

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Andrew Barraclough, a prisoner at HMP Stafford, on 30 May 2024**

**A report by the Prisons and Probation Ombudsman**

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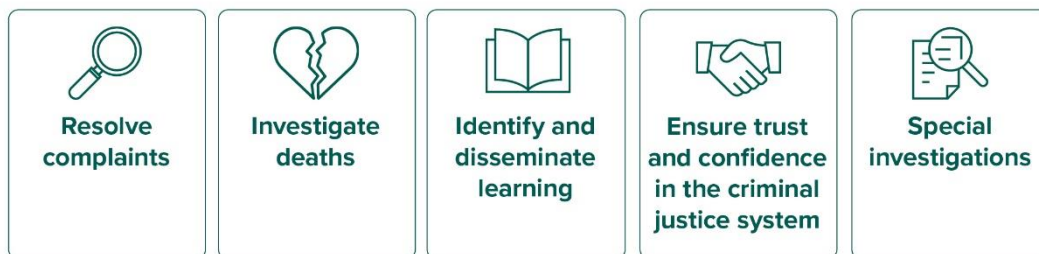
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## **OUR VISION**

**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 29 July 2022, Mr Andrew Barraclough was convicted of sexual offences and sentenced to 16 years in prison.
4. On 30 May 2024, while a prisoner at HMP Stafford, Mr Barraclough died of a malignant tumour of the lung caused by idiopathic pulmonary fibrosis (lungs become scarred and breathing becomes more difficult) and chronic obstructive lung disease. He was 61 years old. We offer our condolences to Mr Barraclough's family and friends.
5. The Ombudsman's office wrote to Mr Barraclough's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.
6. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
7. NHS England commissioned an independent clinical reviewer to review Mr Barraclough's clinical care at HMP Stafford.
8. The clinical reviewer concluded that the clinical care Mr Barraclough received at Stafford was of an excellent standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer found that healthcare staff should be commended for the high quality of patient centred care provided throughout Mr Barraclough's time in Stafford.
9. The PPO investigator investigated the non-clinical issues relating to Mr Barraclough's care.
10. We did not find any non-clinical issues of concern. We make no recommendations.

## Inquest

11. The inquest into Mr Barraclough's death concluded on the 18 November 2024. The coroner confirmed that Mr Barraclough died from natural causes.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**June 2025**

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