Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Willis, a prisoner at HMP Standford Hill, on 28 June 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. In 1987, Mr David Willis was sentenced to life imprisonment for a violent offence. He died of respiratory failure caused by acute respiratory distress syndrome-like lung changes on 28 June 2024, at HMP Standford Hill. (ARDS happens when the lungs are not working properly due to fluid build-up and low oxygen levels.) Chronic obstructive pulmonary disease (COPD- *a lung disease)*, lung cancer and prostate cancer were listed as contributory factors. Mr Willis was 79 years old. We offer our condolences to Mr Willis' friends and family.

4. The Ombudsman's office wrote to Mr Willis' 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. NHS England commissioned an independent clinical reviewer to review Mr Willis' clinical care at HMP Standford Hill.

6. The clinical reviewer concluded that the clinical care Mr Willis received at Standford Hill was equivalent to that which he could have expected to receive in the community. She found that Mr Willis received compassionate, consistent and timely care, managed effectively with care plans. She also noted that there was good communication between healthcare and prison staff. She found areas of good practice as he had access to a named nurse for chronic/life limiting illnesses who had a constant presence throughout his care at Standford Hill. The clinical reviewer made two recommendations that did not impact on her assessment of equivalence, that the Head of Healthcare will wish to address.

7. The PPO investigator investigated the non-clinical issues relating to Mr Willis' care. We did not identify any significant non-clinical learning related to Mr Willis' death and we make no recommendations.

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

Good Practice

9. The compassion demonstrated by both prison and healthcare staff in looking after Mr Willis was commendable. He had a named nurse who was involved in holistically planning his care and he was actively involved in decisions affecting this. The prison arranged taxis to take him to medical appointments (rather than him using public transport), he was moved to a single room and provided with a radio so he could summon help if needed. Officers made considerable efforts during the

emergency response, which also included support from prisoners. Several staff attended his memorial service indicating how well they had got to know him.

10. At the inquest held on 24 April 2025, the Coroner concluded that Mr Willis died of natural causes.

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

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