

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Rowley, on 25 February 2026, following his release from HMP Holme House

A report by the Prisons and Probation Ombudsman

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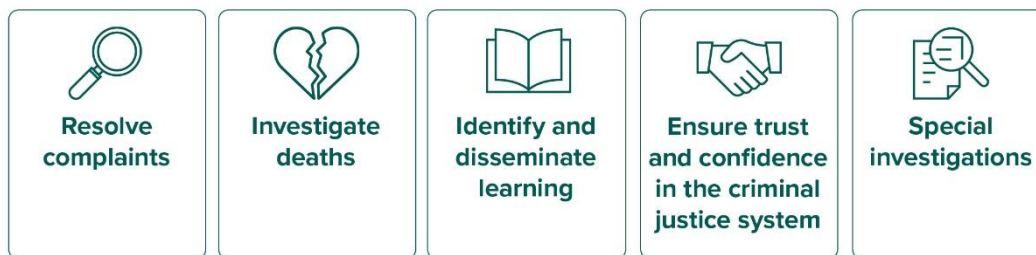
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OUR VISION

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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Summary

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. Since 6 September 2021, the PPO has investigated post-release deaths that occur within 14 days of the person's release from prison.
3. 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.
4. Mr Aaron Rowley died in hospital from brain damage on 25 February 2026, three days after he had been found hanging. He had been released from HMP Holme House on 16 February. He was 36 years old. We offer our condolences to those who knew him.
5. Mr Rowley had been at Holme House since 12 February, following his recall. He gave no indication that he was having thoughts of suicide or self-harm during his four days there.
6. Mr Rowley was released unexpectedly on 16 February. As a result, staff had very little time for pre-release planning. We are satisfied they did what could reasonably have been expected of them to identify and manage Mr Rowley's needs on release.
7. We make no recommendations.

The Investigation Process

8. HMPPS notified us of Mr Rowley's death on 27 February 2026.
9. The PPO investigator obtained copies of relevant extracts from Mr Rowley's prison and probation records and met with Mr Rowley's community offender manager (COM).
10. We informed HM Coroner for Teesside of the investigation. He gave us Mr Rowley's provisional cause of death. We have sent the coroner a copy of this report.
11. The Ombudsman's office contacted Mr Rowley's next of kin to explain the investigation and to ask they had any matters they wanted us to consider. They did not respond.
12. We shared our initial report with HMPPS. They pointed out an inconsistency with Mr Rowley's date of death which has been corrected in this report.

Background Information

HMP Holme House

13. HMP Holme House is a men's local prison, operated by HMPPS. Spectrum Community Health CIC is the main provider of healthcare services. Humankind provides substance misuse psychosocial services.

Probation Service

14. The Probation Service works with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, prepare reports to advise the Parole Board and have links with local partnerships to which they refer people for resettlement services, where appropriate. Post-release, the Probation Service supervises people throughout their licence period and post-sentence supervision.

Deaths following release from prison

15. Between September 2021 and the end of March 2026, the PPO started investigations into approximately 300 deaths of people who died within 14 days of release from prison. The PPO has published two learning lessons bulletins about post-release deaths, most recently in July 2024. Our investigations highlight the acute vulnerability of prison leavers, especially during the first few days post-release, and indicate that prison leavers often have multiple risk factors such as mental health and substance use issues and homelessness which further increase their vulnerability and risk of death following release from prison.

Previous deaths following release from HMP Holme House

16. We have investigated the deaths of nine men (including Mr Rowley) who died within 14 days of release from Holme House between February 2023 and February 2026. Two of those deaths (including Mr Rowley's) were self-inflicted, five were drug related and one was from accidental causes. Up to the end of July 2026, we have started three further investigations.

Key Events

Background

17. In March 2025, Mr Aaron Rowley was remanded in prison, charged with possessing a bladed article, assaulting an emergency worker, possession of drugs and other offences. On 2 October, he was sentenced to 36 weeks imprisonment.
18. Mr Rowley was released on licence on 2 October (due to time already served on remand). On 14 December, he was arrested on suspicion of causing grievous bodily harm and possession of cocaine. The assault case was discontinued but Mr Rowley was charged with possessing a Class A drug.
19. On 15 December, Mr Rowley's community offender manager (COM) applied for Mr Rowley to be recalled to prison for breaching his licence conditions. The recall was authorised the next day and the police notified. However, Mr Rowley was not arrested until 12 February 2026. He was sent to HMP Holme House.
20. At his initial health screening Mr Rowley told the nurse he had a history of anxiety and depression but did not have any thoughts of suicide or self-harm. He said he had not self-harmed in the previous 12 months, had not been prescribed medication for any mental health issues, and he was not taking any prescribed medication. He refused to be referred to the mental health team.
21. Mr Rowley also told the nurse he had a history of using cocaine. He did not provide a urine sample for drug testing as he said he could not give one at the time. The nurse referred him to the substance misuse service (SMS).
22. On 13 February, an SMS worker met with Mr Rowley. He told her his substance use had had a significant impact on his life, and he recognised the need for change. He expressed a desire to reduce his drug use and appeared motivated to make positive changes. Mr Rowley said he was well and he engaged well. The SMS worker gave him harm reduction advice about the dangers of reduced drug tolerance in custody, and the dangers of taking illicit or non-prescribed medication. Mr Rowley said his mental health was okay and he did not express any thoughts, intentions, or plans relating to suicide or self-harm, and there was no indication of risk.
23. On 15 February, a nurse completed a secondary health screening with Mr Rowley. He told the nurse he had cuts on his legs caused in a fight some weeks earlier. The nurse treated his wounds.
24. On 16 February, at about 8.50pm, Mr Rowley was unexpectedly released from custody because he had completed his sentence (given the time he had previously served on remand in 2025).

