Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Maddox, a prisoner at HMP Manchester, on 17 June 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 July 2011, Mr Neil Maddox was sentenced to 15 years imprisonment for sexual offences. Mr Maddox had Advanced Parkinson's disease. He died in hospital of aspiration pneumonia (the inhalation of stomach contents) caused by oropharyngeal dysphagia (a disorder in which you cannot properly swallow food, liquid or saliva) on 17 June 2024, while a prisoner at HMP Manchester. He was 76 years old. We offer our condolences to Mr Maddox's family and friends.

4. The Ombudsman's office contacted Mr Maddox's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He raised no issues and asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer to review Mr Maddox's clinical care at HMP Manchester.

6. The clinical reviewer concluded that the clinical care Mr Maddox received was equivalent to that which he could have expected to receive in the community. She made one recommendation about falls risk assessments, which is not directly related to Mr Maddox's death but which the Head of Healthcare will wish to address.

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

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

9. At the inquest held on 2 July 2024 the coroner concluded that Mr Maddox died of natural causes.

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

11. Mr Maddox's family received a copy of the draft report. They did not make any comments.

Adrian Usher **October 2024**
Prisons and Probation Ombudsman

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100