

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Stafford, a prisoner at HMP/YOI Hollesley Bay, on 25 September 2024

A report by the Prisons and Probation Ombudsman

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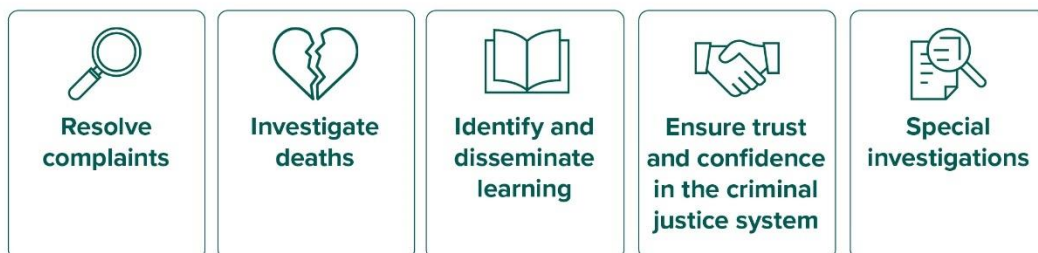
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OUR VISION

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. On 9 December 2010, Mr John Stafford received an indeterminate sentence for public protection for sexual offences and received a minimum tariff of four years and 245 days. He died from a brain haemorrhage on 25 September 2024, while a prisoner at HMP Hollesley Bay. He was 60 years old. We offer our condolences to Mr Stafford's family and friends.
4. The Ombudsman's office wrote to Mr Stafford's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Stafford's next of kin had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer to review Mr Stafford's clinical care at Hollesley Bay.
6. The clinical reviewer concluded that the clinical care Mr Stafford received at Hollesley Bay was of a good standard and equivalent to what he could have expected to receive in the community. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Stafford's care. We identified no significant non-clinical concerns.
8. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS), Practice Plus Group pointed a factual inaccuracy in the clinical reviewer's report, and this has been amended accordingly.
10. Mr Stafford's family received a copy of the initial report. They did not make any comments.
11. At the inquest held on 13 August 2025, the coroner concluded that Mr John Peter Stafford died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman

June 2025

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