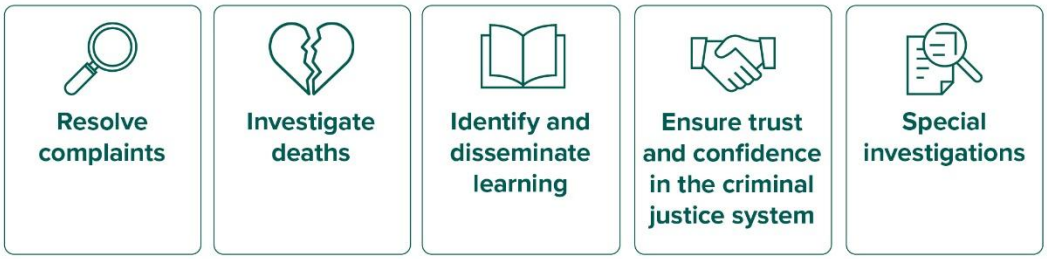
Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Barron, a prisoner at HMP Ashfield, on 18 July 2025

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 30 August 2007, Mr Anthony Barron was convicted of sexual offences and was sentenced to life imprisonment, with a minimum term of nine years.

4. Mr Barron died in hospital of cancer (of unknown primary with liver, spleen and lymph node metastases) on 18 July 2025, at HMP Ashfield. He was 72 years old. We offer our condolences to Mr Barron's family and friends.

5. The Ombudsman's office wrote to Mr Barron's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

6. NHS England commissioned an independent clinical reviewer, to review Mr Barron's clinical care at HMP Ashfield.

7. The clinical reviewer concluded that the clinical care Mr Barron received at Ashfield was of a good standard and was at least equivalent to that which he could expect to receive in the wider community. He found that from the point of referral to the suspected cancer pathway, Mr Barron was seen and assessed in hospital within the current expected timeframe. The clinical reviewer made recommendations not related to Mr Barron's death that the Head of Healthcare will wish to address.

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

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

10. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

Inquest

The inquest hearing was held on 16 April 2026. The Coroner concluded that Mr Barron died of natural causes.

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