Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Farrell, a prisoner at HMP/YOI Forest Bank, on 8 January 2025

A report by the Prisons and Probation Ombudsman

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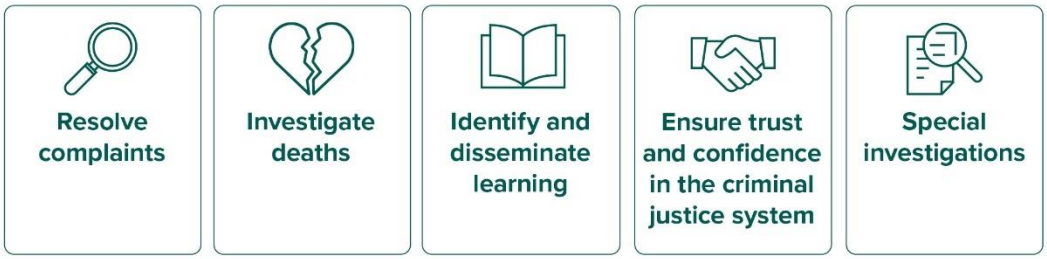
OUR VISION

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. In August 2023, Mr James Farrell was sentenced to 36 months in prison for sexual offences. He died of pneumonia on 8 January 2025, while a prisoner at HMP Forest Bank. He was 77 years old. We offer our condolences to Mr Farrell's family and friends.

4. The Ombudsman's office wrote to Mr Farrell's 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. NHS England commissioned an independent clinical reviewer, to review Mr Farrell's clinical care at Forest Bank. The clinical reviewer's report is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Farrell received at Forest Bank was of a good standard and equivalent to what he could have expected to receive in the community. Mr Farrell was at Forest Bank for a very short period before he was admitted to hospital where he stayed for 16 months until his death on 8 January 2025. The clinical reviewer found that healthcare staff were responsive to his needs and recognised changes in his health. While Mr Farrell was in hospital, healthcare staff asked for regular updates, and communication and key developments were documented well in his medical records. The clinical reviewer did not make any recommendations.

7. The PPO investigator investigated the non-clinical issues relating to Mr Farrell's 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 Farrell's family received a copy of the initial report. They did not make any comments.

11. At the inquest held on 29 July 2025, the coroner concluded Mr Farrell died of natural causes.

Adrian Usher
Prison and Probation Ombudsman **July 2025**

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