

**Prisons &
Probation**

Ombudsman
Independent Investigations

**Independent investigation
into the death of
Mr Andrew Bullough, a prisoner
at HMP/YOI Thorn Cross,
on 21 August 2025**

A report by the Prisons and Probation Ombudsman

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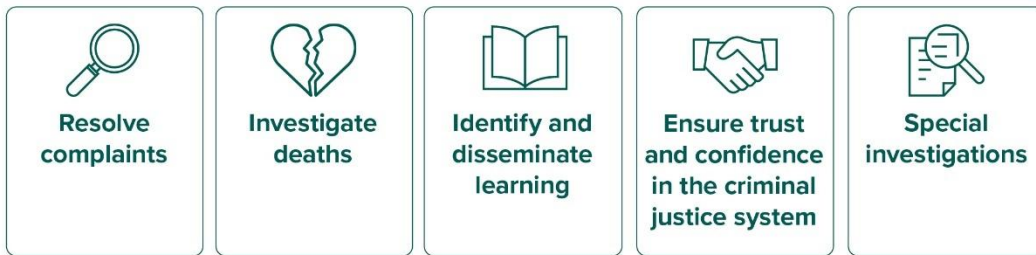
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OUR VISION

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 15 March 2024, Mr Andrew Bullough was sentenced to six years in prison for drug offences. He died in hospital of congestive cardiac failure caused by acute myocardial infarction with rupture and severe coronary artery atheroma on 21 August 2025, while a prisoner at HMP/YOI Thorn Cross. He was 59 years old. We offer our condolences to Mr Bullough's family and friends.
4. The Ombudsman's office wrote to Mr Bullough's family to explain the investigation and to ask if they had any matters they wanted us to consider. They asked questions about the emergency response and asked for a copy of our report. We have answered the family's questions in the clinical review and in separate correspondence.
5. NHS England commissioned an independent clinical reviewer to review Mr Bullough's clinical care at HMP Thorn Cross. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Bullough received at HMP Thorn Cross was of a good standard and equivalent to what he could have expected to receive in the community. He found that Mr Bullough had limited contact with healthcare staff at Thorn Cross, however when appropriate, he was reviewed in a timely manner and his healthcare needs were met and supported. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Bullough'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) and Practice Plus Group. They did not find any factual inaccuracies.
10. Mr Bullough's family received a copy of the draft report. They did not make any comments.
11. At the inquest held on 28 April 2026, the coroner concluded that Mr Bullough died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

April 2026

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