Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Venables, a prisoner at HMP Stoke Heath, on 16 December 2024

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

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 20 July 2022, Mr David Venables was sentenced to life imprisonment for murder. He died from pneumonia on 16 December 2024, while a prisoner at HMP Stoke Heath. He also had urothelial cancer (cancer of the lining of the urinary tract), obstructive uropathy (a condition which blocks the flow of urine) and diabetes mellitus which contributed to but did not cause his death. He was 92 years old. We offer our condolences to Mr Venables' family and friends.

4. The Ombudsman's office wrote to Mr Venables' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. NHS England commissioned an independent clinical reviewer, to review Mr Venables' clinical care at HMP Stoke Heath. The clinical review is attached as Annex 1.

6. The clinical reviewer concluded that the clinical care Mr Venables received at Stoke Heath was of a good standard and at least equivalent to that which he could have expected to receive in the community. She found good communication between healthcare staff, the Marie Curie palliative care team and staff at HMP Stafford.

7. The PPO investigator investigated the non-clinical issues relating to Mr Venables' care. We did not identify any non-clinical learning.

8. We make no recommendations.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

10. Mr Venables' next of kin received a copy of the draft report. They did not make any comments.

11. At an inquest held on 26 June 2025, the Coroner concluded that Mr Venables died of natural causes.

Adrian Usher **July 2025**
Prisons and Probation Ombudsman

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