

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Brady, a prisoner at HMP Ashfield, on 21 December 2024

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



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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 17 July 2021, Mr Patrick Brady was sentenced to 10 years in prison for sex offences. He died from decompensated heart failure on 21 December 2024, while a prisoner at HMP Ashfield. Mr Brady had pneumonia, anaemia and frailty, and these factors contributed to but did not cause his death. He was 78 years old. We offer our condolences to Mr Brady's family and friends.
4. The Ombudsman' wrote to Mr Brady's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not want to be contacted.
5. NHS England commissioned an independent clinical reviewer to review Mr Brady's clinical care at HMP Ashfield.
6. The clinical reviewer concluded that the clinical care Mr Brady received at Ashfield was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. He found that overall, Mr Brady's care was good: he attended chronic disease management reviews, he had blood tests and imaging when required, his leg ulcers were dressed when needed and he was attended to when acutely ill and admitted to hospital when necessary. The clinical reviewer made three recommendations which were not related to Mr Brady's death but which the Head of Healthcare will want to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Brady's care. We did not identify any non-clinical learning and we make no recommendations.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
9. At an inquest held on 23 September 2026, the Coroner concluded that Mr Brady died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

June 2025



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