Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian James, a prisoner at HMP/YOI Elmley, on 23 February 2025

A report by the Prisons and Probation Ombudsman

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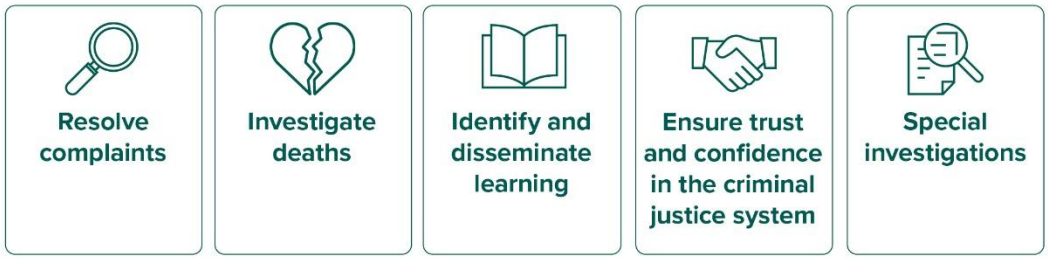
OUR VISION

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 18 November 2024, Mr Brian James was remanded into custody, charged with murder. He died in hospital from acute ischaemia of the bowel, liver and spleen (a reduced blood flow to the organs) on 23 February 2025 while a prisoner at HMP Elmley. This was caused by extensive atherosclerotic disease (a hardening/narrowing of the arteries). He was 81 years old. We offer our condolences to Mr James' family and friends.

4. The Ombudsman's office wrote to Mr James' 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. The PPO investigator investigated the non-clinical issues relating to Mr James' care. We were concerned that Mr James was restrained using a single cuff (where the prisoner is attached to an escort officer by a set of handcuffs) when he was escorted to hospital on 22 February. We note that the healthcare team subsequently identified that the nurse failed to object to the use of restraints and they have since provided training to staff on restraints and escort risk assessments. Given this and that the restraint was removed shortly after Mr James' arrival at hospital, we do not make a recommendation.

6. NHS England commissioned an independent clinical reviewer, to review Mr James' clinical care at HMP Elmley. The PPO investigator and clinical reviewer interviewed two members of staff on 11 April.

7. The clinical reviewer concluded that the clinical care Mr James received at Elmley was of a good standard and equivalent to that which he could have expected to receive in the community. However, this did not extend to the assessment and management of Mr James' acute abdominal issues on 22 February, the day before he died. The clinical reviewer was concerned that some clinical features may not have been fully recognised and staff's reliance on NEWS2 scores may have limited a more comprehensive clinical interpretation. We make the following recommendation:

   The Head of Healthcare should review the current guidance on the assessment and management of acute abdominal pain and provide healthcare staff with relevant training.

8. Mr James' family received a copy of the draft report. They did not make any comments.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

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

Inquest

10. The inquest into Mr James' death was held on 19 January 2026 and a verdict of natural causes was recorded. The coroner concluded that Mr James' death was due to acute ischemia of bowel, liver and spleen and extensive atherosclerotic disease.

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