

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Almond, a prisoner at HMP Liverpool, on 14 September 2024**

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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 21 February 2020, Mr David Almond was convicted of sexual offences and sentenced to 12 years in prison.
4. Mr Almond died in a hospice of brain cancer on 14 September 2024, while a prisoner at HMP Liverpool. He was 80 years old. We offer our condolences to Mr Almond's family and friends.
5. The Ombudsman's office wrote to Mr Almond's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She asked a question about communication with the family when Mr Almond was taken to hospital, which we have addressed in separate correspondence, and asked for a copy of our report.
6. We also shared the initial report with Mr Almond's family. They did not make any comments.
7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
8. NHS England commissioned an independent clinical reviewer to review Mr Almond's clinical care at HMP Liverpool.
9. The clinical reviewer concluded that the clinical care Mr Almond received at Liverpool was of a reasonable standard and equivalent to that which he could have expected to receive in the community. He identified two areas of good practice by healthcare staff. An Advance Care Plan (ACP) was in place and regularly updated, and Mr Almond's do not attempt resuscitation (DNACPR) request documentation was reviewed regularly to ensure that it was up to date.
10. The PPO investigator investigated the non-clinical issues relating to Mr Almond's care.
11. We did not find any non-clinical issues of concern. We make no recommendations.

## Inquest

12. The inquest into Mr Almond's death concluded on 3 October 2025. The coroner confirmed that Mr Almond died of natural causes.

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

**December 2025**

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