Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Chrisopher Harper, a prisoner at HMP Oakwood, on 9 August 2024

A report by the Prisons and Probation Ombudsman

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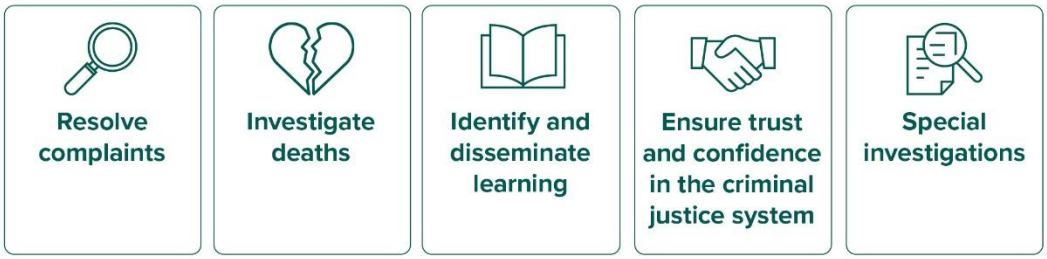
OUR VISION

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. In October 2023, Mr Christopher Harper was sentenced to two years in prison for breaching a Sexual Harm Prevention Order. He died in a hospice of decompensated liver failure, on 9 August 2024, while a prisoner at HMP Oakwood. This was caused by liver metastases (cancer that starts in one part of the body and spreads to the liver). Adenocarcinoma of the ileo-caecal junction (cancer that affects the part of your intestines where the small and large intestines connect) also contributed to his death. He was 65 years old. We offer our condolences to Mr Harper's family and friends.

4. The Ombudsman's office wrote to Mr Harper's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of our report and raised questions regarding Mr Harper's compassionate release application. This has been addressed in separate correspondence.

5. NHS England commissioned an independent clinical reviewer to review Mr Harper's clinical care at HMP Oakwood. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Harper received at Oakwood was of a very good standard and equivalent to that which he could have expected to receive in the community. She found that Mr Harper's medical records contained evidence of good care planning, which was above what she would have expected. She also found that the care coordinator provided good continuity of care and communication on Mr Harper's treatment options and arranged for him to be accompanied by his wife during hospital appointments.

7. The PPO investigator investigated the non-clinical issues relating to Mr Harper's care. We did not find any non-clinical issues of concern. We make no recommendations.

Good Practice

8. The compassion and support demonstrated by the care coordinator was commendable. Staff made considerable efforts facilitating a prison visit with Mr Harper's family under exceptional circumstances, and authorised Mr Harper to move to a hospice near to his family for end-of-life care.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. Mr Harper's family received a copy of the draft report. They raised an issue that did not impact on the factual accuracy of this report and has been addressed through separate correspondence.

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

Inquest

11. At the inquest held on 18 November 2024, the Coroner concluded that Mr Harper died from natural causes.

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