



# **Independent investigation into the death of Mr Edgar Fairhurst, a prisoner at HMP Gartree, on 11 January 2025**

**A report by the Prisons and Probation Ombudsman**

## 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



**OGL**

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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 23 June 2016, Mr Edgar Fairhurst was sentenced to life imprisonment for murder. He died of pneumonia on 11 January 2025, at HMP Gartree. He was 83 years old. We offer our condolences to Mr Fairhurst's family and friends.
4. The Ombudsman's office wrote to Mr Fairhurst'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 Fairhurst's clinical care at HMP Gartree. The clinical reviewer's report is attached as Annex 1.
6. The clinical reviewer concluded that the clinical care Mr Fairhurst received at Gartree was of a good standard and was at least equivalent to what he could have expected to receive in the community. She found that Mr Fairhurst's medical records contained evidence of excellent individualised end of life care planning. The clinical reviewer made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Fairhurst's care. We found non-clinical issues of concern.
8. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS) and the healthcare provider, Practice Plus Group. No factual inaccuracies were identified.
10. At the inquest held on 23 January 2025, the coroner concluded that Mr Edgar Fairhurst died of natural causes.

**Adrian Usher  
Prisons and Probation Ombudsman**

**July 2025**



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