

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Hinchliffe, a prisoner at HMP Ashfield, on 5 October 2024

A report by the Prisons and Probation Ombudsman

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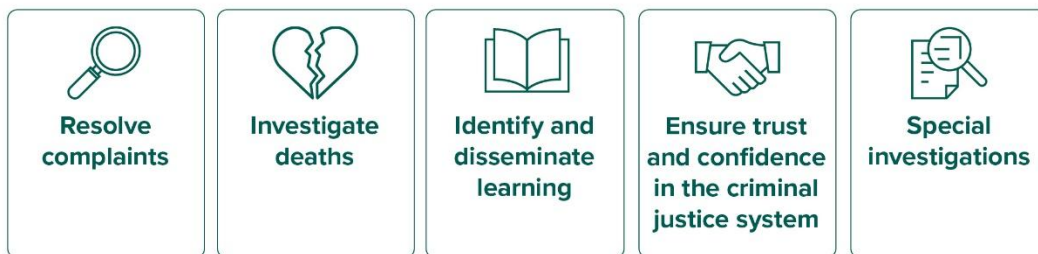
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OUR VISION

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. Mr Edward Hinchliffe was recalled to prison on 5 September 2020. He was later sentenced to five and a half years imprisonment for sexual offences and causing death by dangerous driving. Mr Hinchliffe died in hospital on 5 October 2024, while a prisoner at HMP Ashfield. He was 78 years old. The cause of his death was neutropenic sepsis (a type of sepsis with abnormally low white blood cells) caused by diffuse large B cell lymphoma (blood cancer). He also had underlying cirrhosis, heart disease, heart failure and diabetes, which contributed to his death. We offer our condolences to Mr Hinchliffe's family and friends.
4. The Ombudsman's office wrote to Mr Hinchliffe's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.
5. NHS England commissioned an independent clinical reviewer, to review Mr Hinchliffe's clinical care at Ashfield. The clinical reviewer's report is attached as Annex 1. The clinical reviewer concluded that the clinical care Mr Hinchliffe received at Ashfield was of a good standard and equivalent to that which he could have expected to receive in the community. She made recommendations not related to Mr Hinchliffe's death that the Head of Healthcare will wish to address.
6. The PPO investigator investigated the non-clinical issues relating to Mr Hinchliffe's care. Mr Hinchliffe was granted temporary release on a special purpose licence while he was in hospital. Prison managers discussed the possibility of early release on compassionate grounds. They intended to consider it further after he was discharged from hospital and there was an indication of his life expectancy.
7. We make no recommendations.
8. Mr Hinchliffe's next of kin received a copy of the initial report. He did not report any factual inaccuracies.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

Director to note

10. Mr Hinchliffe transferred to hospital in the early hours of the morning and was restrained by single handcuffs for the journey and for a short while after he was admitted. Healthcare staff were not on duty and could not therefore provide medical input into the restraints risk assessment. However, Mr Hinchliffe was clearly frail,

with reduced mobility and in poor condition. The Director will want to consider the learning from this case.

Inquest

11. At an inquest held on 23 February 2026, the coroner concluded that Mr Hinchliffe died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

December 2025

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