

**Prisons &  
Probation**

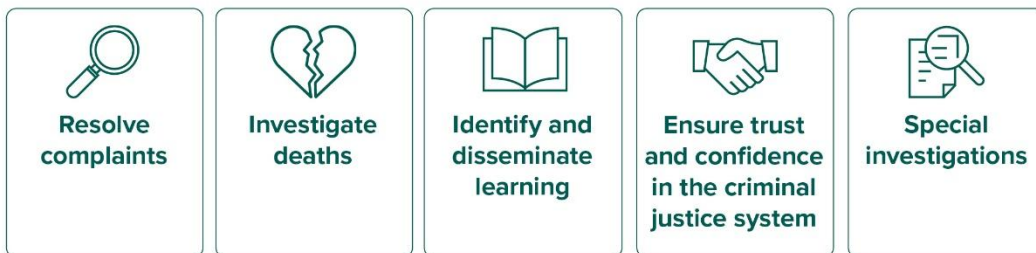
**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Duncan  
Abrams, a prisoner at HMP  
Hewell, on 4 September 2025**

## 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. In July 2025, Mr Duncan Abrams was remanded to prison and taken to HMP Hewell for allegedly breaching his Sexual Harm Prevention Order. He died of adenocarcinoma of the rectum with metastases to liver and lungs (cancer that started in the rectum and spread to the liver and lungs) on 4 September, in a hospice. He was 66 years old. We offer our condolences to Mr Abrams' family and friends.
4. The Ombudsman's office wrote to Mr Abrams' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.
5. NHS England commissioned an independent clinical reviewer to review Mr Abrams clinical care at HMP Hewell.
6. The clinical reviewer concluded that the clinical care Mr Abrams received at Hewell was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer made a recommendation not related to Mr Abrams' death that the Head of Healthcare will wish to address.
7. The PPO investigator investigated the non-clinical issues relating to Mr Abrams care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

**March 2026**

## **Inquest**

The inquest hearing was held on 29 April 2026. The Coroner concluded that Mr Abrams died of natural causes.

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

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100