Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Barker, a prisoner at HMP Peterborough, on 12 September 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

Summary

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 HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Darren Barker died in hospital on 12 September 2023, of pancreatic cancer which had spread to other parts of his body, while a prisoner at HMP Peterborough. He was 46 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Barker received at Peterborough was of a good standard and was equivalent to that which he could have expected to receive in the community.

5. In July 2022, Mr Barker's blood was tested. The liver function tests and C-reactive protein (CRP) that detects infection was not repeated as the sample was lost. The clinical reviewer was unable to comment on whether these blood tests would have provided any indication that Mr Barker had cancer at that time.

6. The clinical reviewer made a recommendation not related to Mr Barker's death that the Head of Healthcare will wish to address.

7. It was not until two days before he died that a prison manager authorised the removal of Mr Barker's restraints in hospital.

Recommendations

- The Head of Healthcare should ensure that there is a robust blood test monitoring system in place so that samples that are lost, insufficient or mislabelled are reviewed and, if necessary, repeated.

- The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, that healthcare staff complete the medical information section of the escort risk assessment in full, and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

The Investigation Process

8. We were notified of Mr Barker's death on 13 September 2023. NHS England commissioned an independent clinical reviewer, to review Mr Barker's clinical care at Peterborough.

9. The PPO investigator investigated the non-clinical issues relating to Mr Barker's care.

10. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded: one subsequently refused to be interviewed and the other had been released and could not be contacted.

11. The PPO family liaison officer wrote to Mr Barker's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

12. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Peterborough

13. In the three years before Mr Barker's death eleven prisoners died from natural causes at Peterborough, one of which was as a result of COVID-19. There have also been two drug related deaths and a self-inflicted death in the same period. Our investigations into the deaths of men in October 2022 and November 2022 found that restraints had been inappropriately used on older, terminally ill prisoners.

Key Events

14. On 4 July 2022, Mr Darren Barker was remanded to HMP Peterborough.

15. On 25 July, Mr Barker saw a nurse because he had a lump under his right armpit. The nurse planned for him to see a GP at Peterborough. In the meantime, blood tests were taken.

16. On 1 August, a GP at Peterborough saw Mr Barker. The GP reviewed some of the blood results, which were normal. He noted that the plan was to await all blood test results, as some were still outstanding. If these results were abnormal then the plan was for further GP review. However, the sample for the liver function tests and C-reactive protein (CRP, that detects infection) was lost, and the tests were not repeated. There are no further entries relating to the lump under his armpit in Mr Barker's medical records until July 2023.

17. On 31 January 2023, Mr Barker was sentenced to two years and seven months in prison for breaching a non-molestation order and for criminal damage.

18. On 22 May, Mr Barker was released on licence. His licence was revoked on 15 June, and he was sent back to Peterborough.

19. On 15 July, a nurse saw Mr Barker in his cell. He told her that he could feel a lump in his right armpit/chest area which he had had for a long time. She booked a GP appointment for Mr Barker.

20. On 18 July, a GP at Peterborough saw Mr Barker and noted that he had a large lump with extensive bruising over the right breast and armpit area. The GP referred Mr Barker to a hospital specialist under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

21. On 20 July, a prison GP saw Mr Barker because the pain under his armpit was getting worse. He noted that Mr Barker had a large cystic swelling (a lump under the skin caused by a build-up of fluid) measuring fifteen centimetres by seven centimetres which extended to the nipple and chest area. He noted that there were no signs that the area was infected. He sent Mr Barker to hospital. When Mr Barker went to hospital, prison staff restrained him with a single cuff. Hospital staff said that Mr Barker had a chest wall haematoma (a collection of blood in the chest wall area) and planned for him to have an ultrasound scan to assess the nature of the lump. Hospital staff sent Mr Barker back to Peterborough.

