Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bradley Finch on 23 September 2022, following his release from HMP Risley

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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

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.

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

Mr Bradley Finch died in hospital on 23 September 2022, following his release from HMP Risley on 9 September 2022. The post-mortem examination found that he died from diabetic ketoacidosis (when a person with diabetes runs out of insulin and harmful substances called ketones build up in the body). He was 24 years old. I offer my condolences to his family and friends.

Mr Finch was released to Chorlton House Approved Premises on 9 September 2022. He had diabetes and arrived with his insulin, which he administered himself. There were no issues up to 15 September, when he failed to return to the AP by his evening curfew. Staff started recall procedures and withdrew his bedspace, so Mr Finch was technically unlawfully at large. On 20 September, police told probation staff that Mr Finch had been admitted to hospital earlier that day after suffering a cardiac arrest. He died in hospital three days later.

Mr Finch died due to poorly controlled diabetes. I am satisfied that there is nothing AP staff could have done to prevent his death.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and residents involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. On 3 May 2019, Mr Bradley Finch was sentenced to seven years and six months imprisonment for arson.

2. On 9 September 2022, Mr Finch was released from HMP Risley to Chorlton House Approved Premises (AP). He had diabetes and arrived with one week's supply of insulin, which he kept in his possession.

3. Mr Finch was subject to daily welfare checks from AP staff which did not raise any concerns. He discussed registering with a GP with AP staff and was reminded to do so at least once in the time he was there.

4. On the morning of 15 September, Mr Finch left Chorlton House to go to the bank and then to an appointment with his probation officer. However, before his appointment, his probation officer contacted him and told him not to attend as there had been a power cut at the office. She postponed his appointment for a week.

5. Mr Finch had not returned to Chorlton House AP by his curfew time of 9.00pm. At approximately 10.45pm, a duty manager agreed to recall Mr Finch. As a result, Mr Finch was unlawfully at large and Chorlton House AP removed his bedspace.

6. On 20 September, police contacted Mr Finch's probation officer and told her that Mr Finch was in hospital. He had been admitted in the early hours after suffering a cardiac arrest.

7. Mr Finch died in hospital on 23 September. The post-mortem examination found that Mr Finch died from hypoxic brain injury (lack of oxygen to the brain) caused by diabetic ketoacidosis (when a person with diabetes runs out of insulin and harmful substances called ketones build up in the body).

Findings

8. Mr Finch had insulin with him when he was released from prison, which he was responsible for administering himself. AP staff advised Mr Finch to register with a GP in the community but were not responsible for ensuring he did. We do not know where Mr Finch was between 15 and 19 September, but it appears that he was not properly managing his diabetes.

9. We are satisfied that AP staff could not have prevented Mr Finch's death. We make no recommendations.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Chorlton House AP informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Finch's prison, probation and medical records.

12. We informed HM Coroner for Greater Manchester West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Finch's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Background Information

Chorlton House Approved Premises

15. Approved premises (formerly known as probation and bail hostels) mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own healthcare and are expected to register with a GP.

16. Chorlton House is a 23-bed approved premises in Greater Manchester for adult males. Each resident is allocated a key worker and an offender manager to oversee their progress and wellbeing and ensure that they adhere to their licence conditions and premises' rules.

Previous deaths at Chorlton House Approved Premises

17. The last death at Chorlton House prior to Mr Finch's was in 2018. This death was due to drug use.

Key Events

18. On 3 May 2019, Mr Bradley Finch was sentenced to seven years and six months imprisonment for arson. He was moved to HMP Risley on 21 March 2021.

19. On 6 April, Mr Finch was allocated a new Community Offender Manager (COM).

20. On 8 June, the COM met with Mr Finch at Risley. She told Mr Finch that he would be required to reside at a probation approved premises (AP) on release.

21. The same day, the COM completed an AP referral. Chorlton House AP in Manchester accepted the referral on 13 June.

22. On 24 August, the COM sent Mr Finch's release licence conditions and reporting instructions to Risley, which included a curfew and drug testing requirements.

23. On 9 September, Mr Finch was released from Risley. He went to Chorlton House AP and completed his induction. He was diabetic and arrived with insulin, which he administered himself. He arrived with one week's supply of insulin, to last him until he could register with a community GP. He was subject to daily welfare checks from AP staff which did not raise any concerns.

24. On 13 September, Mr Finch met his AP keyworker who reminded him to register with a GP.

25. On 15 September at 8.48am, Mr Finch signed out of Chorlton House. He said he had to go to the bank and then had an appointment with the COM at the probation office.

26. At approximately 2.00pm, the COM contacted Mr Finch and told him not to come to the office as there had been a power cut. She gave Mr Finch an appointment for the following week.

27. Mr Finch did not return to Chorlton House and missed his curfew of 9.00pm. At approximately 10.45pm, a duty manager agreed to recall Mr Finch to prison. The COM completed the paperwork the following day and Mr Finch was considered unlawfully at large. As a result, Chorlton House AP manager removed Mr Finch's bedspace. (Staff did not empty his room until 23 September. We do not know if they found any insulin among his belongings.)

28. On 20 September, police contacted the COM and told her Mr Finch was in hospital following a suspected heart attack.

29. Mr Finch died in hospital on 23 September at 1.20pm.

Support for residents and staff

30. After Mr Finch's death, the AP manager contacted all staff and residents. She made them aware of both internal and external support available to them.

Post-mortem report

31. The post-mortem examination found that Mr Finch died from hypoxic brain injury (lack of oxygen to the brain) caused by diabetic ketoacidosis (a serious problem that can happen in people with diabetes if their body starts to run out of insulin and their blood sugar level rises causing a build up of harmful substances called ketones). Pneumonia was listed as a contributory factor.

Findings

32. Mr Finch arrived at Chorlton House with his insulin, which he administered himself. AP staff discussed with Mr Finch that he needed to register with a GP, and reminded him to at least once in the short time he was there. We do not think staff could reasonably have done any more to encourage him to take responsibility for his health.

33. There were no issues up to 15 September, when Mr Finch failed to return to the AP. We do not know where Mr Finch was between 15 and 19 September, but it appears that he did not properly manage his diabetes during this time.

34. We are satisfied that AP staff could not have prevented Mr Finch's death. We make no recommendations.

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