Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Connor, a prisoner at HMP Whatton, on 22 February 2025

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 July 2022, Mr Raymond Connor was sentenced to eight years in prison for sexual offences. He died of prostate cancer on 22 February 2025, at HMP Whatton. He was 94 years old. We offer our condolences to Mr Connor's family and friends.

4. The Ombudsman's office wrote to Mr Connor's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

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

6. NHS England commissioned an independent clinical reviewer to review Mr Connor's clinical care at Whatton.

7. The clinical reviewer concluded that the clinical care Mr Connor received at Whatton was of a reasonable standard overall and broadly equivalent to that which he could have expected to receive in the community. She found that the nursing care he received was of a high standard.

8. However, she noted that there were times where Mr Connor's clinical care was not of an adequate standard, particularly in relation to his rising PSA levels. (PSA, or prostate specific antigen, is a protein released by the prostate gland and levels tend to rise as the cancer progresses.) Mr Connor's PSA level was known to be rising in August 2024 but was not acted on appropriately by the GP. His cancer was progressing, but this was not identified until he was admitted to hospital in November 2024. Also, Mr Connor did not receive some of his hormone injections (Prostap) that he was supposed to get every three months to help control the cancer. We recommend:

   The Head of Healthcare should carry out an investigation into why Mr Connor's rising PSA level was not acted upon between August and November 2024.

   The Head of Healthcare should ensure that there is an effective recall system for patients receiving regular injections such as Prostap.

9. The clinical reviewer made two other recommendations which the Head of Healthcare will wish to address.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. Practice Plus Group pointed out a factual inaccuracy in the

clinical review. This has been corrected. Practice Plus Group provided an action plan which is annexed to this report.

11. We sent a copy of our initial report to Mr Connor's next of kin. They did not notify us of any factual inaccuracies.

12. At the inquest, held on 11 April 2025, the Coroner concluded that Mr Connor died from natural causes.

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

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