Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frederick Barber, a prisoner at HMP Altcourse, on 17 June 2022

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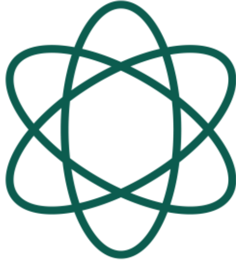
Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

OGL

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Summary

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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Fredrick Barber died of a heart attack caused by a blockage in his heart and cancer on 17 June 2022, while a prisoner at HMP Altcourse. He was 82 years old. We offer our condolences to Mr Barber's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Barber received at Altcourse was equivalent to that which he could have expected to receive in the community.

5. We found no non-clinical issues of concern.

6. This version of my report, published on PPO website, has been amended to remove the names of staff and prisoners involved in my investigation.

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Barber's clinical care at Altcourse. The clinical reviewer's report is attached.

8. The PPO investigator investigated the non-clinical issues relating to Mr Barber's care, including Mr Barber's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Barber'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 to our letter.

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

Previous deaths at HMP Altcourse

11. Mr Barber was the 17th prisoner to die at Altcourse since June 2020. Of the previous deaths, 12 were from natural causes and four were self-inflicted. Since Mr Barber's death, there has been one further death from natural causes. There are no similarities between our findings in the investigation into Mr Barber's death and our investigation findings for the previous deaths.

Key Events

12. On 1 December 2017, Mr Frederick Barber was convicted of sex offences. On 5 January 2018, he was given a 17-year sentence and transferred to HMP Altcourse.

13. At Mr Barber's initial healthcare screening, staff recorded that he had prostate cancer (which was under control), diabetes and a blood clot on the lung. They arranged for him to be transferred to a cell on the prison inpatient unit and for day-to-day support to be provided by two carers.

14. On 18 January 2018, Mr Barber's community GP confirmed that he had prostate cancer, which had been diagnosed in 1997.

15. On 8 February, Mr Barber told the prison GP that he thought his prostate symptoms were coming back. The GP referred Mr Barber to the local hospital, for further investigation. On 15 February, a consultant urologist reviewed Mr Barber's symptoms and requested a blood test. The blood test results did not present any issues of concern and no further action was required.

16. On 12 February 2020, Mr Barber met with a consultant in the local hospital for his routine cancer review. They found that his cancer had spread to his bones. The consultant advised Mr Barber to continue to take his daily cancer medication and explained that his care would be transferred to the palliative team.

17. On 12 July 2021, Mr Barber vomited brown fluid. Healthcare staff called an ambulance, who transferred Mr Baber to hospital. Mr Barber was admitted as an inpatient and diagnosed with right sided hydronephrosis (a condition of excess urine accumulation in the kidney or kidneys, that causes them to swell). Hospital doctors fitted him with a nephrostomy tube (a tube that drains urine from a kidney into a bag outside the body) on 23 July 2021. The next day, Mr Barber was transferred back to Altcourse and the healthcare team created a care plan to ensure that his nephrostomy tube could be appropriately maintained in prison.

18. On 5 January 2022, Mr Barber was diagnosed with a malignant spinal cord compression, a terminal condition. This was due to cancer growing in or around on his spinal cord and pressing on it.

19. On 11 January, Altcourse appointed a family liaison officer, who kept in contact with Mr Barber's family to update them on his health. After consulting with a prison GP, Mr Barber made the decision that he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect.

20. On 16 January, Mr Barber made the decision that he wanted to continue to receive treatment, despite his condition being terminal.

21. On 14 April, a palliative care nurse from the local hospital visited Mr Barber in prison. She assessed that he did not need hospice care, but that his health was poor and early release on compassionate grounds should be considered soon.

22. On 1 June, sent Mr Barber found blood in his urine and the prison GP arranged a transfer to A&E. Mr Barber was admitted as an inpatient and stayed in hospital for

monitoring. The hospital found sepsis of the urinary tract and a blockage in his heart. They discussed whether to fit Mr Barber with a pacemaker.

23. On 16 June, prison staff held a multidisciplinary meeting regarding Mr Barber's care planning. They recorded that hospital doctors had decided it was not appropriate to fit Mr Barber with a pacemaker, and he needed end of life care.

24. At 7.30pm, Mr Barber was discharged from hospital and returned to the prison inpatient unit.

25. On 17 June, Mr Barber died.

Post-mortem report

26. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Barber's cause of death as a heart attack caused by a blockage in his heart and cancer.

Tallulah Frankland
Assistant Ombudsman **November 2022**

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