

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Beaudro, a prisoner at HMP Bristol, on 27 June 2025

A report by the Prisons and Probation Ombudsman

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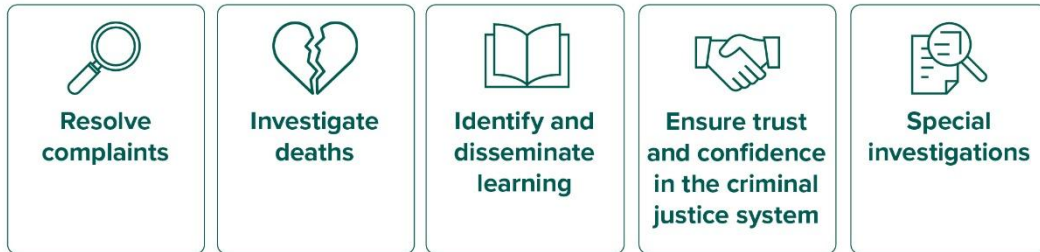
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OUR VISION

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 26 May 2023, Mr Gary Beaudro was sentenced to 30 months in prison for indecent assault. He died from multiple cerebral embolic infarcts (strokes, caused by blood clots travelling to the brain), caused by pancreatic adenocarcinoma with liver metastases (pancreatic cancer which has spread to the liver) on 27 June 2025, while a prisoner at HMP Bristol. He was 76 years old. We offer our condolences to Mr Beaudro's family and friends.
4. The Ombudsman's office contacted Mr Beaudro'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 Beaudro's clinical care at HMP Bristol. The clinical review is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Beaudro received at Bristol was of a good standard and at least equivalent to that which he could have expected to receive in the community. He found that Mr Beaudro was promptly referred to secondary services when he presented with anaemia, and found integrated care between healthcare teams at Bristol and Ashfield. He made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Beaudro'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 Beaudro's family received a copy of the draft report. They did not make any comments.
11. In an inquest held on 8 June 2026, the Coroner concluded that Mr Beaudro died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

February 2026

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