Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Rigby, a prisoner at HMP Wymott, on 17 December 2023

A report by the Prisons and Probation Ombudsman

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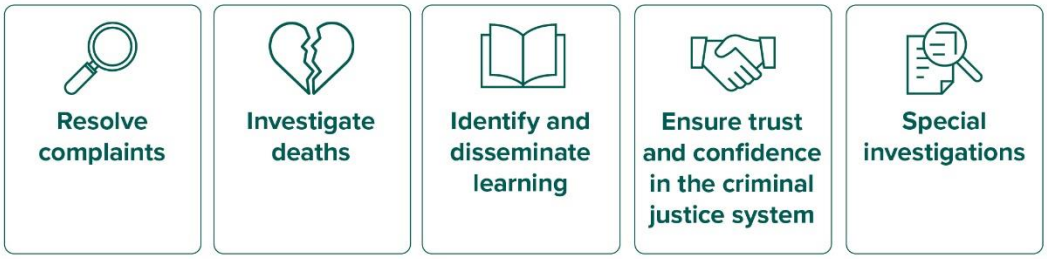
OUR VISION

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 April 2023, Mr John Rigby was sentenced to seven years imprisonment for sexual offences. He died of congestive cardiac failure (the heart does not pump blood sufficiently well) on 17 December 2023, in hospital, while a prisoner at HMP Wymott. He also had coronary artery disease (which also causes reduced blood flow) and malignancy (cancer from an unidentified source) which did not cause but contributed to his death. He was 76 years old. We offer our condolences to Mr Rigby's family and friends.

4. The Ombudsman's office contacted Mr Rigby's son and stepdaughter to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

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

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

7. The clinical reviewer concluded that the clinical care Mr Rigby received at HMP Wymott was variable, with some elements of care which were equivalent to that which he could have expected to receive in the community and other elements which were not. We make the following recommendations related to the clinical care Mr Rigby received:

   - **The Head of Healthcare should ensure that prisoners with ongoing treatment needs are identified and referred back into relevant specialist services to ensure that continuity of healthcare is maintained.**

   - **The Head of Healthcare should ensure that unregistered healthcare staff appropriately escalate changes in a prisoner's weight to registered healthcare staff.**

   - **The Head of Healthcare should investigate why the reason for Mr Rigby's GP appointment on 1 December 2023 was not included on the appointment ledger and take appropriate action.**

   - **The Head of Healthcare should ensure that prisoners with complex care needs are added to the multi-disciplinary team caseload.**

8. The clinical reviewer also made other recommendations not related to Mr Rigby's death that the Head of Healthcare will wish to address.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and the healthcare provider, Greater Manchester Mental Health NHS Foundation Trust pointed out a factual inaccuracy within the clinical review report, which has been amended accordingly.

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

Inquest

At the inquest, held on 8 October 2024, the Coroner concluded that Mr Rigby died from natural causes.

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