

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Barry Wemyss, a prisoner at HMP Northumberland, on 17 July 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



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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 2019, Mr Barry Wemyss was sentenced to 12 years imprisonment for sexual offences. He died of heart failure on 17 July 2023, at HMP Northumberland. He was 46 years old. We offer our condolences to Mr Wemyss' family and friends.
4. The PPO family liaison officer wrote to Mr Wemyss' brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.
5. The PPO investigator investigated the non-clinical issues relating to Mr Wemyss' care. We did not find any non-clinical issues of concern.
6. NHS England commissioned an independent clinical reviewer to review Mr Wemyss' clinical care at HMP Northumberland.
7. The clinical reviewer concluded that the clinical care Mr Wemyss received was of a reasonable standard and equivalent to that which he could have expected to receive in the community.
8. We make the following recommendation related to the clinical care Mr Wemyss received:
  - **The Head of Healthcare should ensure that all patients who present with chest pain have an electrocardiogram (ECG) undertaken in accordance with NICE guidelines NG95 Recent-onset chest pain of suspected cardiac origin: assessment and diagnosis.**
9. We shared our initial report with HMPPS and with the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies. Spectrum Community Health CIC provided an action plan which is annexed to this report.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**May 2024**

## **Inquest**

The inquest, held on 16 July 2024, concluded that Mr Wemyss died from natural causes.

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