February 2025

A report by the Prisons and Probation Ombudsman

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 11 March 2024, Mr Eric Harrison was sentenced to six years and six months in prison for sexual offences. He died of multi-organ failure caused by staphylococcus auris septicaemia (blood poisoning caused by bacteria on the skin) on 14 February 2025, while a prisoner at HMP Whatton. He was 91 years old. We offer our condolences to Mr Harrison's family and friends.

4. The Ombudsman's office contacted Mr Harrison's next of kin to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Harrison's next of kin enquired about the care he received at HMP Nottingham prior to his transfer to Whatton and requested a copy of our report. The care Mr Harrison received at Nottingham has been addressed in the clinical review.

5. NHS England commissioned an independent clinical reviewer to review Mr Harrison's clinical care at Whatton. The clinical reviewer's report was attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Harrison received at Whatton was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Harrison's medical records contained evidence of good communication between the healthcare staff at Whatton and the hospital, as the healthcare team regularly contacted the hospital to check on Mr Harrison's wellbeing. The clinical reviewer made recommendations not related to Mr Harrison's death that the Head of Healthcare will wish to address.

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

8. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Services (HMPPS) and Healthcare. HMPPS and Practice Plus Group did not find any factual inaccuracies.

10. At the inquest held on 14 July 2025, the coroner concluded that Mr Eric Harrison died of natural causes.

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

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