

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Billett, a prisoner at HMP Stafford, on 9 October 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



© 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

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 October 2023, Mr David Billett was sentenced to 20 years in prison for sexual offences. He died from respiratory arrest caused by chronic obstructive pulmonary disease on 9 October 2025, at HMP Stafford. He was 83 years old. We offer our condolences to Mr Billett's family and friends.
4. The Ombudsman's office wrote to Mr Billett's family 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 Billett'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 Billett 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 Billett had a complex medical history, and his various conditions were well managed by the nursing team at Stafford. The nursing care delivered was of a high standard, holistic and responsive to his changing needs. She made a recommendation that does not relate to Mr Billett's cause of death, which the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Billett's care. We did not find any non-clinical issues of concern.
8. The initial report was shared with HM Prison and Probation Service (HMPPS) and Practice Plus Group. They did not find any factual inaccuracies.
9. Mr Billett's family received a copy of the draft report. They did not make any comments.

Inquest

10. At the inquest held on 5 March 2026, the coroner concluded that Mr Billett died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

April 2026

**Prisons &
Probation**

Ombudsman
Independent Investigations

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

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

T | 020 7633 4100