

**Prisons &
Probation**
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Murphy, a prisoner at HMP Haverigg, on 11 February 2026

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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 February 2014, Mr Kenneth Murphy was sentenced to an extended determinate sentence of 13 years imprisonment and eight years on licence for sexual offences. Mr Murphy was 81 years old when he died on 11 February 2026 in HMP Haverigg. We offer our condolences to those who knew Mr Murphy.
4. Mr Murphy died of aspiration pneumonia (infection of the lungs caused by inhaling a foreign substance like food), which was caused by a historic cerebrovascular accident (stroke) which, in turn, was caused by atherosclerosis (when arteries narrow and harden due to fat build-up). The following conditions contributed but did not cause Mr Murphy's death: fibrotic lung disease secondary to sarcoidosis (when chronic inflammation leads to permanent scarring of the lungs), pulmonary hypertension (high blood pressure in the lungs' arteries), extensive aortic aneurysm (swelling of the aorta), chronic obstructive pulmonary disease (COPD – a group of lung conditions) and atrial fibrillation (irregular heartbeat).
5. NHS England commissioned an independent clinical reviewer to review Mr Murphy clinical care at Haverigg.
6. The clinical reviewer concluded that the clinical care Mr Murphy 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 healthcare staff were competent and compassionate in treating Mr Murphy's long-term health care conditions. She also found that there was good communication between healthcare and prison staff. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Murphy's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Spectrum Community Health CIC (healthcare provider) pointed out some factual inaccuracies with the clinical review. The investigator passed these onto the clinical reviewer who amended their report.

Adrian Usher
Prisons and Probation Ombudsman

June 2026

Inquest

The inquest hearing was held on 17 June 2026. The Coroner concluded that Mr Murphy died of natural causes.



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