

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Harrison, a prisoner at HMP Preston, on 24 July 2025**

**A report by the Prisons and Probation Ombudsman**

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

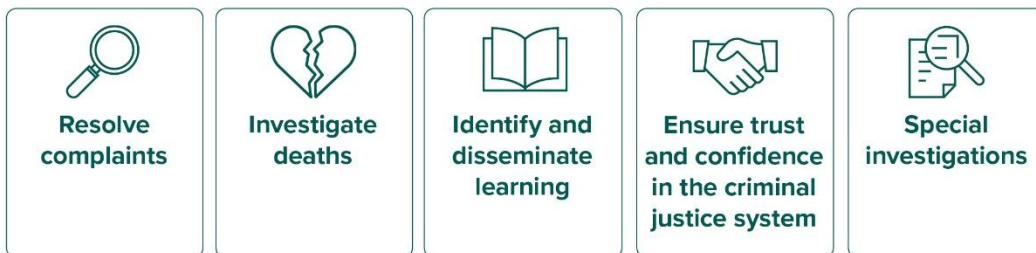
Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

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



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](https://nationalarchives.gov.uk/doc/open-government-licence/version/3)

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 26 June 2025, Mr David Harrison was remanded in prison, charged with sexual offences. He died in hospital of pancreatic cancer on 24 July, while a prisoner at HMP Preston. He was 60 years old. We offer our condolences to Mr Harrison's family and friends.
4. The Ombudsman's office wrote to Mr Harrison's partner to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
5. NHS England commissioned an independent clinical reviewer, to review Mr Harrison's clinical care at HMP Preston.
6. The clinical reviewer concluded that the clinical care Mr Harrison received at Preston was of a reasonable standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation not related to Mr Harrison's death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Harrison's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

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

**October 2025**

## **Inquest**

At the inquest, held on 25 June 2026, the Coroner concluded that Mr Harrison died from natural causes.

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100