

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Sorin Fodor, a prisoner at HMP Bedford, on 4 April 2025**

**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 27 January 2025, Mr Sorin Fodor was remanded to HMP Bedford for weapons offences and breach of bail.
4. Mr Fodor died in hospital on 4 April 2025, having spent nearly two months as an inpatient. His cause of death was multi-organ failure resulting from a surgically treated duodenal (small intestine) perforation. He was 57 years old. We offer our condolences to Mr Fodor's family and friends.
5. The Ombudsman's office attempted to contact Mr Fodor's mother, via a telephone number provided by the Romanian Consulate. The number was not in service and no other contact details were available.
6. NHS England commissioned an independent clinical reviewer to review the clinical care Mr Fodor received at Bedford. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Fodor received at Bedford was of a reasonable standard and equivalent to that which he could expect to have received in the community.
7. The PPO investigator investigated the non-clinical issues relating to Mr Fodor's care. We did not find any non-clinical issues of concern.
8. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.
9. The inquest into Mr Fodor's death concluded on 24 September 2025, and returned a verdict of natural causes.

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

**October 2025**

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