

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Roy Darvill, a prisoner at HMP Isle of Wight, on 11 March 2023

A report by the Prisons and Probation Ombudsman

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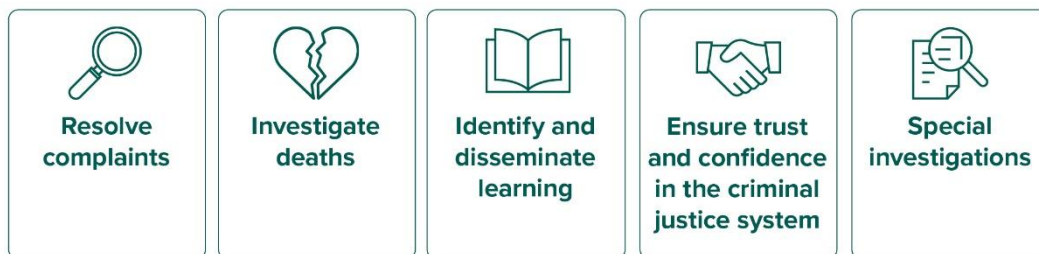
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OUR VISION

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



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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. Mr Roy Darvill died of pneumonia, caused by chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), on 11 March 2023, at HMP Isle of Wight. Heart disease and complications due to diabetes also contributed to Mr Darvill's death. He was 85 years old and had been frail and unwell for a long time. We offer our condolences to Mr Darvill's family and friends.
4. The PPO family liaison officer wrote to Mr Darvill's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Darvill's clinical care at the Isle of Wight. She concluded that the clinical care that Mr Darvill received at the Isle of Wight was of a good standard and was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation not related to Mr Darvill's death which the Head of Healthcare will wish to address.
6. The PPO investigator investigated the non-clinical issues relating to Mr Darvill's care. We did not find any non-clinical issues of concern. We make no recommendations.
7. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies.

Adrian Usher
Prisons and Probation Ombudsman

January 2024

Inquest

8. Mr Darvill's inquest ended on 23 October 2025 and concluded that he died of natural causes.



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