Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Barnes, a prisoner at HMP Elmley, on 21 November 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. On 10 March 2021, Mr Jason Barnes was sentenced to four years and four months in prison for attempted robbery and common assault. On 21 November 2023, Mr Barnes died in hospital from multiple organ failure caused by biliary sepsis (an infection in the bile duct) which was in turn caused by gallstone pancreatitis and biliary obstruction, while a prisoner at HMP Elmley. He was 49 years old. We offer our condolences to Mr Barnes' family and friends.

4. The PPO family liaison officer wrote to Mr Barnes' 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. NHS England commissioned an independent clinical reviewer to review Mr Barnes' clinical care at HMP Elmley.

6. The clinical reviewer found that the clinical care Mr Barnes received at HMP Elmley was of a good standard and was at least equivalent to that which he could have expected to receive in the community. In particular, the clinical reviewer highlighted the good and compassionate medical care provided at Elmley.

7. The clinical reviewer made a number of recommendations not related to Mr Barnes' death which the Head of Healthcare will want to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Barnes' 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 did not find any factual inaccuracies.

10. However, while we note that Mr Barnes was not restrained in hospital in the month he died, the medical information in his escort risk assessment was not completed as it should have been when he was taken to hospital, restrained, on 9 October 2023. HMP Elmley told us that they were unable to explain why this had not happened. We draw this to the attention of the Governor and Head of Healthcare.

11. At an inquest held on 8 December 2023, the Coroner concluded that Mr Barnes' died of natural causes.

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

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