

**Prisons &
Probation**

Ombudsman
Independent Investigations

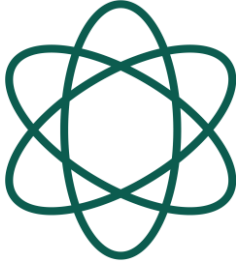
Independent investigation into the death of Mr Raymond Hartigan, a prisoner at HMP Wymott, on 10 August 2022

A report by the Prisons and Probation Ombudsman



Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Raymond Hartigan died of lung cancer in hospital on 10 August 2022, while a prisoner at HMP Wymott. He was 77 years old. We offer our condolences to Mr Hartigan's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Hartigan received at Wymott was partially equivalent to that which he could have expected to receive in the community. She makes several recommendations for the Head of Healthcare, primarily to improve care planning processes, including those which apply to suspected cancer.
5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Hartigan's clinical care at Wymott.
7. The PPO investigator investigated the non-clinical issues relating to Mr Hartigan's care, including Mr Hartigan's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. The PPO family liaison officer wrote to Mr Hartigan's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked how long Mr Hartigan was ill before his admission to hospital, why the prison did not inform them of Mr Hartigan's transfer to hospital straight away and about privacy at the hospital. These questions have been answered within this report and in separate correspondence.
9. Mr Hartigan's next of kin received a copy of the draft report. They did not make any comments.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Wymott

11. Mr Hartigan was the 14th prisoner to die at Wymott since August 2020. Of the previous deaths, 12 were from natural causes and one was drug related. Since Mr Hartigan's death, two further prisoners have died. Of these deaths, one was from natural causes, and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Hartigan's death and our findings for the previous deaths.

Key Events

12. On 11 November 2010, Mr Hartigan was given an 18 year sentence. On 20 July 2015, he was transferred to HMP Wymott.
13. At Mr Hartigan's initial health screenings, healthcare staff did not record any physical or mental health concerns. Between July 2015 and June 2022, healthcare staff did not record any significant healthcare issues in Mr Hartigan's medical or prison records.
14. On 9 June 2022, a medical technical officer examined Mr Hartigan and recorded that he had lost 10kg since 6 February 2022. Mr Hartigan told the medical technical officer that he could not swallow. The information was passed to the prison GP.
15. On 10 June, a prison nurse examined Mr Hartigan and recorded that he was in pain, had been struggling to eat for three weeks and could only drink water in small amounts.
16. On 13 June, Mr Hartigan met with the prison GP who followed up the symptoms recorded by the medical technical officer on 9 June. The GP sent an urgent referral to the hospital gastroenterology department (the hospital department treating digestive issues) and prescribed pain relief medication.
17. On 16 June, Mr Hartigan told a prison nurse that he was in pain and that his pain relief was not lasting. The nurse spoke to a prison GP, who increased the frequency of the dose. The nurse also noted that Mr Hartigan looked like he had lost a lot of weight and that she was going to organise a transfer to the prison inpatient unit.
18. On 20 June, Mr Hartigan called his cell bell and told officers that he was in pain. Officers contacted healthcare and a nurse attended. The nurse recorded that Mr Hartigan had severe abdominal pain and was vomiting. They requested an ambulance and paramedics took Mr Hartigan to A&E.
19. On 21 June, Mr Hartigan was admitted from A&E to the hospital inpatient unit.
20. On 23 June, the hospital told prison healthcare staff that Mr Hartigan was waiting for a gastroscopy (a procedure to check the upper digestive system).
21. On 25 June, the hospital told prison healthcare staff that the gastroscopy had found a mass in Mr Hartigan's throat.
22. On 19 July, a bedwatch officer (an officer responsible for ensuring that prisoners are kept in secure and lawful custody while in hospital) contacted the prison healthcare team and told them that the hospital had confirmed the mass was a tumour of the lung, which was pushing up into Mr Hartigan's throat. The hospital had also confirmed that Mr Hartigan's condition was terminal and that he had a life expectancy of approximately six months.
23. On 25 July, prison healthcare staff told the HMPPS Safer Custody team that they had placed Mr Hartigan on the palliative care register. After a discussion with

hospital doctors, Mr Hartigan signed an order which stated that he did not want anyone to resuscitate him if his heart or breathing stopped.

24. On 9 August, the Offender Management Unit at Wymott started an application for Mr Hartigan's early release on compassionate grounds.
25. At 2.00pm on 10 August, Mr Hartigan died.

Post-mortem report

26. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Hartigan's cause of death as lung cancer.

Inquest

27. The inquest into Mr Hartigan's death was held on 8 June 2023 with a verdict of natural causes.

Tallulah Frankland
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March 2023

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