Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Bradshaw, a prisoner at HMP Manchester, on 30 January 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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Summary

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. Our office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Geoffrey Bradshaw, who was 75 years old, died of acute peritonitis (an infection of the inner lining of the abdomen), caused by a perforated duodenal ulcer on 30 January 2020, while in the custody of HMP Manchester. We offer our condolences to Mr Bradshaw’s family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Bradshaw received was of a good standard and equivalent to that which he could have expected to receive in the community. There are no recommendations.

5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Bradshaw’s clinical care at HMP Manchester.

7. The PPO investigator has investigated the non-clinical issues in Mr Bradshaw’s care, including his location, the security arrangements for his hospital escorts and liaison with his family.

8. The PPO family liaison officer wrote to Mr Bradshaw’s next of kin, to explain the investigation. She did not respond.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out no factual inaccuracies.

Previous deaths at Manchester

10. Mr Bradshaw was the seventh prisoner to have died from natural causes in the custody of HMP Manchester in the last two years. There are no similarities between our findings in the investigation of Mr Bradshaw’s death and the other investigations.

Key Events

11. Mr Geoffrey Bradshaw was remanded to HMP Manchester on 26 July 2018 for breaching the terms of his sexual offences prevention order. He was sentenced to two years and six months in custody. On 27 September 2019, Mr Bradshaw was released on licence from prison. He was recalled to custody on the 14 November for breaching his licence conditions.

12. Mr Bradshaw had several health conditions, including COPD (chronic obstructive pulmonary disease), type 2 diabetes, diabetic leg ulcers, paranoid schizophrenia, retention of urine requiring a catheter and high blood pressure.

13. In July 2018, Mr Bradshaw was diagnosed with non-Hodgkin lymphoma. Mr Bradshaw could not have chemotherapy due to his poor health and the risk of infection, but he remained under the care of The Christie Hospital to monitor the cancer.

14. In December 2019, Mr Bradshaw was admitted to hospital for three days with acute kidney failure. When he was discharged back to prison, he was admitted to the healthcare inpatient unit for monitoring. Prison and healthcare staff allowed him to keep his cell door open.

15. On 5 January 2020, Mr Bradshaw was admitted back to hospital. He was treated for an acute kidney injury, urinary tract infection, lower respiratory tract infection and cellulitis. He was discharged back to the prison and returned to the healthcare inpatient unit, where he remained until his final admission to hospital.

16. On 21 January 2020, during a routine assessment, a healthcare assistant was concerned that Mr Bradshaw's blood pressure was low. A prison GP reviewed Mr Bradshaw and adjusted his medication and his blood pressure improved. Healthcare staff continued to monitor him.

17. On 22 January, a nurse was asked to review Mr Bradshaw because he was slurring and could not sit up. The nurse gave him medication to raise his blood sugar levels and spoke to the prison GP. The GP advised that he needed to go to hospital urgently and the prison requested an emergency ambulance at 12.37pm. Healthcare staff took Mr Bradshaw's clinical observations every 10 minutes until paramedics arrived at 1.17pm. Mr Bradshaw was taken to hospital and admitted as an inpatient. He was not restrained.

18. Mr Bradshaw's health deteriorated and, on 30 January, it was confirmed that Mr Bradshaw had died.

19. The post-mortem examination found that Mr Bradshaw died from acute peritonitis, caused by a perforated duodenal ulcer.

Karen Johnson **June 2020**
Assistant Ombudsman

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