Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Davies, a prisoner at HMP Moorland, on 28 February 2026

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. In October 2017, Mr Andrew Davies was sentenced to life imprisonment for sexual offences. He died of brain cancer on 28 February 2026, at HMP Moorland. He was 69 years old. We offer our condolences to Mr Davies' family and friends.

4. The Ombudsman's office wrote to Mr Davies' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

5. One prisoner contacted us and raised concerns about the care Mr Davies received at Moorland.

6. NHS England commissioned an independent clinical reviewer to review Mr Davies' clinical care at Moorland.

7. The clinical reviewer concluded that the clinical care Mr Davies received at Moorland was of a reasonable standard and was equivalent to that which he could have expected to receive in the community. She made four recommendations on issues unrelated to Mr Davies' death which the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Davies' care.

9. We did not find any non-clinical issues of concern. We make no recommendations.

10. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.

11. At the inquest, held on 8 April 2026, the Coroner concluded that Mr Davies died from natural causes.

Adrian Usher **July 2026**
Prisons and Probation Ombudsman

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