Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clifford Ashton, a prisoner at HMP Rye Hill, on 26 June 2024

A report by the Prisons and Probation Ombudsman

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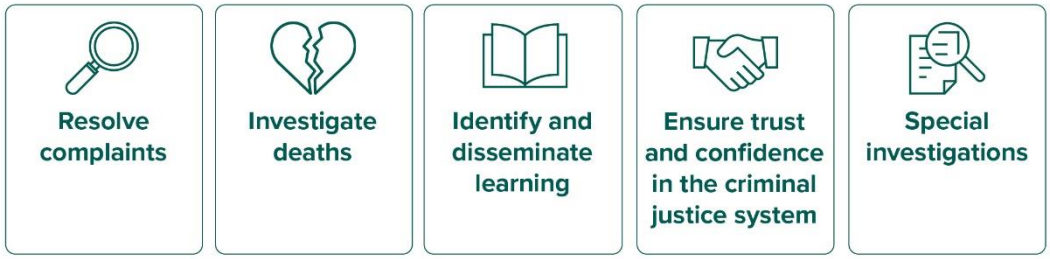
OUR VISION

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. On 5 March 2013, Mr Clifford Ashton was convicted of rape and sentenced to 17 years in prison.

4. Mr Ashton died of metastatic pancreatic cancer, with diabetes and heart failure contributing to but not causing his death, on 26 June 2024 at HMP Rye Hill. He was 54 years old. We offer our condolences to Mr Ashton's family and friends.

5. The Ombudsman's office wrote to Mr Ashton's son to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

6. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

7. NHS England commissioned an independent clinical reviewer to review Mr Ashton's clinical care at HMP Rye Hill.

8. The clinical reviewer concluded that the clinical care Mr Ashton received at Rye Hill was of a good standard and equivalent to that which he could have expected to receive in the community. She made two recommendations not related to Mr Ashton's death that the Head of Healthcare will wish to address.

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

10. We did not find any non-clinical issues of concern. We make no recommendations.

Inquest

11. The inquest into Mr Ashton's death concluded on the 11 November 2024. The coroner confirmed that Mr Ashton died of natural causes.

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

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