

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Barkess, a prisoner at HMP Moorland, on 24 March 2025

A report by the Prisons and Probation Ombudsman

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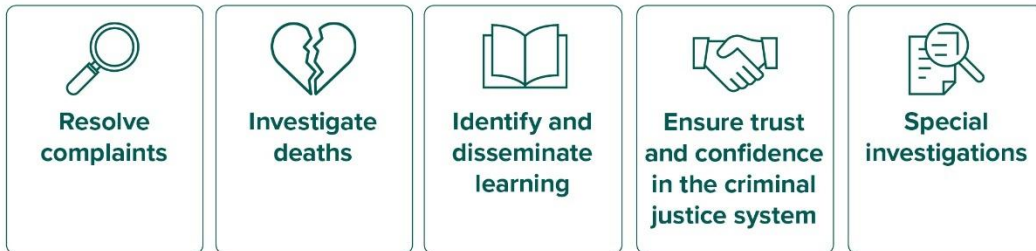
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OUR VISION

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



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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 25 April 2024, Mr John Barkess was sentenced to 15 years in prison for sexual offences. He died in hospital of an acute cardiac event caused by coronary artery atherosclerosis (narrowing of the coronary artery) and cellulitis and streptococcus pyogenes sepsis (an infection in the deeper layers of the skin) on 24 March 2025, while a prisoner at HMP Moorland. He was 84 years old. We offer our condolences to Mr Barkess' family and friends.
4. The Ombudsman's office wrote to Mr Barkess' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked about his medical care, raised concern that they had not been informed of his hospital admission and asked for a copy of our report. These questions have been addressed in the clinical review and in separate correspondence.
5. NHS England commissioned an independent clinical reviewer, to review Mr Barkess' clinical care at HMP Moorland.
6. The clinical reviewer concluded that the clinical care Mr Barkess received at Moorland was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Barkess' health deteriorated quickly and he was transferred to hospital in a timely manner. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Barkess' care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
10. Mr Barkess' family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Inquest

At the inquest held on 25 November 2025, the coroner concluded that Mr Barkess died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

November 2025

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