Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edwin Withers, a prisoner at HMP Holme House, on 21 August 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

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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 June 2025, Mr Edwin Withers was remanded in prison for sexual offences and remained unsentenced at the time of his death. He died in hospital of pneumonia on 21 August, while a prisoner at HMP Holme House. Chronic obstructive pulmonary disease (COPD – a lung condition), hypertension (high blood pressure) and a stroke (when the blood supply to part of the brain is restricted) did not cause but contributed to his death. He was 73 years old. We offer our condolences to those who knew Mr Withers.

4. NHS England commissioned an independent clinical reviewer, to review Mr Withers' clinical care at Holme House.

5. The clinical reviewer concluded that the clinical care Mr Withers received at Holme House was of a reasonable standard and equivalent to that which he could have expected to receive in the community. He found that healthcare staff put care plans in place to meet his needs and managed signs of deterioration effectively. He also noted that Mr Withers was appropriately located in the in-patient unit within Holme House and later transferred to hospital for treatment. The clinical reviewer made two recommendations not related to the cause of Mr Withers' death which the Head of Healthcare will wish to address.

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

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

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

Adrian Usher
Prisons and Probation Ombudsman **May 2026**

Inquest

9. At the inquest held on 23 September 2025, the Coroner concluded that Mr Withers died from natural causes.

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