Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Tullett, a prisoner at HMP Bure, on 26 October 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

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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 23 June 2022, Mr Geoffrey Tullett was sentenced to 18 years in prison for rape. He died from metastatic lung cancer (cancer that had spread from the lungs to other parts of the body) on 26 October 2024, while a prisoner at HMP Bure. He was 79 years old. We offer our condolences to Mr Tullett's family and friends.

4. The Ombudsman's office wrote to Mr Tullett'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.

5. NHS England commissioned an independent clinical reviewer to review Mr Tullett's clinical care at Bure.

6. The clinical reviewer concluded that the clinical care Mr Tullett received at Bure was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She found that healthcare staff appropriately managed and monitored Mr Tullett's health needs, and identified the deterioration in his health. The clinical reviewer made three recommendations which were not related to Mr Tullett's death but which the Head of Healthcare will want to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Tullett's care.

8. We did not find any non-clinical issues of concern and we make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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

10. At an inquest held on 27 June 2025, the Coroner concluded that Mr Tullett. died of natural causes.

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