Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Ms Fiona Barnard, a prisoner at HMP Askham Grange, on 15 September 2024

A report by the Prisons and Probation Ombudsman

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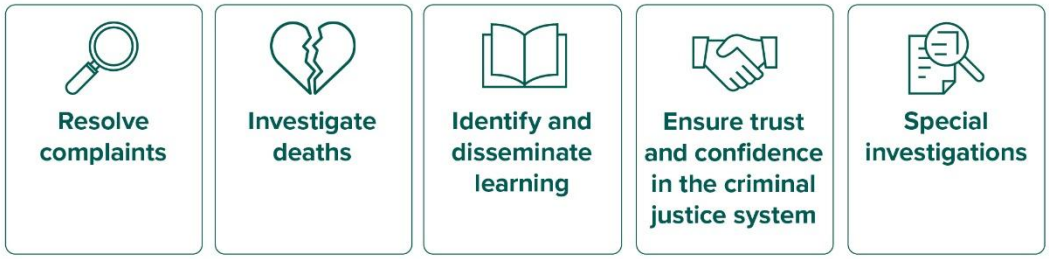
OUR VISION

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 17 August 2023, Ms Fiona Barnard was sentenced to three and a half years in prison for drug offences. She died from small bowel ischaemia (a life-threatening condition that blocks the blood flow to the small intestine) on 15 September 2024, while a prisoner at HMP Askham Grange. She was 59 years old. We offer our condolences to Ms Barnard's family and friends.

4. NHS England commissioned an independent clinical reviewer, to review Ms Barnard's clinical care at Askham Grange. The clinical review is attached as Annex 1.

5. The clinical reviewer concluded that the clinical care Ms Barnard received at Askham Grange was of a good standard and was at least equivalent to that which she could have expected to receive in the community. She found that Ms Barnard's episode of illness was acute and healthcare staff would not have been able to diagnose the bowel ischaemia. She made no recommendations.

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

7. We did not find any non-clinical issues of concern. We make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found one factual inaccuracy in the clinical review and the report has been amended.

9. At an inquest held on 8 July 2026, the Coroner concluded that Ms Barnard died from natural causes.

Governor to note

10. While it would not have made a difference to the outcome for Ms Barnard given her cause of death, there is no evidence in the wing observation book that prison staff completed welfare checks on her from 12 September, as healthcare staff had requested.

Adrian Usher **July 2025**
Prisons and Probation Ombudsman

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