22. On 10 August, healthcare staff sent Mr Barker to hospital because the lump under his right armpit was severely swollen. When he went to hospital prison staff restrained him with a single cuff, which in hospital they replaced with an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). The following day, Mr Barker had a Computerised Tomography (CT) scan which showed that he had a large mass in the right armpit. Hospital staff planned for him to have an MRI scan. Mr Barker returned to Peterborough that day.

23. On 21 August, Mr Barker went to hospital, where he was admitted as an inpatient. He remained in hospital for the rest of his life. When he went to hospital, prison staff

restrained Mr Barker with a single cuff. Mr Barker had an ultrasound guided biopsy (a scan of the body and a sample of tissue taken for analysis), a CT scan and an MRI. The CT scan, carried out on 24 August, showed that Mr Barker had a large mass (cancer) in the head of his pancreas which had spread to other parts of his body.

24. On 29 August, an operational manager reviewed the level of restraint and authorised that Mr Barker be restrained with an escort chain. At 10.30am on 10 September, she again reviewed the level of restraint and authorised that the escort chain be removed.

25. The operational manager said that, on 29 August, she was the duty manager that went to hospital to carry out the manager's bedwatch check and as part of the check reviewed the handcuff arrangements. She said that Mr Barker had been in hospital and was still on a single standard handcuff which made it difficult for movement in bed and to receive treatment. She said that she also took into account the risk that Mr Barker could escape and signed the risk assessment that she was happy for an escort chain to be applied. She said that, on 10 September, the documentation showed that Mr Barker's circumstances had changed, and the hospital were now treating him as end-of-life care. She said that she therefore authorised that the restraint should be removed.

26. On 12 September, Mr Barker died in hospital.

Post-mortem report

27. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Barker's cause of death as pancreatic cancer which had spread to other parts of his body.

Clinical findings

28. The clinical reviewer concluded that the clinical care Mr Barker received at Peterborough was of a good standard and was equivalent to that which he could expect to have received in the community.

29. In July 2022, a GP at Peterborough saw Mr Barker because he had a lump under his right armpit and had blood taken for testing. These were reported as acceptable. However, the liver function tests and C-reactive protein (CRP) that detects infection was not repeated as the sample was lost. The clinical reviewer was unable to comment on whether these blood tests would have provided any indication that Mr Barker had cancer at that time. We make the following recommendation:

    The Head of Healthcare should ensure that there is a robust blood test monitoring system in place so that samples that are lost, insufficient or mislabelled are reviewed and, if necessary, repeated.

30. The clinical reviewer said that the investigations into the lump under Mr Barker's armpit and referral in July 2023, was in accordance with National Institute for Health and Care Excellence (NICE) Guidelines for suspected cancer: recognition and referral which requires patients with suspected cancer to be seen by a specialist within two weeks.

Non-Clinical Findings

Restraints, security and escorts

31. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

32. Mr Barker was sent to hospital on three occasions shortly before his final admission on 21 August. On only one of these occasions is there evidence that the medical section was completed on the escort risk assessment, and there is no evidence that a medical assessment was completed at any time during his final admission.

33. This meant that Mr Barker's medical condition and its effect on his ability to escape was not properly considered when determining the level of restraints. While he was a relatively young man with little evidence of restricted mobility at the earlier hospital appointments, Mr Barker's health rapidly deteriorated during his final admission and it is probable that proper, proactive consideration of his medical condition would have resulted in restraints being removed earlier.

34. Following the deaths of prisoners in 2022, we twice made recommendations about the inappropriate use of restraints on terminally ill prisoners at Peterborough. The Head of Safety told us that the prison is in the process of implementing a review of the medical sections in escort records with the intention of adding a quality assurance procedure to this. It is important that this is completed quickly to ensure that, in future, terminally ill prisoners are no longer unnecessarily handcuffed.

The Director and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints, that healthcare staff complete the medical information section of the escort risk assessment in full, and that assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

Inquest

35. The inquest into Mr Barker's death concluded on 21 August 2024, and returned a verdict of natural causes.

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

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