

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Nash, a prisoner at HMP Bure, on 2 October 2023**

**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 HMPPS in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr David Nash was convicted of sexual offences and was sentenced to six years, six months in prison. He died in hospital of a brain tumour on 2 October 2023, while a prisoner at HMP Bure. He was 37 years old. We offer our condolences to Mr Nash's family and friends.
4. The PPO family liaison officer wrote to Mr Nash's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
5. The initial report was shared with HM Prison and Probation Service HMPPS. HMPPS did not find any factual inaccuracies.
6. NHS England commissioned an independent clinical reviewer to review Mr Nash's clinical care at HMP Bure.
7. The clinical reviewer concluded that the clinical care Mr Nash received at Bure was of a good standard and equivalent to that which he could have expected to receive in the community. She was satisfied that Mr Nash was managed with compassion and cared for by confident, competent staff during his time at HMP Bure with evidence of good multi-disciplinary team working. There was also evidence of kind, respectful and compassionate interaction between healthcare and custodial teams and Mr Nash.
8. The PPO investigator investigated the non-clinical issues relating to Mr Nash's care.
9. We did not find any non-clinical issues of concern. Mr Nash's death was expected, and a prison family liaison officer (FLO) was in place. The FLO supported Mr Nash's family throughout his illness and arranged to meet his mother at the hospital when his health deteriorated. Mr Nash's mother asked the FLO to be with Mr Nash when he died as she would not arrive at the hospital in time. She arrived shortly after Mr Nash died and thanked the FLO for being with him. We consider the provision of family liaison to have been good practice. We make no recommendations.

## **Inquest**

10. The inquest into Mr Nash's death concluded on the 31 May 2024. The coroner confirmed that Mr Nash died of natural causes.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**July 2024**

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