

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Murphy, a prisoner at HMP Liverpool, on 1 March 2025

A report by the Prisons and Probation Ombudsman

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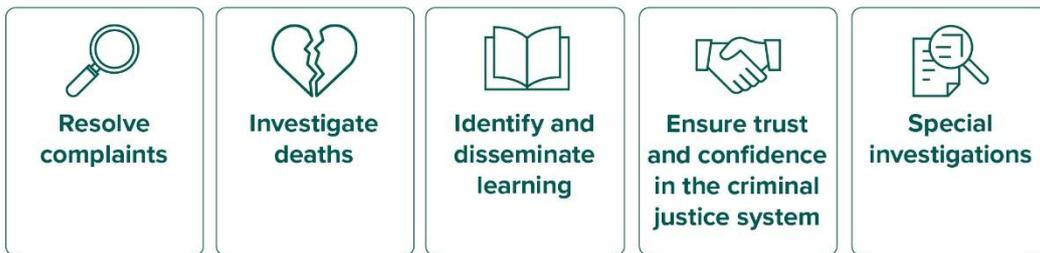
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OUR VISION

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. On 22 August 2024, Mr Joseph Murphy was remanded to HMP Altcourse for robbery. On 6 September, he transferred to HMP Liverpool. On 28 November, Mr Murphy was sentenced to two years and nine months.
4. On 1 March 2025, Mr Murphy died of Class III obesity with cardiomegaly (an enlarged heart) and coronary artery atheroma (accumulation of fatty material in the coronary arteries). He was 49 years old. We offer our condolences to Mr Murphy's family and friends.
5. The Ombudsman's office wrote to Mr Murphy's sister to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Murphy's sister had no questions but asked for a copy of our report.
6. NHS England commissioned an independent clinical reviewer to review Mr Murphy's clinical care at HMP Liverpool. The clinical reviewer's report is attached as Annex 1.
7. The clinical reviewer concluded that the clinical care Mr Murphy received at Liverpool was of a good standard and was equivalent to that which he could have expected to receive in the community. She concluded that the physical healthcare he received was of a good quality with a person-centred approach.
8. The clinical reviewer found that Mr Murphy had long term health conditions, including hypothyroidism (an underactive thyroid) and statin/lipid treatment and that there was ongoing management and monitoring of these conditions. She also noted that staff recorded that Mr Murphy was obese when he was admitted to Liverpool and provided him with advice on his diet and maintaining a healthy lifestyle. The clinical reviewer noted that there was no specific targeted discussion in respect of obesity but acknowledged that, from December 2024 onwards, Mr Murphy's complex mental health needs took precedence.
9. The clinical reviewer made recommendations not related to Mr Murphy's cause of death which the Head of Healthcare will wish to address.
10. The PPO investigator investigated the non-clinical issues relating to Mr Murphy's care. We did not identify any non-clinical issues of sufficient concern to warrant a recommendation.
11. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
12. We also shared the initial report with Mr Murphy's sister. She did not have any comments.

13. At the inquest, held on 19 December 2025, the Coroner concluded that Mr Murphy died of natural causes.

Governor to note

Location of emergency code

14. The officer who initially radioed a medical emergency code blue (used to indicate a life-threatening emergency) set out that this was in Cell H, after which the radio transmission ended. (We do not know whether the officer stopped speaking or whether there was an issue with the radio transmission.)
15. A control room officer then broadcast that the code blue was on H wing (not the healthcare wing where Mr Murphy lived.) Around forty seconds later, staff at the emergency confirmed that the correct location was the healthcare wing.
16. Additional healthcare staff arrived within two minutes of officers calling the initial code blue and we do not therefore consider that this miscommunication caused a significant delay. However, we bring this to the Governor's attention.

Hot debrief

17. The Follow up to Deaths in Custody Policy Framework sets out that a hot debrief must be held as soon as possible after the death. It notes that this should be chaired by a senior member of staff and all staff directly involved in the incident, including healthcare staff, should be invited. The Post-Incident Care user guide notes that the debrief provides an opportunity to understand and deal with chaotic and distressing thoughts to help prevent psychological damage.
18. A custodial manager held a hot debrief following Mr Murphy's death which involved some operational and healthcare staff. However, a number of staff members who had been involved in the emergency were not present at the debrief. Three officers were sent home after the emergency response and some healthcare staff told the investigator they were not invited to a joint debrief. Healthcare staff were told they could go home if they wished.
19. While it is clear that managers were thinking of staff wellbeing by sending them home, the Governor and Head of Healthcare will want to highlight the importance of a joint hot debrief following a death in custody and ensure that those who are unable to attend receive follow-up care as necessary.

Adrian Usher
Prisons and Probation Ombudsman

March 2026

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