

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew White, on 8 March 2026, following his release from HMP Holme House

A report by the Prisons and Probation Ombudsman

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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 Andrew White died from the toxic effects of heroin and alcohol on 8 March 2026, three days after his release from HMP Holme House. He was 45 years old. We offer our condolences to those who knew him.
5. Mr White had a history of drug use, including heroin (an opiate), yet he was not offered naloxone (a medicine that can rapidly reverse the effects of an opioid overdose) prior to his release. The prison's current policy is to offer naloxone only to prisoners who have been receiving support from the prison's substance misuse team and as Mr White was not receiving support, he was not eligible for naloxone. We consider the criteria should be widened to cover all prisoners with a history of opiate use.

Recommendations

- The Head of Healthcare should work in partnership with the regional Health and Justice Leads and regional drug providers to satisfy themselves that the local policy on the offer and issue of naloxone on release captures prison leavers with previous opiate use and other relevant risk factors.

The Investigation Process

6. HMPPS notified us of Mr White's death on 10 March 2026.
7. The PPO investigator obtained copies of relevant extracts from Mr White's prison and probation records.
8. We informed HM Coroner for Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. The Ombudsman's office contacted Mr White's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.
10. We shared our initial report with HMPPS and the prison's healthcare provider, Spectrum CIC. They found no factual inaccuracies. Spectrum CIC provided an action plan which is annexed to this report.

Background Information

HMP Holme House

11. HMP Holme House is a category C men's training and resettlement prison. Spectrum Community Health CIC provides physical healthcare services and Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services. Spectrum Community Health CIC and Humankind provide substance misuse treatment.

Probation Service

12. 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

13. 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

14. We have investigated the deaths of nine men, including Mr White, who died within 14 days of release from Holme House between March 2023 and March 2026. Two of the deaths were self-inflicted, five were drug related, and one was from accidental causes. Up to the end of June 2026, we have started two further investigations, both drug related. In a previous investigation in 2023, we identified that a prisoner with a history of opiate use was not offered naloxone prior to release and subsequently died following opiate use in the community. We did not make a recommendation in relation to the provision of naloxone at that time.

Key Events

Background

15. On 14 January 2026, Mr Andrew White was sentenced to 18 weeks in prison for driving offences and was sent to HMP Holme House.
16. During Mr White's reception screening, he told the nurse that he had a history of crack cocaine use in the community. The nurse completed a urine drug test, which was positive for benzodiazepines and cocaine. Staff started withdrawal monitoring, but Mr White asked to stop it the next day because he felt well and did not think he needed it.

Pre-release planning

Drug use

17. On 27 January, Mr White's community offender manager (COM) emailed Holme House to ask for an update on Mr White's engagement with drug services in prison. She said he had a longstanding addiction to drugs in the community and would be subject to additional licence conditions on release, including drug testing and engagement with substance misuse services (SMS).
18. The same day, Mr White's key worker asked about his involvement with the prison's drug and alcohol recovery team (DART). Mr White said DART had not seen him. The key worker said they would contact DART and arrange an appointment for follow-up and support.
19. On 2 February, a DART worker saw Mr White. He told them that he would not use drugs while in prison and declined to engage with the service because he did not have a treatment need. The DART worker provided harm minimisation advice and told him to submit an application through the digital kiosk if he changed his mind. DART then discharged him from the service.

Housing

20. On 26 January, Mr White's COM applied for his release on home detention curfew (HDC). Mr White's prison offender manager (POM) had applied for housing through the Community Accommodation Service Tier 2 (CAS2, short term accommodation provided by Nacro to those who are otherwise homeless, for the period of HDC). If successful, the CAS2 application would have enabled his release on HDC. Although the application was submitted, there was no accommodation confirmed before Mr White's release.
21. On 2 March, the pre-release team at Holme House referred Mr White to the local council for social housing under the Duty to Refer (requires probation staff to refer individuals who are homeless or at risk of homelessness to a local housing authority).

22. On 5 March, a Commissioned Rehabilitative Services (CRS) accommodation support worker emailed Mr White's COM to confirm risk information ahead of working with him. They agreed that the COM would contact the support worker after their initial appointment with Mr White following his release and would provide further details on his housing requirements.

Release from HMP Holme House

23. On 5 March, Mr White was released from Holme House. He was homeless on release but intended to stay with friends and family.
24. At 2.00pm, Mr White attended his initial probation appointment. His COM talked through his licence conditions, including additional conditions of drug testing and engaging with community substance misuse services. Mr White told his COM that he wanted support with drug and alcohol use now he was released.
25. Mr White said that he planned to stay with friends while awaiting housing and intended to attend the job centre the next day to apply for universal credit. His COM told him his next appointment was 11 March at 3.30pm and that he would be drug tested at that appointment.

Circumstances of Mr White's death

26. On 8 March, Mr White was at a friend's house.
27. At around 7.10pm, his friend found him unconscious and could not find a pulse. His friend started CPR and called for an ambulance.
28. When paramedics arrived, Mr White was in cardiac arrest. They took over CPR and took him to hospital.
29. Despite their efforts, hospital staff were unable to regain a pulse. At 8.38pm, they pronounced life extinct.

Post-mortem report

30. The post-mortem report concluded that Mr White died from cardiorespiratory failure, caused by the central nervous system depressant effects of morphine (heroin) and alcohol.
31. Toxicology results showed that Mr White had taken a large, potentially fatal dose of heroin before his death, together with a significant amount of alcohol. The alcohol may have increased the risk of fatal respiratory depression.

Findings

Housing

32. The COM and resettlement team at Holme House made appropriate housing referrals for Mr White. However, due to the volume of applications received by the local authority, his housing application had not been processed before his release. Mr White said that he intended to stay with friends while awaiting accommodation. We are satisfied that he received appropriate support in relation to his housing needs.

Substance misuse support

33. Mr White was not offered naloxone (a medication that can rapidly reverse opioid overdose) prior to his release. The prison's substance misuse service told us that their local policy was to offer naloxone only to prisoners who were engaging with the service. As Mr White had declined support, he was not offered naloxone. We consider that Mr White would have been a suitable candidate for naloxone on release given his history of opiate use. We are concerned that the provision of naloxone to prison leavers with a history of drug use is inconsistent across the prison estate and should be routinely offered to all prisoners with a history of opiate use. We recommend:

The Head of Healthcare should work in partnership with the regional Health and Justice Leads and regional drug providers to satisfy themselves that the local policy on the offer and issue of naloxone on release captures prison leavers with previous opiate use and other relevant risk factors.

Inquest

34. At the inquest, held on 20 August 2026, the Coroner concluded that Mr White's death was alcohol and drug related.

Adrian Usher
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September 2026



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