

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

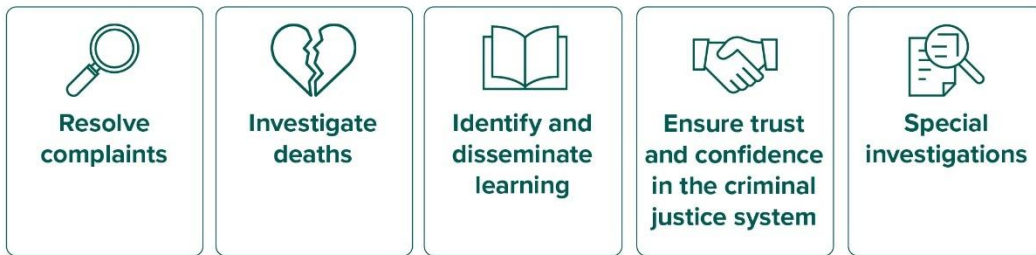
# **Independent investigation into the death of Mr David Ross, a prisoner at HMP Stafford, on 10 October 2025**

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

## 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. In October 2021, Mr David Ross was sentenced to 19 years imprisonment for sexual offences. He died of metastatic prostate cancer, congestive cardiac failure and ischaemic heart disease on 10 October 2025, at HMP Stafford. He was 82 years old. We offer our condolences to Mr Ross's family and friends.
4. The Ombudsman's office wrote to Mr Ross's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond to our letter.
5. NHS England commissioned an independent clinical reviewer to review Mr Ross's clinical care at HMP Stafford. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Ross received at Stafford was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Ross's medical records contained evidence of high quality palliative and end of life care. The clinical reviewer did not make any recommendations.
7. The PPO investigator and his colleague investigated the non-clinical issues relating to Mr Ross's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS) and healthcare. HMPPS and Practice Plus Group did not find any factual inaccuracies.
10. At the inquest held on 2 February 2026, the coroner concluded that Mr Dabid Ross died of natural causes.

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

**March 2026**

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