Pre-release planning

25. The investigation recognises that because of Mr Rowley's unexpected immediate release from prison on 16 February, there was a very limited opportunity for prison or probation staff to plan for his release.

26. On 13 February, Mr Rowley completed a Basic Custody Screening. He engaged throughout the screening process.
27. On 16 February, Holme House contacted Mr Rowley's COM and alerted her to Mr Rowley's imminent release. They asked the COM to provide them with details for Mr Rowley to report to the Probation Service on release. The COM provided Mr Rowley's release licence to which she added further conditions for Mr Rowley to undergo drug testing and engage with drug support services. The COM was not at work but arranged for a duty probation officer to see Mr Rowley if he was released in time, and if not, Mr Rowley was told to report to the probation offices on the morning of 17 February to meet the COM.
28. Before his release from Holme House, a nurse saw Mr Rowley. They gave Mr Rowley a release pack containing harm reduction advice focused on overdose risks and reduced tolerance levels associated with illicit substance use and information on the risks of poly-drug use and the dangers of mixing substances. Mr Rowley declined a community appointment for support but was told he could present for support at any time in the community if required. There is no record that Mr Rowley expressed any thoughts of suicide or self-harm.
29. Mr Rowley was released from Holme House in the evening of 16 February.

Post-release management/release from HMP Holme House

30. After his release, Mr Rowley stayed at the home of a friend.
31. On 17 February, Mr Rowley called his COM. He told her he was released from Holme House the previous night at about 9.00pm and he could not attend his probation appointment with her as his mother was unable to bring him because her car was not working and he had no money to travel another way. The COM told Mr Rowley to try to borrow the money to get to her office, and she would reimburse him. She told him to attend her office the following day, on 18 February at 1.30pm
32. On 18 February, Mr Rowley did not attend his appointment at the probation office. The COM called him. She thought his speech sounded slurred and incoherent. He denied being under the influence of any substance. He told her he had borrowed money to travel to her office but gave it to a friend. As his friend's bank account was overdrawn, he could not withdraw the money to give it back to Mr Rowley. The COM told Mr Rowley she would speak with a supervisor as he had not been seen within the specified timescale.
33. The COM discussed Mr Rowley with a manager because he had failed to attend his appointments and appeared under the influence of a substance during her call to him. They agreed that as there was no evidence of immediate risk to another and Mr Rowley was contactable, a warning would be issued, and a next appointment will be given, with a phone call in between to check on his welfare and encourage him to refrain from substance misuse and engage with services. A drug test would be completed at his next appointment.
34. On 19 February, the COM arranged to send Mr Rowley a travel pass so that he could attend an appointment with her on 26 February. This delay was to ensure that Mr Rowley received the means to travel to his appointment as there had been

postal delays. She called Mr Rowley to tell him and reminded him of his licence conditions.

Circumstances of Mr Rowley's death

35. On 22 February, an ambulance was called to Mr Rowley's friend's home after Mr Rowley had hanged himself from a fence. Mr Rowley was taken to hospital, where tests revealed he had suffered brain damage following a cardiac arrest. He died in hospital on 25 February.
36. The Coroner gave the provisional cause of death as diffuse hypoxic ischaemic brain damage (brain damage caused by lack of blood flow to the brain) with substance misuse as a contributory factor. (The results of toxicology tests are still awaited.)

Findings

37. There is no evidence that Mr Rowley expressed any thoughts of suicide or self-harm during his time at Holme House and no evidence that he expressed any intentions to take his own life following release.
38. Given the short period of time Mr Rowley spent in prison and the circumstances of his unexpected release, we found no issues with Mr Rowley's pre-release planning or post-release supervision.
39. We make no recommendations.
40. At the inquest, held on 8 September 2026, the Coroner concluded that Mr Rowley died by suicide.

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Prisons and Probation Ombudsman

September 2026



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