

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Doughlin, a prisoner at HMP Ashfield, on 14 April 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

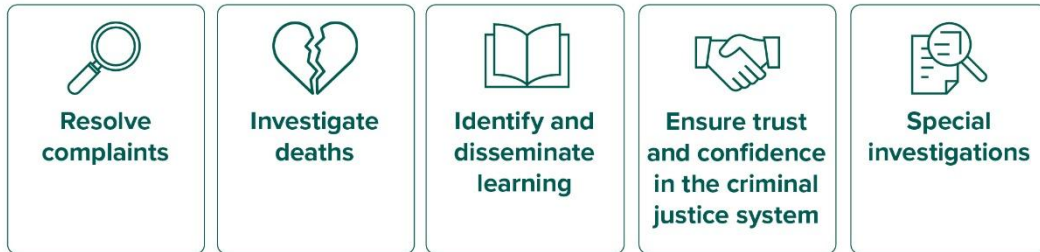
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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 October 2023, Mr Andrew Doughlin was remanded to HMP Bullingdon charged with sexual offences and assault. On 24 October, Mr Doughlin was sentenced to 24 years in prison.
4. On 30 October, Mr Doughlin was transferred to HMP Ashfield.
5. Mr Doughlin died in hospital of heart failure on 14 April 2025. He was 89 years old. We offer our condolences to Mr Doughlin's family and friends.
6. The Ombudsman's office contacted Mr Doughlin's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
7. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS (NHS England – South West) pointed out one factual inaccuracy in the clinical review which we have amended accordingly.
8. NHS England commissioned an independent clinical reviewer to review Mr Doughlin's clinical care at HMP Ashfield. The clinical reviewer's report is attached as Annex 1.
9. The clinical reviewer concluded that the clinical care Mr Doughlin received at Ashfield was of a good standard and equivalent to that which he could have expected to receive in the community. She found that the care extended to Mr Doughlin at Ashfield was compassionate and of a high clinical quality. The end-of-life care provided to him was responsive to his needs and was managed well. The clinical reviewer made three recommendations, not related to Mr Doughlin's death, that the Head of Healthcare and NHS commissioners will wish to address.
10. The PPO investigator investigated the non-clinical issues relating to Mr Doughlin's care. We did not find any non-clinical issues of concern.

Inquest

11. The inquest into Mr Doughlin's death concluded on the 27 February 2026. The coroner confirmed that Mr Doughlin died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

June 2026

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