

**Prisons &  
Probation**

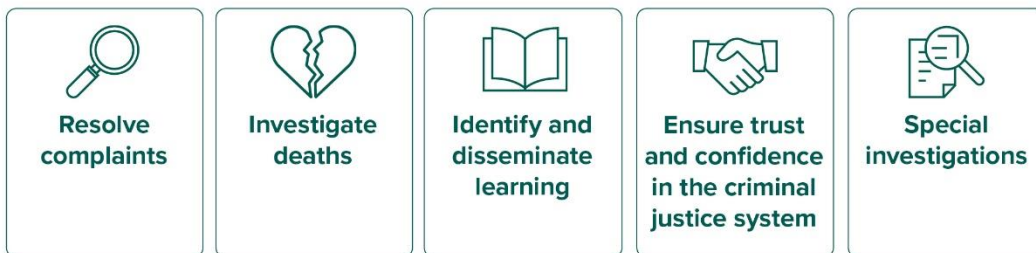
**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Mr Glyn Thomas,  
a prisoner at HMP Holme House,  
on 23 November 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 October 2017, Mr Glyn Thomas was sentenced to 19 years imprisonment for sexual offences. He died of pneumonia on 23 November 2025, at HMP Holme House. He was 76 years old. We offer our condolences to Mr Thomas's family and friends.
4. The Ombudsman's office wrote to Mr Thomas's 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 Thomas's clinical care at HMP Holme House.
6. The clinical reviewer concluded that the clinical care Mr Thomas received at Holme House was of a good standard and equivalent to that which he could have expected to receive in the community. She made no recommendations.
7. The PPO investigator investigated the non-clinical issues relating to Mr Thomas's care.
8. We did not find any non-clinical issues of concern. We make no recommendations.
9. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum Community Health CIC. They found no factual inaccuracies.
10. At the inquest, held on 9 December 2025, the Coroner concluded that Mr Thomas died from natural causes.

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

**April 2026**

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