Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Catchpole, a prisoner at HMP Durham, on 20 October 2023

A report by the Prisons and Probation Ombudsman

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

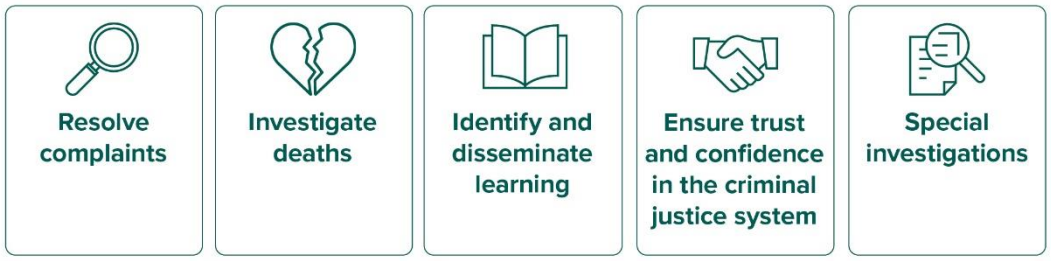
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 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

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 8 September 2023, Mr Raymond Catchpole was remanded in custody for sex offences.

4. Mr Catchpole died in hospital on 20 October 2023, while a prisoner at HMP Durham. He died of heart failure caused by hypoactive delirium (drowsiness and lethargy) which in turn was caused by acute kidney injury. He also had anaemia (a lack of red blood cells) which contributed to but did not cause his death. He was 82 years old. We offer our condolences to Mr Catchpole's family and friends.

5. The PPO family liaison officer wrote to Mr Catchpole's next of kin to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

6. NHS England commissioned an independent clinical reviewer to review Mr Catchpole's clinical care at HMP Durham.

7. The clinical reviewer concluded that the clinical care Mr Catchpole received at Durham was equivalent to that which he could have expected to receive in the community. He found that Mr Catchpole received responsive nursing care, where his specialist needs were met, and his comfort maintained.

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

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy within the clinical review report, which has been amended accordingly.

Adrian Usher **March 2024**
Prisons and Probation Ombudsman

10. The inquest into Mr Catchpole's death was held on 13 June 2024 and a verdict of natural causes was recorded. The coroner concluded that Mr Catchpole's death was due to heart failure. Mr Catchpole also had anaemia, acute kidney injury and hypoactive delirium.

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