Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Radford a prisoner at HMP Peterborough, on 22 November 2024

A report by the Prisons and Probation Ombudsman

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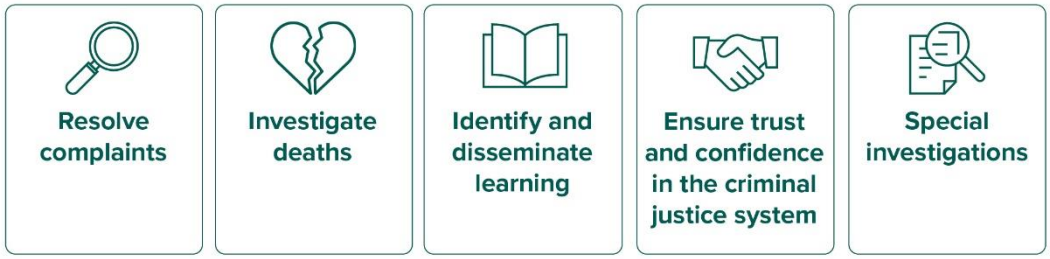
OUR VISION

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

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 18 March 2021, Mr John Radford was sentenced to 13 years in prison for indecent assault. He died of heart failure on 14 November 2024, while a prisoner at HMP Peterborough. This was caused by hypertension (high blood pressure), atrial fibrillation (an irregular heartbeat) and chronic kidney disease. He was 95 years old. We offer our condolences to Mr Radford's family and friends.

4. The Ombudsman's office wrote to Mr Radford'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 Radford's clinical care at HMP Peterborough.

6. The clinical reviewer concluded that the clinical care Mr Radford received at Peterborough was of a high standard and was at least equivalent to that which he could have expected to receive in the community. She found that healthcare staff addressed Mr Radford's health concerns and needs appropriately. The clinical reviewer made recommendations which were not related to Mr Radford's death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Radford'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. Mr Radford's family received a copy of the draft report. They pointed out one factual inaccuracy. This report has been amended accordingly.

10. At an inquest held on 28 November 2024, the Coroner concluded that Mr Radford died of natural causes.

Adrian Usher **June 2025**
Prisons and Probation Ombudsman

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