Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jason Rae, a prisoner at HMP Forest Bank, on 4 March 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 16 July 2024, Mr Jason Rae was sentenced to eight years in prison for robbery, dangerous driving and driving while disqualified. He died in hospital from a gastrointestinal haemorrhage on 4 March 2024, while a prisoner at HMP Forest Bank. This was caused by liver cancer which had spread to other parts of the body. He was 54 years old. We offer our condolences to Mr Rae's family and friends.

4. The PPO family liaison officer wrote to Mr Rae's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

5. NHS England commissioned an independent clinical reviewer to review Mr Rae's clinical care at HMP Forest Bank.

6. The clinical reviewer concluded that the clinical care Mr Rae received at HMP Forest Bank was of a good standard and at least equivalent to that which he could have expected to receive in the community. The clinical reviewer made recommendations which were not related to Mr Rae's death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Rae's care. We did not find any significant non-clinical learning and we make no recommendations.

8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Director to note

9. The record keeping in Mr Rae's escort risk assessment paperwork was poor and some key entries were illegible. The terminology that staff used to explain escort arrangements for Mr Rae during a hospital escort was unclear and incorrect. The prison provided new information about this, which contradicted previous information they had given us, extremely late in the investigation. This prevented us from issuing our initial report on time.

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

10. At an inquest held on 16 January 2025, the Coroner concluded that Mr Rae died of natural causes.

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