Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Crowther, a prisoner at HMP Leeds, on 11 March 2025

A report by the Prisons and Probation Ombudsman

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

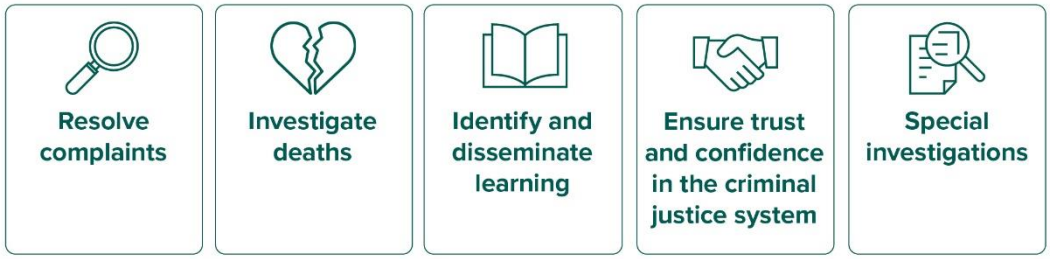
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 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

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 14 January 2025, Mr David Crowther was remanded to HMP Leeds for indecent assault. He died from sepsis of an unknown cause on 31 January 2025, while a prisoner at Leeds. He was 83 years old. We offer our condolences to Mr Crowther's family and friends.

4. NHS England commissioned, an independent clinical reviewer, to review Mr Crowther's clinical care at Leeds.

5. The clinical reviewer concluded that the clinical care Mr Crowther received at Leeds was of a good standard and was at least equivalent to that which he could have expected to receive in the community. She found that the emergency response to Mr Crowther's deteriorating health was timely. The clinical reviewer made two recommendations which were not related to Mr Crowther's death but which the Head of Healthcare will want to address.

6. The PPO investigator investigated the non-clinical issues relating to Mr Crowther's care.

7. We did not identify any non-clinical issues of concern 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.

9. At an inquest held on 20 February 2025, the Coroner concluded that Mr Crowther died of natural causes.

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

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